hfma briefing

Contributing to the debate on NHS finance
December 2013

# Transforming healthcare: the role for the finance team

A discussion paper looking at how NHS finance practitioners can contribute to the transformation agenda

## Foreword

Transforming healthcare is at the top of many organisations' agendas. The drivers are numerous and varied. The NHS must respond to the needs of an ageing population and changes in the prevalence of disease. It must look to improve patient safety and patient experience. And all this must be done in a challenging financial context.

Meeting these challenges requires well-considered, evidence-based plans. But above all, it needs an open mind to change. That change could entail seven-day services, harnessing new technology, supporting increasing numbers of patients in community settings or improving the quality of hospital care to name but a few. While change must be clinically led, in practice transformation demands that clinicians, managers and finance teams work together to understand the impact on each other and how best to support colleagues.

This briefing highlights the variety of important ways in which finance teams contribute to improving healthcare. It draws on interviews with finance and clinical staff at seven organisations to present a comprehensive picture of finance's role.

As well as developing a culture that promotes healthcare improvement, finance teams can provide the long-term financial plans needed to support transformation. These plans need to be based on the best evidence available, underpinned by accurate models and finance teams have the right range of skills required to do this.

Large scale transformation requires strong leadership. Chief financial officers can work in partnership with clinical colleagues to ensure change is understood by finance teams as well as by clinicians – and that clinicians understand the financial implications. Finally, our briefing shows that finance teams can even help to improve healthcare through their rigorous approach to financial governance and accountability.

Transformation is seen by some as critical to the long-term sustainability of the NHS, but it is not always clear what exactly it entails or what is expected of NHS organisations. We hope you find this briefing provides helpful examples of the approach that some organisations have taken and, in particular, how finance staff have enhanced the transformation. The HFMA welcomes your feedback on this briefing and examples from your own organisations that could help others.

**Tony Whitfield, HFMA president**

## CONTENTS


Summary 2

Introduction 4

Context 5

How the CFO and finance team support transformation in practice 6

- Culture 7
- Planning 10
- Analysis 13
- Leadership 14
- Governance and accountability 17

Conclusions 19

Acknowledgements 19


ILLUSTRATION: JAMEL AKIB

## SUMMARY


Transformation is commonly talked about by NHS leaders as the best way to improve the quality of services for patients and get better value from the funds available. It is already clear that budgets are unlikely to grow significantly in the near future, so no organisation can afford not to act.

Transformation means major change – a departure from previous efficiency savings programmes, which have tended to focus on doing things the same way for less money. Real transformation makes a permanent and widespread difference to strategy and culture, which drives the necessary change to an organisation's systems or processes. It could apply to the organisation, or the entire health economy, but it is equally valid to describe a change at ward level as transformational. The defining goal of transformation remains the same throughout the NHS: achieving change that improves services without a significant increase in costs.

Transformation is difficult. The day job of a chief finance officer (CFO)[1] is challenging – even more so with the demands of trying to understand, shape and support large-scale changes. In this briefing, we provide examples of how some CFOs and their teams are managing such demands and creating the space and energy to try new things. It is based on interviews with key staff at a sample of organisations transforming their services. The organisations were chosen to represent different sectors of the NHS and different stories about transformation. We hope to show how finance teams can shape and challenge transformation projects while improving their skills and building relationships with non-finance colleagues.

The Healthcare Financial Management Association (HFMA) is the representative body for NHS finance professionals and through our network of committees and branches we have unique access to NHS finance staff in the UK. The intended audience for this briefing is primarily CFOs, senior finance managers and boards, but also all staff with an interest in understanding how finance staff can make a positive and lasting contribution. Although the majority of the research took place in English NHS organisations, many of the main findings are applicable across the UK.

Research participants were transforming services for a variety of reasons. Some were given impetus by financial forecasts. Many, however, were aiming to improve the quality of their services, cope with demographic change and join up services to respond to changing clinical practice. The common theme was that all the changes were expected to lead to some financial savings.

Transformation of local organisations is unlikely to be the only tool needed to create a clinically safe and financially sustainable NHS. It will require tough decisions to be made at national level to solve some of the difficulties faced by the NHS. So this briefing is not so much about what transformation took place (we do provide case studies, but it is very difficult for organisations to directly replicate these ideas); it is about how the CFO and finance team went about making a contribution to these changes.

The motivation for transformation is clear and has been well articulated across the NHS. We found NHS finance staff consistent in their acceptance that change should be clinically led and patients put first. This in turn means finance staff are ready to change the way they do things; they are willing to support and promote the transformation. Based on the views of our research participants, we have identified 10 recommendations that CFOs and their teams embarking on transformation schemes may wish to consider.

**1. Lead the culture change and promote the transformation.** Change is accompanied by uncertainty, and the potential for staff to lose focus on the performance of an organisation. The CFO can support the successful management of the organisation through transition by setting out a rational business plan supported by a clear financial strategy. A CFO who is committed and enthusiastic will inspire their teams and provide motivation and direction. Leadership requires CFOs to involve their staff at every step and act with integrity when explaining the implications.

**2. Provide long-term vision.** The CFO has a forward-looking remit as an executive director and has a responsibility to develop long-term strategies supported by financial forecasts. CFOs can set the parameters of transformation by defining the scale of the financial challenge, accurately modelling the options and providing expertise and advice to operational managers responsible for managing financial and business risks. CFOs, especially those with extended responsibilities, can shape debate on financial sustainability, capital infrastructure and IT needs, led by the vision for patient services.

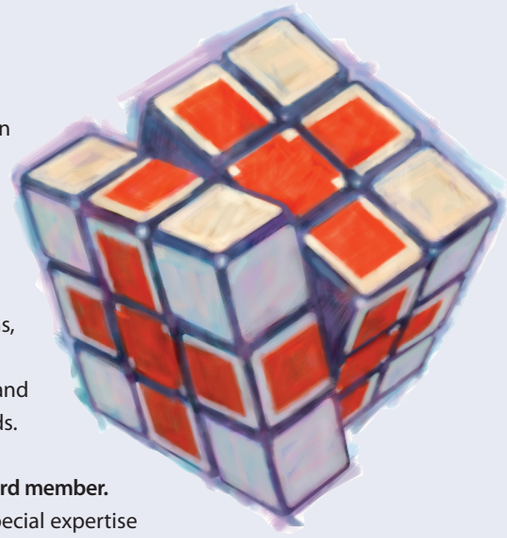
**3. Work locally and collectively to create new payment systems and fund transition.** CFOs turn the clinical model for services into the language of contracts and revenue budgets. In some cases, payment systems have not kept pace with the integrated ways of working and new care pathways being established. CFOs will need to work with Monitor and NHS England to close this gap. At a local level, CFOs can show their commitment to transformation through mature discussions about funding the transition, capital investment, and taking or sharing financial risks.

**4. Be visible and facilitate debate and constructive challenge.** CFOs and their teams who make a positive contribution to transformational change build confidence and credibility and show an understanding of the clinical strategy. Attending transformation project meetings, getting to know staff and being approachable and receptive to new ideas can help CFOs to understand where problems and solutions might lie and help to engage project staff.

**5. Train finance staff to think about transformation rather than transactions.** Senior finance staff should understand the business and transformation objectives of their organisations. To do so, they may need development opportunities that allow them to build relationships with clinicians and partner organisations. Junior staff also benefit from increased exposure to operational staff, to help them understand the purpose of the transformation and its impact on patient services, which in turn helps them to improve the transactional processes supporting it. Staff are more likely to embrace change if they can see first hand what needs to change and what their role might be.

**6. Make the distinction between clinically led and clinically owned.** Clinicians are the right people to make decisions about clinical services. But CFOs need to be involved in the financial aspects of these decisions and need to know when to step in and when to step back. Equally, clinicians need to know when to ask for finance support but can only do so if CFOs make it clear how they can help. CFOs can also use their project management skills to play a key role in delivering project goals without necessarily leading them directly.

**7. Create partnerships between and within organisations.** CFOs can make links with their counterparts in other organisations across the local health economy. There is a balance to be struck between competition and collaboration when transforming services. Taking the lead on whole-health economy working will display credibility and generate support across primary care, commissioners and secondary care. Within organisations, the CFO can develop effective relationships to unblock problems and align internal priorities and demands.



**8. Emphasise the CFO's role as a board member.** The CFO is a board member with special expertise in finance. While the CFO will bring specialist knowledge to support board decisions they will first and foremost be responsible for achieving the organisation's overall transformational objective. Similarly, the board is collectively accountable for financial duties and is guided by the CFO but cannot delegate this responsibility

**9. Make use of evidence.** The CFO can help their organisation see how transformation can result in improved services for patients while saving money. While clinicians use clinical evidence to transform services, the CFO can translate this strategy and raw data into language and models relevant to national financial policy. A good evidence base can help to show where services have improved and forecast savings realised.

