NHS Improvement describes the Q2 results as the service being one-nil up at half time. Now Bob Alexander wants providers to maintain this performance for the second half. Steve Brown reports

HALF TIME LEAD

THEODORE WOOD

NHS providers are doing well financially in extremely trying times – and finance teams are playing a major part in this performance. So says Bob Alexander, director of resources and deputy chief executive at NHS Improvement. But he now wants those finance teams to lead a further push to contain this year's aggregate deficit within planned levels and to enable the service to start 2017/18 as close to run-rate balance as possible.

Mr Alexander, who will address the finance function at the HFMA annual conference this month, spoke to *Healthcare Finance* just after the oversight body had published financial figures for the first six months of 2016/17.

NHS Improvement claims the figures show a sector 'continuing its financial recovery'. While the overall year-to-date position was £22m over plan (compared with £5m under plan at Q1), the oversight body and regulator says the number of providers in deficit has reduced for a second consecutive quarter. And the monthly run-rate has seen 'significant improvement' compared with the same period last year.

The full-year forecast at the half-way mark is for a sector deficit – taking account of provider deficits and centrally held resources – of £669m. This would be £89m over the planned level of £580m, although NHS Improvement says it believes this plan could still be achieved. There is no longer any talk of reducing the current year overspend to £250m – the ambition targeted as part of the financial reset at the beginning of the summer. But this appears to be recognition of what the regulator accepts as 'continued unprecedented growth in demand for NHS services'.

'This is not positive spin,' he says. 'We are being realistic. But without a shadow of a doubt, organisations are working tremendously hard to keep to the financial plan – and at Q2, broadly the provider side is on plan and that is a really good effort.'

NHS Improvement chief executive Jim Mackey put it another way. 'Thanks to a phenomenal effort by staff across the NHS, we're one-nil up at half time.'

Mr Alexander acknowledges there are variations to forecast and that some cost improvements are loaded into the second half of the year – and this will require a redoubling of cost improvement effort. But while overall providers are behind plan in terms of cost improvements, the level of cost improvement in 2016/17 is ahead of last year. So, in summary, good work but more to do. And he is clear that NHS Improvement is determined to help providers meet their targets, not just berate them for under-performance.

Taking control

'We want to support finance professionals and their organisations more broadly in delivering the financial plan for the year and demonstrate to stakeholders that operational financial control exists against unrelenting demand pressure,' he says.

Mr Alexander says that while all providers face this pressure, some are struggling more, whether because of more severe pressures, historical context or other reasons. Providers' financial performance is underpinned

Model hospital

Lord Carter's final report on productivity called on NHS Improvement to develop a model hospital. This information system would bring together key metrics to describe 'what good looks like from board to ward' and enable trusts to compare themselves to national averages or peer organisations.

Six compartments of the model hospital are now live: hospital pharmacy and medicines; estates and facilities; headline finance metrics; visitor cost recovery; nursing and midwifery; and a test workforce analysis.

Further expansion is expected soon, following testing with a small cohort. This will add three modules: emergency medicine; trauma and orthopaedics; and allied health professionals.

New metrics are also being added to existing modules and data will be refreshed with the latest 2015/16 reference costs.

NHS Improvement has also recently launched a purchase price index and benchmarking tool, which is refreshed monthly with trusts' purchase order data. NHS Improvement says that in total it includes £8bn of spend information with about £2bn matched on the price comparison tool. One trust has already made a £150,000 saving on pacemakers and implantable cardioverter-defibrillators as a result.

by £1.8bn from the sustainability and transformation fund (STF). Nearly £1.5bn of this is currently reflected in providers' forecast outturn position, which is a collective £1,067m deficit (offset by £327m of undrawn STF and a technical adjustment of £71m to produce the overall forecast of a £669m overspend).

The deficits in seven of the eight providers in financial special measures add up to more than a quarter of the overall provider deficit of £1bn. And there are 16 providers on the overseer's financial improvement programme (albeit with three organisations on both lists). Trusts on the initiative bring in outside help to help them deliver more difficult saving opportunities.

Mr Alexander is clear that no-one wants to be under financial scrutiny. But he says the way both these programmes have been delivered demonstrates NHS Improvement's 'support' credentials. He insists that improvement programme trusts have found it helpful, and the approach with special measures, involving other NHS professionals and organisations, seems to be working well with recipients. While three trusts only entered special measures in October, the initial entrants 'are all in a better place now than when they were put in', he says.

Decision-making

Despite significant pressure to keep costs down, he says the overarching requirement is to ensure organisations properly think through big decisions that have implications for resources. Some turnaround programmes in the past have been criticised for being short sighted – delivering financial targets at the expense of services, for example. But Mr Alexander says the current pressure to contain costs is not a simple 'swing of the pendulum'. 'We used to worry about this and now we are worried about something else.'

For example. the new agency controls come with 'break glass' arrangements that enable trusts to breach caps where required to deliver services. Mr Alexander says that is characteristic of the approach in general.

'We are looking for more control and more advance thinking about decisions – that feels like an okay place to me,' he says.

Agency staff costs are a good example of the challenges for providers. As they struggle to fill substantive positions, and demand pushes activity above planned levels, some drivers are outside providers' control. However, NHS Improvement says caps and other controls are helping to contain these costs.

