Financial planning at a System level

Welcome

17 September 2024

Financial Recovery

Mark Mansfield, NED Chair of the Finance and Performance Committee at University Hospitals Birmingham NHS FT (and Former Regional Director of Finance for the Midlands)

Financial Recovery : Some Thoughts

Mark Mansfield

17 September 2024

What’s in a Name ?

- Financial Reset
- Financial Retrenchment
- Waste Reduction Programme
- Financial Transformation Programme
- Cost Reduction Programme
- Financial Recovery Programme
- Financial Turnaround
- ….and many others.

An Historical Perspective !!

“ In practice, FRPs are the formal expression of how an organisation plans to deal with a “cumulative deficit position”. The aim of a FRP is to demonstrate a well structured, well planned and practical way forward that will achieve financial balance and sustainability. Out of context this may sound fairly straightforward. However, given the critical importance of financial stability and delivery……FRPs are rarely straightforward in practice.”

(p10 “Financial Recovery Plans in the NHS” HFMA 20??)

“The Past is a foreign country, they do things differently there”.

- The “drivers of the past” included :
  - Structural Imbalance
  - Demand and “over-trading”
  - Supply and “under-trading”
  - Staff Costs
  - “Delayed Transfers of Care”
  - Low Productivity
  - Weak Financial Management
  - Focus on short term fixes rather than systematic change
  - Lack of Leadership
  - Failure to Deliver
- Some of that might sound familiar !!

Mark Twain

“History doesn’t repeat itself but it does often rhyme”.

What I'll try to cover

- How you might be approaching SYSTEM recovery
- Some of the dilemmas systems and organisations are facing and how these might be being resolved.
- ….some of it from my new-found Non-Exec status ! How it feels to wear that hat during financial recovery !

- I will not be talking about "the how" (because you are the experts) but we can discuss that !!

The “Three Phases”

- ST Stabilisation and developing the plan
- Delivery and consolidation
- Steady State

“You May be Needing” for phases 1 and 2

- A pathway to deliver 2024/5 ! (? Partly “divorced” from the following….).
- A medium term financial plan (for the System) – a direction of travel, even if it is lab based. As realistic as possible.
- An agreed list of places to look for transformation, efficiency, savings.
- A project structure to deliver the above.
- A project team
- Leadership of the above
- “Rules of the Game”.
- Clear view on “governance”.

A word on the Project Structure

- Most programmes will contain : “The Traditional”, “The Transformational”, and “ The Strategic”. They tend to need different approaches.
- Most programmes will contain – over 3 to 5 years - increasing amounts of collaboration rather than traditional “silos”. (And some provider collaboratives are acknowledging the **financial** implications of this too).
- For the collective projects a full time, dedicated (but small !) project team might be sensible. NOT necessarily a PMO !
- The project oversight of everything MIGHT be best done collectively…..

A Further word on Project Structure

- The key question around “degree” of collaboration and “how tight”.
- Close/ Loose/ “Medium-Loose”.
- Not about “recovery” alone
- It links to governance.
- It feels very complicated !

A word on Leadership

- Strong and collective CEO leadership is often a prerequisite
- A TD (or a FRD or a group of TDs) is unlikely to replace engaged CEOs.
- Do not make a “TD” a panacea.
- A collective Project Executive Team is likely to be essential for a SYSTEM approach.
- The PET needs to involve a range of disciplines.
- Be prepared to change this between phase 1 and phase 2.

Rules of the Game (1)

- It may be best to decide explicitly how this should be done (more difficult if it implicit perhaps).
- Attempts to determine : Who Owns ? (Target attribution and “ownership” of outcomes).
- Controls :
  - Essential but not sufficient ?
  - Linked to “traditional” and “salami sliced” elements ?
  - A question of “how” and “how systemised” ?
  - Pay/ Non-Pay/ Other (business case controls)

Rules of the Game (2)

- Traditional – Usually organisationally owned. Question of transparency ?
- Transformational – Many (but not all) projects will have a collective element. (Might be best if explicit, open and shared).
- Strategic – Collective and will need “collective agreement” (inc for some “traditional” areas – eg Shared Services
- Governance structures – Role of organisational and system Finance committees ?

A word on system infrastructure…

- Financial Recovery approaches have to “go with the grain” of other system arrangements.
- The system infrastructure has to be supported by/ support the agreed “rules of the game”.
- The system infrastructure should not impede the recovery approaches to project management.
- System infrastructure can (and perhaps needs to) go beyond “organisational assurance”.

Finally….Planning

“Having something in front of you, a map, a plan, a list of treatments, even if it isn’t completely right, is better than nothing.”

(Quoted in “The Premonition” – Michael Lewis).

“An idiot with a plan can beat a genius without a plan.”

(Warren Buffett).

Value and system-based health and care

Lee Outhwaite, Chief Finance Officer at South Yorkshire ICB

Value and system based health and care

Lee Outhwaite, SY ICB CFO

Content

1. Me
2. Health and Care Act and Value based healthcare
3. Darzi Review
4. “Quality” Improvement
5. Virginia Mason Institute and VMI Pilots – Leeds Way and UCHWi
6. If the NHS Finance Profession isn’t interested in process mapping, process optimisation and waste reduction why not? – EVO.
7. The changing nature of our savings/transformation approach
8. Further Questions

Biography – Lee Outhwaite – South Yorkshire ICB CFO

Lee joined South Yorkshire ICB as CFO in June 2022. His role covers Finance and Estates. Prior to this he was Director of Finance at Chesterfield Royal NHS FT and Derbyshire Community Health Services NHS FT. He was also the Finance Lead for Joined Up Care Derbyshire (the Derbyshire ICS). Lee has worked in the NHS, since 1993, in a number of finance roles, and has been a Director of Finance since 2008.

Lee qualified with, and now sits on the Council of, the Chartered Institute of Public Finance and Accountancy (CIPFA) and is Chair of their Public Policy and Reform Faculty Board. He is also Vice President of the Healthcare Financial Management Association (HFMA) and chairs their Policy and Research Committee.

In addition, he recently completed a Professional Doctorate in Public Policy and Management from Keele University. He is a member of QSIR college and is interested in how we implement the NHS Impact framework well in systems.

2022 Health and Care Act - Doing what?

- “The Bill will overwrite the current local structure of the NHS, where local Clinical Commissioning Groups pay NHS trusts and others to provide care in what is meant to be a competitive “internal market”.
- Instead, under clauses 12 to 25 of the Bill, representatives of trusts, GPs and councils will sit together on the boards of “Integrated Care Systems” responsible for overseeing health services in 42 regions. Each of these will also have a wider partnership committee making plans for greater cooperation across health and social care.”

Nuffield Trust (2021) Briefing: July 2021 - Second Reading of the Health and Care Bill The Nuffield Trust

Oh no, not again; or big opportunity?

- “The NHS does not need a distracting and unproved reorganisation that, for all the rhetoric about devolution, leaves unchanged, or even strengthened, the capacity for the centre to micromanage the service into the ground. What is required is a fundamental rethinking of the relationship between central government and the NHS.”

Smith J, Walshe K. and Hunter DJ (2001) BMJ The "Redisorganisation" Of The NHS: Another Reorganisation Involving Unhappy Managers Can Only Worsen the Service British Medical Journal , Dec. 1, 2001, Vol. 323, No. 7324 (Dec. 1, 2001), pp. 1262-1263

The case for change socially determined disease and Marmot

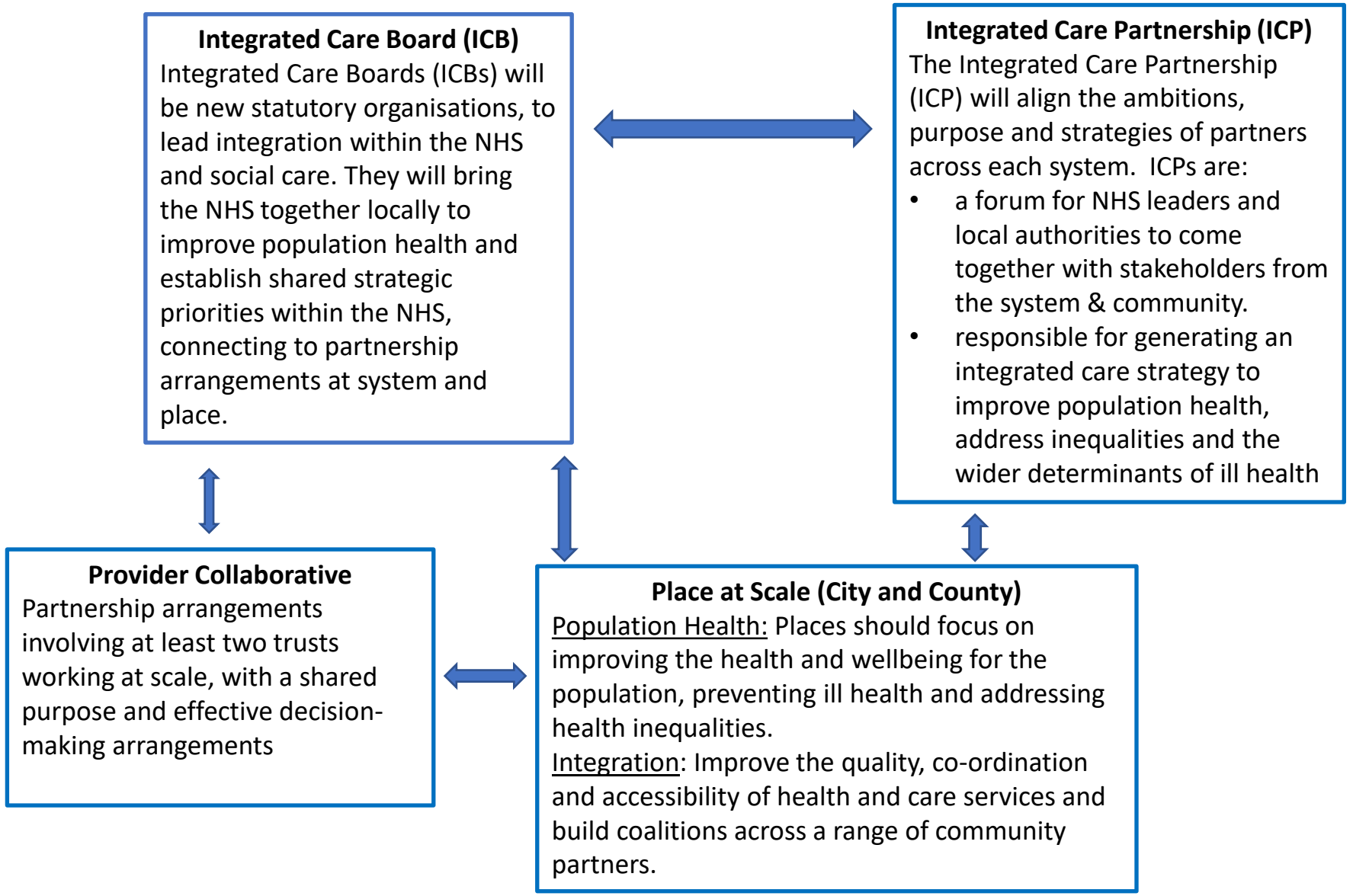
From the beginning of the 20th century, England experienced continuous improvements in life expectancy but from 2011 these improvements slowed dramatically, almost grinding to a halt. For part of the decade 2010-2020 life expectancy actually fell in the most deprived communities, outside London, for women and in some regions for men. For men and women everywhere the time spent in poor health is increasing. . . . . Put simply, if health has stropped improving it is a sign that society has stopped improving.

Research into the precise causes of disease and ill-health actually shows that the contribution of the healthcare service itself, in terms of quality and access to care, is a relatively low contributing factor at around 20% of overall health and well-being. The wider causes of ill-health relate to health behaviours, socio-economic factors and the built environment. This is shown in the Figure, above. This Robert Wood Johnson Foundation research (which is part of the Harvard University – School of Public Health).

