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Contents

September 2019

News

Comment

Professional lives

Page 20 **Achieving the right focus: management information will play a key role in delivering the long-term plan's mental health service promises**

Features

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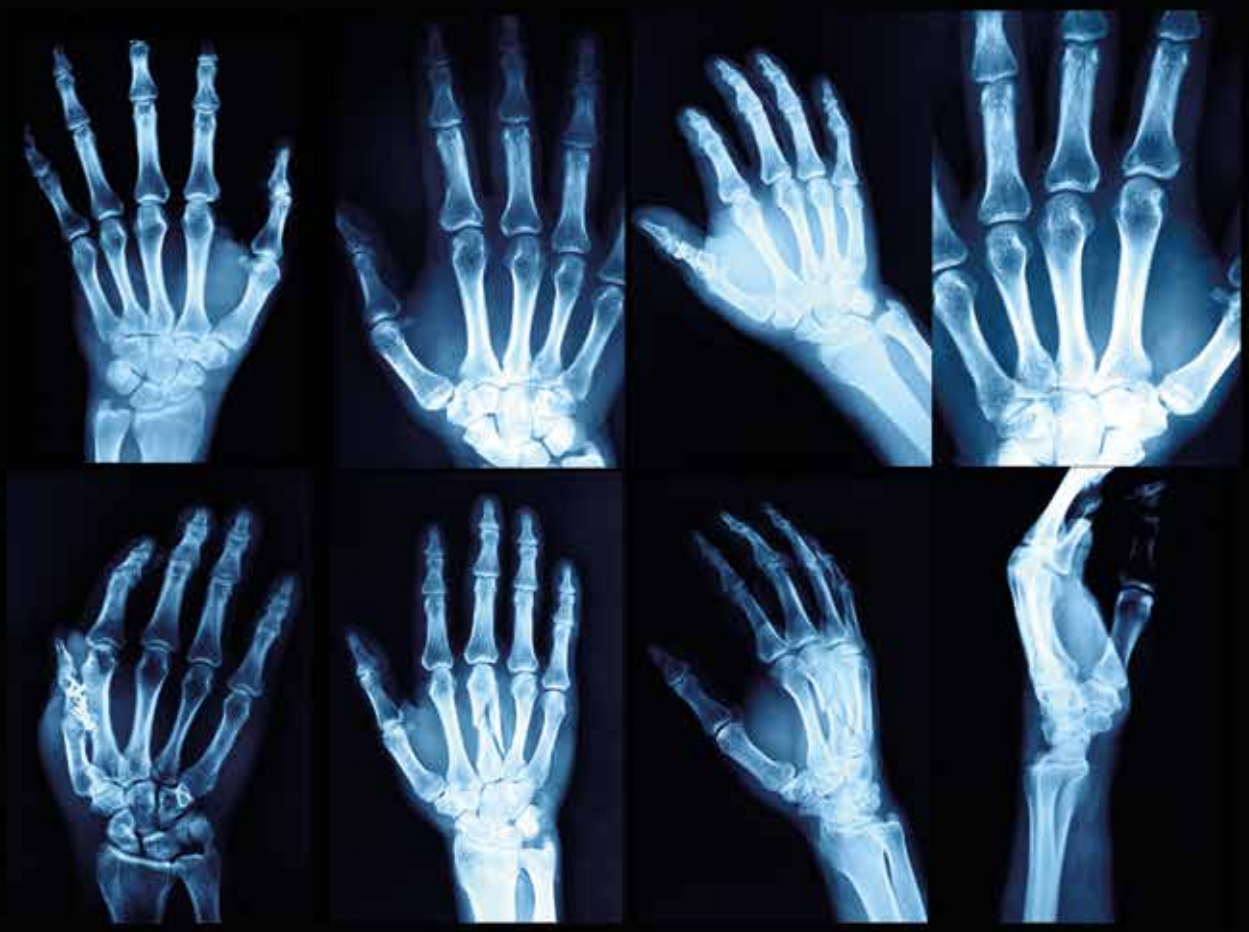

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News

Capital constraints pose risk to safety and transformation

By Seamus Ward

Eight in 10 trust leaders in England believe the current restrictions on capital funding are putting patients at risk and could undermine plans to transform the health service, according to NHS Providers.

In a survey, 82% of chief executives and chief finance officers said the limited availability of capital was posing a medium or high risk to patient safety. Almost all of those surveyed (97%) said capital constraints were hampering the delivery of transformed services, as set out in the *NHS long-term plan*. The survey received 200 responses from 143 trusts.

NHS Providers called on the government to address the issue of capital funding in the forthcoming spending round.

The NHS had been waiting for the outcome of the spending review to receive news on capital funding over the next five years. However, with the uncertainty over Brexit, the Treasury decided to limit the review to a single year – 2020/21 – with a multi-year review to take place in 2020.

Chancellor Sajid Javid was due to announce the results of the one-year spending round on 4 September, but as *Healthcare Finance* went to press, it was unclear what would be announced.

The Treasury said the spending round would deliver on the prime minister's priorities, including health. But it added that Mr Javid's announcement would focus on revenue spending – capital budgets are already in place for 2020/21, it said.

However, the government has already revised capital funding since Boris Johnson took power in July. In one of his first policy announcements, the prime minister pledged £1.85bn in capital for the NHS – £1bn was allocated as a one-off capital boost for 2019/20, with the remaining £850m to be spent on 20 capital projects.

NHS Providers insisted this funding could only be considered a first downpayment on the funding required. It called on the government to set out a multi-year capital settlement; commit to bringing NHS capital budgets up to levels in comparable countries; and establish an efficient, effective mechanism for prioritising, accessing and spending NHS capital based on need.

Next year, 2020/21, is the final year of the 2015 spending review period and figures for the final year are often revised in a new spending review. According to the last Budget, the overall capital available to health (the capital departmental expenditure limit) in 2020/21 – before the recent boost in funding – was due to be £6.8bn.

HFMA members are not only concerned about the overall limit on capital spending, but also about the availability of capital funding. Not all bodies have internally generated resources to fund capital projects or the freedom to use them. Many also point at the complexity of the system for managing capital, which often involves bidding for separate pots of funding.

"Government support needs to be translated into urgent action because the risk to patients is rising every day"
Chris Hopson, NHS Providers

In its 2018 briefing, *NHS capital – a system in distress*, the HFMA called for a simplification of the system that allows NHS organisations access to capital and for the process to be made more transparent.

NHS Providers chief executive Chris Hopson said a capital funding settlement was needed to rebuild the NHS. He highlighted the impact of capital constraints, citing the A&E department at Kettering General Hospital NHS Foundation Trust, which was seeing three times more patients than its intended capacity. This was compromising care, NHS Providers said.

Mr Hopson added: 'We know the government shares our aim of a properly funded, well-designed system of capital funding, but this support needs to be translated into urgent action because the risk to patients is rising every day.'

• *See technical news, page 23*

Oversight framework moves to greater system focus

NHS England and NHS Improvement have released details of a joint approach to overseeing organisational performance in 2019/20 ahead of introducing a new integrated approach from next year.

The NHS oversight framework replaces the separate provider single oversight framework and clinical commissioning group improvement and assessment framework. It will be used to identify support needs.

Although the existing statutory roles and responsibilities of NHS Improvement and NHS England in relation to providers and commissioners are unchanged, the framework will have a greater emphasis on system performance. Where possible, problems will be tackled by 'working with and through system leaders' with greater autonomy for systems with a track record of success.

Quarterly system review meetings will be at the heart of the new system, with a focus on a merged set of metrics from the previous assessment frameworks – though more regular engagement will be triggered where necessary.

Proposals for a new oversight framework for 2020 onwards will be worked on during the year, focusing on the balance between organisational and system oversight and how system maturity affects this.

Miriam Deakin (pictured), NHS Providers' director of policy and strategy, welcomed the moves as providers were concerned regulation was not keeping pace with developments.

'This framework should help to support collaboration,' she said. 'But much will depend on ways of working and the development of positive relationships, particularly between frontline organisations, system leaders and NHS England/NHS Improvement's new regional teams.'

• *See comment, page 10*

Report says five-year plans will make mental health funding more transparent

By Seamus Ward

Local systems will be required to show in their five-year plans how they intend to meet the NHS pledge to increase mental health funding at a faster rate than overall funding growth.

The *NHS long-term plan* announced a ring-fenced fund for mental healthcare of at least £2.3bn a year in real terms by 2023/24. It pledged that mental health funding will grow faster proportionately than the overall NHS budget, while children and young people's mental health funding will rise faster than both the overall funding and total mental health funding.

The implementation plan outlines the profile of funding for the next five years that will be invested in delivering both the mental health five-year forward view and the long-term plan. Funding for these programmes will rise from £481m in 2018/19 (baseline year) to just over £3bn in 2023/24.

Total funding for children and young people's mental health services will increase from the baseline of £289m in 2018/19 to £380m this year, rising steadily to £904m in 2023/24.

The funding will be delivered via two streams – clinical commissioning group baselines and a central transformation fund.

The implementation plan said financial transparency will ensure the investment pledges are met. Sustainability and transformation partnerships and integrated care systems must set out how the mental health investment standard will be achieved across their systems, demonstrating this through planned investment in CCG baselines. Systems will also plan for the use of the transformation funding to deliver the overall funding commitments.

Draft plans are due at the end of this month, with final versions completed by mid-November. The implementation plan also promises a review of the current approaches to payment, to develop a national payment mechanism for mental health services.

Mental health providers welcomed the implementation plan, but were concerned over timescales and workforce. Sean Duggan, chief executive of the NHS Confederation's Mental

HFMA offers support to improve NCC

The HFMA has highlighted issues that need to be addressed in the national cost collection (NCC) following feedback from costing practitioners.

This summer acute trusts took part in the first mandatory submission of patient-level cost data, using new costing standards and guidance. Following a survey of costing practitioners, the HFMA has written to NHS England and NHS Improvement director of pricing and costing Chris Walters to offer support to improve the process for next year.

Practitioners raised concerns in a number of areas, including the standards and guidance, the collection process and the impact on costing teams.

In some trusts, the burden of the NCC submission meant there was not sufficient time to use the patient-level cost data to support improvement work locally.

The letter underlines that the association and its Healthcare Costing for Value Institute remain strong advocates for robust patient-level cost data.

Budget balanced but NHS must retain finance focus

The NHS balanced its budget and the Department of Health and Social Care delivered a 2018/19 outturn within the Parliamentary vote, the Department's annual report and accounts states.

However, the report warned that the level of rigour needed to deliver this outturn would have to be maintained to support long-term financial sustainability.

The Department had underspent on its resource departmental expenditure limit (RDEL) – day-to-day spending and administration costs – by £646m, mostly due to an underspend in resource administration (£605m).

When an underspend in central capital budgets was taken into account, overall capital expenditure was £42m under budget at £5.94bn.

The report said the tighter financial controls on NHS bodies, introduced in 2016 to tackle financial problems, have been broadly successful. Provider finances had stabilised, with the majority 'demonstrating strong, effective and sustainable financial management'.

In 2018/19, early action was taken on potential overspends in providers and clinical commissioning groups, helping to deliver financial balance across the NHS for the third consecutive year.

Though CCGs reported a cumulative overspend of £150m, this was balanced by underspends in other parts of the sector, principally central NHS England budgets (£756m) and direct commissioning (£310m).

The NHS England annual report said that, overall, the commissioning sector delivered a £916m underspend.

The Department's permanent secretary Chris Wormald (pictured) said the health and care system had achieved financial balance due to the focus on financial rigour and efficiency. Most providers had met their control totals, which contributed to the Department achieving financial balance. He acknowledged 2018/19 had been a difficult year for the NHS, with the service failing to hit a range of targets.

The service continued to seek to strike the right balance between performance, quality and safety, transformation and living within its financial means, he said.

The report said the new financial framework would promote financial sustainability, but the level of rigour seen in 2018/19 'will need to continue in future years to support long-term financial sustainability'.

"With mental health services suffering from particularly high vacancy rates, we will need to see support from the centre"
Sean Duggan, NHS Confederation, pictured

Health Network, said: 'The timescales are tight for planning in the first year and we must be careful, too, about being too prescriptive.'

Local systems would seek to understand their workforce needs to deliver the mental health plan. System plans should include a delivery plan covering workforce as well as finance and activity. 'Workforce remains a worry,' Mr Duggan said. 'It is good news that local areas will be more involved in developing their workforce but, with mental health services suffering from particularly high vacancy rates, we will need to see support from the centre.

'Importantly, investment is needed in the wider health and care system – including in social care, capital, public health and supported housing – if the vision of the long-term plan is to be achieved.'

• *Achieving the right focus, page 20*

BMA calls for fund rise

Scotland's NHS budget should be raised to 10% of GDP and the government should foster a more supportive culture where the workforce is valued, according to the British Medical Association.

A BMA Scotland report on the local service called for urgent action to put the NHS on a sustainable footing, warning that morale among staff was at 'rock bottom'.

Secondary care matters: shaping the future of safe, sustainable hospital-based healthcare in Scotland set out a 20-point plan for ensuring hospitals can continue to provide comprehensive care. It said the government should aim to increase health spending to 10% of GDP – in 2017/18, this would have swelled the budget by £2.6bn.

It said a more supportive culture would include ending 'mutually incompatible goals', such as asking health boards to make 'stringent' efficiency savings while delivering unachievable targets.

BMA Scotland consultants committee chair Simon Barker said doing nothing meant ministers were choosing to reduce services, cutting staff numbers and the motivation of those who remained.

'The care provided in our hospitals suffers from a chronic lack of coherent planning, substantial underfunding that forces impossible prioritisation decisions on frontline clinicians, and undeliverable targets that seem to be driven by arbitrary lengths of time, rather than quality of care,' he said.

'For our hospitals and the people who depend on them, this simply has to change. If it doesn't, we can no longer expect hospitals to provide the kind of comprehensive care we have always relied on.'