**10. Balance finance and quality.** The CFO can provide real challenge and add value to transformation by bringing strict governance and financial control to the delivery of projects. Finance analysts, when working closely with clinical transformation leads, can guide discussions around cost centres and budgets to drive consistency across an organisation and highlight where accountability within the transformation plan is not clear. Finance staff should feel able to start conversations about clinical issues and risk management, to ensure they are consistent with sound business decisions.

The HFMA believes NHS leaders should examine their own transformation plans to see how the CFO and finance team can best contribute their skills. Finance needs to support rather than lead transformation, but can play an important role in framing the scope of transformation and delivering a structure that ensures financial savings are realised.

FOOTNOTES

[1] NHS chief finance officers are also known as finance directors or directors of finance. We use the term CFO throughout this briefing, in line with terminology used in the Health and Social Care Act 2012.

## Introduction

The NHS in England finds itself, not for the first time, in the midst of a major reorganisation and under severe financial pressure. Additionally there is a national focus on the quality of services. Government, civil servants, patients, service users, carers and the media, as well as NHS employees, all talk of transformation as the key to improving patient care while reducing costs.

HFMA president Tony Whitfield summarises the issue: 'As finance leaders, we need to be working with clinicians, as we design different ways of treating patients. We can't just come along at the end and add things up; we need to be in the middle of the design process providing insight into whether what is being suggested will push up or reduce costs.'

But it is not clear what exactly transformation entails for each organisation, nor what the role of staff in those organisations is. This work seeks to identify the role of the CFO and the finance team.

We undertook the research to help the HFMA's members meet this challenge. This briefing is intended to provide guidance, share learning and start a debate about the role of finance in transformation.

The briefing does not offer high-level predictions about what needs to change in NHS organisations and health policy to ensure it is safe and sustainable. Neither does it seek to address the kind of strategic questions facing chief executives and their boards. It is about how CFOs are going about effecting transformational change now, to meet the immediate challenges around quality and finance. We highlight the positive contribution of the CFO in transforming services and show how they and their teams can be seen as enablers rather than gatekeepers.

The research is based on qualitative research, using interviews with key finance and clinical staff at seven sites. The sites were selected to represent a range of healthcare sectors and transformation stories from across the country.

We have identified common themes describing the role of the CFO and the finance team in contributing to transformation projects. From these themes, we identified a set of recommendations for CFOs, to help them review the approach in their own organisations and where they might be able to learn from others.

*We have identified common themes describing the role of the CFO and the finance team in contributing to transformation projects. From these themes, we identified a set of recommendations*

The key messages have been validated with the HFMA's Financial Management and Research committee and the Policy Forum. The research is limited by the number of sites it was possible to visit but represents a fair reflection of the role of the CFO in practice.

This briefing offers an overview, but the HFMA is undertaking further research that will explore the balance between finance and quality in decision-making. The HFMA is always interested to hear from members about what further support could be provided and would be happy to receive transformation stories from other organisations, to help build up a compendium of evidence from which others can learn.

## Context

The scale of the financial and quality challenge in the NHS is unprecedented and there is much written about transforming services and making financial savings. Planning guidance from the Department of Health and its agencies has gradually increased the emphasis on improving the quality of services. For instance, the guidance for NHS trusts for 2013/14[2] states: 'We want to ensure that the plans NHS trusts prepare for 2013/14 show that every organisation has a clear strategy to deliver against each of the key areas of quality, finance and performance.'

Guidance from NHS foundation trust regulator Monitor and NHS England places similar expectations on FTs and clinical commissioning groups (CCGs).

For some organisations, a quality and finance strategy could represent significant service transformation. The NHS Institute for Innovation and Improvement published a literature review to help NHS leaders develop their understanding of transformational change[3]. One conclusion they drew is that 'the role of the change agent is very much to 'steer the ship' and, as such, their key roles are likely to be to reduce uncertainty and involve a range of stakeholders in the change process'. While this is helpful advice, our research shows CFOs can play an active role too.

In practice, for many organisations, quality and finance strategies will be delivered over the

medium- to long-term. The HFMA and Grant Thornton surveyed finance directors in 2012 to understand their approach to cost improvement programmes. Some 49% of respondents said service and pathway redesign would make the biggest contribution to efficiency savings in 2012/13[4], while 30% felt expenditure controls would make the biggest contribution. However, less than half of respondents felt their cost improvement programmes (CIPs) would have a positive impact on quality. There was also a lack of confidence in meeting financial targets in future.

The National Audit Office made an assessment of progress in making efficiency savings in the NHS and found: 'There is limited assurance that all the reported savings were achieved'[5] but that 'the NHS maintained or improved its performance against key indicators of quality'. There is therefore some uncertainty around whether current approaches to CIPs can meet the aims of transformation to improve quality and make savings.

The King's Fund has analysed future trends in the NHS[6] and drew the following conclusions about the likely drivers that will affect healthcare:

- **Global context** Our analysis suggests an uncertain environment that could generate a range of 'shocks', both positive and negative.
- **Financial context** Current spending projections suggest significant financial pressures on services for the next 20 years.
- **Demography** An ageing population with uncertainty about the future impact on services and society.
- **Determinants of health and disability** The future economic context casts a shadow over recent improvements.
- **Healthy behaviours** Current behavioural trends suggest health inequalities may worsen.
- **Future patterns of disease and disability** A significant rise is expected in chronic and multiple chronic disease.
- **Medical advances** The pace of innovation is breathtaking but the future funding model is under challenge.
- **Information technologies** Information technologies offer huge opportunities to improve health and social care, but it is not certain that these opportunities will be grasped.
- **The workforce** Is the workforce fit for the future?
- **Public attitudes and expectations** There are increasing demands for care services but strong support for a 'fair' NHS. Will it be sustained?

The number of factors identified by the King's Fund that could affect the way healthcare is delivered is daunting. Many of these are beyond the control of individual organisations or even national governments. Many of the challenges that CFOs are grappling with relate to transforming the quality and efficient operation of the services they currently provide.

The HFMA believes: 'Some transformation projects will not reduce costs, some will deliver direct savings, others will show financial benefits over time. But the service needs to plan these new models to be as cost-effective as possible and at the very least to enter into the new ways of working understanding the likely consequences in terms of patient flows, patient outcomes and costs across whole health economies. Finance professionals need to be fully involved in this process.' [7] Whether or not NHS transformation can keep pace with factors such as demography, health inequality, medical advances and public expectations remains to be seen.

The Nuffield Trust has identified three determinants of hospital efficiency[8]. These are as follows:

- **The external environment** This includes such factors as the financial pressure on hospitals; competition and other market forces; performance monitoring and management; and the availability of cost-effective treatments and technologies.
- **Hospital management** This covers such factors as leadership and the use of effective management practices; cooperation between managers and clinicians; and the speed at which new and cost-effective treatments and technologies are adopted.
- **Hospital operational processes** These include the control of labour costs; the use of nursing skill mix; shortening length of stay; and measures intended to reduce errors and increase quality.

These determinants identify the areas that providers and their commissioners need to focus on to transform services and they will be familiar to CFOs. Our research explores how CFOs contribute to transformation rather than what strategic and operational change is taking place. So it is helpful to note another of the Nuffield Trust's conclusions that, 'one of the strongest findings was that good leadership, and effective general and clinical management, are both crucial for making productivity gains'.

FOOTNOTES

[2] NHS Trust Development Authority (2012). Toward High Quality, Sustainable Services: Planning Guidance for NHS Trust Boards for 2013/14. London: NHS Trust Development Authority.

[3] Matrix Research and Consultancy (2006). What is Transformational Change? London: NHS Institute for Innovation and Improvement.

[4] Mellor C (2012). Targets in sight: Approaches to Delivering NHS Cost Improvements. London: Grant Thornton/ HFMA.

[5] National Audit Office (2012). Progress in making NHS Efficiency Savings. Report by the Comptroller and Auditor General, HC 686, Session 2012–13, 13 December. London: The Stationery Office.

[6] Imison C (2012). Future Trends: An Overview. London: the King's Fund.

[7] Brown S (2012). The Transformers, Healthcare Finance Magazine December 2012 (p20-22). Bristol: Healthcare Financial Management Association.

[8] Hurst J and Williams S (2012). Can NHS Hospitals do More with Less? London: Nuffield Trust.

