SHUTTERSTOCK

A NEW WAY

How can transformation and prevention be incentivised to deliver the healthcare needs of an ever demanding population? The HFMA assembled a roundtable to find out what strategies are being used across all four nations of the UK

How can finance leaders incentivise and achieve the transformation towards prevention and care in the community while coping with lengthy waiting lists and stretched budgets? The question causes headaches across all four nations of the UK, with finance teams taking their own approach to a familiar problem.

Are the challenges across England, Scotland, Wales and Northern Ireland so similar that best practice can be transferred from one setting to another? Or does the different makeup of each health system mean that each needs to plot its own path?

A roundtable discussion conducted by the HFMA and sponsored by consultancy IMPOWER heard from those at the forefront of this challenge across all four nations to find commonalities and ways in which familiar problems can be confronted.

HFMA ROUND TABLE

What is transformation?

Andrew Bone, director of finance at NHS Borders and the roundtable's chair, started proceedings by defining what he felt 'transformation' meant in the context of healthcare, and particularly the shift towards prevention and providing greater care in the community.

'More generally, transformation is something that's on a spectrum between the narrow focus of how you build an invest-to-save case that might have very specific cashflow paybacks, but moving all the way into the space of how you make that long-term shift in population health outcomes, where there might be a health economic basis for making changes but demonstrating the cashflow is much less defined,' Mr Bone said.

In prevention terms, he added, the transformation spectrum could move from preventing hospital admissions at a particular location by taking specific actions in community services, through to spending a bigger slice of a budget on keeping people healthy and well, rather than treating their illnesses at a later stage.

With this in mind, Mr Bone asked what financial mechanisms were in place to either force or incentivise this change, or to facilitate investment in new or different models.

Robert Holcombe, executive director of finance and procurement at Aneurin Bevan University Health Board in Wales, spoke about the challenges of having to improve and shift services upstream in a financially rationed

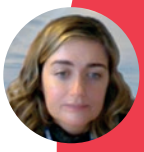
ROUND THE TABLE

- Oliver Barnes, IMPOWER Consulting

- Andrew Bone (chair), NHS Borders

- Maureen Edwards, Belfast Health and Social Care Trust

- Bev Evans, healthcare management consultant



- Kristin Gillies, Argyll and Bute Health and Social Care Partnership

- Rob Holcombe, Aneurin Bevan University Health Board

- Elmer McCauley, Western Health and Social Care Trust

- Lee Outhwaite, South Yorkshire Integrated Care Board

- Samuel Rose, IMPOWER Consulting

- Wendy Thompson, South Eastern Health and Social Care Trust

world while being under pressure to reduce waiting times.

'Whatever we invest in outside of a hospital setting has got to have a compensating equal or greater effect on what we don't then deliver in hospital,' he said. 'So, this upstream shift has to be recompensed by reduction in the demand on the hospital. And that is the big challenge.'

Maureen Edwards, director of finance at Belfast Health and Social Care Trust, said her organisation had received money earmarked for transformation and prevention over the years, which had garnered some positive results. But this activity was conducted 'around the edges, often spent on non-recurrent pilots, and then not sustained as everyone moves on to the next big thing'.

'Often, what is needed to make change is up-front money and right now there is no money,' she added. 'We will hit a wall if we don't do the right thing now with regards to the transformations needed in our communities to ensure a sustainable healthcare system, but we haven't worked out how we're going to do that without disinvesting in the acute world. Experience tells us that when A&Es start to struggle, the money goes that way.'

Bev Evans, a healthcare management consultant, identified three key components needed to facilitate this transformation, none of which are fully in place and working effectively at the moment. First, she identified standardisation outside of the hospital care provision. She cited efforts she had made in NHS systems in her career to ensure the public were aware of what community services were on offer, and improving the consistency of that offer to stop people thinking 'I need healthcare, therefore I need the hospital'.