Health leaders warn over social care spending

By Seamus Ward

Pressure is increasing on the new government to fulfil prime minister Boris Johnson's promise to address the problems facing social care.

As he entered Downing Street, Mr Johnson said he had a clear plan to 'fix the crisis in social care once and for all'. More than 150,000 people signed a petition asking the government to increase social care funding, suggesting a minimum increase of 3.9% a year. The petition called for access for everyone to the care they need. It said social care cuts had left 1.4 million people without access to the care they required.

The petition also called for a long-term plan for social care that includes a workforce strategy and support for a diverse and stable market of providers.

Petition organiser the NHS Confederation believes it is the largest of its kind. Separately, it has put together an alliance of 50 NHS leaders – Health for Care – to write to Mr Johnson.

Health for Care said cuts were having a knock-on effect on the NHS and this placed delivery of the *NHS long-term plan* in jeopardy. The Local Government Association said councils overspent on children's social care budgets by £770m in 2018/19 due to demand pressures and lack of funding.

The letter called for immediate funding increases in the upcoming one-year spending round. It also urged the prime minister to hold cross-party talks to deliver a more sustainable social care system that is backed by a long-term financial settlement. The new system should be reformed to widen eligibility criteria.

Confederation chief executive Niall Dickson said: 'The level of distress being experienced by hundreds of thousands of vulnerable people and their carers is now much greater and on a wider scale than at any time in living memory. This is a crisis and it has to be urgently addressed.

'We welcome the prime minister's early commitment to find a solution. As our petition shows, the public recognise the human cost of inaction and they want this resolved. Successive governments have failed to address this issue – the new government has a chance to put this right.'

Niall Dickson: 'This is a crisis'

News review

Seamus Ward assesses the past two months in healthcare finance

Summer brought a change in personnel at the top of government in Westminster, with Boris Johnson now prime minister, though Matt Hancock remained health secretary in the ruthless reshuffle that followed. But that did not mean all was quiet at the health department, as the new administration seemed to move into election mode, making announcements on capital funding and the NHS pension tax issue (see p10).

A general election could be the ultimate outcome of the Brexit debate, but leaving the European Union by 31 October and preparing for a no-deal exit are the government's prime focus. The Department of Health and Social Care is at the forefront of preparations and in August invited bids for a £25m contract to set up an express air freight service for urgent medicines and medical products post-Brexit. The contract allows for small parcels of urgent medicines or products to arrive within 24 hours. Larger pallet goods would arrive within two to four days.

Mr Johnson has famously called for a can-do spirit and positivity on Brexit, but at the beginning of the summer finance directors' outlook remained pessimistic despite the additional funding that is going into the NHS from April this year. According to the King's Fund's *Quarterly monitoring report,* 27% of trust finance leaders expect their trust to be in deficit at the end of this financial year. Most of them predict that the NHS will fail to achieve targets set out in the *NHS long-term plan*, including for the sector to be in balance in 2020/21 and the aim for deficits in NHS organisations to be eradicated by 2023/24.

Around half of the population believe it is difficult to get a GP appointment, while most (86%) say too many people use A&E departments unnecessarily, according to the latest *British Social Attitudes Survey*. While 17% prefer A&E to GPs because they can get tests done more quickly, the preference rises to 29% among people from the most deprived areas. And though 11% said they have no confidence in GPs, this rises to 18% in the most deprived areas and 20% among those with children under 5.

July saw the highest number of people seeking emergency and urgent care since records began, according to NHS Providers. It said the latest performance figures for England reflected sustained increases in demand, particularly from older and frail people. The NHS England figures showed attendances at A&E up by 4% on those in July 2018, while emergency admissions were 4.6% higher than a year earlier. The number of patients waiting to start elective treatment also increased – at the end of June there were 4.4 million people on the waiting list, also 4.6% more than in June 2018. NHS Providers said that, unlike previous years, trusts had not been able to use lower emergency demand in the summer months to clear waiting lists.

Many senior doctors are reportedly angry over potential pension tax bills, though they did receive some good news as consultants and dentists were handed a 2.5% pay rise, backdated to April. The Department of Health and Social Care said the award was worth between £1,940 and £2,630 for consultants. The value of clinical excellence awards is being frozen. Specialist doctors and associate specialists will in addition receive an extra 1% in 2020/21 conditional on contract form, through a multi-year deal. The deal follows the June announcement of a four-year deal for doctors and dentists in training, which guarantees an uplift of 2% a year.

The month in quotes

'This express freight service sends a clear message to the public that our plans should ensure supply of medical goods remains uninterrupted as we leave the EU.'
Health minister Chris Skidmore on the Department stepping up preparations for Brexit

'These figures show the health service is still struggling to climb out of the morass created by a decade of austerity. Year on year, the demands made on frontline services continue to grow, with attendances at A&E significantly higher than at this time last year. Our dedicated staff do all they can for patients, but they are being stretched to breaking point.'
The NHS is struggling to escape the effects of austerity, says Nick Ville, director of membership and policy at the NHS Confederation

'There is a clear need for the NHS to make a broader contribution to people's lives, leveraging its considerable resources to improve the economic and social conditions that so fundamentally affect our health.'
Dominique Allwood, Health Foundation assistant director of improvement, says the NHS must contribute to the wider determinants of health

'Despite the funding boost, unrelenting financial and operational pressures suggest patients are not going to see improvements in care for some time yet. Thanks to the hard work of staff, the NHS is treating more patients than ever. But without a concerted effort to address staff shortages and more investment, ambitions to improve patient care will remain more aspirational than realistic.'
King's Fund chief analyst Siva Anandaciva says its latest QMR offers a reality check

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The Department has invited bids for a £25m contract to set up an express air freight service for medical products post-Brexit

NHS Improvement claimed that the national staff retention programme has been a major step forward in supporting trusts to encourage staff to remain in the NHS. A review of the programme, which was launched two years ago, said it has given trusts the 'tools, knowledge and expertise' to develop staff retention initiatives. National nursing turnover has fallen from 12.5% to 11.9% and mental health clinical staff turnover has decreased from 14.3% to 13.4%, the report said.

NHS Improvement also published a flow chart setting out the process for filling a vacancy for admin and clerical or estates and facilities post or shift. Under new rules, from this month trusts will be required to use bank or substantive contracts to fill administration and estates shifts rather than using agency staff. There are a few exceptions and the flowchart sets out the decision-making process trusts should adopt.

The health and social care (HSC) workforce in Northern Ireland increased by 12% between 2010 and 2019, according to the latest census of local staff. The Belfast Trust is the largest employer with almost 18,000 whole-time equivalents or 31% of all staff. The census also found that 38% of HSC staff are employed at Agenda for Change bands 1 to 4, and 79% of staff are women. Administration and clerical staff make up 19% of the workforce – nursing and midwifery is the single biggest group (34%).

A national clinical plan for specialist services in Wales is under development, according to a written statement from health and social services minister Vaughan Gething. He said clinicians will be expected to work to national clinical pathways set out in the plan. The pathways will be based on prudent healthcare, value-based care and quality improvement at scale and pace. They will focus on system working and include prevention and population health as well as secondary and tertiary care.

The NHS should make a greater contribution to improving social and economic conditions for people in their local area, according to the Health Foundation. In a report, the foundation proposed NHS bodies should be 'anchor institutions' for local areas. An anchor institution is 'a large, public sector organisation with sizeable assets that could be used to support community wealth building and development, and in doing so, advance the welfare of local people', it said. The report, *Building healthier communities: the role of the NHS as an anchor institution*, said NHS organisations could achieve this by several means, including widening access to quality employment; leveraging assets and land for community benefit; and leading on environmental sustainability.

from the hfma

Over the summer the HFMA invited commentators to examine the key issues, challenges and opportunities in the *NHS long-term plan* in a series of blogs.

In the first blog, Public Health England chief economist Brian Ferguson says the NHS must shift spending towards prevention of ill health. Embedding prevention as a 'must do' is fast becoming imperative as projections show the funding gap is likely to widen.

In his blog, Raj Patel, NHS England deputy national medical director of primary care, outlines the benefits of primary care networks (PCNs). As the population ages, primary care will help meet the consequent demand – PCNs will offer greater coverage, with collaboration between practices and new multidisciplinary teams.

Safer and more efficient care can be gained from new digital technologies in healthcare, says James Hawkins, director of strategy (AI) at NHS Digital. Technological advances can free up clinicians' time and support patients to self-care, but the NHS must also gain public trust over the use of their personal data, he adds.

In the final blog in the series, Michael Dimov, NHS England and NHS Improvement senior adviser (Community Health Improvement), says significant developments at the centre will likely drive the transformation of community services. These include the release of activity data, which will allow robust and transparent benchmarking – the first step to developing comprehensive dashboards demonstrating the value delivered by community services.

• Visit www.hfma.org.uk/news/blogs for more

News analysis

Headline issues in the spotlight

Taxing problem

Clinicians are angry about the impact of pension tax rules that could leave them facing large bills. The government has promised to solve the problem, but what is it proposing? Seamus Ward reports

Pension tax has been the NHS issue of the summer. It has been blamed for senior doctors leaving the NHS, considering retirement, reducing their hours or refusing to take on additional work – to reduce waiting times, for example – because they fear being saddled with significant tax bills. The issue is regarded as so serious that, over the course of 16 days this summer, the government moved twice to settle the issue.

The problem has arisen due to the tax policies set by the Treasury, but both the health department and Treasury accept the need to resolve the issue. It affects a relatively small number of highly paid staff. Some will find it difficult to sympathise, but it is important to remember how vital they are to patient services.

There is evidence that the problem is having an impact on the delivery of services and trusts' financial position (see box). But the NHS pension is also a key element in recruitment and retention of staff. And, though the pension scheme remains generous even when the pension tax issue is taken into account, the service would not wish to see it devalued.

The issue has sprung from the introduction of an annual allowance to limit the amount of tax relief received by higher earners. The value of the allowance rose steadily from its introduction in 2006 to £250,000 in 2010/11, but fell sharply under austerity measures and stood at £40,000 for the 2018/19 tax year.

While this means more people are facing tax bills, the allowance can be tapered down further, potentially increasing the size of the bills. If a doctor, for example, earns less than £110,000, they keep the full £40,000 allowance. For those earning more, there is a further test. Their income – from all sources – is added to the growth in their pension over the year – this is known as their adjusted income. If this totals less than £150,000, they retain the £40,000 allowance. If it's more than £150,000, the allowance is tapered, falling to £10,000 for adjusted incomes of £210,000 and above.

Tackling the issue is now high on ministers' agendas. Just before Boris Johnson took over as prime minister, on 22 July Theresa May's government proposed a scheme where employers and employees reduced their contributions to 50%. In exchange for this 50:50 option, clinicians would cut their rate of pension growth in half. A consultation paper was published, but the proposal was rejected immediately by the British Medical Association, the doctors' trade union.

Shortly after Mr Johnson took the keys to number 10, it became clear that the 50:50 option was to be abandoned in favour of a more flexible proposal that will allow, from April 2020, clinicians to set their contribution rates to limit their chances of having to pay pension tax.

Exactly what the government is now proposing is unclear – it has promised a new consultation, but this had yet to be published as *Healthcare Finance* went to press. What is clear is that it will apply only to senior clinicians – chiefly doctors and nurses – but not to managers.

There is no flexibility in the current scheme – staff are either opted in (paying 100% contribution) or opted out (paying no contribution) of the pension scheme, but the new proposal would allow greater variation in contribution rates.

A Department of Health and Social Care press release gives an example of a senior clinician giving '30% contributions for a 30% accrual rate, or any other percentage in 10% increments depending on their financial situation'.

This would mean the senior clinician reducing their pension contribution to 30%, but it would also mean their pension on retirement would be reduced commensurately. In the case of a clinician earning more than £111,377, their contribution is currently 14.5%, so their new contribution would be 4.35% (30% of 14.5%).

The cut in employee contributions can be tailored in 10% increments to suit their personal circumstance and ensure they do not fall foul of the pension tax rule or, for very high earners, reduce their exposure.

By reducing the potential tax bill – or

Finance concern

Senior finance staff are worried about the impact of the pension tax issue, according to a recent HFMA survey.

The survey received 74 responses from a range of NHS bodies. While 54% of finance staff were very concerned, 34% were 'quite concerned'. A fifth said clinicians had already taken action that is affecting patient care and their organisation's financial position. This included reducing their hours, refusing to work extra hours or take new responsibilities – including waiting list work – or taking early retirement.

While around a quarter reported that staff had taken early retirement but they had not yet seen an impact on patients, their financial position or both, a similar proportion said they knew staff were planning to take early retirement and they expected this to have an impact on patients, their financial position or both.

There were similar responses to questions on the impact of reduced hours.

Finance staff said the solution lay in reform of the annual allowance. It affected managers as well as senior clinicians and any reforms should apply to all affected.

• Visit hfma.to/9x for the HFMA briefing

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eradicating it totally – it is hoped the clinicians will maintain or return to the additional hours they have worked previously.

The proposal has a number of other potential benefits. It could keep senior clinicians in the NHS pension scheme – any significant outflow of contributors could undermine the scheme.

Additionally, by remaining in the scheme, even with reduced contributions, clinicians can continue to take advantage of some of the attractive add-ons to the pension scheme, such as life and ill-health insurance, which are important in recruitment and retention.

What is less clear is how reduced employee contributions would affect employers. Though not confirmed, it appears that employer contributions could decrease, either by an amount agreed with the clinician or to match the employee's reduced rate.

It is not a given that an employer's contributions will align with their employee's. For example, in the local government scheme, employees can reduce their contributions to 50%, but employers are still required to pay the full contribution.

It is possible that employers will have to maintain a level of contribution to fund other benefits, such as the insurance safety nets mentioned above.

Any funds not paid as an employer's contribution could be paid to the employee as salary, though the clinician should be keeping one eye on how increased earnings – fuelled by reduced employee pension contributions and recycled employer contributions – might affect their exposure to pension tax.