The actual change that is taking place will vary greatly from trust to trust or commissioner to commissioner, and there are many sources of information to help organisations develop the evidence base and a case for change in all areas of healthcare. Thinktank Reform categorised the benefits of health reform into four areas, based on national and international case studies of healthcare transformation[9].

The areas include reduced costs through integration and competition; reduced costs through standardisation of clinical practice; greater patient safety through service reconfiguration and greater patient safety through better data. These four areas would meet our initial definition of transformation as they address both quality and finance. From our research, it would be possible to add to this list some softer benefits, such as improved working relationships and improved understanding among staff of each other's areas of expertise.

One piece of research explores this idea in more detail and found that mutual trust is at the heart of organisational and behavioural change. It found that managers (including CFOs) can develop mutual trust in their organisations in the following ways[10]:

- Helping staff to make sense of what is changing in their part of the organisation and why
- By openly and transparently sharing information with staff and other stakeholders, even when the information is unlikely to be received favourably
- Listening to employees' concerns and opinions
- Reframing changes to help staff understand how they can take control and influence the changes in their part of the system
- Working politically across organisation boundaries to build connections, dispel rumours, develop shared agendas and looking for opportunities for integrating services
- Supporting stakeholders to make sense of what is changing and how.

Our research found examples of all of these actions taking place and we highlight some of them though quotes and case studies. For many of our research participants, the development of trust, culture change or any other description for successfully influencing staff and organisations to work together to deliver transformation was critical to their success.

FOOTNOTES

[9] Cawston T, Haldenby A, Seddon N (2012). Healthy Competition. London: Reform.

[10] Day A and Lubitsh G (2012). Mutual Trust is Essential for Successful Change: Lessons from Implementing NHS Reforms, The Ashridge Journal Autumn 2012 (p13-21). Ashridge Consulting.

## How the CFO and finance team support transformation in practice

In this section, we present the main findings from fieldwork interviews. In each interview we asked participants a series of questions around their organisations' transformation schemes and the role of finance within them. The detail of the schemes was individual to local circumstances and we document these throughout in case studies.

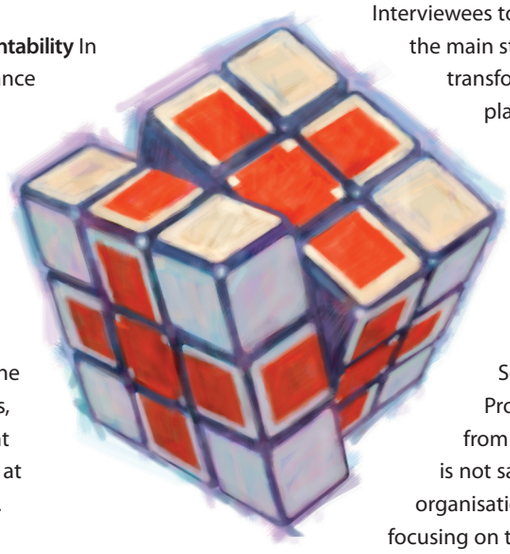
These are intended to provide an illustration of what is taking place around the country and, while we do not present them as the only solution, it is clear that a lot of good work is being done to address the challenges at these organisations. We also include case studies from organisations that do not provide services directly but have a role in supporting service transformation.

Our research found some themes were common to more than one organisation. We have analysed these themes to identify the role of the CFO and the finance team in the following sections. The themes can be broadly categorised as:

- **Culture** Many participants talked about the importance of ensuring finance staff understand the business, the need for clinically led transformation and that clinicians and managers alike understand and discuss the financial context. This helps to develop trust between colleagues and good working relationships with partner organisations, which interviewees felt were critical to success. Culture change also includes balancing a more commercially focused attitude to payment for services, by both providers and commissioners with an altruistic approach to transformation that recognises when it is right to support rather than compete with other organisations for the common good of the health economy.
- **Planning** This relates to the CFO's ability to provide a long-term financial vision for an organisation that can shape the way transformation evolves, maximising the chance of its success. The finance vision needs to support the clinical strategy; the role of the CFO must therefore include ensuring the two are aligned.
- **Analysis** Participants highlighted the CFO and finance team's ability to turn clinical vision into the language of payment systems and policy frameworks. CFOs and board members are skilled in developing coherent strategies that can withstand scrutiny by Monitor and other regulators and stakeholders. This role depends on

strong financial analysis supported by evidence from accurate activity modelling and clinical assumptions. It is in this role that finance teams can challenge and improve the clinical vision through their oversight of budgets and costs across an organisation.

- **Leadership** Our research identified several leadership roles held by the CFO. The first is as a board member with shared responsibility for the quality of services but as a specialist adviser in finance. The second, in relation to transformation, is as a senior manager with the skills to drive change through drawing on an ability to inspire and motivate, but also solve problems as they arise. As a leader, this may involve delivering difficult messages and changing the nature of relationships internally and with other organisations. The CFO also has a role to lead the local and national debate on matters of financial policy and strategy. At the local level, this is through building the trust and support of partner organisations.
- **Governance and accountability** In this role, the CFO and finance team can contribute to improvements in clinical governance and accountability through parallel work setting up the right financial governance and accountability systems. This work takes place as the transformation progresses, establishing the important role finance staff can play at each stage of the process.



However, there are some financial aspects of transformation that may be beyond the ability of the CFO to remedy. Interviewees felt that the national payment system, historic configuration of hospital services and buildings in their areas, allocations to commissioners, and local and national politics were all examples of things that could act as barriers to transformation. These will need national level coordination to solve.

The transformation taking place across the NHS is different and specific to local circumstances. Some of the drivers are push factors that make transformation a more pressing necessity in some areas than others, rather than one organisation being either behind or ahead of another. The pressures facing some NHS organisations can create inertia that leads to a focus on short-term fire-fighting rather than planning long-term transformation that will lead to sustainable finances and better services.

The following five sections distil what can help to make transformation projects successful and highlights the role of the CFO and finance team. It provides evidence for the positive role that finance can play, but also as a means for CFOs to review their own teams to see where else they could add value. These findings reflect the thoughts of the NHS staff we spoke to. The role varies across organisations according to the type of transformation taking place, the local constraints placed on the CFO and the existing culture, but there were some themes common to all of our research participants.

## *Culture*

Interviewees told us that culture change is the main starting point for successful transformation. They felt the CFO plays a critical role in changing not only the culture of the finance team but also the way that finance is viewed by the rest of an organisation. In Scotland, the government and the NHS have set up the Scottish Patient Safety Programme, which stemmed from 'a global challenge that care is not safe enough'. English NHS organisations and their boards are also focusing on this and building transformation programmes centred on meeting the quality challenge. The role of the CFO, therefore, is to support their organisation to meet that challenge.

One interviewee said there was an important distinction to be made: 'CFOs need to talk about quality and finance rather than finance and quality.' In Scotland the government has produced a Quality Strategy, which is supported by the financial strategy. Interviewees stressed: 'The Scottish Patient Safety Programme is not about savings at all, the discussions are about patient experience and harm.' This approach, they felt, ensured safety and quality of services became the main priority but that because of this, savings were realised. Case study 1 (overleaf) describes the

Scottish Government's approach. It is clear from our interviews that NHS finance staff believe clinical transformation must be clinically led. But it is not always clear across the NHS that the balance between quality and finance considerations – or considerations such as organisational and personal reputation and governance and risk management – is being achieved. Case study 2 describes how Sussex Community NHS Trust has made progress in this area. As a recently set up community trust, it has taken the opportunity to make changes and is starting to see the benefits.

## CASE STUDY 1: SCOTTISH GOVERNMENT HEALTH AND SOCIAL CARE DIRECTORATE

The Scottish Patient Safety Programme began in January 2008 as the Scottish response to what is seen as a deep seated, global challenge that care is not safe enough. The programme is clinically led and does not include financial targets, but there is support from the finance community as savings are realised.

Interviewees view the challenge facing Scottish Health Boards, and across healthcare systems in general, as one where patients suffer as a result of their care rather than their condition. The Scottish Government and NHS Scotland have taken a systematic approach to addressing this. Initially piloted in Ninewells Hospital in Dundee, the work was done in partnership with the Institute for Healthcare Improvement in America, when Don Berwick was the chief executive officer. The programme is clinically led but also includes the directors of the Scottish Health and Social Care directorate. Management is devolved into Scotland's 14 regional integrated delivery boards. The national management board visibly leads the programmes.