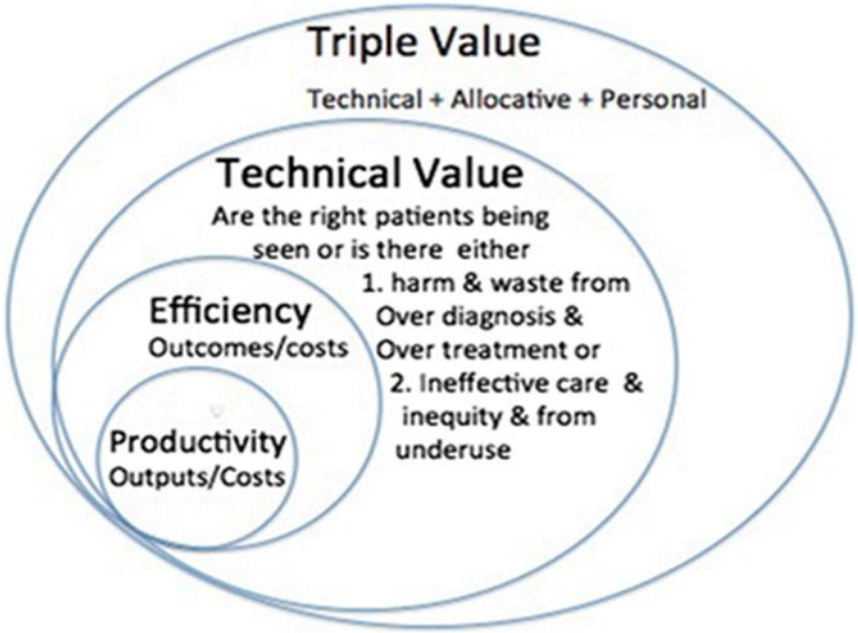
Three multi-disciplinary challenges the NHS faces – the “what”

- How do we get primary and secondary care to work differently together to alleviate failure demand and deliver more proactive and responsive care, like Kaiser Permanente or the Valencia model?
- How do we get health and social care to work differently together to alleviate the strain by more appropriately managing chronic disease and frailty delivering smoother transitions between different settings of care?
- How do we really start to deliver a health and wellbeing (not illness) service by really addressing and tackling the broader determinants of disease working differently within each broader health and care partnership?

Integrated Care System Architecture – Who does what?



Value based healthcare – a common set of definitions



Muir Gray has identified different layers of measuring value in healthcare, shown in Figure.

- productivity and the need to drive down the costs of delivery of healthcare outputs
- cost of outcomes to define the next layer of efficiency
- the need to ensure we are utilising services well and not over or under treating patents, and
- the need to ensure that patients and citizens that are in receiving value-adding.

The internal market in health made the provider organisations concentrate mainly on productivity, whilst commissioning and local government have tried to champion the wider value of healthcare. However, this separation may not have led to services being delivered optimally.

To progress as an ICS we need a common definition and view on value that we can all deploy and utilise.

Darzi Review

NHS South Yorkshire Integrated Care Board

Darzi Investigation of the NHS in England

The investigation explores the challenges facing the NHS and sets the major themes for the forthcoming 10-year health plan

Context for the Independent Investigation of the National Health Service in England

- **The National Health Service is in serious trouble:** The NHS is a much-treasured public institution embedded into the national psyche but is now in critical condition and experiencing falling public confidence
- **The health of the nation is worse**: increasing long-term conditions and worsening mental health, leading to a spike in 2.8m long-term sick from 2m, while the public health grant reduced by 25% and the public health body has been split into two
- **This is not a reason to question the principles of the NHS or to blame management:** managers have been "keeping the show on the road" and there is a virtuous circle where the NHS can help people back to work and act as an engine for national prosperity

Where are we?

How did we get here?

The challenges facing the NHS are interlinked…

Waiting time targets have been missed consistently for nearly a decade and satisfaction is at an all-time low

People struggle to see a GP despite more patients than ever being seen, the relative number of GPs is falling, particularly in deprived areas, leading to record low satisfaction

Community waiting lists have soared to 1million with 80% being children and young people; 345k people are waiting more than a year for **Mental Health** services

A&E is in an awful state and long waits contribute 14,000 additional deaths per year, while **elective waits have ballooned** with 15x more people waiting >1 year

People receive high quality care if they access the right service at the right time, without health deteriorating

- **Cardiovascular** mortality has rolled back as rapid access has deteriorated
- **Cancer** mortality is higher in part due to minimal improvement in detecting cancer at stage I and II
- **Dementia** has a higher mortality rate in the UK than OECD and only 65% of patients are diagnosed

Funding has been misaligned to strategy, with increased expenditure in acute driven by poor productivity

Too great a share of funding is on hospitals, increasing from 47% to 58% of the NHS budget since 2006, with 13% of beds occupied by people who could be discharged

The number of hospital staff has increased sharply, equal to a 17% since 2019, with 35% more working with adults and 75% more working with children

Patients no longer flow through hospitals properly leading to 7% fewer OP appts. per consultant, and 18% less activity for each clinician working in emergency

Four main drivers are identified…

It has been the most austere period in NHS history with revenue prioritised over capital

- 2010-2018 funding grew at 1% compared to long term average of 3.4%
- £4.3bn has been raided from capital budgets between 2014 and 2019
- £37bn shortfall of capital investment has deprived the system of funds for new hospitals, primary care, diagnostics or digital

The pandemic's legacy has been long-lasting on the health of the NHS and population

- The NHS entered the pandemic with higher bed occupancy, fewer clinical staff and capital assets than comparable systems
- NHS volume dropped more sharply than any other comparable health system, e.g. 69% UK drop vs OECD 20% in knee replacements

The voice of staff and patients is not loud enough as a vehicle to drive change

- Patients feel less empowered or secure and compensation claims stand at £3bn per year
- Priorities of patients have not been addressed, notably in maternity reviews
- Staff sickness is equal to one-month a year for each nurse or midwife
- Discretionary effort has fallen up to 15% for nursing staff since 2019

Management structures and systems have been subject to turbulence and are confused

- The 2012 Health and Social Care Act was disastrous
- The 2022 Act brought some coherence but there is a lack of clarity in responsibilities and in performance management
- Regulatory organisations employ 35 staff per trust, doubling in size in the last 20 years
- Framework of standards and financial incentives is no longer effective

What should we do next?

Addressing these in the forthcoming 10-year health plan needs to include…

- **Re-engage staff and re-empower patients**, harnessing staff talent to deliver change and enabling patients to control their care
- **Change financial flows** to promote and **sustain the expansion of GP, MH and Community services** at a local level, embracing a **multidisciplinary neighbourhood care team model** that brings these services together
- **Improve productivity** in hospitals through improved **operational management**, **capital investment** and **empowering staff**
- Across the system, **tilt towards technology** through **digital systems**, especially for staff **outside hospitals**, and **embracing the potential of AI** for **care** and **life sciences**
- **Clarify roles and accountabilities** in NHS England and ICBs, **rebalancing management resource** with emphasis on the **capacity to deliver plans**, while **avoiding top-down reorganisation**
- **Direct effort** at aspects that will **drive national prosperity** by supporting people to **get back to work**, and **working with British biopharmaceutical** companies

Quality Definition

In “Quality and the NHS: Fair-weather Friends or long lasting relationship?”, Millar, Waring and Lani (in The NHS at 75-the state of UK health policy, edited by Exworthy, Mannion and Powell) it is observed that the quality framework for the NHS has often been developed due to high profile lapses in the quality of care in the English NHS. Issues around Bristol cardiac surgery, Harold Shipman, Mid Staffs and ongoing maternity failings have given rise to a “patchwork of quality responses”.

Millar, Waring and Lani also define quality through a number of lenses including:

1) Safety
2) Effectiveness
3) Patient centred.
4) Timely
5) Efficient
6) Equitable

They then go on to pose the question, however, about whether or not 5) efficiency should be included in this list, (or is it an independent objective outwith quality); and whether or not 6) equity of access, should be included in this list, from a narrower quality definition perspective – it is possible to have high quality services, but they may not be equally or equitably shared.

Quality Improvement

There is a long history of quality interventions in the English NHS, which they go onto describe including:

1989 - “working for patients” introduced a definition of quality improvement.

1990 onwards - Concepts around total quality management, statistical process, control, and PDSA cycles were introduced.

1998 – “first class service” introduce the concept of clinical governance and quality accountability to organisational CEOs.

2001 – the modernisation agency was introduced.

2003 – the Dr Foster Hospital guides, including HSMR were introduced.

2005 - the NHS Institute for innovation was introduced, including the productive series.

2013 - the Berwick review introduced the need for a NHS wide quality improvement approach.

2017 - a quality improvement partnership with five Trusts and the Virginia Mason Institute was introduced.

2023 - the NHS launched “NHS impact” which reinforced the need for a strong quality improvement approach.

NHS IMPACT | Driver Diagram

Aligned to the five components of NHS IMPACT

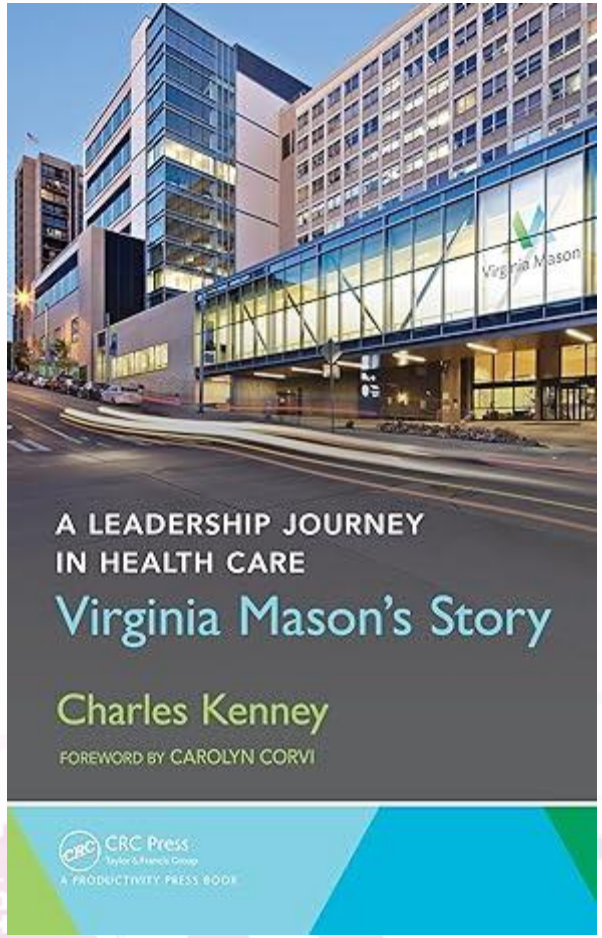
Aim

To mainstream continuous improvement across the entire NHS to achieve enhanced patient outcomes, increased operational efficiency and overall excellence in healthcare delivery.