BMA council chair Chaand Nagpaul said the proposal was a step forward. 'We said clearly when it launched that the earlier consultation on the 50:50 model – whereby doctors and employers halve what they put into their pension pots – was not fit-for-purpose and we are pleased that the government has heeded the BMA's concerns by ditching it. This method is overly restrictive and can leave doctors putting either too much or too little into their pensions.

"The government has listened to us on offering full flexibility – meaning doctors can choose the amount they and their employer wish to put away"
Chaand Nagpaul, BMA

'The government has listened to us on offering full flexibility – meaning doctors can choose the amount they and their employer wish to put away – and we note the assurance that this will not mean doctors "losing out on the value of unused employer contributions". This must mean full recycling of the entire employer's contribution being paid back into doctors' salaries.'

Dr Nagpaul insisted the proposed flexibilities were a short-term measure and tackling the underlying problem meant tax reform. In particular, changing the annual allowance taper was imperative.

The Treasury has committed to reviewing how the allowance operates with a view to supporting the delivery of public services.

Guidance will also be given to employers, setting out how they can use existing local flexibilities to address the pension tax issue.

NHS Providers welcomed the government's 'pace and focus' on the issue. Chief executive Chris Hopson added: 'The government needs to listen carefully to the views of those affected – for example, there is a strong argument that income for extra work beyond normal contracted issues should not be counted in annual allowance taper calculations.'

It is important the government recognises that the issue affects managers too, he said.

Some providers have taken steps locally to mitigate the tax allowance issue. Three types of scheme are most common, according to NHS Providers. One scheme pays staff who have opted out of the NHS pension scheme the equivalent of the locally administered employer pension contribution (14.3%).

Staff would not be subject to pension tax unless they join an alternative pension scheme. A higher proportion of an affected employee's pay could be made non-pensionable, possibly by splitting their role into two assignments with separate employment contracts (one where the pay is non-pensionable). In a third scheme, staff could be given additional leave in return for working more than their contracted hours.

But all three approaches could be problematic. For example, while the first option may be a relatively simple and potentially cost-neutral option, there are concerns that it could be discriminatory, and risks being seen as an inducement to opt out of the pension scheme.

A handful of trusts have explored the idea of paying for services from consultants who have formed a limited liability partnership.

The trusts believe this arrangement could allow more flexibility for the staff to manage their pension savings. But these could fall foul of IR35 tax rules.

Clearly, there is an appetite at trust level to sort out the issue. Surveys from the HFMA (see box) and NHS Providers have both found that trusts have developed or are considering local schemes – a signal of the importance of affected clinicians to trusts' performance. But most providers would prefer a national solution and will be looking in detail at the consultation and eagerly awaiting the review of the taper.

Comment

September 2019

Seeing the positives

While challenges remain, recent changes help to address some difficult issues

HFMA president Bill Gregory

I hope you managed to fit in a bit of down time during the summer period. However, we all know that this is never a quiet period, despite the need to take summer holidays.

This year has been no different, with plenty of activity under way in developing system plans for discussion with regulators during the early autumn.

With the change in government leadership, we are starting to see decisions being made on some of the things that are inhibiting progress in improving services for patients.

The recognition of the problems created by the way the NHS pension scheme interacts with the tax regime is welcome. And I am sure the process of consultation will yield an improvement on the current position once the process has been completed.

Those of you who have seen economic cycles before, will not be surprised to see that capital constraints are the first area that get a look-in, as government starts to prioritise for the future. The one-off nature of this type of spend makes it an attractive way of making an impact in the NHS.

Critics will say it's not new money, or too little too late. But let's not look a gift horse in the mouth. We badly need investment to address

Steps towards system oversight

New framework makes small moves towards system-level regulation

Healthcare Finance editor Steve Brown

NHS England and NHS Improvement's new oversight framework is a good statement of intent, but changes very little in the short term. The framework continues the ongoing alignment between the two bodies that have been acting as a single organisation since April. It also makes a move towards addressing one of NHS practitioners' biggest concerns over the move to integrated working – how can we work as systems if you continue to regulate us as separate organisations?

At this point, the NHS remains well short of a regulatory system that is focused on systems not organisations. This is understandable. Systems have no statutory basis and so NHS England and NHS Improvement's respective regulatory focus has to be on clinical commissioning groups and providers. Their formal powers to intervene to improve local performance is firmly at the organisational level.

This position would only change with the creation of new system-level bodies, and the appetite for further structural change is minimal both inside the NHS and at the political level.

So, the changes have to be looked at in this context. On the one hand, the 'new' oversight framework looks like little more than a stitching together of the metrics used in the pre-existing sector-specific oversight frameworks – the single oversight framework for providers and the improvement and assessment framework for CCGs.

"We badly need investment to address backlog maintenance issues in our hospitals, and the previous capital constraints have made this very difficult"

backlog maintenance issues in our hospitals, and the previous capital constraints have made this very difficult.

In addition, most sustainability and transformation partnerships or integrated care systems have a strategic case for capital investment to transform service provision, and we now have an opportunity to pursue the ones that offer best value.

In July, HFMA chief executive Mark Knight and I hosted HFMA's annual key supporter's event in London (*see page 30*), which is an opportunity to acknowledge the contribution made to the association by individuals and organisations.

As is tradition, we also acknowledged a number of individuals with fellowships of the association.

It was particularly pleasing for me that this included Tim Crowley and Jonathan Stevens.

Tim retired from his role as managing director of Mersey Internal Audit Agency earlier this year – a role in which he has made a significant contribution to the development of governance in the NHS.

Jonathan, now the north west regional director of finance, was recognised for his contribution to the technical work of the association.

As we head into the autumn, a quick look in my diary suggests that I'm going to be clocking a fair number of miles over the next few months. Nine of the 13 HFMA branch conferences take place during this period.

I hope to see as many of you as possible supporting your branch event, and also at the national conference in early December.

Contact the president on president@hfma.org.uk

SHUTTERSTOCK

There are a few new oversight metrics. For example, metrics have been introduced on the overall size of the waiting list and patients waiting over 52 weeks for CCGs, and a set of staff survey metrics for providers. But there are no major departures in terms of what is being looked at and the focus is firmly on organisations.

On the other hand, it demonstrates that the powers-that-be do recognise the importance of moving regulation to a system level alongside the continued development of sustainability and transformation partnerships and integrated care systems.

And there are some small, but important changes of emphasis. NHS England and NHS Improvement say they intend to work 'with and through' system leaders wherever possible to tackle problems and to provide greater autonomy for systems with 'evidenced capability for collective working'.

At the heart of the new framework will be quarterly system review meetings – bringing the regulators' regional teams together with system leaders. These meetings and performance data will inform decisions about what support might be needed.

Organisational-level information flows remain in place, in part so that the centre can spot where good system performance might otherwise mask emerging problems at the local level.

So there is a hint of a greater system focus and there is a promise for this to increase in subsequent years. Recognising that the 2019/20 approach – which has been published without consultation and nearly half-way through the year – effectively combines current approaches, NHS England and NHS Improvement say they will use this year to develop proposals for a new framework starting from 2020 onwards.

"There is a hint of a greater system focus and there is a promise for this to increase in subsequent years"

Crucially, the document introducing the new framework says the design of the 2020 framework will involve partners at key stages. This will include a consideration of the purpose of the framework and the balance between organisational and system oversight.

It will be important that these changes are subject to full consultation and that finance practitioners – as those arguably most aware of the importance of governance and regulation and how it works – are at the heart of this process.

Regulation that is appropriate and in tune with the move to system working will be crucial to delivering the long-term plan goals.

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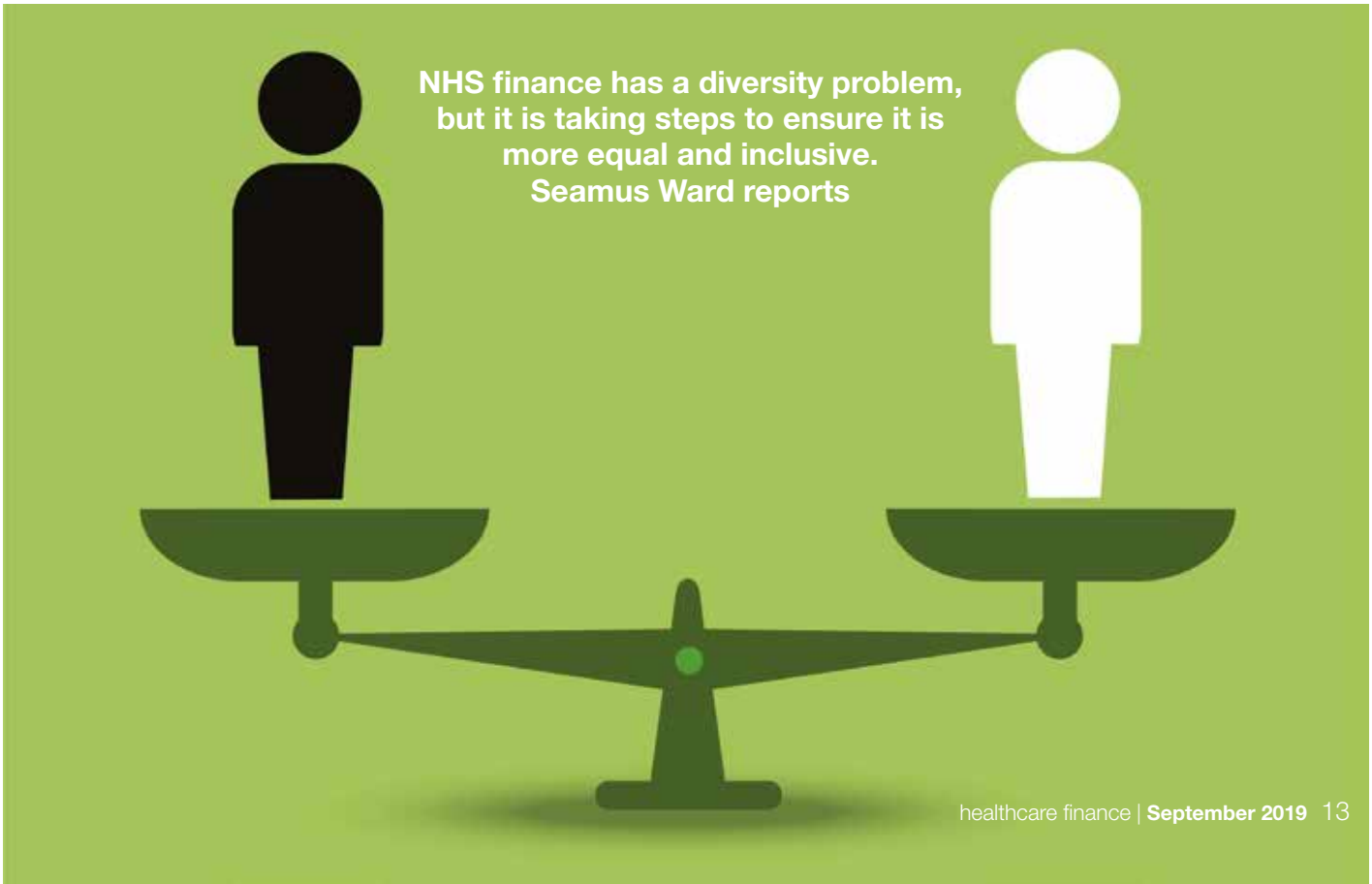
Balancing up

NHS finance has a diversity problem, but it is taking steps to ensure it is more equal and inclusive. Seamus Ward reports



SHUTTERSTOCK

It's been made clear from finance departments up and the Finance Leadership Council (FLC) down that NHS finance must address diversity in the workplace. Indeed, the FLC has encouraged initiatives to tackle the issue in England. There is little doubt there is a problem, but how should the finance function go about addressing it?

A recent Future-Focused Finance conference looked at practical steps to bring greater equality to employment and promotion decisions. They included recognising and eliminating unconscious bias, reverse mentoring (see box overleaf) and how to measure progress.

Equality is not new to the wider NHS – there have been measures going back years – but it seems its time has truly come. Health and social care secretary Matt Hancock is committed to moving the diversity agenda forward. Last year, he set a new target of eliminating the ethnicity pay gap, with black, Asian and minority ethnic (BAME) representation in senior roles matching that across the rest of the NHS, by 2028. BAME representation among the non-medical NHS workforce stands at 17%, but only 11% of senior managers are from a BAME background. This falls to 6.4% at very senior level.

Mr Hancock told the King's Fund in November that 40% of hospital doctors and 20% of nurses in the NHS are from a BAME background, yet BAME representation on NHS trust boards is only 7%. More than half of all NHS trusts in England have no black or ethnic minority staff at the very senior manager (VSM) level.

'Over 75% of the NHS workforce are women, yet at board level that figure is just 40%,' he said. 'We need 500 more women on boards to make them gender balanced,' he said – a message he has since reiterated.

Mr Hancock continued: 'However, it's not just a question of fairness and justice. Diversity of leadership is a diversity of experience, a diversity of perspectives. Different ways of thinking, fresh ideas, new solutions to old and seemingly insurmountable problems.

'Diversity of thought is essential to the future of the NHS. It is essential to make the best, and most intelligent use, of the £20bn a year extra we're putting into the NHS.'

New goals published

In July, NHS England and NHS Improvement published guidance outlining goals for health service organisations to reduce the disproportionate rates of disciplinary action taken against BAME staff compared with white staff by 2022.

The position in NHS finance is similar to that in the wider NHS. In the 2017 NHS finance function census, women outnumbered their male colleagues in every grade up to and including band 8b. Women accounted for 61% of the finance workforce, but only 28% of finance directors. Two-thirds of women working in NHS finance were at band 6 and below, compared with 46% of men.

While 70% of the NHS finance workforce in England said they were white British, some 86% of finance directors were white British. However, it should be noted that 11% of organisations did not disclose their employees' ethnicity.