There are four strands to the safety programme, covering adult care, maternity and paediatrics, mental health and primary and community care. The Scots also have a national productivity and efficiency programme, which includes initiatives to reduce length of stay and increase the use of day surgery, for instance. This is 'not unlinked to the safety programme'. The aim is to make savings in an intelligent way, using this as a driver.

Under the programme, infection rates have fallen dramatically. For instance, MRSA rates fell by 80% between 2007 and 2010. This saves money – the savings are not cashable but they increase productivity as beds can be reused more quickly and indeed should in most cases cost less.

Interviewees felt it is lack of quality that costs money and that quality should not cost more. The management team talk about quality-driven financial performance. When reviewing regional health boards' financial plans and organisational strategies, they look at the numbers but also quality, performance, workforce, efficiency and productivity indicators to allow them to see the totality of the picture.

Conversations between CFOs and clinicians have, believe interviewees, moved on from savings to a conversation about the quality of services, out of which comes a discussion about process and how savings could be made within a fixed financial envelope.

In common with Sussex Community NHS Trust, many interviewees spoke about the CFO's role in ensuring finance staff and clinicians are knowledgeable, trained and prepared for service transformation. CFOs felt that finance staff at all levels need to:

- Understand their organisation from an operational point of view
- Understand the need for transformation that is clinically led.

As one interviewee noted: 'It is as essential for CFOs to have bedside awareness as it is for clinicians to have financial awareness.'

Some finance staff pointed out the active role they can play in demonstrating to clinicians and transformation leads the contribution that finance teams can make. Our research found that some transformation leads, perhaps through a lack of finance knowledge, regretted not involving finance staff in their strategic and operational discussions at an earlier stage. CFOs therefore have a remit, and the motivation, to change the culture of clinical leaders as well as their own staff.

Starting with the need for finance staff training, interviewees felt that many of their more junior staff would benefit from greater exposure to clinical and managerial aspects of their organisations. The more senior staff, it was felt, should aim to develop relationships, either within or between organisations and therefore become more skilled at identifying and delivering transformation opportunities. CFOs highlighted the tension between a necessity to become more commercial or competitive in mind-set, but at the same time less parochial in their attitude to partner organisations. CFOs viewed their role as becoming an enabler rather than gatekeeper.

Great Western Hospitals NHS FT outlined some initial plans for staff training. 'Some training is required in finance teams. We are planning capacity demand workshops to help understand how changes will affect the system. We are also looking at overseas models and quality initiatives and how our staff can use these.

'We plan to rotate finance staff through the clinically led programme management office and hope this will lead to transformational rather than transactional thinking by our accountants. The benefit to the trust from working more closely

with clinicians has come through being able to talk the same language and understand the business better.

'We have improved the accuracy of costing. Finance staff are also starting to understand the bigger picture, for instance, that it may be necessary to make an investment in an overspending department to help it reduce its costs over the longer term.'

At Sussex Community NHS Trust, there was a strong feeling among participants that finance is a key part of the organisational culture change. As well as a structural transformation of services, the trust itself is transforming as it transitions from a newly created trust formed through the merger of two community services providers to being a fully independent organisation.

Interviewees spoke about moving to a more commercial mindset. 'We look at services carefully and make sure we are being paid for them properly. This helps to ensure we can fund further transformation and have more mature, evidence-based discussions with commissioners about changes to block contract funding,' they said.

Interviewees reported that 'messages around culture of transformation are coming from all corners', including from the trust's transformation director, clinicians and finance staff. This has led to staff increasingly rising to the challenge, and interviewees felt some new executive directors may have helped usher in this change.

In particular, interviewees felt the trust has moved beyond simply restating and reinforcing a mantra of clinically led transformation to 'we are all in it together now and need to learn from each other'. In addition to its service transformation programme, the trust is carrying out a 'cultural inquiry' that aims to help spread the positive changes and learning throughout the trust.

Another aspect of culture change raised by some participants was around attitude to risk and risk management. Transformation involves major change that carries inherent risk. The traditional image of the prudent CFO is giving way to the challenges of increasing competition and the necessity of funding constraints.

In commissioning organisations, the NHS RightCare organisation is helping some CFOs to

## CASE STUDY 2: SUSSEX COMMUNITY NHS TRUST

The trust was established as a community trust in 2010. One of its main service transformation projects covers services in the north of the county, but cultural changes taking place across the trust are expected to bring wider benefits.

The service transformation is clinically driven but expected to deliver efficiencies through bringing together different elements of care provision into hubs of multi-disciplinary teams. Interviewees felt that previous projects under the QIPP programme may have lowered morale, potentially affecting services in a less positive way and increasing staff turnover. This time, transformation has involved a long consultation period, which has led to growing relationships with local acute trusts and commissioners.

The transformation includes: creating multi-disciplinary hubs; exploring how the trust can provide proactive care (early intervention and prevention); an exercise to use data to examine the characteristics of admissions; and increased use of community in-reach teams in acute hospitals. While the hub approach is expected to save money by eliminating duplication of staff roles previously located at several different sites, there are also non-pay savings linked to the improvement and standardisation of care.

Interviewees felt transformation is beginning to change the organisational culture. An example of learning by clinicians and finance staff is that finance staff were potentially not involved in the project as early as they could have been. It was felt by interviewees that they may have been able to add more value if they had played an active role in transformation sooner. This has led to closer working once it became clear what role finance staff can play.


Clinicians at the trust felt the proximity of divisional management accountants and working relationships with finance staff have improved. When clinical and finance staff work closely, interviewees felt, they could produce a better business plan and improved reporting. It is also quicker and easier for them to make changes to plans if there is a dedicated finance staff member on the project team. Overall, clinicians felt the quality of finance information has improved, which could not be done without having an embedded finance staff member with working knowledge of transformation.

The benefit of the clinically led philosophy of the transformation at the trust means finance staff feel they are less likely to be viewed with 'a degree of suspicion' when starting discussions about budget-setting, for instance. This is a cultural change whereby finance staff understand the business much better and can contribute to team meetings by sharing finance information across a department. It is helping close the gap between finance and clinicians, which results in deeper understanding of each other's view and greater trust.

Added benefits relate to a clearer understanding of how finance operates. Interviewees mentioned small differences, such as clinicians coding invoices more accurately or complying closely with procurement policies. Finance can also act as a facilitator for discussions between clinicians from different departments, which, while based on finance decisions, can lead to clinical improvements.

The trust has commenced a significant new transformation project since these fieldwork interviews took place.

review their attitude to risk. One interviewee said: 'Some CFOs are understandably risk-averse when calculating the savings potential. Finance staff are skilled at costing projects but find it harder to quantify the amount and likelihood of savings, to give a rounded picture of what the potential savings are.

'Sometimes savings are not accounted for in proposals because of a negative track record of negotiating with providers. This can lead to a culture of avoiding spend to save schemes, rather than a focus on becoming more robust and successful in negotiations.'

Interviewees also explained how they felt clinicians could benefit from an increased understanding of the contribution of finance. They felt the CFO could do much to 'close the gap', perhaps by reducing the remoteness of the finance function but also by making sure finance staff at all levels have opportunities for joint working, ultimately leading to a shared understanding of the transformation aims.

Pennine MSK Partnership has adopted an almost entirely clinician led approach, outlined in case study 3.

In general, interviewees felt that there can be benefits, both expected and unexpected, that can accrue from creating a culture of closer working relationships and greater understanding of each other's work. The most successful way of bringing this about comes through cultivating good relationships, listening and being visible to staff. The role of the CFO is to help create a culture where staff feel empowered to make changes without feeling change is being imposed.

The culture aspect of the role of the CFO and finance staff involves:

- Developing trust and understanding between colleagues and with partner organisations
- Supporting the organisation to talk about quality and finance rather than finance and quality
- Exploring whether any unexpected benefits have arisen from culture change
- Investigating the training and development needs for all finance staff, including understanding the business, building relationships and looking at the organisation's attitude to risk
- Working with clinicians so they understand how finance can help them to succeed.

### *Planning*

Interviewees from almost all of the organisations we spoke to identify the CFO's ability to provide a long-term financial plan as a critical role. Financial planning can shape the way transformation evolves, maximising the chance of its success, by setting the parameters of the resources available and modelling the transformation plans. It covers revenue and capital spending and draws on the CFO's training and long-term vision but also their

## CASE STUDY 3: PENNINE MSK PARTNERSHIP

Pennine MSK Partnership is a small, GP/clinician-led organisation, providing musculoskeletal services (MSK) including rheumatology, chronic pain and orthopaedic services in the Oldham area. The management structure consists mainly of clinicians and, because there is only one member of staff with finance expertise, finance is regarded as the enabling professional rather than in a gatekeeper role.