Primary Drivers	Secondary Drivers
Building a shared purpose and vision Our workforce, trainees and learners understand the direction and strategy of the organisation / system, enabling an ongoing focus on quality, responsive and continued learning	Inclusive shared vision and purpose co-designed with local communities Embed shared purpose into everyday work Align improvement work to the shared purpose and vision
Investing in people and culture Clear and supported ways of working, through which all staff are encouraged to lead improvements	Cross system learning and innovation Cultural readiness and shared values Invest in and support teams to own and lead improvement in their everyday work
Developing leadership behaviours for improvement A focus on instilling behaviours that enable improvement throughout organisations and systems, role-modelled consistently by our Boards and Executives	Leadership development strategy and Board development Create values driven leadership, stability and continuity of style and approach Senior and Executive leaders engaging in frequent huddles or workplace visits, coaching staff at the front line
Building improvement capability and capacity All our people (workforce, trainees and learners) have access to improvement training and support, whether embedded within the organisation/system or via a partner collaboration	Establish an improvement methodology for use across your entire organisation Training Strategy with universal access to training and support Demonstrable impact through organisational focus on data
Embedding improvement into management systems and processes Embedding approaches to assurance, improvement and planning that co-ordinate activities to meet patient, policy and regulatory requirements through improved operational excellence	Explicit management system that aligns the strategy, vision and purpose at Board level throughout workforce structures and functions Systems to identify and monitor early warning signs and quality risks, with clear processes to respond to these Board committed to owning and using this approach to manage the everyday running of the organisation

NHS IMPACT
Improving Patient Care Together

The Virginia Mason Story



1. Gary Kaplan CEO
2. Hitatchi and Toyota (Jerry Liker)
3. A production system for healthcare
4. Everyone is employed to improve the work as well as do the work
5. Kaizen – Continuous Improvement
6. Standard Work, Visual Control and Production Boards
7. Psychological Safety and non hierarchical approaches to ideas generation for improvement
8. On the Genba

Psychological Safety

The importance of trust and inclusion on the nature of high performing teams and healthcare organisations, and healthcare systems, can't be underestimated. The Five Dysfunctions of a Team is a business book by consultant and speaker Patrick Lencioni was raised. It describes many pitfalls that teams face as they seek to "grow together". He noted the need for teams to trust each other to enable them to engage in necessary disagreement, before giving shared commitment to accountability and then the delivery of results. He cites the Dysfunctions as:

Absence of trust: unwilling to be vulnerable within the group

Fear of conflict: seeking artificial harmony over constructive passionate debate

Lack of commitment: feigning buy-in for group decisions creates ambiguity throughout the organization

Avoidance of accountability: ducking the responsibility to call peers, superiors on counterproductive behaviour which sets low standards

Inattention to team results: focusing on personal success, status and ego before team success

At a macro level the psychological safety for NHS managers can be questioned, and this needs to be addressed for the NHS to adopt the NHS Impact Framework well. As Ed Smith, former chair of NHS Improvement, lamented "If you live in a country, where the firing squad is the basis of encouraging people to step up and take risk, you're not going to get people appearing to innovate, wanting to improve because they know what's coming."

Strategic Alignment

Aligning vision and strategy from the board room to the front line

WBS – Leeds Way and UHCW and EVO

Leading change across a healthcare system:
How to build improvement capability and foster a culture of continuous improvement
Lessons from an evaluation of the NHS-VMI Partnership1,2
Extended summary findings - Spring 2022 – Warwick Business School

The Leeds Improvement Method aims to reduce variation and waste, empowering staff to use small-scale tests of change to continuously improve the quality of care we provide to our patients and their careers.

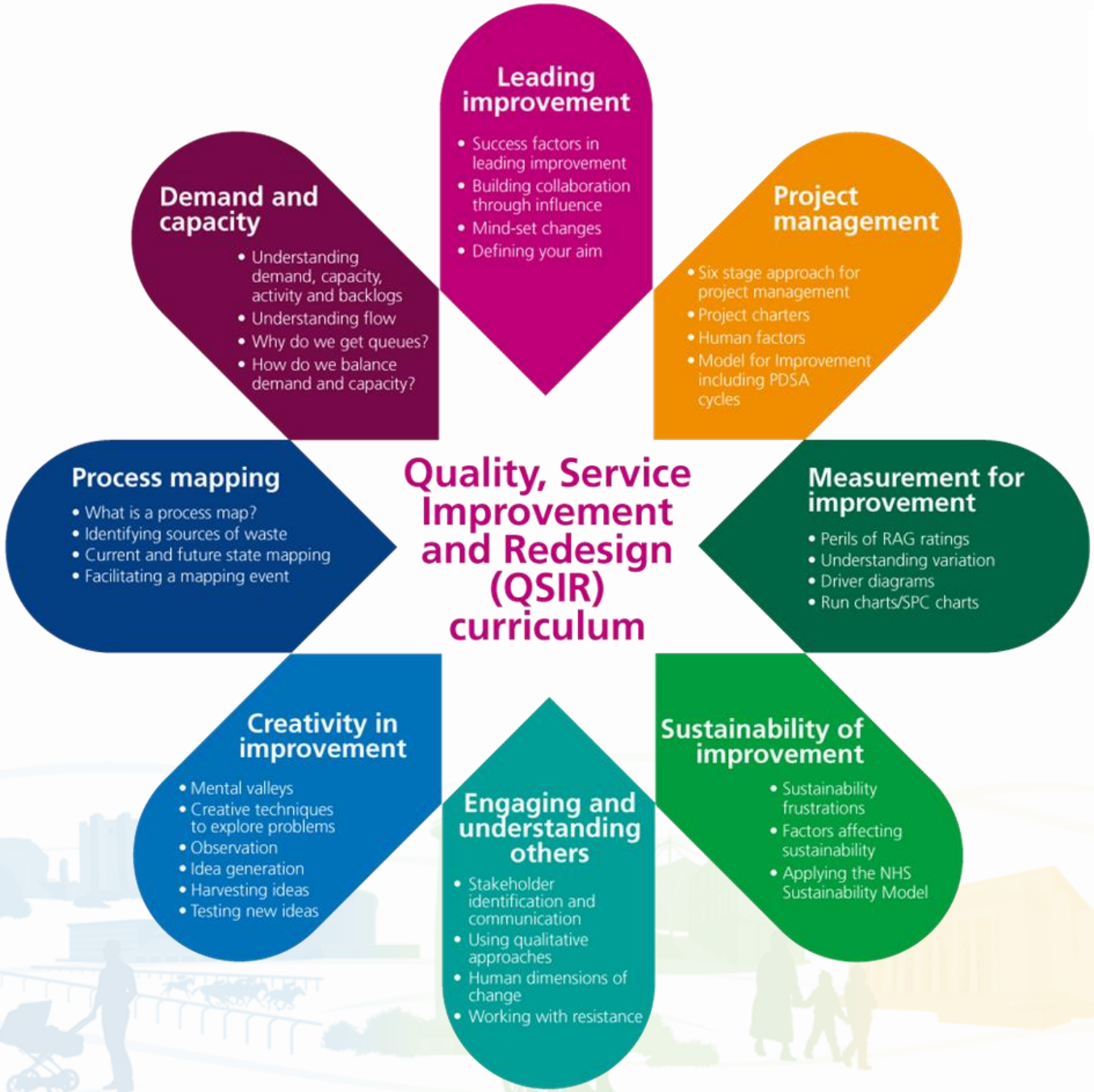
I WANT EVO

Engagement Value Outcome

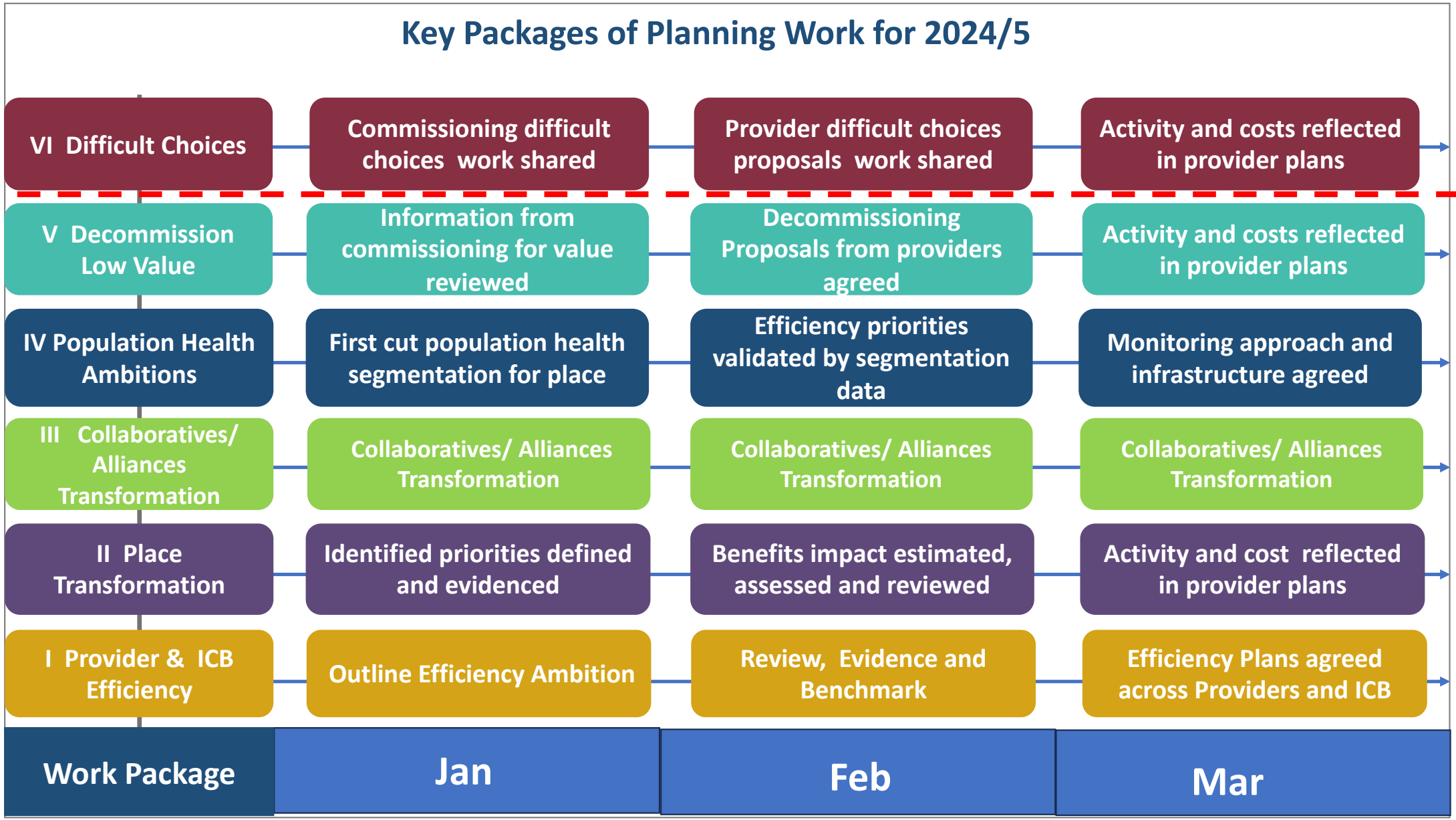
FUTURE FOCUSED FINANCE | FINANCE INNOVATION FORUM

NHS
South Yorkshire
Integrated Care Board

The Finance Role in QI and QSIR



Steps to underpin a robust whole system change plan



Organisational Plans placing reliance on whole system change

Will our blend of savings/transformation on these themes change over time?