Success in promoting diversity and inclusion could be measured by whether organisational, cultural and personal beliefs had been shifted, Edward John, FFF's diversity programme lead, told the conference. Of

Reversing the trend

Many finance managers will have experience of mentoring, but not so many will have experienced reverse mentoring, whereby they are mentee to a more junior member of staff. A new project aims to use the latter to help address issues of diversity and inclusion in the NHS.

ReMEDI (reverse mentoring for equality, diversity and inclusion) expands reverse mentoring to include mentors to people with less (perceived) power, in a more disadvantaged position or under-represented group or from a marginalised or oppressed group.

Stacy Johnson (pictured below), programme lead and University of Nottingham associate professor, told the event that there was growing evidence that reverse mentoring can stop individuals acting in a discriminatory way, change organisational culture in gender and race equality, and contribute to organisational diversity and inclusion.

ReMEDI has been operating across around 15 NHS organisations. It is being evaluated, though Ms Johnson recognised that individual organisations are at various stages in their development of reverse mentoring to improve diversity and inclusion.

The programme has been welcomed, she said. One board member had told her that being a reverse mentee was the most important piece of work they had done in 30 years in the NHS.

Finance leaders were particularly keen to be involved, she added. 'I believed the finance professionals would be the hardest nut to crack but my stereotypes are so not borne out.'

Her assumption was that finance staff would be cynical and uncaring about patients. 'But finance directors have been a revelation – that's why I'm so pleased to be here [at this event].'

She highlighted Guy's and St Thomas' NHS Foundation Trust chief financial officer Martin Shaw who filmed a video (available on YouTube) with his reverse mentor – no-one else had done this, she added.

The programme aims to disrupt the traditional power dynamic by giving lower band staff an opportunity to speak up without consequence. But, to be successful, reverse mentoring had to go beyond cosy chats about cultural differences, she added.

'If you want inclusion, you can't limit the conversation just to culture. And you can't just pick two people and hope for the best when you are pairing mentor and mentee. We want to facilitate different conversations – not just about culture. You want conversations that are uncomfortable.'

these, cultural changes would be the trickiest, he added.

Targets could be set and reached, but people in protected groups had to feel welcome and included. They must be supported. 'We can set targets – great,' Mr John said. 'But what about the softer stuff? What makes somebody lack confidence because they think they don't talk or look the right way?'

He praised the introduction of a BAME representative on interview panels in some trusts – something he believes should be rolled out across the NHS. But he added: 'In NHS finance, we are behind the curve and need to make an impact. It's taking a bigger priority and we all need to be behind that.'

Paul Deemer, head of diversity and inclusion at NHS Employers, told the conference about how Australian airline Qantas had turned a AU$2.8bn deficit in 2013 to an AU$850m surplus in 2017. The airline's chief executive believed this was largely due to the introduction of a culture of inclusivity and diversity.

"I believed the finance professionals would be the hardest nut to crack but my stereotypes are so not borne out"
Stacy Johnson, University of Nottingham

Business benefits

It's a bold statement and it attracted the attention of Deloitte, which looked into the business benefits related to diversity and inclusion. It spoke to 50 of its biggest global customers and reported there are eight 'powerful truths' on diversity and inclusion. These included:

- Diversity of thinking, rather than in numbers and demographics, was the most significant factor in a lot of the organisations' success
- Diversity had to be more holistic that just meeting targets – it had to be inclusive too
- Inclusive leaders cast a long shadow – committed senior board members makes a huge difference
- Middle managers matter – Mr Deemer said this was often forgotten. This layer of management implements strategy, so their buy-in can determine success or failure
- Tangible goals must be set.

Asked what finance departments should be doing now, Mr Deemer said they should make equality impact assessments of their recruitment processes. 'I would also encourage you to speak to your HR colleagues and see if there's any way to integrate some of your work with their work to get cross-fertilisation of ideas, which I find really exciting,' he said.

In a session on unconscious bias, delegates heard that everyone holds unconscious prejudice or stereotypes. The key to addressing these is first to pay attention to your reactions to people, news or social media posts and have the courage to be honest that you hold these biases, according to consultant Desiree Silverstone.

These thoughts can be countered using a range of strategies, including avoiding generalisations; being more positive about people you have stigmatised; putting yourself in someone else's shoes; and increasing

opportunities for contact with a diverse range of people, she added.

Speakers shared their own experience of discrimination. Arnold Palmer, a coach and mentor, and former NHS finance director, said: 'I remember going to my first finance directors' meeting in London and being the only black face there. It's not like that now and I am really pleased the NHS is moving in the right way.'

"Diversity of thought is essential to the future of the NHS. It is essential to make the best use of the £20bn a year extra we're putting into the NHS"
Matt Hancock, health secretary

Many speakers and delegates spoke of imposter syndrome – a feeling of inadequacy based on looking or being different from peers, despite doing the same job just as well. Lei Wei, deputy chief financial officer at North West London Collaboration of CCGs, spoke of her discomfort at her first regional meeting. 'I looked around and thought, "I don't think I belong here" as I was surrounded by middle-aged men in grey suits. At first, I wanted to run out but then one of the speakers called me over.'

But instead of words of encouragement, he was asking for help as he thought she was one of the conference support team. The key was to draw strength from these difficult situations, she said. 'It was quite difficult at first, but it is important to remind yourself that this is something you really want to do. If it is what you want, keep going and don't let some bad experiences scare you away.

'We need to set a good example; speak up and challenge bad behaviour and put diversity and inclusion in our day-to-day work. We must listen to the views and good ideas of people from diverse backgrounds. Gradually, people will listen, and the culture of the organisation will change.'

While much of the attention has been on discrimination on the grounds of sex and race, the event included a welcome focus on discrimination against people with disabilities. The conference heard that though only 3% of NHS staff declare a disability on their electronic staff record, around five times more said they are disabled in the (anonymous) NHS staff survey. It appears that many staff with a disability fear discrimination if they notify their employer officially.

Hayley Ringrose, Stockport NHS Foundation Trust chief financial analyst, said being invited to speak at a HFMA costing event gave her confidence to take the podium at this and other events. 'I got an email asking me to lead a workshop and I replied, "You do realise I have a speech impediment?" They said they did know and wanted me to lead the workshop.'

Referring to the gap between those who declare a disability in ESR and the staff survey, she said. 'Some of us don't have a choice and because of that I feel I have to be seen as a role model – to promote and challenge, not through what I say; not through going to the board and saying, "We don't have enough disabled representatives or BAME representatives", but just by being the best you can be in every role. We will break through those barriers, but it will take time.'

The promotion of diversity and inclusion is now at the top of finance departments' agendas – as it is in the wider NHS – and finance leaders will seek to use some of the tips provided at the conference to find a better balance.

Going beyond

The London-based *Going beyond* programme continues to evolve and grow, with strong support from London regional finance director Ann Johnson.

The programme aims to support and expand the number of women and BAME finance staff at senior levels. It focuses on supporting these staff in bands 8c and above to step up to finance director posts. *Going beyond* is now part of a new umbrella structure, explains Central and North West London NHS Foundation Trust chief finance officer, Hardev Virdee (pictured), who, along with Chelsea and Westminster NHS Foundation Trust chief financial officer Sandra Easton, is leading the programme.

An overarching London finance talent board has been established to bring together several workstreams on diversity and inclusion, as well as those supporting talent development in general. In addition to *Going beyond*, the workstreams include projects from the HFMA London Branch, the NHS Leadership Academy and FFF.

Mr Virdee chairs the talent board, with Ms Easton providing representation at a national level. Both are due to move to new roles shortly, but will continue their work with *Going beyond* and the talent board.

Six modules have been developed for *Going beyond* and approved by the talent board. The modules, which are due to be launched shortly, are designed to help staff take a step up. They include:

- **Understanding yourself** – defining career goals, understanding skills gaps and addressing confidence issues
- **Understanding the organisation** – relationship management, working with peers and non-executives and managing poor performance in others
- **Understanding the role** – how to influence and make an impact, negotiation and leadership
- **Understanding the environment** – change management project, system leadership, working with partners and engaging with the private sector
- **The interview** – CV review, simulated interview, recruitment agency support and feedback
- **Lived experience** – delivered by chief finance officers, candidates look at 'what it takes' to do senior jobs and they gain shadow experience.

'We are working with the HFMA branch and with FFF to help people understand what we are doing and how we can best support them in terms of diversity and inclusion,' Mr Virdee says.

'I think we are seeing more good practice as a result of what we are doing. It seems more commonplace to have more diverse interview panels at senior level and shortlisted candidates from a wider background, so we must ensure that we build on this.'

Though focused on London for now, other regions have shown interest in *Going beyond*. 'It is designed so it can be easily replicated. I expect it will be rolled out across the country as good practice,' he adds.

Modernising move

Almost six months after the formal launch of a central procurement scheme, Seamus Ward asks how it has progressed and how the NHS has reacted

For years, the NHS has talked about leveraging its buying power when it comes to goods and services. And with an estimated £9bn annual spend on goods and services – £6.5bn on clinical and general items – it would appear the potential for savings is significant.

Lord Carter thought so in his 2016 review of acute trust productivity and efficiency – he believed savings of at least £700m a year on clinical items and general supplies could be realised. And now a national bulk buying scheme seeks to address his recommendations.

Though many of the elements of the new strategy were established last year, Supply Chain Co-ordination Limited (SCCL) was only formally launched in April. It replaces the contract operated by logistics firm DHL, which delivered about £300m in savings since 2015.

SCCL is the management function of NHS Supply Chain and aims to lower prices and drive efficiencies through product rationalisation and economies of scale. It has divided goods into 11 procurement towers and three enabling services (logistics, IT and transactional services), each operated by companies such as DHL and Unipart, as well as some public sector bodies.

The procurement tower operators are incentivised to deliver lower prices but SCCL is funded through an adjustment to the national tariff (see box overleaf), prompting complaints from some trusts.

The adjustment of the national tariff is one obvious difference from previous attempts to get national purchasing off the ground, but there are others.

SCCL has a single shareholder – the health secretary – and its board draws representatives from the Department of Health and Social Care and NHS Improvement, together with four non-executive directors. This makes it more accountable than previous attempts to save on procurement spending, according to Alan Wain, SCCL's chief operating officer.

NHS Supply Chain has been moving to the new system for the last year, gradually transferring in-house a £3bn business from DHL. Back-office functions were the final activities to move over before the programme launched in full on 1 April.

The new organisation's work has also included letting contracts to new partners that provide logistics and IT and establishing the 11 category towers and their providers.

'All trusts have contributed in some way to the cost of our operation,' Mr Wain says. 'As a result, we have removed the margin from the price paid for products. Under the old operating model, DHL funded its operation using the margin – a bit like a retail model – but in this model there are variables in the margins and it is not transparent. That transparency is there now because the price we buy at equals the sale price.'

Early successes

Mr Wain says SCCL has achieved some early successes. The business case setting out the rationale behind the new operating model was that there would be a £68m annual saving. But in the last financial year, savings of £286m were achieved by elements of the new model that were up and running, such as the category towers, plus the old DHL model.

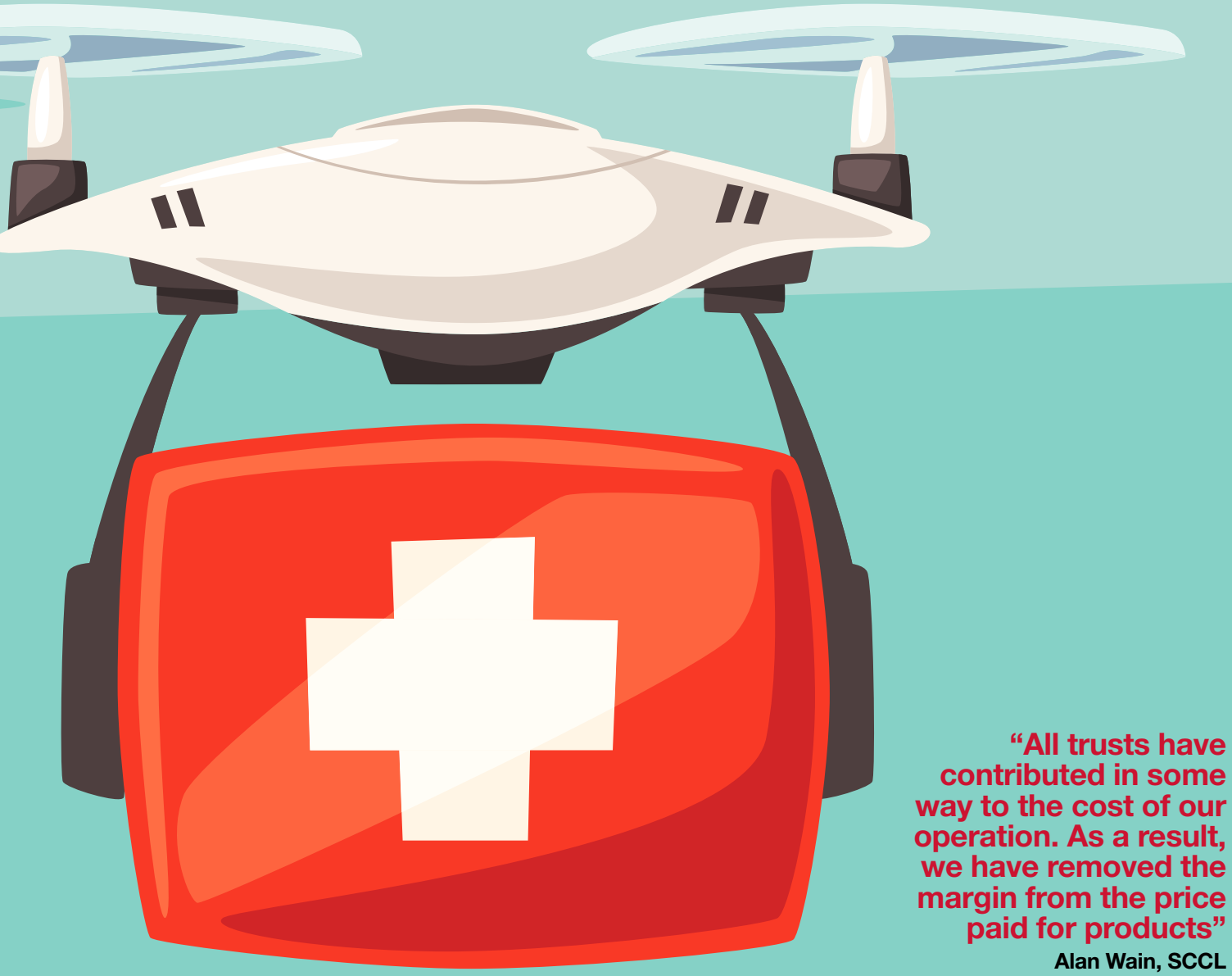
'Our target is to deliver cumulative savings of £2.4bn by 2022/23. Currently, our cumulative savings are standing at £800m – a third of the way to the target and way above our trajectory.'