The organisation has transformed the way these services are delivered by screening GP referrals, so that patients who may not need to see a hospital consultant are treated quickly by clinical specialist physiotherapists and podiatrists and often treated and discharged on their first appointment. They ensure that patients who do need consultant input have their conditions fully investigated before they move into secondary care. The result has been that much of the care and treatment has moved out of the local acute hospital and into the community. This has led to improvements in the experience for patients, including access, waiting times and patient satisfaction.

The service aims to direct patients into the right place for the care they need and makes better use of consultants' time at the acute hospital. The partnership believes only 30% of patients now see a consultant, rather than all patients who were previously referred directly into secondary care by GPs.

The service is supported by the local commissioner as it has enabled a significant level of pathway redesign. Procedures previously provided by the local acute trust as day cases are now treated in outpatient appointments. In this case, the role of the CFO has been to develop a number of local tariffs, based on the national tariff, for new and follow-up appointments and for procedures, but at a discount to nationally agreed prices.

The clinician-led management approach has also meant that there is a patient-centred approach to the service – for instance, the partnership has agreed with GPs that if a patient's symptoms re-occur within 12 months, they can self-refer back to the service. As well as improving patient satisfaction, this saves time for the GPs.

The role of the CFO has been to support the management team to make the services financially viable and the outcome has been improvements to patient care at a lower cost to the commissioner.

ability to understand the finance data in the context of other performance indicators. As one clinician put it: 'Clinicians do not normally think 10 to 15 years down the line; CFOs bring finance vision to planning conversations about services.'

Thinking long-term means that revenue and capital plans need to be modelled using activity, demand and finance assumptions. But interviewees felt the key to improving the chances of transforming services successfully lies in linking the financial plans to well thought out clinical and quality strategies. One of our research participants, the Scottish Government Health and Social Care Directorate, has had a quality-led strategic and operational approach for some years and it is this that drives the financial planning.

Capital planning, especially where this might include the closure or sale of NHS assets, is as much a political issue as a quality or finance issue and the CFO can often only advise rather than make decisions of this magnitude. Some interviewees felt local politics or public opinion could override clinical evidence for transformation. In Scotland, the revenue and capital programme is driven by the Quality Strategy and quality approach, which can help to overcome some of these issues.

Interviewees felt this required additional skill and collaboration between CFOs and clinicians. 'CFOs need to look at the totality of spend rather than individual key performance indicators without context. They need to unpick the data and not look at it in one dimension, which is what an immature CFO or clinical director might do.'

Planning involves long-term financial modelling skills, bringing in activity forecasting and knowledge of public health and likely trends in drugs and technology, for instance. Finance teams, can, in conjunction with clinical colleagues develop sophisticated models. Planning requires access to all of the available evidence, including non-finance information to produce accurate, reliable models. This requires good data and good analysis and participants felt that where it can be done, finance teams will be able to demonstrate the likely impact of the transformation and where it could be improved.

One trust, Great Western Hospitals NHS Foundation Trust (case study 4) has produced a transformation strategy with clear links to the

## CASE STUDY 4: GREAT WESTERN HOSPITALS NHS FT

Great Western Hospitals is an acute and community FT. It has produced a strategy for its proposed service transformation that outlines the case for change from 2012 to 2016. It centres on 'reducing hospital use, increasing community provision and improving health outcomes'. It is a health-economy-wide transformation involving the CCG, local authority social care and a social enterprise community services provider, as well as the FT's own integrated community services to develop the future specification of services.

The project is headed by the FT's chief executive and there is a strong emphasis on forging partnerships with other organisations. The transformation will result in a 'hub and spoke' model of multi-disciplinary clinical teams that will provide services throughout the health economy. This is expected to be achieved through reconfiguring some existing services, either through collaboration or competition, and tendering other services in the future.


Overall, the transformation is about shifting the setting of care into the community and supporting infrastructure investment costs. Services need to be transferred out to community settings from the acute hospital to improve their quality and reduce the cost but also to create the space for the expected increase in local demand for acute services, such as cancer care. The associated financial savings plan is based on the transformation, as well as efficiency approaches to cost savings and cost avoidance. To achieve the transformation, working in partnership with other local organisations is necessary to meet the challenges that are shared by all.

The CFO is clear that financial and clinical planning should cover the medium to long term and this cannot be left too late. To support the strategy, the FT has undertaken detailed work to support planning in several areas:

- Examining discharge arrangements to cut the time taken to transfer patients to external partners, the FT is piloting a single point of discharge with other partners, this will support the FT to meet the additional demand
- A partnership model at the 'front door' in the emergency department with a single point of access system, which links into social and community care
- 'Rapid improvement' events with GPs, social care and commissioners, introducing case managers to align provision with commissioning intentions
- Looking at models of care for people with long-term conditions, including international examples
- Using community beds more wisely to create capacity in the acute hospital and to reduce travel costs
- Forecasting growth in acute care, such as cancer care, that can be expected from the screening programmes and other activity that is already taking place.

The FT has also carried out some detailed planning work to support the transfer of some services to community settings. This has involved using the evidence around ambulatory care sensitive conditions to decide the most appropriate setting for treatments and how to fund them.

Being an integrated acute and community trust has been important to the project although the FT is also working closely with the social enterprise community provider in another part of its catchment area.

supporting evidence. Planning also includes the ability to advise whether informed, managed risks, such as creating new organisations or transferring or transforming parts of existing organisations will be successful. Indeed, with good planning it is possible to keep the direction of an organisation firmly within the control of the board, rather than subject it to external review and intervention.

## CASE STUDY 5: WYE VALLEY NHS TRUST

The CFO of the trust first produced a detailed long-term financial model four years ago, in conjunction with the PCT in place at the time. The local health economy has a history of innovation – for instance, the county council and PCT shared a chief executive officer.

But the main issues affecting the area are its rurality and its ageing population and the effect of these on healthcare costs. The health community's financial planning suggested a financial deficit of £23m would develop within three years, and this was forecast to increase over time. Therefore, further local innovation and joint working saw the creation of an integrated organisation in April 2011 that combined the local acute trust, social care and community services into the current organisation, in a plan to reduce costs.

Ultimately, this arrangement did not result in the savings expected as it was unaffordable to make the investment in the community services infrastructure required to move services from the acute part of the trust. The trust now finds itself in financial difficulty and is in receipt of external financial support.

However, the integrated trust is keen to retain local control of this difficult financial situation. The trust board has made sure patient services are put first rather than risk potentially dangerous cost improvement measures that could otherwise help it to meet financial targets. The latest financial planning by the CFO has made it clear that the trust is not viable in its current form. The trust recently wrote an outline business case offering five options:

- Becoming the junior partner of a trust which has already attained foundation trust status
- Going into partnership with a private organisation and run as a local franchise where all staff and assets would remain in the NHS
- Breaking up the trust and dispersing its services to be run by a range of providers (which could be both public and/or private sector)
- Including primary care services (such as GPs) in the trust, creating a one-stop shop for health
- Increasing the number of patients it serves, thus increasing its income


In this situation, the transformation planned is not what the trust initially envisaged but it still retains a focus on putting patients first, in a way that is financially stable, in common with other transformation projects. The role of the CFO, especially for financial planning, has been instrumental in retaining control within the trust. It aims to ensure the transformation is trust-led and shows external agencies it is in the best interests of patients and local people.

The trust is not unique in being in this situation and over the coming years, as financial constraints tighten, there will be more trusts where the initial transformation plans do not result in long-term financial sustainability expected. The combination of financial planning and leadership means the trust has demonstrated its ability to plan and manage its own future.

In case study 5, although the initial transformation scheme did not have the desired impact, the actions of the CFO have been instrumental to the trust board retaining control of the trust's future and managing the risks locally, under difficult circumstances.

There were mixed views from participants about integrating services and whether or not organisations themselves need to be integrated. While most felt it was entirely possible to integrate services between independent organisations, one noted that the financial challenge, demanding market and significant regulatory and statutory burden makes it difficult for small organisations to carry the overhead needed to properly support the services they need. They felt the financial benefits only materialise if the overheads can be spread across a large, integrated, organisation.