VI Difficult Choices

V Decommission Low Value

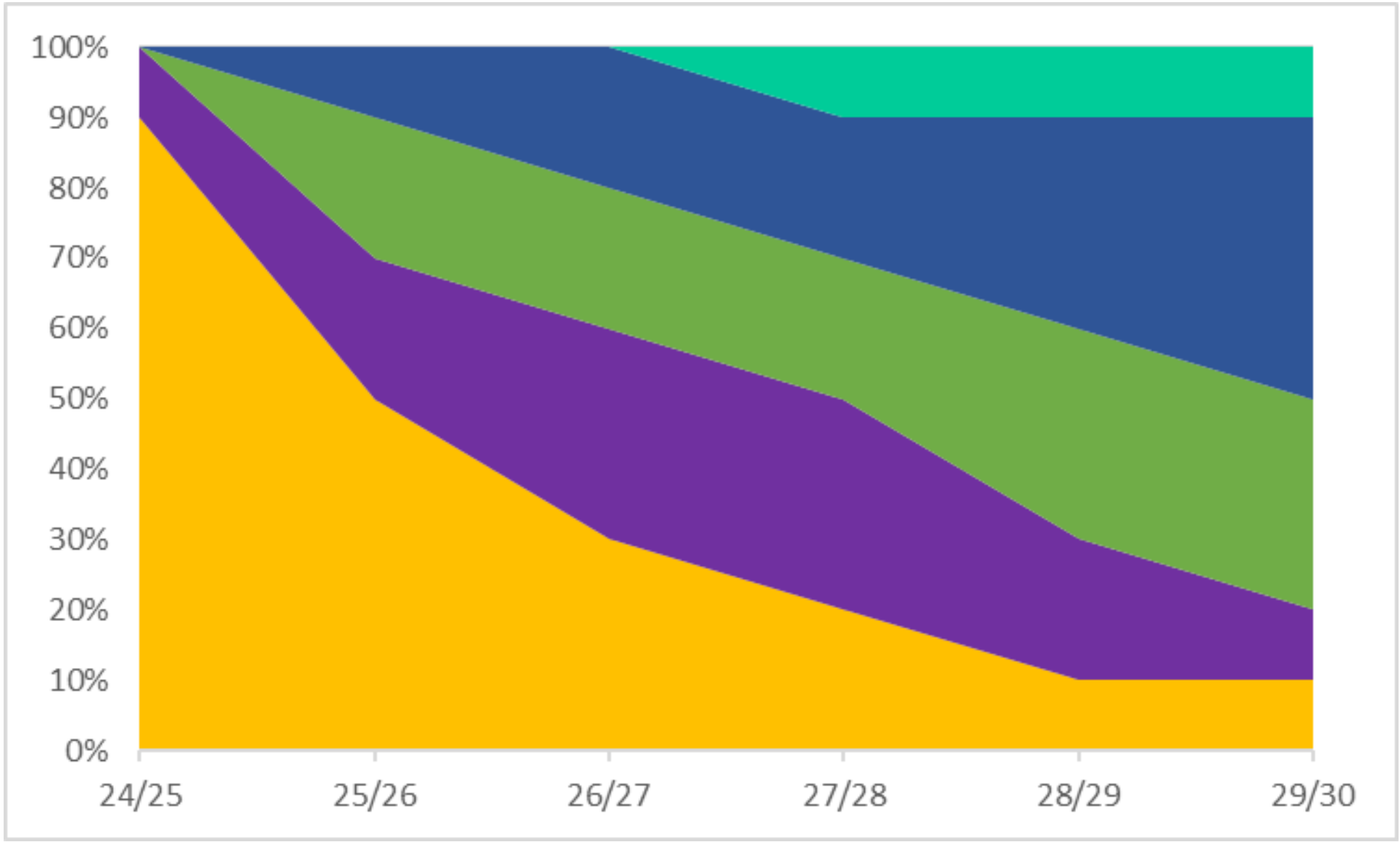
IV Population Health Ambitions

III Collaboratives/ Alliances Transformation

II Place Transformation

I Provider & ICB Efficiency

Work Package



Questions from One NHS Finance VMI Visit

NHS South Yorkshire Integrated Care Board

- The extent to which you can get sustainable change in the NHS without having a real clarity around strategic goals at all levels of systems.
- The nature of the current fatigue, and potential alienation of the NHS workforce and whether this could provide the preconditions for sustainable change.
- How we manage the tension between top-down policy development and the need for bottom-up engagement in improvement ideas and approaches.
- We identified the clear need for a QI methodology, good strategic alignment, and a resultant QMS.
- We observed the usefulness of the NHS impact framework.

Is the derivation of strategic goals for the English NHS acting as an impediment to the VMI approach. The focus of a unitary organisation like VMI gave perhaps greater freedom to act than within the English NHS. The strategic goal setting in the English NHS has i) a national dimension, ii) a health and care system dimension, and iii) an organisational dimension, unlike at VMI. These three layers in England need to be reconciled to ensure the strategic goal setting is clear.

Costing

Hayley Ringrose, Senior Policy Manager at HFMA and Scott Hodgson, Head of Clinical Accounting and Costing Transformation at Nottingham University Hospitals NHS Trust

Finance planning at system level

Making use of costing data

Hayley Ringrose
Senior policy manager

hayley.ringrose@hfma.org.uk

Healthcare Costing for Value Institute

Who we are

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff working in healthcare. For over 70 years it has provided independent support and guidance to its members and the wider healthcare community.

It is a charitable organisation that promotes the highest professional standards and innovation in financial management and governance across the UK health economy through its local and national networks. The association analyses and responds to national policy and aims to exert influence in shaping the healthcare agenda. It also works with other organisations with shared aims in order to promote financial management and governance approaches that really are fit for purpose and effective.

The HFMA is the biggest provider of healthcare finance and business education and training in the UK. It offers a range of professional qualifications in both healthcare business and finance, and primary care management, which also provide a route to an MBA in healthcare finance. The association is also an accredited provider of continuing professional development, delivered through a range of events, e-learning and training.

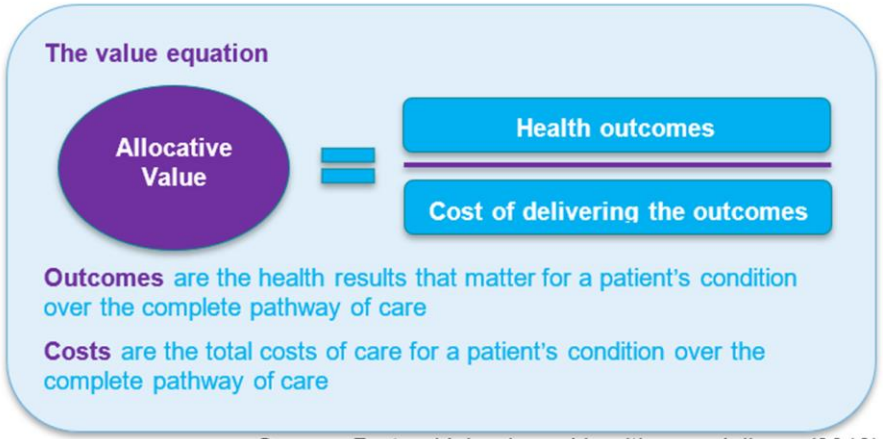
Healthcare Costing for Value Institute

The Institute supports the NHS to improve costing, turn data into powerful patient-level information, champion multi-disciplinary engagement, and ultimately drive value across patient pathways.

The Institute: Purpose, objectives and themes

Healthcare Costing for Value Institute

Purpose statement	**The Institute supports the NHS to improve costing, turn data into powerful patient-level information, champion multi-disciplinary engagement, and ultimately drive value across patient pathways**
Objectives	a) promote the concept of value in healthcare, as a means of supporting healthcare decision making b) support the NHS to improve costing, turning data into powerful patient-level information
Themes	Confident costing Translating data Driving value Innovation



Source: *Porter, Value-based health care delivery (2012)*

Why do patient level costing?

"I don't think there has been a more pressing time to drive value-based healthcare because if we can't continue to provide high quality care at lower cost then I think we are going to be, as a nation, in quite a difficult position. So, if you're not been a believer in value-based healthcare, in producing high quality at the lowest possible cost then you need to become a believer, because that is the way we're going to have to deal with the challenge we have ahead of us."

Professor Sir Stephen Powis, National Medical Director, NHS England speaking at the Institute value masterclass in 2024