The second area flagged by Ms Evans was the need for different payment mechanisms. 'That's one of the areas that is a particular challenge given our financial constraints, because people can't ringfence money,' she said. 'We always seem to have to steal from Peter to pay Paul. And that's why, while the demand on acute is increasing, we don't have any headroom to invest in the services outside of the acute setting and improve that care.'

> **"We will hit a wall if we don't do the right thing now with the transformations needed, but we haven't worked out how we'll do that without disinvesting in the acute world"**
>
> **Maureen Edwards, Belfast Health and Care Trust**

Finally, Ms Evans echoed Ms Edwards' point about spending too much time and money on non-recurrent pilot schemes. 'We don't make these pilots sustainable when it's that sustainability that has got to change in terms of making the actual transformation and prevention agenda real,' she said.

Kristin Gillies, head of planning for Argyll and Bute Health and Social Care Partnership, said funding that was made available nationally didn't always match local needs.

'An example of this in Scotland is community walk-in centres,' she added. 'In Argyll and Bute, we do not have a problem with GP waiting times as we only serve very small communities. However, we have been given a significant amount of money to put in community walk-in centres to solve this "problem", and it's not a priority for us. But we're not allowed to redirect that.'

Lee Outhwaite, chief finance officer at South Yorkshire Integrated Care Board, added that to deliver value-based healthcare well in a preventative model, there needed to be a very deep system understanding about what the additional requirements are.

'This applies to the announcement of 250 neighbourhood health centres in England,' he said. 'Why 250? Where are they going? To what purpose? So the huge disbenefit of being a publicly funded healthcare system is the fact

that we have bounded rationality about where the investment goes. We need to have a really deep conversation about how effective general practice is, as an example. What patients are they seeing? Are they seeing the right ones to add maximum value?'

Oliver Barnes, a delivery director at IMPOWER, said he saw many healthcare finance leaders who feel a disconnect between central policy and local need, and floated the idea of these leaders being more engaged in the policy design process 'so that there are more options to consult upon these policies before they come down as mandates'.

Regional variations

Mr Outhwaite asked about the differences in the four UK nations when it came to delivering any transformation. 'In Wales, Scotland and Northern Ireland, you've got a better vertically integrated supply side that ideally should enable you to think quite differently about how you see patients in a more proactive and anticipatory model that avoids the unnecessary decompensating of acute care.

'So why is it that Wales, Scotland and Northern Ireland aren't better at this than England?' he asked.

Mr Holcombe acknowledged that public health is more closely tied to health boards in Wales, while it sits under local authorities in England. However, he added: 'There is a challenge within our financial environment in that we have targets and funding given to us that are not really designed to drive investment in public health and prevention.

'I'm sure, if you talked to the Welsh government, they would challenge that observation, but the targets that really matter – and therefore get the money – are based around referral-to-treatment waiting times. We have many other targets, but it's the waiting times that the government really scrutinises.'

HFMA ROUND TABLE

From a Scottish perspective, Mr Bone said a common issue affecting performance on prevention was that there just wasn't enough money to do everything, so prioritising prevention means deprioritising other functions, unless there is tangible cash release.

Speaking about Scotland specifically, he added that although the country's health system had enjoyed some integration, statutory responsibilities across health and social care continued to drive rigidity of approach.

'That means all the conversations that need to be had don't necessarily happen in the right spaces,' said Mr Bone. 'There is a tension between the points of interaction, between health and social care, and there can be disincentives to doing the right thing because of who owns the budgets and its responsibilities.'

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> **Lee Outhwaite, South Yorkshire Integrated Care Board**

Best practice and barriers

Mr Bone then moved the conversation on to areas of best practice the participants had seen within their regions, and what barriers they were experiencing when it came to transformation and prevention.

Wendy Thompson, director of finance, contracts and estates at Northern Ireland's South Eastern Health and Social Care Trust, brought up the lack of a role for primary care as one such barrier.