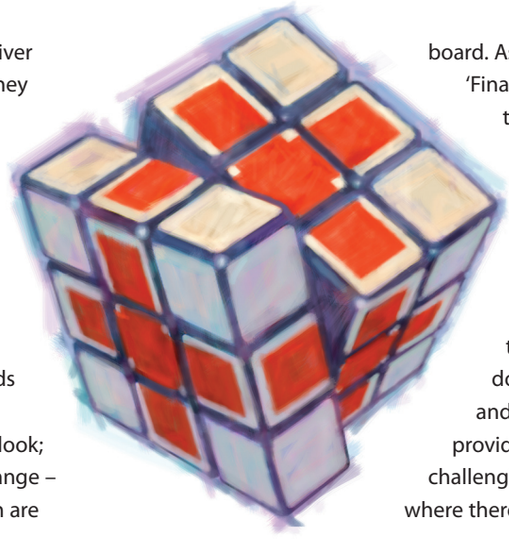
CFOs of providers and commissioners alike can provide long-term financial planning support. Newly established commissioning organisations are developing plans for how their budgets are spent and how they can be used to improve outcomes for their local population.

The Department of Health's Quality, Innovation, Productivity and Prevention (QIPP) programme was intended as a way for PCTs to make transformational savings, but in some cases commissioners' plans have been short term and lacking in detail. One of our research participants, NHS RightCare, helps commissioners develop evidence-led long-term approaches to improving outcomes and reducing costs.

In describing the approach one interviewee said: 'The approach is novel in that it combines all component parts to build up evidence to identify where to improve, work out what good looks like and why and how you need to get there. The NHS RightCare approach aims to help commissioners do QIPP properly by focusing on quality, innovation and prevention as well as productivity.'

In the NHS RightCare approach, the role of the finance team, as was also mentioned by several other interviewees, is to focus planning on the 95% on the budget used for delivering services, rather than planning to achieve 5% savings. They

felt this approach could deliver improvement and save money where the effort is focused on transforming activity for which data, such as programme budgeting data, shows an organisation is an outlier on quality and finance measures. The NHS RightCare approach depends on bringing together three principles areas – where to look; what to change; how to change – and making sure all of them are addressed.



In summary, the planning aspect of the finance team's role means:

- Revenue and capital planning can be used to set the parameters of the transformation but it must be based on a clinical vision and a quality strategy.
- Good financial planning shows that financial risks are being considered and managed appropriately.
- The evidence base must be strong and comprehensive, requiring the finance team to work closely with clinical colleagues.
- Good financial planning can help boards keep the organisation on track and under control by demonstrating external intervention is not required, but only if those plans are delivered.
- CFOs can use financial plans to demonstrate they are getting value from constrained budgets.

## *Analysis*

Many participants highlighted the CFO's ability to turn a clinical vision into a business strategy, written in the language of payment systems and policy frameworks. Such a strategy would need to withstand scrutiny by regulators such as Monitor and the CQC, as well as other stakeholders, and be well understood by other board members. In undertaking this role, the CFO requires the support of the finance team to provide high-quality financial analysis and supporting evidence.

Interviewees reported that finance analysts can provide a helpful and welcome challenge to clinicians that can improve delivery and consistency of the transformation. In turn, it was felt this can provide greater assurance to the board. As one interviewee put it: 'Finance gives the transformers the tools to make changes'.

A theme running throughout the interviews was that finance should play a supporting, enabling role to clinicians. However, this does not prevent the CFO and finance team from providing this support through challenging the clinical approach where there is the evidence.

It will take the guidance of an experienced CFO to ensure that the best costing accountants, capable of understanding the aims of the transformation, are given the task. Accurately costing the savings and benefits is important too, although many participants felt this is a much more difficult task.

As one interviewee noted: 'Costing the benefits is hard – it's a real challenge to measure the savings arising from patients not arriving in the first place. But if the transformation approach can be demonstrated to reduce infections and length of stay, which saves money, you would be unlikely not to do it'.

In delivering the transformation, finance staff can help project leads with their skills in writing business cases and setting up the budgets and coding structures. Through this process, finance can challenge and improve the financial management system.

At Sussex, interviewees reported some of the ways this was done. 'Finance can compare budgets across budgetholders to improve consistency and look for savings opportunities, especially around non-pay. Finance staff have a high-level view across a whole department or division and can see where there are inconsistencies between teams.

'This way, finance can own some of the drive of the implementation. Finance can help clinicians by profiling the savings plan so that clinicians do not feel pressured to deliver unrealistic levels of savings every month. Equally, clinicians know that finance staff are reflecting the numbers fairly and this helps them to investigate variances, which in turn helps to provide assurance to directors.'

At Great Western Hospitals NHS FT there was a great deal of effort put into financial modelling, described in case study 6.

The payment system can have some benefits in terms of creating greater visibility of clinical services according to one of our participants. Interviewees from Southern Health NHS FT saw the payment system as 'a finance vehicle that can deliver a better clinical product'.

The trust now feels it has a greater sense of what is happening for certain groups of patients and the introduction of mental health PBR clustering, although not perfect, has increased the visibility of the variance in the services patients receive in different settings across the trust. Clinicians can use this data to review the service packages for each cluster so that they are consistent. The trust is holding a workshop to discuss this issue and it will be the first time the trust has had this level of detailed thinking about a very particular set of patient needs – something brought about indirectly by the data made available by the CFO and finance team.

The experience of Great Western Hospitals NHS FT in the previous example shows that good-quality evidence is important. In the case of Wye Valley NHS Trust, the modelling set the course of the transformation and gave assurance to third parties that the trust was doing all it could to meet its financial targets. The CFO attended meetings with the strategic health authority and the NHS Trust Development Authority among others, and also asked management consultants to carry out a review that provided evidence that the additional 8%-10% savings required to meet financial targets would be incredibly problematic to deliver. This helped the CFO set the course of the financial plan and advise the board on courses of action.

In commissioning organisations, CFOs can place emphasis on the ability of finance staff to work with clinicians to cost savings properly and understand where savings can be found. Commissioners' CFOs have a role to play in improving the value of healthcare they buy with their commissioning budgets, as described in case study 7.

The analysis part of the CFO and finance team's role can be summarised as:

- The ability of the CFO to turn the clinical vision for transformation into a business strategy
- The ability of finance staff to develop business cases to support transformation
- Providing challenge and scrutiny of business decisions to help improve clinical transformation
- Providing good information on the financial benefits and savings relating to transformation.

### CASE STUDY 6: GREAT WESTERN HOSPITALS NHS FT

The trust, through its transformation strategy, is driving the local QIPP plan. Financial analysis has identified that the trust is losing revenue because of the marginal rate emergency tariff applied over a set level of activity and from emergency readmission penalties in its acute hospital. It plans to move activity to the community sector where possible to address these losses. The business case and supporting analysis for this plan is based on published data sources, such as the NHS Institute for Innovation and Improvement's work on ambulatory care.

The trust used a range of data sources to model activity and finance, which identified services generating revenues of £15m that could be safely transferred from acute to community settings. Another driver for this was, in part, that the trust determined it could not absorb year-on-year growth in demand for services without increasing the capacity of its acute hospital building and medical workforce and the analysis carried out helped to show the effect of increasing demand on the trust.

Financial modelling has examined the tipping points to show the circumstances when it becomes cheaper to provide services in the community – for instance, if it could avoid the need to build a new acute hospital. The trust expects to use some of the freed up acute capacity to absorb forecast growth in its cancer services as well as to begin a ward refurbishment programme. The role of the CFO and the finance team has been to provide the evidence to support the transformation and ensure the right services are being changed.

## *Leadership*

Leadership is an ability all board-level officers demonstrate and much of what we heard from CFOs on this theme could also be true of other board members. Several research participants made the distinction between the role of the CFO as a board member and as finance lead.

When transforming services, boards make decisions that need to balance quality, finance and other concerns. Interviewees noted that boards have a collective responsibility for quality and finance, as well as the other business of the organisation. They felt the CFO should act as a

board member but with special expertise in finance. But to aid this, there needs to be appropriate challenge of each member's specialism. As one interviewee said: 'Board members need to challenge each other and think in a parallel rather than sequential way – they need to look at next few years' financial targets in partnership with what other directors have to deliver around clinical targets, workforce targets and estates, for instance.'

The Scottish Government Health and Social Care directorate uses a balance scorecard approach to board reporting and monitoring. In discussing board-level conversations about quality, one interviewee noted: 'Those conversations will be more productive if CFOs talk about quality and then finance. A conversation with a clinician about savings will be short and defensive; talking about quality of services is better, which leads to discussion about processes and how savings could be made within a fixed budget.'

Pennine MSK Partnership has transformed the way rheumatology and orthopaedic services are delivered in the Oldham area by moving much of the care and treatment out of the local acute hospital into the community. The CFO felt her leadership role is to be flexible and make services work for patients by negotiating financial management arrangements to support them.