He says the NCP (nationally contracted products) procurement initiative – an NHS Supply Chain and NHS Improvement pilot project that sought to aggregate demand at national level – offered proof of concept for the new operating model. 'We did some rationalisation and at the same time drove down the prices – on average we achieved around 22% savings. We have embedded the NCP principles in all of our category towers,' Mr Wain says.

'We are also looking at deals of more than one year. Typically, the NHS operates on a one-year cycle, but we are moving to three-year deals to get better value for money.'

He believes the new model is a step forward compared with previous attempts to save money on NHS procurement. The procurement towers mean buying teams are focused on particular types of related products – under the old model, expertise was spread across all categories of products.

Previously, central procurement competed with the regional NHS procurement hubs. Many are now part of the new system, with four of the old hubs coming together as CPP, which manages three clinical category towers.



"All trusts have contributed in some way to the cost of our operation. As a result, we have removed the margin from the price paid for products"
Alan Wain, SCCL

SHUTTERSTOCK

Mr Wain explains that clinical and product assurance is one of SCCL's driving forces. 'One of the ways we are driving value for the NHS is by regular rationalisation of products. But to be able to rationalise, you must be sure those that are remaining are clinically sound, fit for purpose, high quality and fit for the NHS.'

SCCL uses its clinical and product assurance (CAPA) process to follow the Carter principles of reducing variation. 'It's good to assure ourselves in the NHS that these are the right products. The CAPA team sits within SCCL and sets the framework for how we expect the tower service providers to work.'

SCCL is also working closely with other national programmes, such as *Getting it right first time* (GIRFT), as well as the national wound care and excellence in continence care strategies. The intention is to ensure best value and to check that towers focus on the products identified as best for patients.

Anecdotally, *Healthcare Finance* has heard that some trusts have complained about the new arrangements. For one trust, question marks over switching to SCCL are primarily over the accuracy and timeliness of the receipt of goods.

'At a hospital level, our first priority is product availability. Long delivery lead times and variable fill rate performance remain a barrier to giving growth to the new model,' says one procurement lead.

Others say they can find supplies offered through the new tower system at lower prices, even when the suppliers' margin is factored in.

Mr Wain accepts that some trusts have taken this position on prices, but he also points out that DHL had about 38% of the market share, while SCCL has 53%. This shows that trusts are moving their purchasing to SCCL, he insists, though switching could be delayed where trusts still have a contract with other suppliers.

'They might be complaining about specific items, but they are moving their activity to us more generally,' he says. 'Last year's savings were three times the business case target, which is higher than in any year with DHL. In our first quarter, we are already two-thirds of the way towards our target this year.'

Mr Wain adds that SCCL's customer satisfaction index is high – in one month since April the index hit 8.5 out of 10, matching the previous high under the old system.

He believes some trusts are being offered lower prices for a number of reasons. Suppliers that have not won contracts under the new system – or do not want to contract with SCCL – may be offering attractive deals to offload excess stock, he says. 'I would anticipate that when we are doing national level procurement,

there will be opportunities for trusts to get better deals. But I have a message for finance directors: they must take a system-wide view.

'If you take these spot deals, it may work for your trust, but it is undermining the whole system at national level. If we commit to a volume of goods at national level and we can't deliver it because trusts are taking spot deals, maybe next time we won't be able to commit to the same volume.'

Lower amounts of goods equals lower savings, he says.

Are some types of trust, such as major teaching hospitals, more likely to take local deals than that offered by SCCL? Mr Wain says teaching hospitals will be able to leverage the volumes of supplies they use, although these volumes are not as big as national levels, and some suppliers will sell at lower prices to have their name associated with a particular trust.

However, a supplier could also offer a district general a good deal for the volumes they use – it could happen at all levels, he argues.

'We have got to get all trusts behind the principle at national level so we can get better deals for the whole system.'

Looking ahead two or three years, Mr Wain says value-based procurement will be important to the NHS, increasing value and quality. 'We are looking at whether we can contract for outcomes – this could mean fewer days before discharge, for example. This is important to us because if you keep driving prices down, you come to a point where a supplier can't do any more.' At this point, value can be driven by increasing productivity.

Supply Chain is also looking at asset utilisation. 'For an asset such as an MRI scanner you will pay £600,000 to £1m, so we want to get better information to the NHS on how they can utilise assets to get more out of them and get better throughput,' says Mr Wain.

Asset use evaluations are being carried out at trust level, though increasingly system-level use across integrated care systems will be more important. 'It could be about sharing assets and reconfiguring the system to utilise the assets better. It could mean replacing an asset less frequently or not having to replace them at all.'

Five finance messages

As well as insisting trusts do not undermine national savings efforts by taking spot deals, Mr Wain has a further five messages for finance teams. The first is not to miss out on easy savings. At the beginning of the year trusts were provided with a list of margin-free prices on all products and were asked to indicate which products from NHS Supply Chain they would like to switch to. This was called demand capture. Mr Wain says that with the variable margin model in the old model, and margins as high as 25%, savings opportunities were expected in all trusts. But only 60% of trusts filled out demand capture forms to the value of around £100m.

This indicates that either the other 40% had no savings opportunities from margin removal or had not looked closely enough at the pricing information and are leaving savings on the table, he adds.

By July, almost half of the £100m of demand capture had been moved to NHS Supply Chain, but that means 50% of the savings available through demand capture have not been taken, Mr Wain says. Further savings may have been available if all trusts had filled in their demand capture forms.

'I know there are legitimate reasons why some trusts can't move across, such as commitments in contracts, but the overriding message to finance directors is that they must check with their procurement staff that they have cross-checked with Supply Chain to ensure they are getting the best deal.'

Mr Wain's second message is to raise awareness of the potential for value-based contracting with suppliers, which would include an element for patient outcomes. 'This is something for finance directors to think about – how will we do this? How do we realise that value?

'If it comes down to reductions in beds or fewer interventions, it may be challenging but how does that affect a department's budget?'

His third point is for finance directors to be aware new medical device regulations come into force at the end of May 2020. These place greater emphasis on traceability through a unique device identification system and new standards for clinical evidence. If products are non-compliant, the Medicines and Healthcare products Regulatory Agency can prevent them being used, potentially leading to longer waiting times and loss of income.

The opportunity to redeploy procurement staff to value-generating work is Mr Wain's fourth message to finance directors. 'It makes no sense to duplicate services you've already paid for through the tariff. They could look at other procurement areas where resources have not been there to focus on them in the past. "Evergreen" contracts have always been there. Or you could redeploy staff into the management of service contracts.'

Finally, he adds that Supply Chain will be investing in upgrading its IT to ensure all processes are carried out online.

SCCL is bullish about its prospects, buoyed by its early savings successes. Its overriding message to trusts is that national procurement releases savings, but the NHS must think collaboratively to get even better value from purchases and existing assets.

Funding overheads

The funding of NHS Supply Chain overheads via the tariff rather than a margin on goods is a step forward, according to Mr Wain. 'It gives trusts an incentive to use us as they have already paid for it,' he adds.

Some trusts see the tariff reform as a reduction in their income that applies whether they source supplies from SCCL, are tied into a contract with another supplier or can find the supplies at a lower price elsewhere.

Under tariff changes for 2019/20, SCCL's overhead costs (estimated at £253m in 2019/20), will mostly be

funded from central funds.

With the mark-up removed from product prices, the direct cost to providers should fall if they choose to procure supplies from SCCL.

To reflect the new funding arrangements prices under the national tariff have been adjusted, removing around £204m from the amount reimbursed through the national tariff.

The tariff adjustment has been achieved by reducing the cost uplift factor, reflecting the reduced cost of SCCL products. For nationally determined prices, the adjustment is 0.36%.

The adjustment has been varied, reflecting the likely use of SCCL between acute, mental health, community and ambulance trusts. For both national and local prices, the reduction in tariff for acute trusts is 0.36%; for mental health 0.1%; ambulance 0.08%; and community 0.05%.

"I have a message for finance directors: take a system-wide view. If you take spot deals, it may work for your trust, but it is undermining the system at national level"

Alan Wain, SCCL

The NHS long-term plan

Since the publication of the *NHS long-term plan* in January, the HFMA has been working to produce resources that support our members with the plan's implementation. Publications and resources include:

- Summary of the NHS mental health implementation plan 2019/20 – 2023/24
- Summary of the NHS long-term plan implementation framework
- Summary of the Interim NHS people plan
- What does the NHS long-term plan mean for the finance function?
- Summary of NHS operational planning and contracting guidance
- Summary of the NHS long-term plan

Visit **hfma.to/ltp** to find out more

The long-term plan prioritises a widely supported expansion of mental health services. Management information will play a key role in delivering these goals, but it needs to be the right data and timescales need to take account of significant service pressures. Steve Brown reports

achieving the right focus

The *NHS long-term plan* renews a commitment to pursue the most ambitious transformation of mental healthcare England has ever seen. Mental health clinicians and leaders fully support the ambitions set out in the plan. However, despite a promised increase of £2.3bn in real terms for mental health by 2023/24, mental health bodies face significant challenges in meeting the plan's goals.

They say it is vital that everything they do is focused on delivering these goals – including delivering a major boost to children and young people's services and community mental healthcare, expanding access to IAPT services and providing comprehensive crisis care.

Data and management information will be key to the sector's success. However, practitioners say the sector needs to be collecting the right data, the requirements need to be achievable and the collection needs to be affordable.

According to Suzanne Robinson, chair of the HFMA's Mental Health Finance Steering Group, the debate has long centred on the implementation of clustering. But it is much wider than that.

'It can get confusing,' she says. 'Clustering, the mental health service data set (MHSDS), the Model Hospital, the mental health investment standard (MHIS), outcomes measures (such as the Health of the Nation Outcome Scales, HoNoS) patient-level costing, reference costs… the list goes on. Which one adds most value? And how do we prioritise where we direct our resources? It can often depend on who you ask.'

A task and finish group led by NHS England and NHS Improvement has been looking at tariff development, which is underpinned by having good data. The group has been looking at current uptake and trying to understand why there hasn't been universal appetite for this and possible alternative designs that could be adopted.

Finance practitioners and clinicians at an HFMA workshop in July discussed the different data and information sources available and how the sector should navigate these to provide a clear roadmap to implement an agreed way forward. The session was framed around five

SHUTTERSTOCK

principles. The data and information framework:

1. Needs to be simple
2. Needs to be clinically engaging
3. Needs to be meaningful for commissioner and providers
4. Must deliver value for money from any investment in infrastructure
5. Must utilise the expertise of highly skilled costing practitioners and information specialists.

Cluster focus

One area receiving attention is the currency built around mental health clusters. Introduced around 2012, the 21 clusters group patients by their characteristics and requirements, rather than the individual interventions they receive or their diagnosis. Providers have had to submit cluster-based costs for much of the last decade as part of their reference cost submissions.

The original key driver for the cluster currency was to support the development of a payment system amid concerns that the lack of a link between payment and activity was disadvantaging the mental health sector. In some providers, use of clusters has been embedded well – with clusters providing the initial way to separate out different pathways and explore variation within them. But this is not the case everywhere.

One deputy medical director at the workshop said clustering at his trust was seen as a bureaucratic exercise – with a system based on diagnosis and condition complexity likely to have more resonance with clinicians. However, there appears to be broader acceptance of the HoNoS scales that are used as a core part of the clustering process.

A finance director said clusters were not being universally used and were not well understood outside mental health secondary care. To really be useful in developing mental health services, GPs and social care would need to be familiar with their use, he said. The fact that this wasn't the case undermined moves to system working and integrated care.

Practitioners said the world had moved on from activity-based payment approaches. With capitated budgets now seen as the future, was a payment currency even relevant?

Recognising that the current currency approach is not working as well as it could for the sector, NHS England and NHS Improvement have been reviewing the suitability of clusters. As part of this review, the organisations have looked at a number of options to develop a currency model that suits service delivery and incentivises high-quality care. This has included a review of existing local approaches.

One trust has been implementing a system where clinicians assign patients to condition-specific pathways. Cluster allocation has been standardised through use of an algorithm and clusters are used to understand patient severity and risk. Another provider has developed a needs-based currency approach, grouping patients based on their team/setting and their needs and engagement with their care.

The review has noted that all the local approaches work well when the organisation is committed to them and use the information that underpins the currency model for other purposes. This includes the clusters. NHS England and NHS Improvement plan further testing to identify the most appropriate approach.

For many finance practitioners at the HFMA workshop, the need for a national currency is inextricably tied up with payment by results and the context has changed. If integrated care systems develop as many commentators suggest they should, the service could be moving towards capitated budgets covering whole populations rather than paying for individual episodes of care.

Helen Todman, NHS England and NHS Improvement mental health infrastructure programme manager, says there is a consensus at the centre on the need for a currency. 'A national currency model supports effective investment, by improving the transparency of funding flows through the mental health payment system, which works alongside the mental health investment standard (MHIS) to ensure that long-term plan priorities have sufficient investment,' she says.

And she insists that whatever payment system is used – locally or nationally – needs to be informed by a currency (see box). 'We have to have a currency as a building block for any funding system,' she says, 'whether that is blended payment or population-based.'