'The answers to a lot of these problems don't sit with secondary care and social care providers, they sit with primary care,' she said. 'One of the reasons why it isn't working in Northern Ireland is because secondary care providers could have a better relationship with our GP providers.

'I think the GPs feel left out in the cold in all this and the conversation is very contractual. The key to prevention and this transformation has got to sit with the GPs and how we, as a system, bring them more into the fold.'

Ms Edwards agreed that the sidelining of primary care represented a barrier to the transformation in prevention, but added that the general public had a role to play too.

She said patient-initiated follow-up appointments in Northern Ireland had helped the public to look beyond the acute sector for support if it was needed. But there was still a tendency to think: 'I can't get into hospital, I should be in hospital, I should be able to stay there for as long as I want.' She added: 'The public health messaging isn't good enough. The public can't expect secondary care to look after them the whole time.'

Ms Gillies said she wanted to see more of a whole-system approach. 'You will get a chronic obstructive pulmonary disease patient going to A&E and then going home to a mould-ridden house and a boiler that doesn't work,' she added. 'Should we not be spending the money on a new boiler, and working with our housing colleagues to make sure their home is in an acceptable condition rather than having them visit A&E every two weeks, so we don't just keep on treating people?'

Mr Outhwaite added that he is seeing wider efforts to offer a broader service to citizens, but with a focus on being as cost-effective as possible. He expressed an interest in how the Northern Irish neighbourhood team model worked, given that the model is going to be used in England.

Eimear McCauley, director of finance, contracts and capital development at Western Health and Social Care Trust, said her region has existing and highly effective community planning arrangements. But detail on the role that secondary care will play in the shift to greater community care and more work on prevention was still being developed.

'We know there's a huge gap in what we're delivering versus seriously tackling the social determinants of health,' she said, adding that department officials are starting to talk about working cross-departmentally in this area.

She said that evidence of this producing results would be really useful 'because as a system we currently need to deliver 12% of savings in 2026/27 for financial balance, which is significant and well beyond what's possible through normal levels of efficiency and the identification and removal of waste'.

'This could have a serious, long-term impact on services,' added Ms McCauley. 'While we're not moving at the pace some might hope we are, the recognition of this model as part of the solution going forward is very positive.'

Samuel Rose, a director at IMPOWER, said he had seen it was possible to deliver this transformation. 'If you look at frail and elderly people and how their care is managed in different areas, you get vast differences, even between areas that have quite similar population demographics,' he said.

'So it is possible. However, it's extremely hard in the current environment, because the NHS is facing a cash crisis. But the NHS was born out of crisis and it will, and it can, deliver change in crisis.'

Mr Rose said he had seen three different funding routes that had been effective. The first was delivering process improvement internally to move away from embedded models to release cash, and then using that cash to prime community investment.

The second and most straightforward route, according to Mr Rose, was protecting growth funding and then choosing to invest that as a system. The third was looking for alternative funding models to prime prevention, such as social impact funding.

Mr Barnes said he had been working with a group of providers in Nottingham, where there are numerous integrated programmes under way, including in primary, secondary and community care.

'But they are still working through the problem of how to shift this at scale,' he said. 'However, my reflection from this work was that a neighbourhood programme does give us a test bed to learn and a safe space in which to try some of these new approaches.

'Success is not guaranteed, because it is very difficult, but if we recast how some of these programmes are set up, they can be good testing grounds, learning opportunities and practical examples to work through about how far we can go without new sets of policy direction.'

Leading the transformation

Mr Bone asked what practical measures could to taken to drive or design this transformation. Mr Holcombe said there were multiple ways in Wales, from promoting and pursuing the policy agenda to bringing in the private sector.

'But what we're talking about is how to get money into this shift in the context of a very limited financial envelope that we have,' he added. 'Here we need the NHS to start building propositions that have good feasibility assessments, because I've met with community cluster leads and asked them what they would do if I gave them all the funding they were asking for, and they were unable to provide clear proposals. So we need to give financial business advice to our cluster areas to help develop that agenda and pull the shift, rather than trying to push it.'