She said: 'The CFO's role is to support clinically led services that are good for patients because we can still make financial savings. We agreed new prices with commissioners based on offering a discount to the existing PBR national price, where we have moved services previously provided as outpatient appointments to single 'see and treat' sessions. The commissioner makes a saving but we are able to cover our costs by changing the way the service is delivered.

'We are set up as a limited company, so we aim to break even, but we reinvest in equipment with surpluses. As we are a small organisation we can start providing new services very quickly. This is different to larger organisations, where, although budgets may be devolved, decision-making is not.

'Setting up the service was a risk in the beginning as service levels were not guaranteed by the GPs referring their patients. But the service is popular with patients and has improved outcomes, which has led to a strong business model.' In this role as board member with finance expertise, the CFO can support successful transformation.

Experience of working with several commissioning organisations through the NHS RightCare programme led one interviewee to comment: 'Transformation of commissioning can be finance-led but always needs a diverse group of GPs, clinicians, managers and finance staff. The CFO's role is also to help prioritise the many schemes that might be worth considering, especially where this could involve creating savings from quick wins that would allow investment in other schemes with a longer payback period. Phasing is important, so schemes can start to generate full-year savings immediately in the next financial year.

'Some CFOs in commissioning organisations have not always viewed quality improvement as a direct savings opportunity but as an additional cost to avoid. CFOs can empower their organisations by strengthening contract management and helping them see the impact on the whole health economy.'

But leadership also requires the CFO to be a project director. This requires the ability to inspire and influence people, as well as the relationship building, motivational and organisational skills required to support delivery of a major transformation project. One clinical interviewee felt strongly that: 'Boards need operational leads to be fully bought into delivering safe and high-quality

### CASE STUDY 7: NHS RIGHTCARE

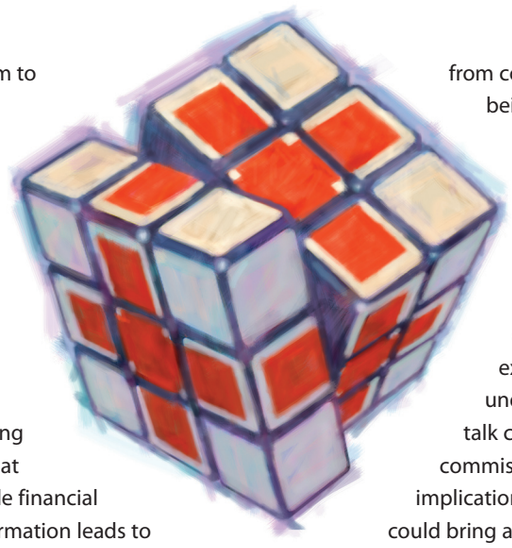
The NHS RightCare approach to the analysis role of the finance team is to use programme budgeting data to identify services that might be financial outliers when compared with other commissioners, to determine where to look for improvement. These can be compared with data on service quality to identify those services that are high cost but low quality – in other words, low value.

For this analysis to be effective it is important that programme budgeting data is accurate and of good quality.

The NHS RightCare approach can be thought of as three parts: where to make changes to services; what a better service might look like in that area; and how to change it. The role of the CFO and finance team is particularly important in analysing where to make service changes and determining the financial impact of those changes.

Finance can play a support role too when designing what a good service looks like. The role of finance is to cost the current and future models, so that potential service changes can be properly assessed. When costing the new models, savings need to be properly considered, including those that might be made by other services that could benefit from a change to an overlapping care pathway. This requires finance staff to have a good knowledge of clinical services and to work closely with clinical colleagues.

care, but CFOs need them to have their eyes and ears open to finance. Operational leads must know the CFO and board stand behind them, or are clear when they do not, as well as challenging plans.'



There was a feeling among clinicians we spoke to that CFOs must create a stable financial envelope for the transformation leads to work within. Where the board is confident it has identified the right approach, this can create an ethos of success and improve the chance of savings arising. Interviewees felt that where the CFO joined transformation team meetings, for instance, this gave a signal of its importance to the organisation and the support for it.

A lot of transformation and integration work is supported nationally and so it is important that higher level national policies are entirely consistent with the local transformation plans. The CFO and finance function can offer the link between local work and consistency with what is happening nationally. This is a leadership role because it is likely to involve high-level conversations between commissioners and providers from different organisations.

Southern Health NHS FT discussed their plans for integrating physical and mental health services. 'Although we know our approach will lead to improvement in the quality of care we provide and financial savings, we don't know precisely where those savings will be realised. The case for change in acute and community services means there are clinical and financial benefits that do not accrue to any one part of the system. There needs to be a high-level CFO conversation around this. If clinicians can see there are diffuse financial savings across the system they need to be encouraged to pursue these as a group because it is really hard to attribute the savings to one particular organisation.'

A theme common to several participants was the role of the CFO in leading the strategic finance input and developing relationships with other organisations. Several providers we spoke to highlighted the importance of getting support from commissioners for the savings being made. They highlighted the need to develop and consolidate the relationships and translate clinical language into management language that other CFOs and chief executive officers could understand, allowing them to talk credibly and convincingly to commissioners about the contractual implications. Interviewees felt this could bring acknowledgement from commissioners that the transformation is serious and will bring about savings. This could flow through to annual contracting negotiations and help fund further transformation.

Transformation requires the CFO to use non-finance skills of the kind they will have developed during their training and throughout their careers, in project management and taking part in difficult negotiations. Where the CFO has a wide portfolio, this can help in solving difficulties in other parts of the organisation, not just finance.

An example from one participant highlights the complexity of some transformation projects and the leadership actions required from the CFO. The CFO is the board member sponsor for the urgent care workstream of the trust's transformation. The role has involved many difficulties:

- Overcoming local politics by ensuring local partners, especially the organisations with much smaller turnover, are included and listened to
- Negotiating payment terms for services moved from the acute part of the trust to the community part no longer covered by national PBR prices
- Discussion with the commissioner about how they intend to apply competition and tendering legislation to the services being transformed
- Repositioning QIPP as a whole health economy problem, rather than just a commissioner issue
- Setting up risk-sharing arrangements with the commissioner and agreeing the scope and use of quality funding
- Developing and improving partnerships by setting a tone of talking about clinical change and quality impact before finance issues
- Creating trust and a shared approach to issues – in chairing a meeting, one CFO agreed an urgent care action be delivered by another provider but

*Transformation requires the CFO to use non-finance skills of the kind they will have developed during their training and throughout their careers*

was able to get agreement from several providers to top-slice quality funding to pay for that action.

Inevitably, however, there will be external factors that cannot be controlled by a single organisation. The role for the CFO is to lead the organisation as best they can, always putting quality first and delivering what is planned. Wye Valley NHS Trust, for a variety of reasons, found that it could not transform its services as planned and would therefore require external financial support.

The CFO noted: 'The board and chair were adamant that quality would not be compromised for achieving FT status and that the trust was clear about not trying to deliver CIPs that would be dangerous in terms of quality of services. As CFO, I had been explicit and transparent about the financial pressures and risks. The board accepted my steer on the long-term financial model and the options available to the trust, with a focus on securing the best health services.

'As a trust we tried to do something different, which did not work as planned, in part because investment in community infrastructure did not materialise. We are now trying to manage the situation in an alternative way and so we need to demonstrate we can retain control in the trust by delivering a new service plan, which will give support and reassurance to all concerned.

'The health economy's financial sustainability problems have been verified by external consultants. Therefore the trust's plans for integration of acute, community and social care proved to be a step too far partly because it was not possible to agree a payment system that covered a whole episode of care across the acute and community sector within the resources available to the commissioners.

'Part of the CFO's leadership role in transforming services is therefore to draw attention to and collectively respond to the national challenges that will affect all NHS organisations – for instance, around payment systems where they no longer support the services that are being designed.'

Our participants discussed the national challenges they face, especially around the payment system. The issues that were mentioned by CFOs include:

- Financial pressure from emergency readmission rules and marginal rate emergency tariff
- Instances where the national prices do not keep pace with clinical practice – for instance, around inpatient and day-case prices paid for ambulatory emergency care that do not incentivise moving treatment to outpatient settings
- Mental health PBR prices that do not support payment for integration of physical and mental healthcare.

There will be others, such as difficult decisions to be made on reconfiguring services and potentially merging or closing some organisations. These questions did not arise as we only explored the transformation projects that have been signed off as feasible and deliverable. CFOs need to take on a collective leadership role to debate these areas in more detail with the national policy-makers and regulators capable of making changes.

In summary, in transforming services the CFO will need to show leadership across several areas:

- Board member role
- Project director
- Local and national problem solver.