A currency also enables services to demonstrate how much safe and effective care costs, she adds. 'Currency allows understanding of whether services are delivering value to patients; by providing comparison between the cost of service delivery with quality, safety and effectiveness for specific patient groups,' she says.

Costing – and in particular the move to patient-level costing – is one of the other issues challenging mental health finance managers. There are different views around the introduction of patient-level costing for mental health providers. Some organisations have been pursuing patient-level costing for years, despite typically having fewer resources dedicated to costing than acute providers.

North Staffordshire Combined Healthcare NHS Trust implemented patient-level costing in 2015 and has been an early implementer of the new national costing standards. Its work was recognised with the HFMA Costing Award in 2016.

But not all mental health trusts have made this sort of progress and

Payment plan

July's *NHS mental health implementation plan* states clearly that NHS England and NHS Improvement remain committed to developing national payment approaches for adult and older, perinatal and children's mental health services. 'This will involve review of current approaches to develop a national currency model, piloting of models with mental health systems, and implementation from 2020/21.'

As a starting point, a blended payment system has been issued this year as a default mechanism for mental health service contracting.

The new system splits payment into three components. A fixed element is based on the agreed forecast level of activity required to meet planning objectives. A variable element is based on an estimate of the incremental cost of activity increasing or decreasing. The third element links payment to locally agreed outcomes.

This has been introduced to ensure activity is rewarded and that systems are incentivised to deliver improved outcomes. It is expected that further development of this approach will take place over the coming years, including to the underlying currency.

According to the blended payment guidance, 'mental health clusters are the basis for the blended payment approach'.

However, use of an alternative currency is possible. Clusters have been the set currency for years, yet uptake in contracts has been limited or tokenistic.

The 2017/19 tariff guidance, for example, called for mental health contracts to use episodes of care based on care cluster currencies or capitation 'having regard to the care cluster currencies'.

Despite this, most contracts up until this year have remained on a block basis – simply rolling forward the previous year's contract values updated for new investment and price increases.

some managers at the workshop said it was hard to make a business case locally for the investment of time and money needed to meet next year's mandatory patient-level cost submission deadline. (Acute trusts faced their first mandatory collection this year.)

Ms Robinson says the sector is committed to ensuring all services add value and make a difference and that it maximises the value of the mental health pound. 'But there is concern that clustering and a tariff-based system may not answer this question from a system perspective, at least not in the short/medium term,' she says.

It was highlighted that a huge amount of detailed data is needed to deliver a patient-level cost submission. Some at the workshop said this was difficult to deliver with current information systems and would provide uncertain benefits – especially given the existence of other benchmarking tools such as the Model Hospital. (The plan is for the Model Hospital to draw information direct from patient-level cost data, but it currently uses a bespoke collection for workforce cost submission.)

For some, the key issue is timescale and prioritising the initiatives that will best support the delivery of the long-term plan goals.

'There may be more value in focusing in the short term on the key data sets,' says Ms Robinson, although there is some recognition around the service that the overall goal of developing a deeper understanding of patient costs is valuable. And the demanding deadlines for patient-level costing have encouraged some trusts to make steps towards being compliant, even if many are still some way off being able to produce meaningful patient-level costs.

Mental health trusts are often less well advanced in terms of costing than acute colleagues, a position created by the introduction of tariff-based systems in the acute sector many years ago. This has driven up the data quality for acute trusts, but there are questionmarks around the affordability of the framework for mental health trusts. Ms Robinson believes there is a danger that next year's costing submission could end up as a tick-box exercise producing data of little value.

One finance director at the workshop was concerned there would be no return on patient-level costing if it was just an annual submission that disappeared into a central black hole. It has to add value. Simply cranking the handle to make the submission would consume all a typical mental health trust costing team's time, when these teams could be more usefully supporting clinical teams to improve service costs, he said.

Improving transparency

Ms Robinson believes improving transparency around the mental health investment standard (MHIS) should be top of the agenda. This should focus on helping to demonstrate that the standard is being met and that additional investment from the forward view and the long-term plan is reaching its intended areas. Beyond that, she says, agreeing a common, well-defined set of service lines would improve the sector's ability to compare and contrast and provide better assurance across systems (and multiple providers) that they are making a difference.

There is broad support for the goals set out for mental health in the *NHS long-term plan*. Management information will be vital in helping to deliver these goals and demonstrating their achievement. But the clear message from July's HFMA workshop was that current initiatives should be working together to ensure they support these goals. And timescales must take into account the sector's starting point and existing pressures.

The HFMA Mental Health Finance Faculty is working with NHS England and NHS Improvement to set out some principles and key milestones that might support a clearer roadmap for mental health providers to work to on their costing journey.

hfma
professional lives
Events, people and support for finance practitioners

Increased spending limit reduces capital concerns, but better forecasting needed

Technical

Capital funding may have taken a back seat in recent years with an all-consuming focus on limiting providers' revenue deficit, *writes Steve Brown*. But it moved firmly back to centre stage, dominating discussions in finance circles in the early summer. Julian Kelly gave up a good proportion of his first major speech to the profession since becoming chief financial officer at NHS England and NHS Improvement to it.

There was a specific problem this year. NHS providers' initial plans for spending on capital for 2019/20 would have breached the Department of Health and Social Care's capital departmental expenditure limit (CDEL).

In fact, this is not that unusual. Take 2018/19 – providers started the year planning to spend £4.64bn, despite just £3.46bn of capital being available in their initial allocation from CDEL. They ended the year with actual spend of £3.93bn – an underspend of £712m compared with plan, but still nearly £400m over their final allocation.

The DHSC accounts – published in July – confirmed this overspend against CDEL by providers was compensated for by underspends in central capital budgets, giving an underspend against the overall CDEL of £42m.

Providers also overspent their CDEL allocation in 2016/17 (see table).

It is curious that in 2018/19, providers set off the year planning to spend £1.2bn or 35% more than was available – but triggered no central crackdown. The DHSC has traditionally been able to rely on providers significantly underspending against their capital plans – by more than £1bn in 2016/17 and 2017/18 and by more than £700m in 2018/19.

But 2019/20 was seen as providing something of a perfect storm, meaning that actual spending would get a lot closer to planned levels. Limited capital (CDEL) for the service overall; a growing need for capital projects to address backlog maintenance and underpin new models of care; and crucially, in some organisations, the cash available to fund these schemes.

Providers' capital spending

	Plan £m	Actual £m	(Underspend)/ overspend against plan £m	Available CDEL £m	(Underspend)/ overspend against available CDEL £m
2016/17	4,071	2,900	(1,171)	2,774	126
2017/18	4,334	3,063	(1,271)	3,330	(267)
2018/19	4,644	3,932	(712)	3,555	377

Plan figures taken from NHS Improvement quarter 4 figures. Actual, available CDEL and underspend against CDEL from Department of Health/Department of Health and Social Care annual accounts. Underspend/overspend against plan is calculated

This cash has been built up thanks to the Provider Sustainability Fund, which has rewarded trusts that were able to improve their financial position compared to control totals. In many cases, this revenue belt-tightening was sold to clinicians with an explicit promise that it would enable capital investment this year.

Calls on the service by Mr Kelly's department to voluntarily reduce these capital plans – by a reported 20% – did not appear to be delivering the required reduction. It was looking as though cuts and capital control totals might be imposed.

But the increased capital funding announced by Boris Johnson as part of the new prime minister's spending spree in August has now removed this specific tension. Of the £1.8bn cash injection, £850m is tied to specific projects, but £1bn is being used to enable increased capital spending this year – removing the need for the 20% cut in planned spending.

This led to an interesting debate on whether the £1bn actually represented new money. No, said the respected Nuffield Trust, arguing that providers were merely being allowed to spend their own savings. Yes, insisted the government, pointing to a real increase in the departmental spending limit.

It is easy to see both sides. The cash will indeed, at least in part, come from trust reserves. But is this really smoke and mirrors? This is the case every year. The CDEL sets the limit for all capital spending, irrespective of whether it is financed by public dividend capital, a loan from the Department or internally generated funds including depreciation charges and previously made surpluses.

But back to the issue of planned capital spending and limits. The real difficulty for the Department is knowing how actual capital spending will turn out. Hoping previous years' underspending against plan will materialise again is being judged as too risky and Mr Kelly wants to see capital forecasting improve.

In an August letter, providing details of the increased spending limit, he called for the NHS to 'collectively improve our forecasts and provide a taut and realistic view of the forecast outturn for your organisations in September'.

More specifically, Mr Kelly previously told the HFMA summer conference that he wanted trusts' mid-year forecasts to be within 1% of their outturn spend.

Technical review

The past two months' key technical developments

Technical

The Department of Health and Social Care will produce additional guidance as part of the finalisation of the IFRS 16 guidance and this will flow into the 2020/21 *Group accounting manual*. The Department's response to the consultation on the 2019/20 manual, which included a consultation on an IFRS 16 supplement, said the public sector approach to the **new leasing standard** remained a work-in-progress. Respondents requested additional guidance on the use of IFRS 16 to measure liabilities arising from service concession arrangements and on how recognition and derecognition will work in accounting for subleases. With the Treasury finalising the accounting and budgeting approach, this will enable robust guidance to be developed in the manual around all of the proposed public sector interpretations and adaptions of IFRS 16, the Department said. The HFMA also updated its *Accounting for leases – application of IFRS 16* briefing at the end of July. **hfma.to/9t**

Newly published guidance from NHS England and NHS Improvement aims to support commissioners looking to develop an integrated budget as part of the integrated care provider (ICP) contract. The guidance introduces the **whole population budget** (WPB) approach and summarises the steps involved in designing a pooled budget. A whole population budget represents the total payment amount available to the ICP for all services in-scope for the whole population, which could include general practice, NHS and potentially local authority services. Key steps in developing a WPB include: calculating the WPB baseline; estimating WPB values for future years; and converting estimated WPB values to contract values for each year in a contract. A question and answer document has also been published on the ICP contract, covering issues such as the impact for the voluntary sector and VAT recovery. **hfma.to/9u**

The key points in the *NHS mental health implementation plan 2019/20-2023/24* are set out in a new summary briefing from the HFMA. The implementation plan explains how a £2.3bn local investment fund will be used to build upon the work of the *Five-year forward view for mental health*. It also describes how the ambitions for **mental health** fit with the system planning approach and other sections of the *NHS long-term plan*. **hfma.to/mhip**

A **personalised care** handbook covers the finance, commissioning and contracting aspects of implementing personalised care locally. The guidance aims to help staff understand what the expansion of the programmes means for their areas of work, the support available, and the impact on current processes. The guidance covers methods for funding personalised care but stresses that it is crucial to maintain stability of the provider sector. **hfma.to/9v**

The first clinical service **benchmarking** metrics have been launched as part of the Model Community Health Services. The metrics cover 10 key areas and are based on organisations' submissions to the community services data set. The range of services covered will be expanded over the next year. **model.nhs.uk/**

NHS Improvement has published **trust accounts consolidation (TAC) data** for 2018/19. The information is drawn from the information trusts are required to include in their annual accounts. However, the data does not include all consolidation adjustments made by NHS Improvement, such as those to eliminate income and expenditure between NHS providers. This means it may not agree with the consolidated provider accounts. **hfma.to/9w**

Treatment for SMA patients gets go-ahead

Technical: NICE

NICE published nine technology appraisals, one public health guideline and one diagnostics guidance item this summer.

Under guidance TA588, *Nusinersen for treating spinal muscular atrophy,* more children with the rare genetic disorder spinal muscular atrophy (SMA) can be treated. This followed a proposal to extend the terms of the managed access agreement between NHS England and Biogen for funding it.

SMA affects the nerves in the spinal cord controlling movement, causing muscle weakness, progressive movement loss and difficulty breathing and swallowing. Those with the most severe forms usually die before the age of two. Without nusinersen, the condition is managed with supportive care to minimise the impact of disability, tackle complications and improve quality of life.

A further technology appraisal, TA593, recommends ribociclib used with fulvestrant as an option for people with hormone receptor-positive, human epidermal growth factor receptor 2 (HER2)-negative, locally advanced or metastatic breast cancer who have had previous endocrine therapy.

The positive recommendation follows an improved patient access scheme by the company as part of a commercial arrangement. The appraisal committee recognised that ribociclib with fulvestrant has the potential to be cost-effective, and recommended it for use in the Cancer Drugs Fund. This will allow more evidence to be collected to address the uncertainties around overall survival and cost-effectiveness.

Elsewhere, guideline NG135, *Alcohol interventions in secondary and further education*, replaces NICE public health guideline PH7 (November 2007). The interventions aim to prevent and reduce alcohol use among those aged 11 to 18. It also covers people aged 11 to 25 with special educational needs or disabilities in full-time education. Costs associated with implementing the guideline are not expected to be significant.

NHS in numbers

A closer look at the data behind NHS finance

Providers

Technical

We may be moving towards system working, but providers – both NHS trusts and foundation trusts – remain major players in the achievement of the *NHS long-term plan*.

The service ended 2018/19 with 227 providers in total and twice as many foundation trusts (150) as trusts (77). This followed some minor reconfiguration during the year with the dissolution of two trusts and one foundation trust, following acquisitions by foundation trusts.

So, NHS Improvement's *Consolidated NHS provider accounts 2018/19* reports that there were 230 NHS providers in existence during the year.

Of these 230 providers, 133 acutes accounted for 75% of the overall sector's £85bn turnover (up from £81bn the previous year). Some 53 mental health trusts shared a further 15%, with the remainder split across 10 ambulance trusts, 17 specialist trusts and 17 community trusts.

The acute sector was also primarily responsible for the sector's overspend. Acute providers' £1.3bn deficit was offset by a net surplus of £416m across mental health trusts, £209m for specialist trusts and a combined £78m for ambulance and community trusts. In total, this delivered a £575m overall provider sector deficit.

Not all acute providers made a deficit and not all non-acutes were in surplus. Of 106 providers reporting a deficit for the year (before impairments and transfers), 88 were acute, seven mental health, three each for ambulance and community and five specialist.