System Finance Event

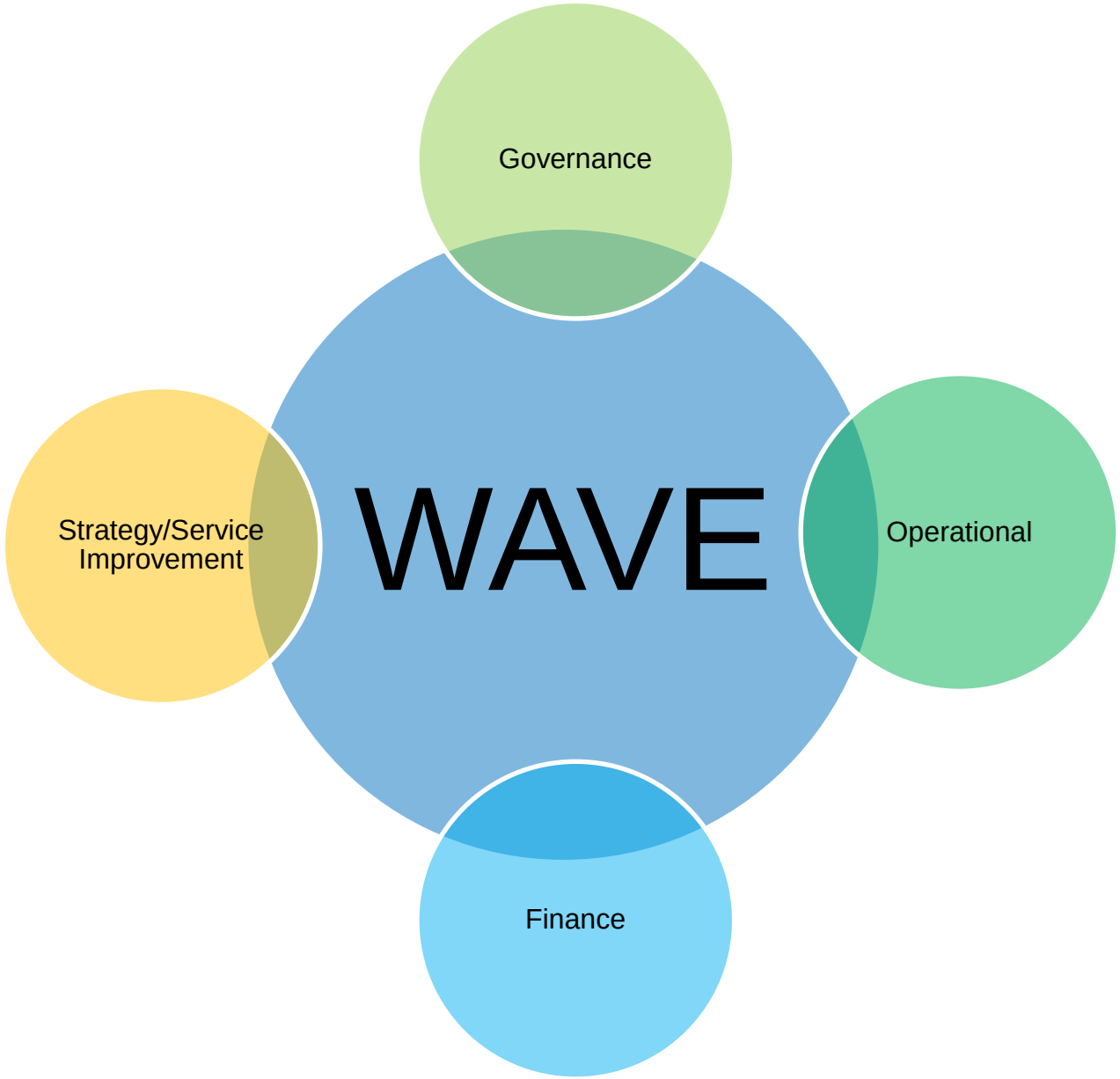
PLICS at NUH

Scott Hodgson – Head of Clinical Accounting & Costing Transformation

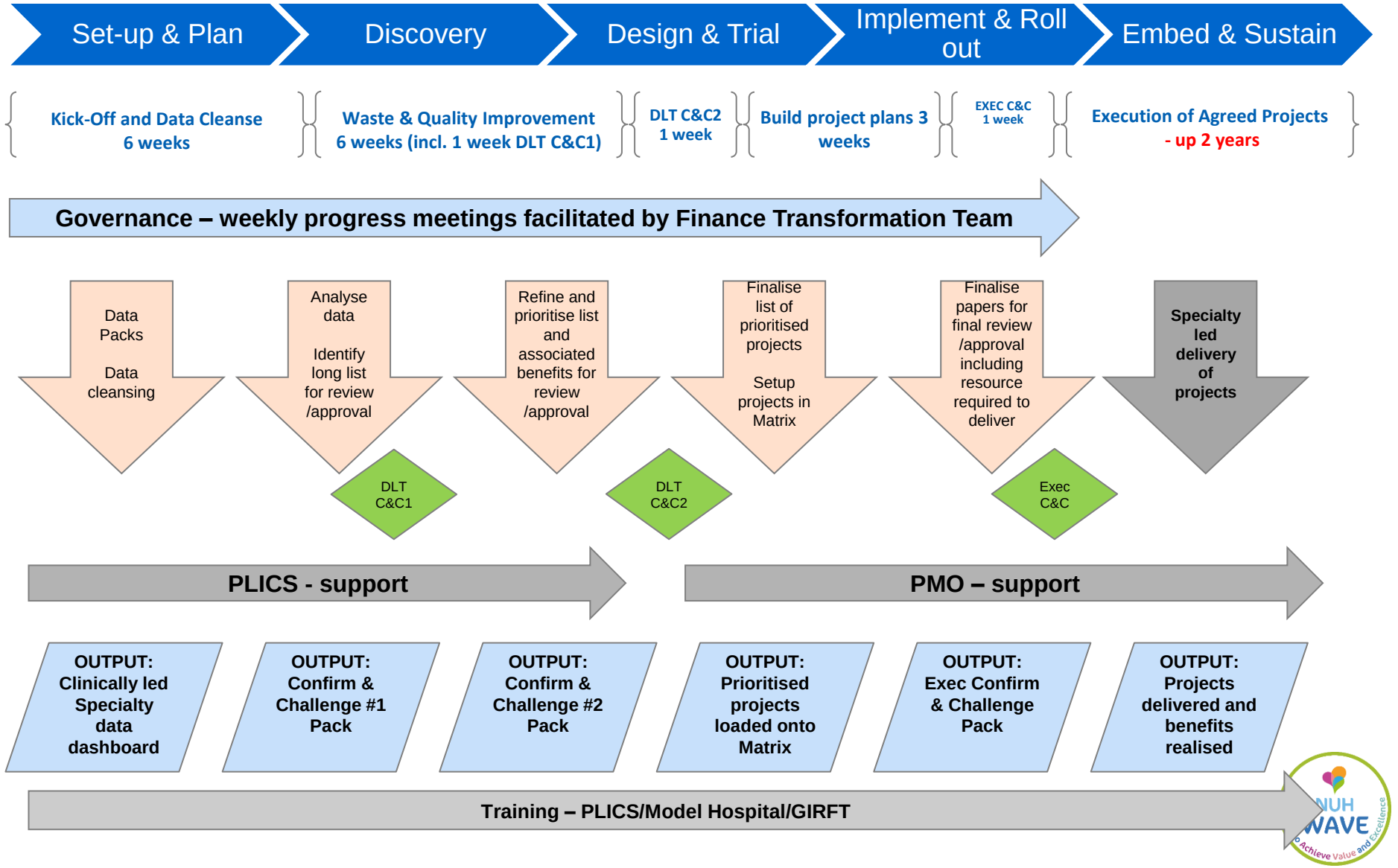
Scott.Hodgson2@nhs.net

NUH PLICS Timeline

2010	Implemented PLICS in October – clinicians involved in selection process
2011	Steady roll out across all Directorates Established PLICS Board and Data Quality Panel – clinician led
2012	Focussed on data quality rather than roll out Increased the number of data feeds (e.g. Therapies)
2013	HFMA Costing Award Winners Financial Management engagement (key to Directorate buy-in) Moved to monthly PLICS (August 2013)
2014	MAQS gold was the aim of DQP – used this to target resources Specific Roll out plan targeting business analysts and clinicians – scorecards
2015	Launch consultant-built app with intuitive reporting Change culture – knowledge workers – leadership programme
2016	Further automation of feeder systems led to quicker and improved reporting
2017	Linked up with Service Improvement – NUH WAVE team as main clinical engagement vehicle
2018	Set up programme 12 Specialty WAVEs per year with bespoke PLICS dashboards
2020	COVID changed the focus but was still able to with Elective specialties
2022	HFMA Costing Award winners for 2nd time – Working with WAVE System Costing Group quarterly meetings arranged
2023	Adrian Kwa - HFMA Clinician of the Year award for GIRFT High Volume Low Complexity work with Cataract Surgery
2024	System WAVE in Urology with Sherwood Forest Hospitals


Governance
Strategy/Service Improvement
WAVE
Operational
Finance

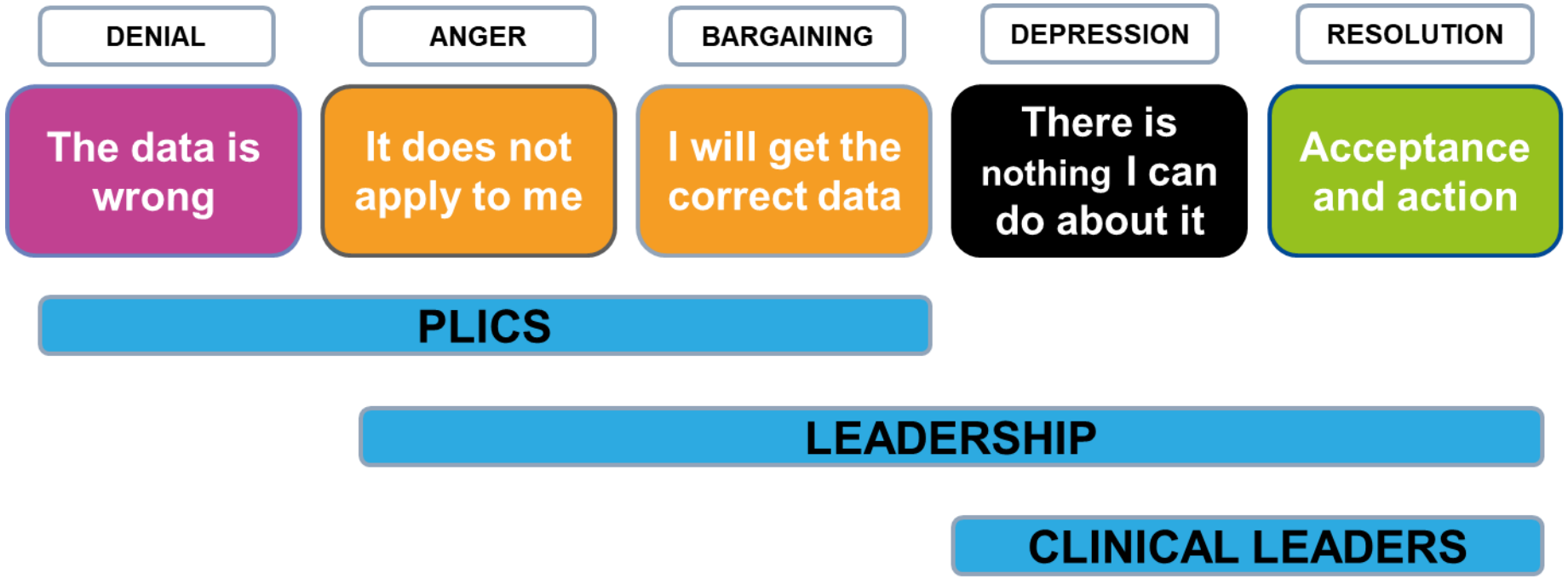
Overview of key activities, expectations & outputs



Programmes/Projects Outcomes – last 12 months

- Development of Business cases and funding approved for
  - Paediatric Medical Day Case Unit
  - Renal Home Therapies rightsizing
  - Breast 2ww pathway
- Design and development of new MRI Express pathway
- Funding for play specialist intervention in GA MRI
- Development of new nurse led discharge protocol & training within Paeds Day Case surgery
- SDEC both Adults & Paeds
- Genomics Nanopore Technology
- Mobile Stroke Unit
- Virtual Wards
- Reducing Health Inequalities for ‘Was Not Bought’ in Paeds OP
- ‘Trigger Tool’ for Palliative Care Patients
- Combined Hand Surgery Service (T&O & Plastics)

The Data Grief Cycle



Linus's Law "given enough eyeballs, all **bugs** are shallow"

i.e. Let's jump into the "sandpit" and explore our Data!!

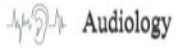
PLICS Dashboards

PLICS

Name

Audio Dewax Sankey

Audiology - S27DW Flow



Audiology Q-S28T1 Sankey

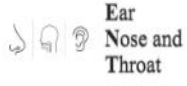
BADS Opportunity (Apr 23 - Mar 24)

BADS Opportunity (Apr 24 - Mar 25)

Coding Review (Apr 23 - Mar 24)

Coding Review (Apr 24 - Mar 25)

DRAFT - 21-22 National Cost ...



ENT Dashboard

Medically Safe (Apr 19 - onwards)

NCC 21-22 Cost Check

NCC 22-23 Cost Check

NCC 23-24 Cost Check

NCCI Report - TEST

Ophthalmology WAVE 2024

Palliative Dashboard

PLICS (Apr 21 - Mar 22)

PLICS (Apr 22 - Mar 23)

PLICS (Apr 23 - Mar 24)

PLICS (Apr 24 - Mar 25)

PLICS Unit Cost Tracker (Apr 19 ...

Resource Cost Tracker (Apr 22 - Mar 23)

Resource Cost Tracker (Apr 23 - Mar 24)

Resource Cost Tracker (Apr 24 - Mar 25)

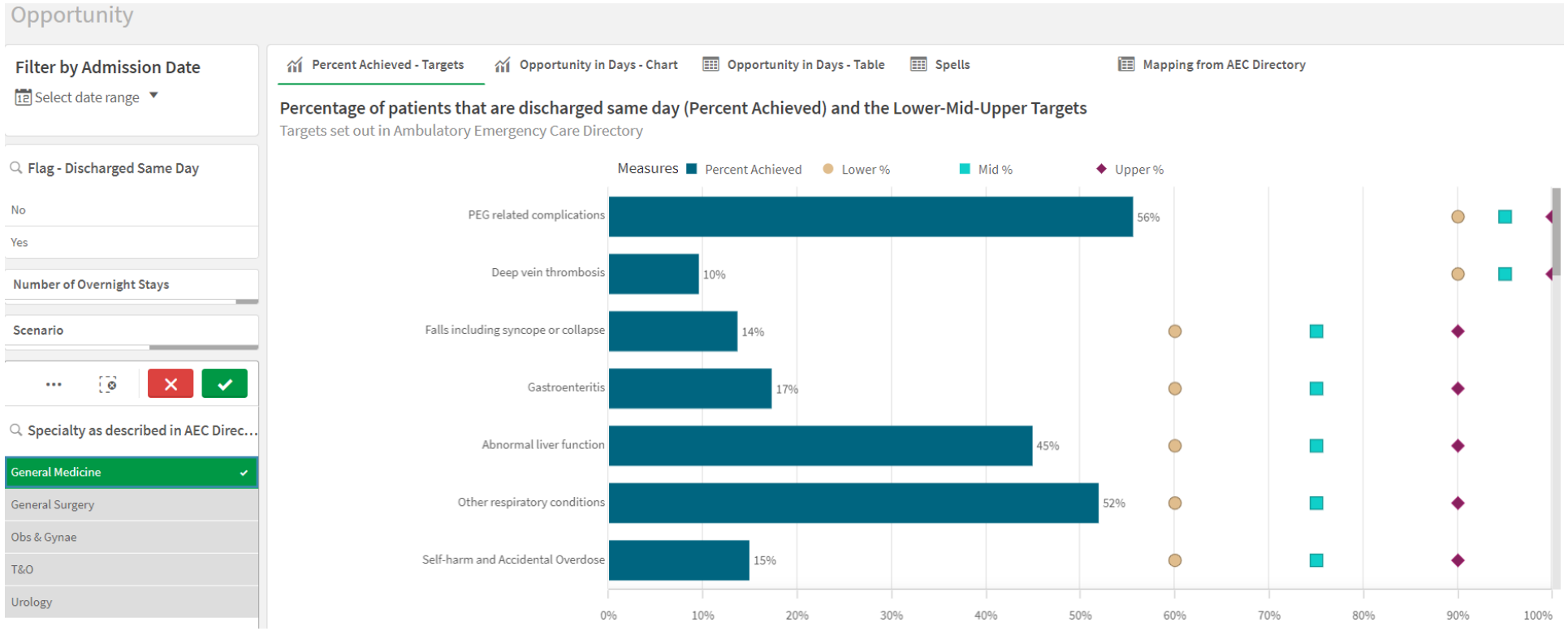
Same Day Emergency Care Opportunity (Ap...

Same Day Emergency Care Opportunity (Ap...

Same Day Emergency Care Opportunity (Ap...