While agency spending at Q2 remains ahead of plan by some £200m, it is £300m less than in the same period last year. And this is against a trend of year-on-year increases – 25% in the three years up to the introduction of the controls. NHS Improvement has already highlighted differences in the success of the caps to date on temporary nursing and locum doctor spending (*Healthcare Finance*, November 2016, page 8).

It suggests some of the difference is down to better data and faster response by nursing directors in getting to grips with both reporting and cost reduction.

But there are other factors behind the continued high spending on locum doctors. 'The challenge around medical locum expenditure is more difficult than with other clinical staff,' says Mr Alexander. 'This brings us back to sustainable services and services in some locations that are propped up by medical locums. There needs to be some honest conversations around that,' he says.

He adds that these conversations need to be as much about the quality and safety of services as the costs of delivery. 'It is not just the provider that has to make the argument, there is a big commissioning responsibility in this too,' he says. 'There is also a big primary care responsibility in thinking about how local services that are run by predominantly locum staff do the right thing by their patients.'

The publication of highest and lowest spenders on agency staff (compared with agency spending ceilings and as a percentage of total pay) is not just to put pressure on the poorer performers but to demonstrate where organisations may be getting to grips with the issue. It is an approach that NHS Improvement is keen to expand and its Carter-commissioned model hospital is already giving trusts comparative data in a range of areas (see box).

Mr Alexander points out that despite very real system-wide pressures, 120 providers forecast a surplus for the current year (118 forecast a deficit) and many will enter next year in run-rate balance. Some of this will be about good financial management and best practice in service delivery. The challenge remains to spread best practice where appropriate.

Efficiency map

An updated *NHS efficiency map*, produced by NHS Improvement and the HFMA, was published in November to support best practice in cost improvement (see page 7). The map is split into three sections: enablers for efficiency; provider efficiency; and system efficiency. It signposts existing tools and reference material to support cost improvement and includes case studies about specific improvement projects.

NHS Improvement has also called on the finance function to make a direct contribution to improved efficiency by exploring the potential to share financial services across local health system providers. The financial reset called for the consolidation of back office services across local sustainability and transformation plan (STP) footprints. 'As a minimum, organisations should be able to demonstrate why they have got the back-office arrangements they have,' says Mr Alexander. But in reality, he believes providers could and should be more ambitious. 'Some parts of the

country are having productive conversations in this area,' he says.

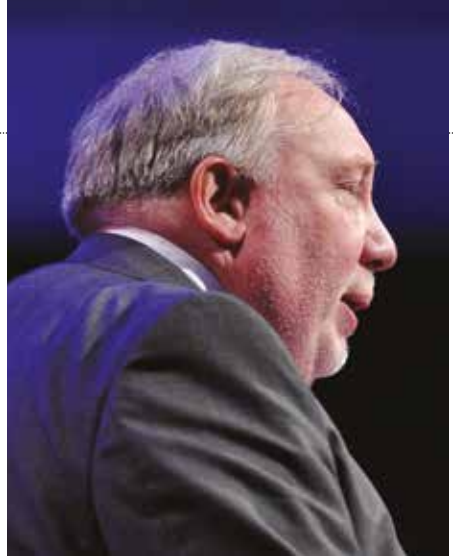
Given current pressures, it seems a tall order for the service to enter 2017/18 with an aggregate underlying run rate balance. But Mr Alexander refuses to rule it out.

'We'll test that through the operational planning for 2017/18 and 2018/19,' he says. The parameters have been set to encourage aggregate balance and there has been an agreed approach on expected activity pressures, but he acknowledges that local health economies need to factor in the impact of this year's activity increases as they develop plans.

This recurrent balance would provide the foundation for the next two years (underpinned by a two-year tariff to provide some provider stability) and for local health systems' STP plans. Entering this period with an underlying run-rate deficit will make the challenge even harder.

These system-wide plans aim to deliver services that will be sustainable over the medium to long-term – with many targeting a shift of care from acute into local care settings.

There have been concerns that a shortage of capital to support this transformation might undermine plans. But Mr Alexander insists



this is not an issue for all areas. 'We have to recognise that capital availability is a challenge within the settlement,' he says. 'Some STPs need capital, though many remain a work in progress. And some of the STPs that are most developed are relatively capital-light, because the best STPs are an articulation of a journey that's been going on for some time.'

That said, NHS Improvement chief executive Jim Mackey has floated the idea of a new bond to provide an alternative source of capital funding. Mr Alexander says the idea is still in the very early stages. But he calls on local systems to engage with local authority partners, which have a little more flexibility around capital.

'Some areas could be a bit more joined up with how they deal with existing infrastructure, sharing more and possible capital receipt opportunities. Some systems are in dialogue and in others this could be a real opportunity.'

Regulation call

The move to a greater system focus has led to calls for regulation to be focused on systems rather than organisations. Mr Alexander accepts that oversight bodies and regulators must be sensitive to the fact that local organisations 'stand or fall in this together', though it is not clear how regulation could work at a system level. He accepts that systems control totals are a simple addition of provider and commissioner targets and don't yet offer any broad flexibility. 'But we have said we are open to that conversation,' he says.

There would be two issues for NHS Improvement and NHS England: what are the reasons for the change and what is the confidence that the shared arrangements would be strong enough to deliver? With tight financial control so important within such a difficult settlement, it seems unlikely there will be any major change in this area over the next 12 months.