The gross deficit of all providers in deficit was £2.7bn – up from the £2.4bn recorded by 101 deficit trusts in 2017/18. Ten of the most financially challenged trusts are in the financial special measures programme and made up 26% of the reported gross deficit. (See figure below for trusts with deficits greater than £30m.)

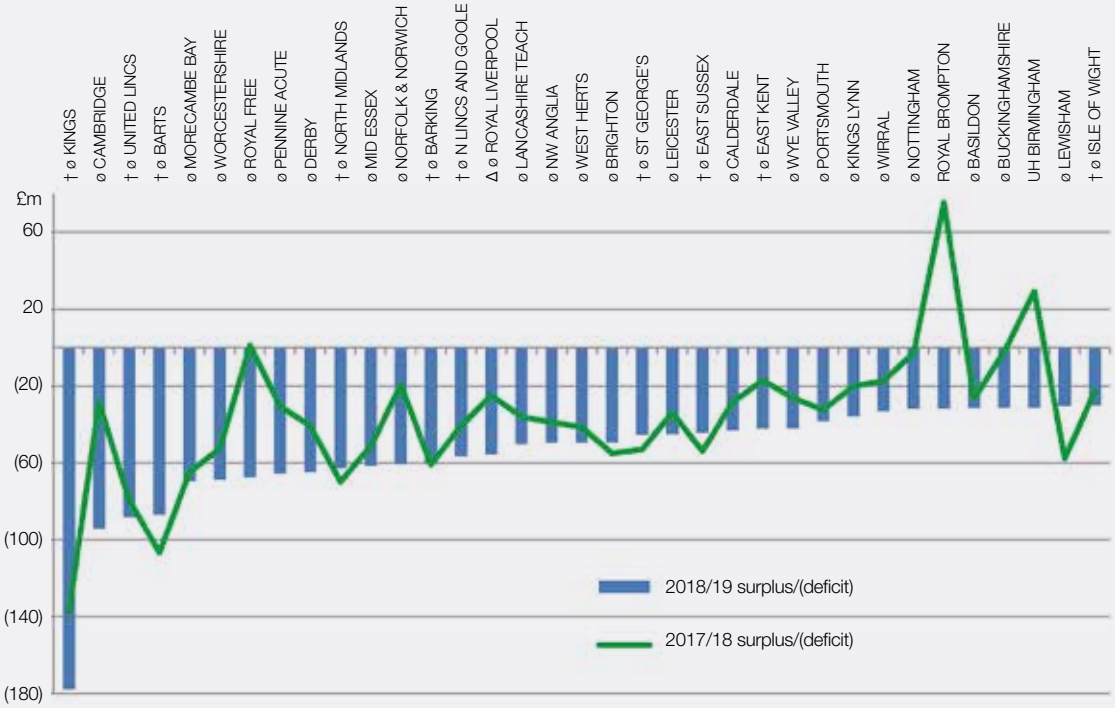
There were a total of 124 trusts that made a surplus or broke even.

The overall financial position of the sector benefited from £2.45bn of funding from the Provider Sustainability Fund (PSF). Access to the fund depended on providers accepting and achieving a financial control total, 92 of which were set below break-even (after PSF).

Some 201 providers accepted their control totals in 2018/19, and 149 of these met or exceeded their full-year control total and received their full entitlement of PSF income. A further 43 providers received part of their initial PSF allocation and eight providers didn't meet their control total at any point in the year but benefited from a general distribution of the fund.

In addition, three providers received PSF funding where their integrated care system exceeded its system plan, but the providers did not accept an individual control total.

Deficit before impairments and absorption transfers greater than £30m



† Receiving intensive support through the financial special measures programme as at 31 March 2019
ø In receipt of interim revenue support funding from DHSC during 2018/19
Δ Excludes gain recognised on part-constructed PFI asset following liquidation of Carillion

Source: NHS Improvement

Bitesize learning

By Alison Myles, HFMA director of education

News and views from the HFMA Academy

Training

Around 500 learners have now achieved a qualification from the HFMA Academy, helping to improve these individuals' knowledge and career prospects. Some of them are even continuing their studies by moving on to the MBA programme with our partner university BPP.

Studying while working in a highly pressured environment requires real commitment, and the academic route is not for everyone. Recognising this, the HFMA Academy is developing new bitesize continuing professional development (CPD) courses.

The new CPD courses will be based on the same subjects that make up the qualifications and draw on much of the same content. Available from the end of 2019, each diploma module will be broken down into at least 10 different courses.

All three of the intermediate (level 4) modules are being given the bitesize treatment – *How finance works in the NHS; Governance and risk management*; and *Management skills*. The advanced (level 7) module *Tools to support decision making* will also be made available as CPD programmes.

For example, the level 4 *How finance works in the NHS* module will include separate bitesize courses covering healthcare financing, commissioning, providing services, revenue and capital, and integration – to name just a few.

These new bitesize courses will not feature the live elements that characterise the studying approach used for the intermediate and advanced diplomas. So there will be no tutor-led sessions or discussions.

However, students will benefit from much greater flexibility and will be able to start a course whenever they want, rather than wait for the next cohort start date.

They will be encouraged to complete the course in a set time period, although access to the material will last for longer than this.

There is no formal application/acceptance and paying on a course-by-course basis may be more suitable for individuals and organisations in some cases.

The courses themselves will not lead to level 4 or level 7 qualifications and do not include support for the development of academic skills.

> "As well as appealing to individuals from all disciplines within the NHS and social care, the new bitesize courses should also be of interest to department managers"

However, following completion of all the courses that make up a module, certificate or award, a student would be free to pay an additional fee and complete the qualification module assessment, giving them a chance to gain the relevant certificate, award or diploma.

As well as appealing to individuals from all disciplines within the NHS and social care, the courses should also be of interest to department managers. Feedback suggests that there is a demand for affordable training that could be offered more broadly to staff to fill training needs identified in the appraisal process.

Each bitesize CPD course will take around six to 10 hours on average to complete and will include in-built opportunities for students to test their understanding of the subject.

The new bitesize courses sit neatly between the association's existing e-learning offerings and higher level qualifications – both in terms of the detail provided and the commitment needed.

We think they will prove a popular way to enable more people to access the growing educational resources provided by the Academy.

Finance Leadership Council changes

Future focused finance

Following recent changes to the structure of NHS England and NHS Improvement, members of the Finance Leadership Council (FLC) have been changed so that the senior responsible officers (SROs) leading Future-Focused Finance's five themes and the chair of the Finance Development Foundation (FDF) become full voting members.

This will ensure a broad spectrum of finance staff is represented at meetings, with members having a detailed understanding of day-to-day issues that affect colleagues working in trusts, CCGs and national bodies.

The FLC was set up in 2014 to support FFF programmes and the Finance Staff Development Network to ensure consistent, high-quality finance development across the NHS in England.

The FLC's membership now includes the following leaders:

- **Julian Kelly**, NHS chief financial officer (chair)
- **Chris Young**, finance director, Department of Health and Social Care
- **Calum Pallister**, director of finance, Health Education England
- **Alex Gild**, HFMA representative, and chief financial officer, Berkshire Healthcare NHS Foundation Trust
- **Jill Robinson**, finance director, Shrewsbury and Telford and Wrekin Sustainability and Transformation Partnership (SRO)
- **Claire Yarwood**, chief finance officer, Manchester Health and Care Commissioning (SRO)
- **Simon Worthington**, director of finance, The Leeds Teaching Hospitals NHS Trust (SRO)
- **Adrian Snarr**, director of financial control, NHS England and NHS Improvement (SRO)
- **Richard Alexander**, chief finance officer, Imperial Healthcare NHS Trust (SRO)
- **Andrea McGee**, director of finance and commercial development, Warrington and Halton NHS Foundation Trust (FDF chair).

Diary

September

12-13 B South Central: annual conference
18 I Institute: introduction to costing, London
19-20 B Wales: conference, The Vale resort
23-24 N CEO forum and dinner, London
25 F Provider/Commissioning Finance: technical forum, London
26-27 B South West: conference, Bristol

October

1 F Provider Finance: NHS as an anchor institution, webinar
3 I Institute: international symposium, London
10 F Chair, Non-executive Director and Lay Member: forum, London
11-12 B Kent Surrey Sussex: conference
15 I Institute: costing with informatics, webinar
17 I Institute: costing together (North), Manchester
17 N Mental Health Finance: conference, London
18 B Eastern: conference, Newmarket
23 N Could the Government Digital Service and GOV.UK Pay help my trust? webinar
24 B Wales: VAT training day, Cardiff
24-25 B Scotland: conference
30 B London: annual conference, London
31 F Chair, Non-executive Director and Lay Member: harnessing the power of internal audit, webinar

November

7 N Estates forum, London
7-8 B Northern: conference
12 N Charitable funds, London
13 F Audit conference, London
14-15 B East Midlands: conference
14 F Commissioning Finance: forum, London
21 B London: VAT level 2
21-22 B Northern Ireland: conference
27 I Institute: technical costing update

December

4-6 N HFMA annual conference, London

For more information on any of these events please email events@hfma.org.uk

key B Branch N National F Faculty I Institute

CPD accredited events and webinars

The HFMA is pleased to announce it has achieved accredited continuing professional development (CPD) status with the CPD Standards Office for its national and network events and webinars.

Delegates who attend one of these events or webinars will be issued with an accredited CPD certificate of attendance for inclusion in their CPD records for their professional body, institute, regulator or employer.

Previous attendance at HFMA events and webinars counted towards CPD, but these would have been 'unaccredited hours'. Several professional bodies are now insisting that up to 50% of CPD should be accredited hours – where members are taking part in accredited activities.

Now that the HFMA's national and network events have achieved this accreditation, the association is committed to working hard to maintain, and exceed, the excellent standard it has already set. The HFMA's e-learning modules and NHS operating game also have CPD accreditation.

Events in focus

Estates and facilities forum
7 November, London

NHS capital funding has been high on the news agenda this summer, with the prime minister giving the service access to additional funds this year and pledging £850m for 20 capital projects (*see p23*). The Naylor review of 2017 set the direction of travel for NHS estates in England, estimating that total sustainability and transformation partnership capital requirements could reach £10bn, but also highlighted opportunities to release capital funding by selling surplus estate. STPs now have estates plans with proposals for capital investment to support the transformation of services across their systems, though the long-term funding picture remains unclear.

This conference – aimed at senior finance and facilities staff – will explore how capital can be financed, as well as considering strategic estate planning at a system-wide level. It will look at how to maximise estate productivity, ensure construction and maintainance is sustainable and increase energy efficiency. The event is free to all HFMA members and is open to non-HFMA members.

• **For more details, email josie.baskerville@hfma.org.uk**

HFMA annual conference
4-6 December, London

The highlight of the NHS finance year is fast approaching, with less than three months until the HFMA annual conference. Finance staff from across the UK will gather under the theme of 2019 HFMA president, Bill Gregory – *Value the opportunity* – in London at the beginning of December.

It is a time of significant transformation and ambitious plans across the UK as nations seek to address challenges such as staff shortages, an ageing population, rising demand and increasing costs. At the same time, the NHS must face external challenges, such as the UK's exit from the EU.

The annual conference offers an unparalleled opportunity to hear from the leading thinkers on healthcare finance from home and abroad, learn about best practice, see different approaches to common issues and to network with colleagues. There will also be a chance to celebrate the best of NHS finance at the annual HFMA Awards ceremony, held during the conference. Conference speakers include NHS England and NHS Improvement chief financial officer Julian Kelly (pictured), NHS productivity and efficiency leader Lord Carter and BBC Europe editor Katya Adler.

• **Email josie.baskerville@hfma.org.uk or visit the HFMA website for details**

New term time

Association view from Mark Knight, HFMA chief executive

To contact the chief executive, email chiefexec@hfma.org.uk

My HFMA

We are now emerging from the summer holiday period and I hope that, if you managed to get some time off during July or August, it was relaxing and enjoyable.

It has been an eventful couple of months in the life of our nation, with the accession of new prime minister Boris Johnson. It will be fascinating to see how the Brexit issue is resolved over the coming months with his hardening stance over leaving the EU.

A spin-off from his appointment has been announcements around transport, full-fibre broadband and, of more direct relevance to those of us working in the health service, a much needed injection of capital into the NHS.

The ensuing debate about whether money was really new or not is possibly the first time that the mechanics of the capital departmental expenditure limit and how this spending allowance is funded have been discussed in the mainstream media (see technical page 23).

There is a more important debate needed around how far this goes towards meeting the service's capital investment needs.

It is an issue the HFMA continues to promote, as well as continuing to provide valuable feedback to central bodies. I'd like to thank all those involved in the development of this work.

September is a busy month for the association as we start our autumn term leading up to the annual conference in December.

We have three branch conferences during the month – South Central, South West and Wales – all of which are usually very well attended. The contributions made by the local committees are invaluable, whether in programme design and delivery, turning up on the day to volunteer or supporting sponsorship.

While there is some paid help, it is the energy and enthusiasm of volunteers that makes our operation tick in these and other places.

As far as national events go, we will be hosting another chief executive forum in September.

HFMA chief executive Mark Knight

It's important we provide services for all our member groups and twice a year we invite chief executives along for a finance-related briefing.

There are also quite a number of chief executives who are former finance directors, so for them it's a chance to keep in touch with friends and colleagues.

In early October, the Healthcare Costing for Value Institute hosts its annual international symposium. Experts from across the globe will come to the UK to talk about what's going on in their country in terms of value-based healthcare. With a couple of member webinars and a few other national meetings, it all adds up to a packed line-up for this month.

The autumn will also see the usual round of committees. The HFMA has an extensive list of groups and committees in areas such as policy, governance and accounting. We're often looking for new faces for these groups, so look out for notifications of vacancies or contact me directly at chiefexec@hfma.org.uk

Enjoy the rest of the summer and I hope to see you at one of our autumn events.