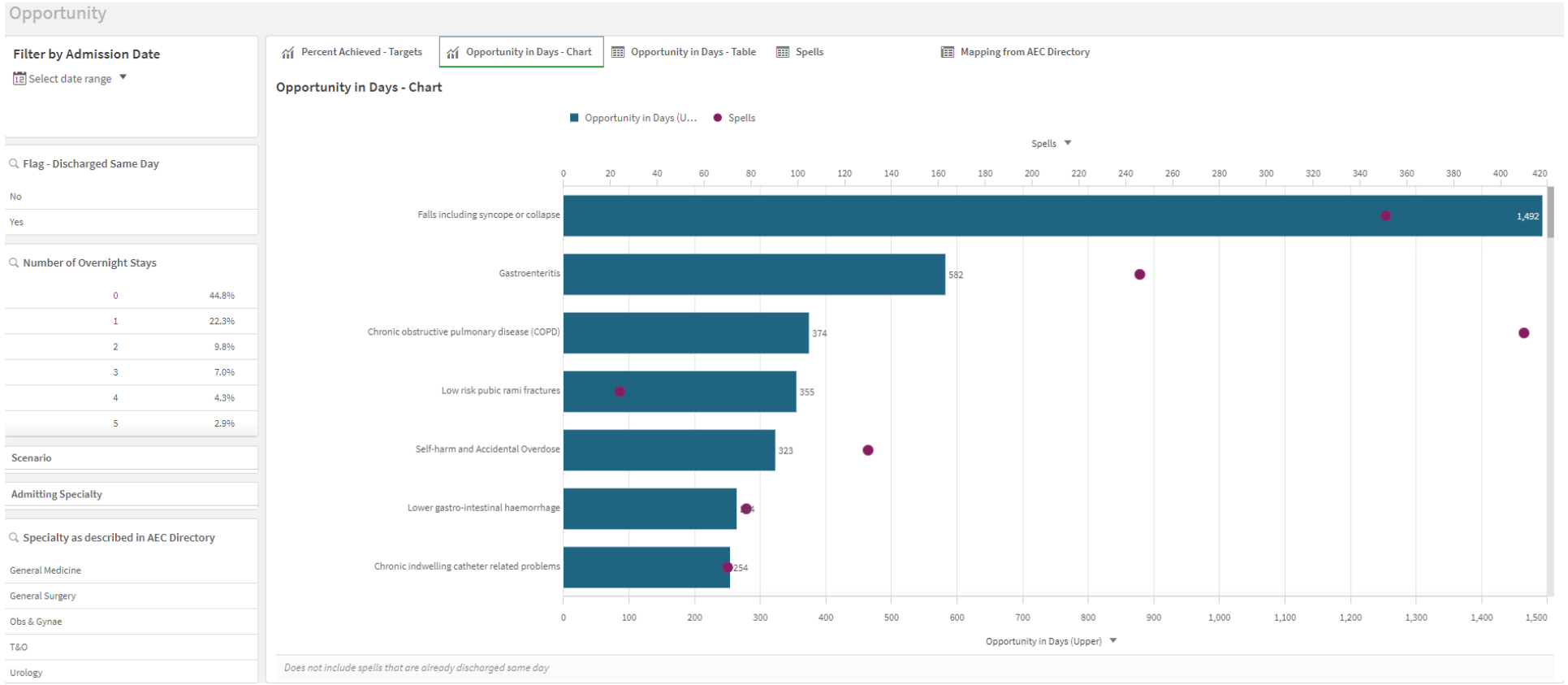
Vascular WAVE 2024

PLICS – SDEC (1)



- Highlights where specialties are performing against SDEC targets
- Shows data by the Ambulatory Emergency Care Scenarios
- Full drill down to patient detail – Sankey charts showing flow

PLICS – SDEC (2)



- Show opportunity in days against each scenario
- Full drill down to patient detail

PLICS – High Volume Low Complexity

Endo sinus surgery

Metadata

Procedure code (first position): E133 or E142 or E081 or E148 or E132 or E143 AND Procedure code in any position Y761
Age>= 17 years
Main specialty: 120 or Treatment function code: 120 or 215

Excluding all patients with head and neck cancer

girft Pathway: EndoSinus

Activity YEAR	MONTH	POD DC	EL	Grand To	%
21/22	Apr	3	2	5	60%
	May	3	2	5	60%
	Jun	11	1	12	92%
	Jul	5	2	7	71%
	Aug	1	1	2	50%
	Sep	3	1	4	75%
	Oct	5		5	100%
	Nov	4		4	100%
	Dec	4		4	100%
	Jan	3		3	100%
	Feb	6		6	100%
	Mar	2	1	3	67%
21/22 Total		50	10	60	83%
22/23	Apr	2	1	3	67%
	May	5	1	6	83%
	Jun	3	2	5	60%
	Jul	3	1	4	75%
	Aug	4	1	5	80%
	Sep	8	2	10	80%
	Oct	4	2	6	67%
	Nov	4	2	6	67%
	Dec	3		3	100%
	Jan	1	2	3	33%
	Feb	4		4	100%
	Mar		2	2	0%
22/23 Total		41	16	57	72%
23/24	Apr	4	1	5	80%
	May	3		3	100%
	Jun		2	2	0%
	Jul	1	2	3	33%
23/24 Total		8	5	13	62%

Peer value = 81%
Benchmark = 95%

Tonsillectomy

Metadata

Procedure code (first position): F341 or F342 or F343 or F344 or F345 or F347 or F348 or F349
Age>= 17 years
Main specialty: 120 or Treatment function code: 120 or 215
Excluding all spells with procedure codes D345 or F346
Excluding all patients with head and neck cancer

girft Pathway: Tonsil

Activity YEAR	MONTH	POD DC	EL	Grand To	%
21/22	Apr	7	2	9	78%
	May	7	2	9	78%
	Jun	6	2	8	75%
	Jul	8	1	9	89%
	Aug	2	2	4	50%
	Sep	6	2	8	75%
	Oct	4	1	5	80%
	Nov	7	2	9	78%
	Dec	4	1	5	80%
	Jan	5	1	6	83%
	Feb	12	3	15	80%
	Mar	2	2	4	50%
21/22 Total		70	21	91	77%
22/23	Apr	8		8	100%
	May	9	1	10	90%
	Jun	7	2	9	78%
	Jul	2	2	4	50%
	Aug	5	2	7	71%
	Sep	2		2	100%
	Oct	12	3	15	80%
	Nov	3	2	5	60%
	Dec	5	3	8	63%
	Jan	6	2	8	75%
	Feb	14	3	17	82%
	Mar	11	2	13	85%
22/23 Total		84	22	106	79%
23/24	Apr	3	4	7	43%
	May	7	1	8	88%
	Jun	8	4	12	67%
	Jul	19	5	24	79%
23/24 Total		37	14	51	73%

Peer value = 82%
Benchmark = 90%

Myringoplasty

Metadata

Procedure code (first position): D141 or D142 or D148 or D149
Age>= 17 years
Main specialty: 120 or Treatment function code: 120 or 215

Excluding all patients with head and neck cancer

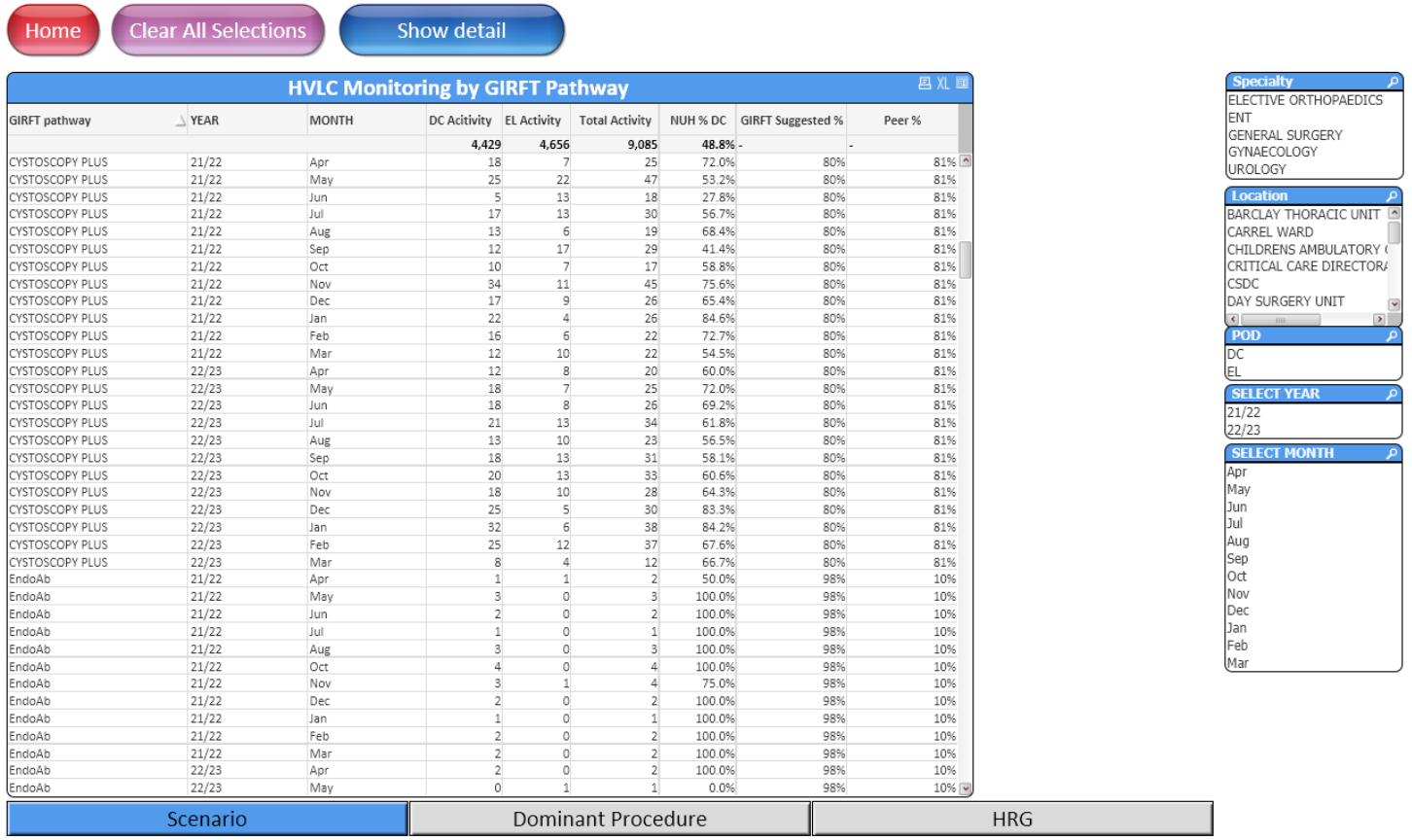
girft Pathway: Myringoplasty

Activity YEAR	MONTH	POD DC	EL	Grand To	%
21/22	May	1		1	100%
	Jun	3		3	100%
	Jul	5		5	100%
	Aug	1		1	100%
	Sep	4		4	100%
	Oct	3	1	4	75%
	Nov	8	1	9	89%
	Dec	6		6	100%
	Feb	9	1	10	90%
	Mar	2		2	100%
21/22 Total		42	3	45	93%
22/23	Apr	4		4	100%
	May	4		4	100%
	Jun	3	2	5	60%
	Jul	3		3	100%
	Aug		1	1	0%
	Sep	1	1	2	50%
	Oct	4		4	100%
	Nov	2		2	100%
	Dec	3		3	100%
	Jan	2		2	100%
	Feb	1		1	100%
	Mar	3	1	4	75%
22/23 Total		30	5	35	86%
23/24	Apr	4		4	100%
	May	5		5	100%
	Jun	3		3	100%
	Jul	3		3	100%
	Aug	1		1	100%
23/24 Total		16		16	100%

Peer value = 91%
Benchmark = 95%

- Highlights where specialties are performing against GIRFT targets and Peer Benchmarked Trusts
- Shows data by the GIRFT HVLC Scenarios