### *Governance and accountability*

Research participants agreed that an area where finance teams can challenge transformation plans and add value while the transformation takes place is in setting up governance and accountability arrangements. Through applying a consistent approach to the systems of internal control, they felt improvements could be made in a way that might not arise otherwise.

In a complex environment such as the NHS, the regulatory and statutory requirements require corporate support that can lead to high overhead costs. These need to be used to best advantage. Many interviewees felt corporate overheads could be a barrier to transformation because of their cost. Some felt it might be easier to transform services with smaller overheads that allow flexible and fast decision-making about service changes; others felt that in some circumstances a large, critical mass of support is necessary to provide safe patient care on a large scale.

Importantly, some felt that, while separate organisations could work together to transform services, the benefits of the reduced costs from not duplicating overheads in merged or

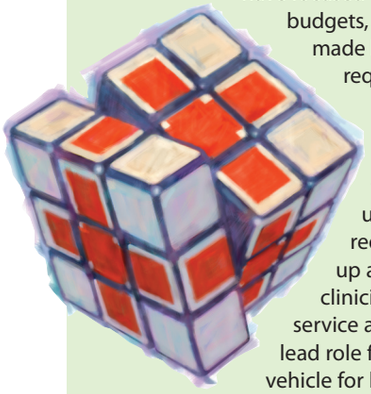
*An area where finance teams can challenge transformation plans and add value while the transformation takes place is in governance and accountability arrangements*

## CASE STUDY 8: SOUTHERN HEALTH NHS FT

The FT's transformation project will bring benefits to patients by reducing the divide between general and mental health care. To do this, the FT is integrating its community teams for older people's physical and mental healthcare as there are demonstrable clinical benefits from this approach, such as diseases progressing less rapidly and the patient experience and patient functioning being improved. The approach also reduces costs across the health system through fewer GP and hospital visits, reduced use of psychiatric services and medication and savings in social care placements.

The clinical strategy is led by clinicians and supported by clinical and corporate functions, including a programme of work to support governance structures. This includes clinical teams' ways of working and reporting lines – the hierarchy of the system – and the systems for maintaining clinical safety.

The financial strategy supports the clinical integration by building on the 'business as usual' processes in the FT to support clear lines of financial accountability with routine and accurate reporting. The CFO and finance team have focused on building a robust system of cost centres and budgets, ensuring this reflects the service design decisions made by clinicians and supports operational requirements for financial accountability and responsibility.



The FT feels the process itself of clarifying financial governance arrangements can facilitate useful clinical debates to find solutions for service redesign. For instance, a discussion about setting up a cost centre can lead to a useful debate among clinicians about which department should host a service and which clinician should take the professional lead role for clinical safety. So the financial debate is a vehicle for having a detailed debate about clinical safety.

Interviewees also felt that a divisional accountant, fully embedded in their management team, would often have an extra level of knowledge not obvious at CFO level. This can be the lever to solve some of the difficult problems that can arise during transformational change programmes. For instance, a divisional accountant is likely to be the person who has the knowledge about the history and audit trail regarding previous funding decisions, which can then bring context to discussions about transformed structures and hierarchies. This two-stage approach to financial and clinical governance operating together is where the finance team can help turn the clinical vision and strategy into something that is operationally sustainable.

For the finance teams working with clinicians, the FT feels it is important to ensure the financial control and governance that underpin the change are robust. The FT says this is not about imposing rules and procedures on teams but working collaboratively with them to understand the changes they are making, so they can assess and review existing systems and recreate new arrangements that most effectively support the new clinical model. This process is resource-intensive and is driven by conversations with managers and clinicians, which finance can then translate into an organisational hierarchy to maintain financial control and clarity around accountability.

A key risk when going through major transformational change is that staff lose focus on day-to-day management, including financial performance. The role of the CFO and finance team is to set up a strong governance and accountability system to support and control the transformation and give assurance to the FT's board and the public. This can encourage constructive challenge about the clinical vision and generate debate on how the changes should be implemented for maximum benefit to patients, service users and carers.

integrated organisations would be the only way to realise financial savings through transformation.

The role of the finance team, then, is about reporting appropriately up, down and outwards and making sure the right people are involved at the right time. This means getting the balance right between empowering people to transform services but challenging, managing them and putting in the right safeguards at the same time.

Some research participants felt their finance teams have in the past taken a step back from being fully involved transformation as the messages have been so clearly around clinically led projects. In some cases, there may be a role for the CFO to set the tone that finance teams can and should challenge financial control and governance arrangements but still allow clinicians to be fully involved in these decisions. One interviewee said: 'Finance was able to take control of the framework designed by clinicians and then hand it back at the right point, in a better state.'

There are additional benefits that the CFO and finance team can bring through their approach to governance and accountability. These include providing training and development for clinicians in writing business cases, financial planning and forecasting. Interviewees felt that transformation leads were usually good at reading and understanding budget statements. But they highlighted the importance of giving clinicians the opportunity to make more informed decisions based on the detail in budgets and an improved understanding of the costs incurred by services.

To aid this process, the CFO and finance team can often play a role. For instance, interviewees noted that finance could help to ensure that technical issues around the transformation, such as contracting, are managed properly and are not over-burdensome. Similarly, where there are standard procedures in place, such as around procurement, finance staff need to be open to questions from operational staff and to make changes where improvements could be made.
In summary, the finance team's role is to:

- Set up the internal control structure and monitoring and reporting tools in a way that involves clinicians and facilitates discussion about improving services
- Ensure the key financial risks identified through financial planning and analysis are monitored and

there are clear lines of accountability
- Establish and enforce appropriate procurement and contracting procedures
- Provide training for business case writing and help clinicians to understand and use finance information to improve services.

## Conclusions

Through this research we do not define a formulaic role for the CFO and finance team in transforming services but we do identify the areas where they can provide the biggest positive contribution. We show that finance teams can actively improve transformation schemes while still allowing clinicians to lead them.

The changes taking place under the badge of transformation are different to previous attempts to deliver savings through cost improvement programmes and, in some cases, require a change in mindset. The most important aspect is to change the culture of the organisation to think about transformational rather than transactional approaches. Once culture and staff perceptions change, there will be increased willingness to support a strategy of transformation. This will then flow through to the everyday systems and processes of the finance department and how they need to work with clinicians and managers.

It may call for extra training and development for finance staff, and it will require partnerships and relationships to develop. Above all, it needs strong and visible leadership. These changes will remain in the organisation after the transformation is complete and will continue to generate benefits.

But there is recognition that CFOs do not operate with autonomy. External regulation and political interest in the NHS mean there will always be external factors for which CFOs cannot plan. And there are issues CFOs cannot solve themselves – there will need to be national debate about them to help transformation succeed.

The HFMA has a role in agreeing consensus for change and to collectively engage with national bodies. There are a number of areas, specifically around the payment system, where these financial policies and frameworks need to be aligned with the clinical practice being established.

The foreseeable financial future will be tough. The NHS may meet the immediate challenge of maintaining or even improving quality while achieving financial balance, but the transformation required to survive the rest of the decade will be difficult. However, there was much to be positive about from our research, and the staff we spoke to had confidence in their plans. ■

**Published by the Healthcare Financial Management Association (HFMA)**
**Albert House, 111 Victoria Street, Bristol BS1 6AX**
**Tel.: 0117 929 4789 Fax.: 0117 929 4844 E-mail: info@hfma.org.uk Web: www.hfma.org.uk**

This briefing was produced under the guidance and direction of the HFMA's Financial Management and Research Committee and Policy Forum. The author was HFMA research manager Richard Edwards. The HFMA is very grateful to the staff of the following organisations who generously took the time to talk to us about the interesting transformation work they are part of and, without which, we would not have been able to produce this briefing:
- Maria Moore, Great Western Hospitals NHS Foundation Trust
- Matthew Cripps, NHS RightCare
- Ann Todd, Pennine MSK Partnership
- John Matheson and Jason Leitch, Scottish Government Health and Social Care Directorate
- Helen De Val and Dr Paul Hopper, Southern Health NHS Foundation Trust
- Sara Charman, Sarah Eggleton, Tracey Paton, Anne Marie Whent and Nadia White, Sussex Community NHS Trust
- Howard Oddy, Wye Valley NHS Trust

# Transforhfmation

This briefing has been produced by the Policy & Technical team at the HFMA.

Influential and insightful, our P & T team issues authoritative content on healthcare finance topics on an almost daily basis, online and in print.

Combining thought leadership with practical guidance, this knowledge can transform the way you work.

Only those who are part of the HFMA have full and free access to our output.

If you're not currently a member, you can change that now.

For more information visit **www.hfma.org.uk** today.

hfma