Member news

Team HFMA, taking on the Three peaks challenge in October, has already raised over £5,150 for mental health charity Mind. This includes more than £950 from a raffle at the HFMA Summer conference and £636 in a raffle at the West Midlands Branch annual conference. Team HFMA went on a practice walk in the Brecon Beacons (pictured) to prepare for the challenge and are planning further fundraising activities to reach their goal. Support them at hfma.to/3peaks

The HFMA Northern Branch has introduced an initiative to improve engagement and communication with finance colleagues in the region. HFMA champions in each organisation in the area will promote HFMA opportunities in their finance teams, ensure people are aware of mentorship opportunities, and motivate them to submit nominations for the annual branch awards and the national HFMA Awards. For further information, please email catherine.grant2@nhs.net

On the hottest day in June, Stuart Wayment cycled 45 miles in the New Forest as part of the Wiggle New Forest Sportive. It is the latest in his fundraising efforts for PLANETS Cancer Charity, which helps patients with pancreatic, liver, colorectal, abdominal and neuroendocrine cancer by funding patient support groups, treatments and research. Support him at: uk.virginmoneygiving.com/StuartWayment

Do you have any news about you, your team or a colleague, that you would like to see in our membership news or appointments sections? Please email yuliya.kosharevska@hfma.org.uk with the details.

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Member benefits

Membership benefits include a subscription to *Healthcare Finance* and full access to the HFMA news alert service. Our membership rate is £65, with reductions for more junior staff and retired members. For more information, go to www.hfma.org.uk or email membership@hfma.org.uk

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Academy

Looking to help shape the future of healthcare finance?

From January 2020, HFMA will be offering apprenticeships in Professional Accounting. We are looking for a team of experienced finance professionals, with NHS management or accounting experience, to help us deliver our new apprenticeship programmes within the healthcare context. The role will include training and coaching apprentices, supporting learners in the workplace and providing guidance to both learners and employers. **Training will be provided.**

Visit **hfma.to/skillscoach** to find out more and apply

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HFMA national and network events are now CPD accredited

Book onto one of our CPD accredited events here: **hfma.to/hfmaevents**

The CPD Standards Office
CPD PROVIDER: 50137
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Accredited cpd Activity

Key supporters recognised

The HFMA honoured members who have made a significant contribution to the association at a key supporters dinner in London this summer

awards

The association awarded four honorary fellowships and five key contributor awards. The winners received their awards from HFMA president Bill Gregory during a ceremony at the Institution of Civil Engineers in London.

Chief executive Mark Knight said the HFMA would not be as successful without its key supporters, who work hard for the association. 'Thank you to all our award winners and to all of our members, our key contributors, our corporate partners and all the staff at HFMA. We really do depend on your support and loyalty and it is you that make us unique.'

Honorary fellowships, which recognise members who have made a sustained contribution to the life and work of the association, went to:

Pam Hobbs Nominated by the HFMA South Central Branch and the Skills Development Network, Ms Hobbs (left) has been an advocate of finance staff development throughout her career. She cares deeply about providing opportunities for school leavers, graduates and those in roles to progress in their careers through learning.

Ros Preen Ms Preen (right) has been an HFMA member throughout her career in the NHS, spanning more than 20 years. She recently stepped down from the association's board of trustees and the fellowship is an acknowledgment of her service. (Ms Preen was unable to attend the presentation and received her award later in the summer.)

Tim Crowley The HFMA North-West Branch nominated Mr Crowley (left) to acknowledge his commitment to local NHS finance over many years. The award is a mark of its appreciation of his work and the fact that his input will be greatly missed now that he has stepped down from the Mersey Internal Audit Agency.

Jonathan Stephens Nominated by the HFMA Payment Systems and Specialised Services Group, Mr Stephens (left) previously took an active role in the association's Prescribed Specialised Services Commissioning Group. He continued to chair the group when it merged and has only recently stepped down. The group said his vast knowledge and a level head have been great assets and he has always ensured detailed and often difficult discussions are kept focused.

The association made three bronze and two silver **key contributor awards**. The bronze awards went to:

Mike Townsend A stalwart of both local and national HFMA activities, Mr Townsend (left) was nominated by the Kent, Surrey and Sussex Branch. As well as playing a key role in the branch for at least 12 years, he is also a member of the national HFMA Governance and Audit Committee. He single-handedly organises one of the branch's largest events each year, the annual accounting standards update, and turns what some think as a dry topic into an entertaining informative session.

Neil Kemsley Mr Kemsley (right) was honoured for his work with the South West Branch, which he chaired. Described as having a calm and welcoming manner, his leadership skills invigorated the branch and brought together an excellent, proactive committee. Those who have worked with him will have benefited from his focus and commitment.

Sheila Stenson Mr Knight paid tribute to Ms Stenson's commitment to the HFMA. She is currently Kent, Surrey and Sussex Branch chair and is passionate about staff development, the branch and its members. She won the HFMA Deputy Finance Director of the Year Award in 2016 and was the first member of the national talent development pool to secure a finance director post. (Ms Stenson, right, was unable to attend the presentation.)

The silver award is given to bronze award winners who continue to contribute to the association. This year's winners were:

Kavita Gnanaolivu Ms Gnanaolivu (left) has played an active role in the Wales Branch for more than 10 years and is the driving force behind its research and development work. She has led and contributed to projects that have benefited the NHS in Wales and the UK.

Phil Foster Mr Foster (right) was nominated by the Provider Finance Faculty Technical Issues Group. A supporter of the HFMA for years, he is the faculty's vice chair. His experience and knowledge are greatly valued by the group. He can be relied upon to comment on any issues that arise and often brings new issues to the committee's attention.

Branch focus

My HFMA **West Midlands**

The *NHS people plan* encourages collaborative working throughout the NHS, including between finance and human resources professionals. 'We can't continue to work in silos, as disjointed working has an impact on expenditure and efficiencies,' says Kim Li (pictured), director of finance at South Warwickshire NHS Foundation Trust and chair of the HFMA West Midlands Branch.

To empower finance professionals to appreciate working with HR colleagues, the branch is hosting a joint event with the Healthcare People Management Association (HPMA) on 18 October to highlight the *NHS people plan* and the value of working in collaboration.

Speakers include NHS England and NHS Improvement director of workforce and organisational development Steve Morrison, who will explore the opportunities for effectiveness and efficiency involved in the *NHS people plan*.

'No organisation has all the answers,' says Ms Li. If people come together, she says, they will have the chance to exchange and develop ideas.

'The role of commissioning is changing, and providers will take on more of the tactical commissioning currently managed by clinical commissioning groups. The closer we work now, the smoother this transition will be,' says Ms Li. 'We are moving from competition to collaboration and this will require a different skillset and more soft skills.'

The *NHS people plan* aims to make the NHS an employer of excellence and to improve the leadership culture. The HFMA has a key part in supporting its members in achieving these objectives.

The need for finance professionals to develop soft skills was also the driver for the branch to organise four workshops focused on coaching for resilience and performance management. They aimed to develop participants' coaching skills to support themselves and their teams. Ms Li, a strong advocate of coaching, says the HFMA can provide technical knowledge and focus on skills.

The coaching events were so well-received by branch members that the committee is looking to make this support available in the upcoming year.

• For more on the branch, visit hfma.to/westmids or email fleur.sylvester@hfma.org.uk to share your views

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Appointments

James Drury is the new interim director of finance at Shrewsbury and Telford Hospital NHS Trust. Mr Drury has nearly 15 years' experience working in the NHS, as well as 15 years at KPMG. He will remain in the position while the substantive director of finance **Neil Nisbet** is on secondment to NHS Improvement.

John Williams (pictured) has been appointed executive director of finance at Sheffield Children's NHS Foundation Trust. He joins after six years at Chesterfield Royal NHS Foundation Trust, where he was deputy director of finance and most recently managing director of its wholly owned subsidiary, Derbyshire Support and Facilities Services. Mr Williams has been part of the Future Focused Finance national talent pool. He takes over from **Mark Smith**, who remains at the trust as associate director of finance.

Two directors of finance have taken up charity trustee positions. **Rob Pickup** (pictured), interim director of finance, procurement and information management and technology at Dudley and Walsall Mental Health Partnership NHS Trust, is now also a trustee at John Taylor Hospice. The charity provides specialist support for people living with a terminal illness and their families. **Tracey Cotterill**, interim director of finance at Kingston Hospital NHS Foundation Trust, has become a trustee at Sustainability First, an environment think-tank with a focus on practical policy development in the areas of sustainable energy, waste and water. She is also a primary school governor.

Steve Warburton (pictured) has been named chief executive of the organisation to be created from the merger of Royal Liverpool and Broadgreen University Hospitals NHS Trust and Aintree University Hospital NHS Foundation Trust. The new organisation will be called Liverpool University Hospitals NHS Foundation Trust and the merger is scheduled to complete in October 2019. Mr Warburton is currently chief executive at Aintree University Hospital NHS Foundation Trust. He first joined the organisation as director of finance and business services and deputy chief executive in 2006 and became chief executive in 2015. Mr Warburton started his NHS career in 1989 as a graduate finance trainee in Mersey Regional Health Authority.

Hardev Virdee has been appointed group chief finance officer at Barts Health NHS Trust. He is currently the chief finance officer at Central and North West London NHS Foundation Trust. Mr Virdee who first began his NHS career as part of the national graduate training scheme, will be joining Barts Health in November, where he will take over from interim Bill Boa.

Obituary: Tony Waite

Left: Tony Waite at the 2008 HFMA Awards, when he was shortlisted for Finance Director of the Year

Obituary It was with great sadness that the HFMA learned of the passing of Tony Waite, a leading NHS finance director and enthusiastic contributor to the life of the association.

Two years' ago, he was diagnosed with a brain tumour, which was removed. Following treatment, he was hoping to use his expertise and experience in a non-executive role. However, his cancer returned, and he died peacefully on 2 August at the Wakefield Hospice. He is survived by his wife Lynn and two daughters.

A native of Wakefield, Mr Waite spent almost eight years as finance director of the local Mid Yorkshire Hospitals NHS Trust. When he joined in 2003, the trust was in deep financial difficulty. In 2003/04, it reported an £18.6m deficit, the largest of any single organisation in the English NHS that year.

As a result of ongoing financial difficulties, the trust was placed in special measures in 2007 – under the new financially challenged trusts regime. However, Mr Waite successfully led the trust out of special measures in 2009, partly by taking a system-wide approach involving the local primary care trusts and strategic health authority.

Andrew Pepper, who worked with Mr Waite at the Mid Yorkshire trust and has known him for 16 years, said: 'One of his main achievements at Mid Yorkshire was organising the new hospitals at Pinderfields and Pontefract. The time and effort, strategic thinking and resilience needed to deliver that was significant. I spoke to him a month or two ago and he said it was always his aim to get the doors open on the new hospitals, and he achieved that.'

'I got to know him personally and he was kind, generous and he had a brilliant strategic brain. Added to that, he had integrity, he had wisdom and he was fiercely loyal.'

Jane Hazelgrave, the current finance director at the Mid Yorkshire trust, also speaks warmly of Mr Waite. 'I was at the strategic health authority when Tony was at Mid Yorkshire and we did a lot of work together, particularly on the new private finance initiative hospitals and because the trust was financially challenged.

'The PFI was a mammoth job for him. He worked really hard on it and was instrumental in bringing the hospitals to the patients and populations of Wakefield and Pontefract. I don't think we would have these hospitals without him.'

Mr Waite is still fondly remembered in his former finance team in Wakefield. 'One of my heads of finance said he encouraged them to qualify and was so supportive in getting them there. Clinicians here also speak highly of him. He was a really nice person – I spoke with him frequently and he always gave me good advice.'

Mark Johnson worked with Mr Waite at the Mid Yorkshire trust while it was in special measures, having first met him through the HFMA. 'He was a really easy person to work with and led by example. He used to get everybody involved to produce a collaborative solution. He kept a stack of books where he'd write down the numbers and he'd refer to them during meetings. You knew you could never pull the wool over his eyes.'

He encouraged finance staff to join the HFMA – as well as chairing the HFMA Yorkshire and Humber Branch for many years, Mr Waite was also a member of the association's Provider Finance Faculty. He was always keen to support staff who wanted to add to their skills. 'Getting training was never an issue. He didn't force anyone to train, but he created an atmosphere where it was a positive thing,' Mr Johnson added.

> "The PFI was a mammoth job. Tony was instrumental in bringing the hospitals to the patients and populations of Wakefield and Pontefract. I don't think we would have these hospitals without him"

Mr Waite's work on the trust's financial turnaround and the PFI led him to be shortlisted for the HFMA Finance Director of the Year Award in 2008.

In 2011, he became finance director and deputy chief executive of Burton Hospitals NHS Foundation Trust and then joined Sandwell and West Birmingham NHS Trust in 2014 as finance director.

Toby Lewis, the Sandwell trust's chief executive, said: 'Tony was a valued colleague and leader in our organisation, with a wide circle of friends both inside and outside the trust. As one of the principal architects of our work on long-term finance, on new estate including the Midland Met, and on public health, Tony was passionate about the NHS and placed the highest value on improving the quality of patient care.

'I know that he remained fiercely proud of this organisation, clinically and in terms of our ambitious vision, and will be missed in all the organisations he served over a career with more than 30 years as a director, including his five years with us. Our aim going forward in his memory will be to continue to try and deliver our 2020 Vision – reporting back next year to local residents as we promised we would.

'Trust was such an important part of how Tony worked, and who he was, and I know he would want to try and build even more confidence from local people in the honesty with which we deliver change and improve care.'

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Could this be **your** year?

There's only one way to find out. The nominations for the HFMA Awards 2019 are closing soon. Nominate before **27 September.**

The HFMA Award categories for 2019 are:

- Finance Director of the Year
- Finance Team of the Year
- Deputy Finance Director of the Year
- Working with Finance – Clinician of the Year
- Costing Award
- Value and Innovation Award
- Governance Award
- Havelock Award

Find out more and submit your nominations at **hfma.to/awards**

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