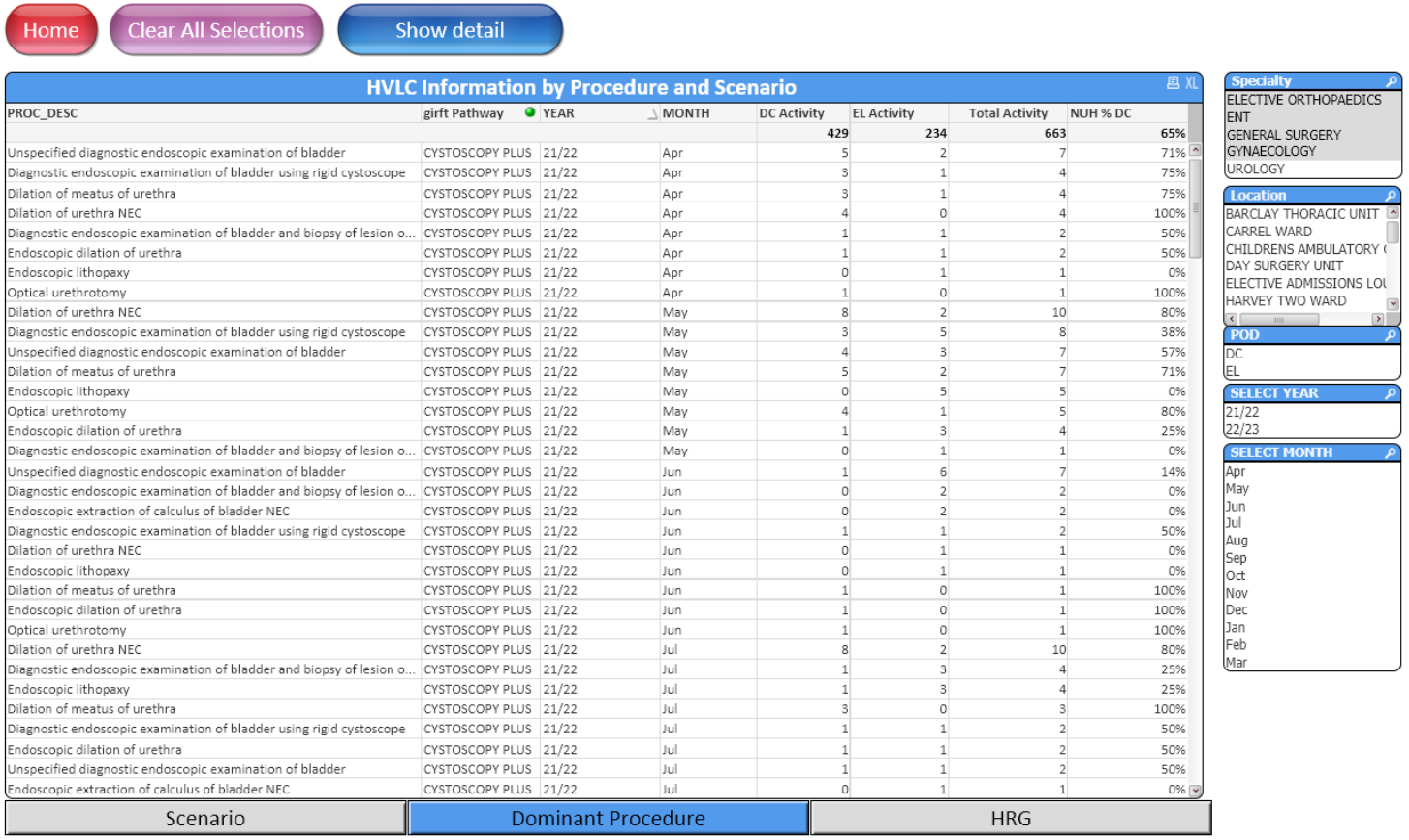
PLICS – HVLC Dashboard (1)



GIRFT pathway	YEAR	MONTH	DC Acitivity	EL Activity	Total Activity	NUH % DC	GIRFT Suggested %	Peer %
			4,429	4,656	9,085	48.8%	-	-
CYSTOSCOPY PLUS	21/22	Apr	18	7	25	72.0%	80%	81%
CYSTOSCOPY PLUS	21/22	May	25	22	47	53.2%	80%	81%
CYSTOSCOPY PLUS	21/22	Jun	5	13	18	27.8%	80%	81%
CYSTOSCOPY PLUS	21/22	Jul	17	13	30	56.7%	80%	81%
CYSTOSCOPY PLUS	21/22	Aug	13	6	19	68.4%	80%	81%
CYSTOSCOPY PLUS	21/22	Sep	12	17	29	41.4%	80%	81%
CYSTOSCOPY PLUS	21/22	Oct	10	7	17	58.8%	80%	81%
CYSTOSCOPY PLUS	21/22	Nov	34	11	45	75.6%	80%	81%
CYSTOSCOPY PLUS	21/22	Dec	17	9	26	65.4%	80%	81%
CYSTOSCOPY PLUS	21/22	Jan	22	4	26	84.6%	80%	81%
CYSTOSCOPY PLUS	21/22	Feb	16	6	22	72.7%	80%	81%
CYSTOSCOPY PLUS	21/22	Mar	12	10	22	54.5%	80%	81%
CYSTOSCOPY PLUS	22/23	Apr	12	8	20	60.0%	80%	81%
CYSTOSCOPY PLUS	22/23	May	18	7	25	72.0%	80%	81%
CYSTOSCOPY PLUS	22/23	Jun	18	8	26	69.2%	80%	81%
CYSTOSCOPY PLUS	22/23	Jul	21	13	34	61.8%	80%	81%
CYSTOSCOPY PLUS	22/23	Aug	13	10	23	56.5%	80%	81%
CYSTOSCOPY PLUS	22/23	Sep	18	13	31	58.1%	80%	81%
CYSTOSCOPY PLUS	22/23	Oct	20	13	33	60.6%	80%	81%
CYSTOSCOPY PLUS	22/23	Nov	18	10	28	64.3%	80%	81%
CYSTOSCOPY PLUS	22/23	Dec	25	5	30	83.3%	80%	81%
CYSTOSCOPY PLUS	22/23	Jan	32	6	38	84.2%	80%	81%
CYSTOSCOPY PLUS	22/23	Feb	25	12	37	67.6%	80%	81%
CYSTOSCOPY PLUS	22/23	Mar	8	4	12	66.7%	80%	81%
EndoAb	21/22	Apr	1	1	2	50.0%	98%	10%
EndoAb	21/22	May	3	0	3	100.0%	98%	10%
EndoAb	21/22	Jun	2	0	2	100.0%	98%	10%
EndoAb	21/22	Jul	1	0	1	100.0%	98%	10%
EndoAb	21/22	Aug	3	0	3	100.0%	98%	10%
EndoAb	21/22	Oct	4	0	4	100.0%	98%	10%
EndoAb	21/22	Nov	3	1	4	75.0%	98%	10%
EndoAb	21/22	Dec	2	0	2	100.0%	98%	10%
EndoAb	21/22	Jan	1	0	1	100.0%	98%	10%
EndoAb	21/22	Feb	2	0	2	100.0%	98%	10%
EndoAb	21/22	Mar	2	0	2	100.0%	98%	10%
EndoAb	22/23	Apr	2	0	2	100.0%	98%	10%
EndoAb	22/23	May	0	1	1	0.0%	98%	10%

- Shows GIRFT pathway by month and %DC achieved against target and Peers
- Filters for Specialty, Location, POD, Year and Month
- Full drill down to patient detail

PLICS – HVLC Dashboard (2)



- Dashboard showing GIRFT pathway by procedure
- Filters for Location, Year and Month
- Full drill down to patient detail

PLICS – BADS Dashboard (1)

BADs - Opportunity

Tabular View - For Export

Specialty	Patients	Avg LoS	LOS <24HRS (Daycase)	LOS <24HRS (Elective)	LOS <24HRS (Combined)	LOS 24-48HRS	LOS 48-72HRS	0 Night Stay Target	1 Night Stay Target	2 Night Stay Target
Breast Surgery										
Axillary dissection / clearance	29	1.14	41 %	45 %	86 %	14 %	0 %	95 %	5 %	0
Incision of breast	3	1.67		67 %	67 %	0 %	33 %	100 %	0 %	0
Insertion, revision, removal, renewel of breast prothesis	21	1.05	86 %	10 %	95 %	5 %	0 %	99 %	1 %	0
Mammoplasty (reduction, augmentation, revision)	13	1.15	54 %	38 %	92 %	0 %	8 %	75 %	25 %	0
Mastectomy without axillary surgery	88	1.20	41 %	47 %	88 %	5 %	8 %	75 %	25 %	0
Mastopexy	4	1.00	50 %	50 %	100 %	0 %	0 %	75 %	25 %	0
Microdochotomy + other operations on duct of breast	4	1.00	100 %		100 %	0 %	0 %	100 %	0 %	0
Operations on nipple	24	1.00	88 %	13 %	100 %	0 %	0 %	100 %	0 %	0
Re-excision of margins	18	1.00	83 %	17 %	100 %	0 %	0 %	100 %	0 %	0
Sentinel lymph node biopsy	1	1.00		100 %	100 %	0 %	0 %	100 %	0 %	0
Wide local excision of breast including wire guided	219	1.02	68 %	31 %	99 %	1 %	0 %	99 %	1 %	0
Emergency Surgery										
Appendicectomy, including laparoscopic	111	2.09		19 %	19 %	53 %	28 %	15 %	80 %	5
Evacuation of retained products of conception	2	1.00	100 %		100 %	0 %	0 %	95 %	5 %	0
Incision and drainage of perianal abscess	77	1.16	27 %	61 %	88 %	8 %	4 %	95 %	5 %	0
Incision and drainage of skin abscess	306	1.24	20 %	63 %	83 %	10 %	7 %	100 %	0 %	0
Laparoscopic cholecystectomy	174	1.11	52 %	40 %	92 %	5 %	3 %	25 %	25 %	0
MUA fracture and application of plaster cast	249	1.04	8 %	89 %	97 %	2 %	1 %	100 %	0 %	0
Primary reduction and open fixation of ankle	6	1.17		83 %	83 %	17 %	0 %	25 %	50 %	25
Reduction of fractured mandible	52	1.96		35 %	35 %	35 %	31 %	20 %	70 %	10
Removal of foreign body from skin	46	1.09	57 %	35 %	91 %	9 %	0 %	100 %	0 %	0
Removal of products of conception from fallopian tube (ectopic pregnancy), including laparoscopically	1	2.00				100 %	0 %	55 %	40 %	5
Repair of hand or wrist tendon	110	1.11	72 %	20 %	92 %	5 %	3 %	95 %	5 %	0
Suture of skin wound	138	1.21	37 %	49 %	86 %	8 %	7 %	75 %	25 %	0

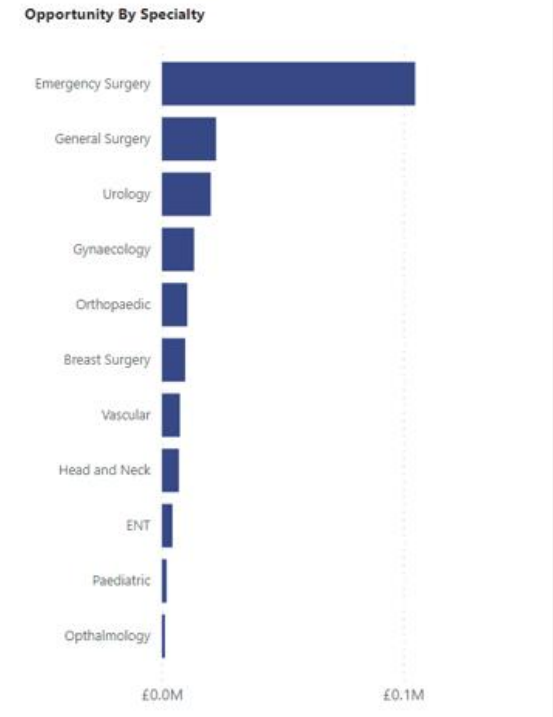
- Dashboard showing Specialty and procedure highlighting areas for improvement
- Full drill down to patient detail

PLICS – BADS Dashboard (2)