'We need to use our roles to influence the change,' said Ms Edwards. 'We need to be the ones not saying no to things because there is no money now and no immediate return on investment. We need to help others to find investment through charitable funds or whatever way we can get this money.

'In our boards, we need to be willing to take some financial risks when we know it's for the right cause. We also have to keep everybody optimistic, because when the directors of finance give up, everybody gives up.'

Mr Outhwaite said that financial leaders needed to foster an environment with much better partnerships across finance within the public sector.

'If you think about the needs challenge and what goes on in education, if you think about the sort of dementia challenge and what goes on with social care, if we are not having a broader conversation across the different bits of the machinery of the state, we are not going to deliver cost-effective services to the citizens we serve,' he added.

"The NHS is facing a cash crisis. But the NHS was born out of crisis and it will, and it can, deliver change in crisis"

Samuel Rose, IMPOWER

HFMA ROUND TABLE

Building coalitions was a theme picked up by Mr Barnes. 'You have to get out of your comfort zone and have new conversations with people you wouldn't ordinarily come across in your day-to-day business-as-usual to construct those coalitions,' he added.

Mr Bone commented that the model in Scotland, with integrated joint structures, provided such opportunities, but taking them was a different matter.

'I attend our integrated joint board within Scottish Borders and there are individuals who sit on that joint board representing the third sector and other such areas,' he added.

'I have to be honest and say I never have a discussion with them on any topic outside of that space; we do not engage one to one. The opportunity is there, but structures alone don't make it happen.'

Ms Thompson said that in her organisation, South Eastern Health and Social Care Trust, many people want to have an impact on the transformation and come up with innovative projects to do so.

'But how do you take what is a good idea and then demonstrate that it is going to lead to long-term change in the move to prevention?' she asked. 'What finance teams can bring to that is the rigour of the business case process. That means that if we are going to take financial risks, they are done in a very data-driven, analytical way, so that we know we are taking those risks with solid thinking behind us.'

A way forward

Looking at what can be taken away from the roundtable and put into action, Ms McCauley said changes must be made with longer term goals. 'In our system, we can do lots of things without really focusing on the one thing that's going to make a difference,' she added. 'I've been around for more than 20 years and we've been talking about this transformation for that long. So as a director of finance, also a future user of our services, my hope is that we start to make changes for the longer term.'

Ms Evans hoped that finance leaders would keep on 'challenging up the line and influencing in terms of how we interact across other parts of the state', while Ms Thompson said she hoped that the NHS would become less insular in dealing with the private sector.

'We've so many problems to deal with, and we're maybe not looking outward enough to see if there are other people who can help us to solve some of them,' she added.

It was a point backed up by Mr Outhwaite, who said: 'You cannot manage health spend effectively solely within the health silo.'

Summing up, Mr Barnes said communication and innovation were two important factors going forward. 'Part of the role of director of finance is creating a permissive culture where the teams around you and the organisations you're in are receiving positive communications that you are open to innovation,' he added.

'You want to see your colleagues come forward with innovative proposals, so investing in hard skills – such as how you enable those teams, how you upscale their ideas and business cases with confidence – is a really important part of this.'

Transformation in any walk of life is, by its very nature, complex and difficult to achieve, but the health service in every part of the UK cannot keep working in isolation, focusing primarily on hospital waiting times. Finance managers know this, but they are also well aware of the constraints they are increasingly working under. As Ms Edwards stated: 'Investment is needed to drive change away from secondary care closer to people's homes but right now there is no money.'

This doesn't stop the need for change, however. Indeed, there was a consensus around the table that there is little choice but to act.

Mr Rose concluded: 'It's an exciting time because the risk of doing nothing is bigger than the risk of doing something.'