BADs - Opportunity

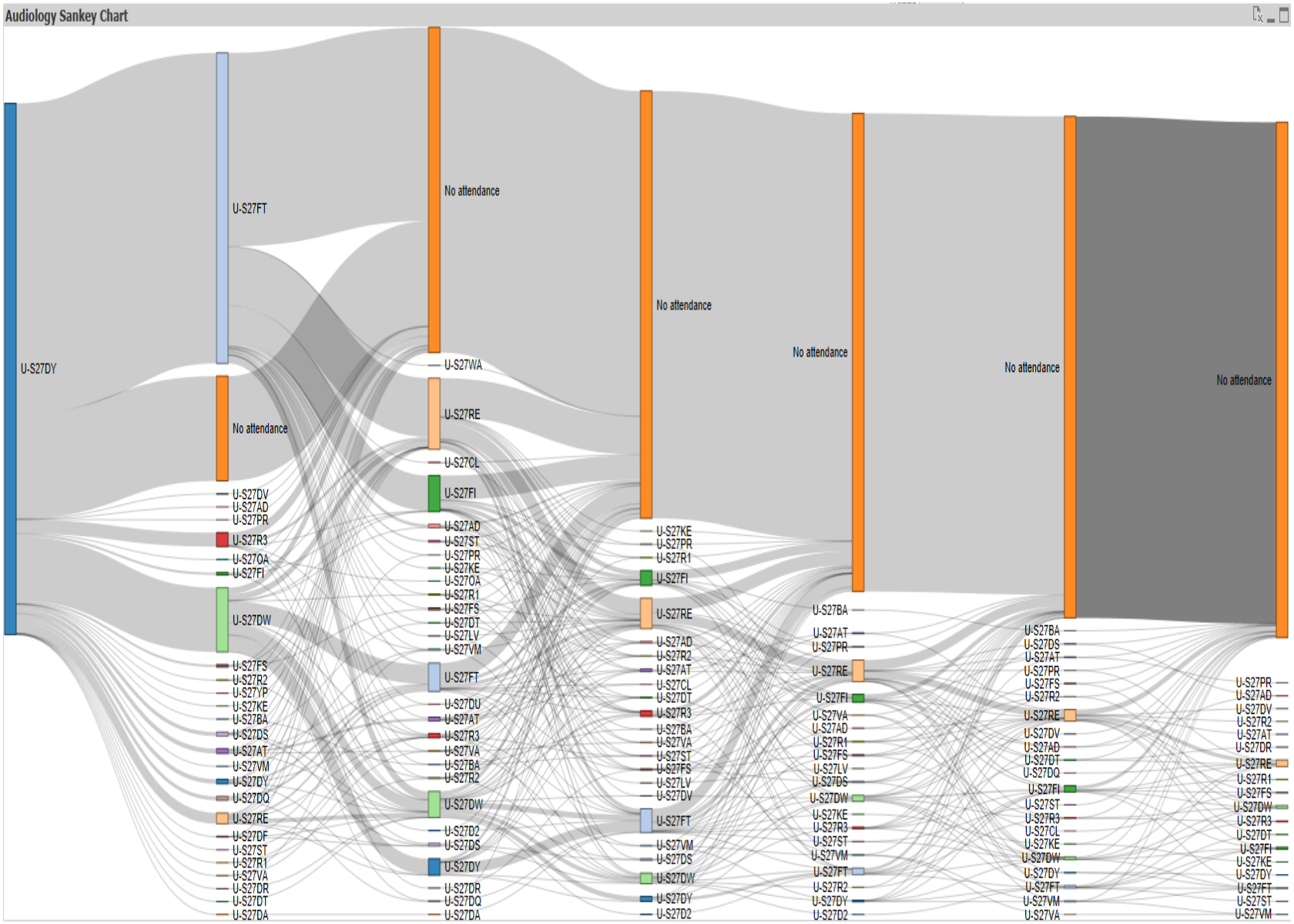
Opportunity for savings if procedures are moved away from Inpatient setting to Day Case Setting

Specialty	Patients	Avg LoS	PatExpense	Unit Cost	Bed Cost Saving
Emergency Surgery	**703**	**1.39**	**2,071,911.37**	**£583,553.98**	**£73,597**
Incision and drainage of skin abscess	306	1.24	606,858.31	£101,143.05	£33,033
Appendicectomy, including laparoscopic	111	2.09	500,349.10	£380,671.01	£29,240
Incision and drainage of perianal abscess	77	1.16	204,915.38	£23,951.15	£6,048
Repair of hand or wrist tendon	110	1.11	358,044.38	£29,294.54	£2,657
Reduction of fractured mandible	52	1.96	280,372.99	£155,283.50	£1,359
Removal of foreign body from skin	46	1.09	116,507.32	£10,131.07	£1,180
Removal of products of conception from fallopian tube (ectopic pregnancy), including laparoscopically	1	2.00	4,863.89	£4,620.69	£80
General Surgery	**489**	**1.22**	**1,461,838.45**	**£230,187.24**	**£13,636**
Closure iliostomy	5	2.40	27,204.17	£8,161.25	£7,246
Primary repair of inguinal hernia	171	1.08	506,843.32	£29,639.96	£2,415
Excision biopsy of lymph node for diagnosis (cervical, inguinal, axillary)	58	1.12	165,701.13	£17,141.50	£1,142
Diagnostic laparoscopy	43	1.05	100,168.28	£4,658.99	£754
Repair of umbilical hernia, adult	99	1.14	285,003.65	£28,788.25	£611
Laparoscopic repair of hiatus hernia with anti-reflux procedure	3	1.33	15,816.14	£3,690.43	£417
Repair of recurrent inguinal hernia	22	1.14	64,700.63	£8,822.81	£305
Treatment of anal fistula including seaton suture	30	1.13	66,152.22	£6,615.22	£238
Repair of rectal mucosal prolapse	6	1.33	17,089.81	£2,848.30	£221
Appendicectomy, including laparoscopic	41	2.20	169,202.03	£135,980.65	£198
Primary repair of femoral hernia	11	1.36	43,957.06	£7,992.19	£89
Urology	**452**	**1.23**	**1,556,870.67**	**£275,552.33**	**£13,218**
Endoscopic resection/destruction of lesion of bladder	218	1.13	652,196.32	£36,199.89	£6,988
Endoscopic insertion of prosthesis into ureter	106	1.30	354,662.28	£86,992.63	£2,238
Endoscopic laser fragmentation of calculus of kidney	23	1.35	137,782.36	£35,943.23	£1,193
Ureteroscopic extraction of calculus of ureter	57	1.26	220,395.47	£38,665.87	£1,130
Total	**5372**	**1.25**	**17,740,490.32**	**£3,180,210.76**	**£141,550**



- Dashboard showing potential bed cost savings by specialty and procedure
- Full drill down to patient detail

Audiology - Is the current patient journey optimised?



Audiology - Is the current patient journey optimised?

Discovery

- Multiple patient pathways
- Lost patients
- Interaction with ENT not efficient

Solutions

- Audiologists Transformation into Primary Care Model – ICB
- Optimisation of Best Practice Pathways
  - Within NUH
  - New Nationally Commissioned Services
- Improved Systems & Processes
  - Online ordering of spare parts & Online hearing tests
  - Patient initiated Follow-ups
  - Skill mix improvements

HCOP – Right Patient, Right Pathway (Bed)

Comparison between HCOP and Cardiology on the top four cardiac type conditions that present in HCOP:

FrailtyScore	
0. Not Populated	256
1. Very fit	6
2. Well	43
3. Managing well	168
4. Vulnerable	160
5. Mildly frail	237
6. Moderately frail	511
7. Severely frail	245
8. Very severely frail	16
9. Terminally ill	3

Discharge Year
2019
2020
2021

Age Groups	
56-60	1
61-65	3
66-70	29
71-75	95
76-80	287
81-85	391
86-90	455
91-95	315
96-100	67
100+	5
0-5	0

Spells with a Frailty Score or cared for by HCOP

HRG Root	Discharging Ward Specialty	Activity (Spells)	Average LOS	Readmissions within 7 Days	Readmissions from 8 - 30 Days	Red Days (% of LOS)	Average Red Days	Average Cost	Med Safe (% of LOS)	Average Medically Safe Days
Heart Failure or Shock	Healthcare of Older People	583	11	6%	13%	15%	2	-£5,226	10%	15
	Cardiology	166	9	5%	14%	5%	1	-£4,961	4%	30
Syncope or Collapse	Healthcare of Older People	497	6	11%	12%	14%	1	-£3,214	15%	17
	Cardiology	28	2	4%	11%	3%	0	-£1,345	0%	-
Arrhythmia or Conduction Disorders	Healthcare of Older People	114	6	11%	7%	9%	1	-£3,315	4%	14
	Cardiology	146	3	5%	10%	0%	0	-£1,546	0%	-
Unspecified Chest Pain	Healthcare of Older People	91	4	9%	19%	16%	1	-£2,201	5%	18
	Cardiology	20	2	10%	5%	0%	0	-£1,130	0%	-

Initial findings show elderly patients currently in HCOP beds with a frailty score 1-5 with the same primary condition but in a Cardiology bed have a lower length of stay, lower readmission rates & lower mortality.

A solution being explored, to optimise patient care is to create a Cardio-Geriatrician service or a HCOP in-reach program to support treatment of higher frailty patients with cardiac conditions.

HCOP – Right Patient, Right Pathway (Bed)

- Patient journey
- Frailty Scores
- Is the patient in the right place
- Hypothesis – inpatients admitted to HCOP
  a) Outside of their definition for the service (being over 74 and having a frailty score of at least ‘6. Moderately frail’)
  b) Presenting with a primary condition which would be better treated with the associated specialty. For example, Heart Failure patients to be better managed in Cardiology. Primary condition, not age.
- Exploring the data to support the three ideas to optimise inpatients in HCOP
  1) Getting patients to the right place, first time
  2) Variation in outcomes, by discharging specialty, primary condition, age and frailty score
  3) Variation in HCOP wards

Cost of Medically Fit patients (1)

Cost and Days trend since April 2019

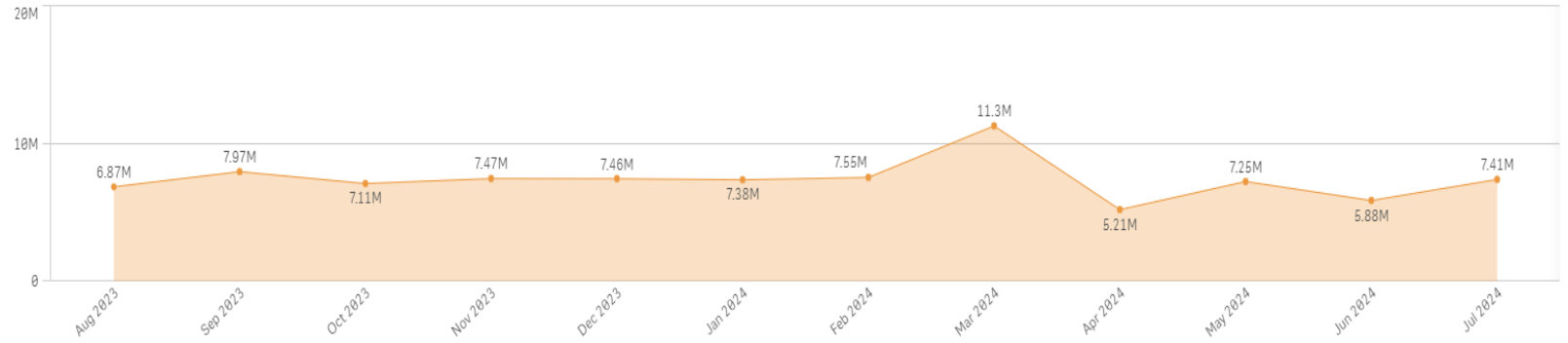
Please note that prior to April 2021 the number of Medically Safe Days counted was from the ***final*** date the patient was flagged as Medically Safe to discharge. From April 2021 onwards we have calculated Medically Safe Days from the point at which the patient is ***first*** flagged as Medically Safe for discharge. We have not included in the days and the cost, the time where the patient was flagged as Medically Safe and midnight the same day - this is so that we allow time for discharge to occur, and so we don't count days and cost for which patients are and could be discharged that day.

Average Daily Cost
£635

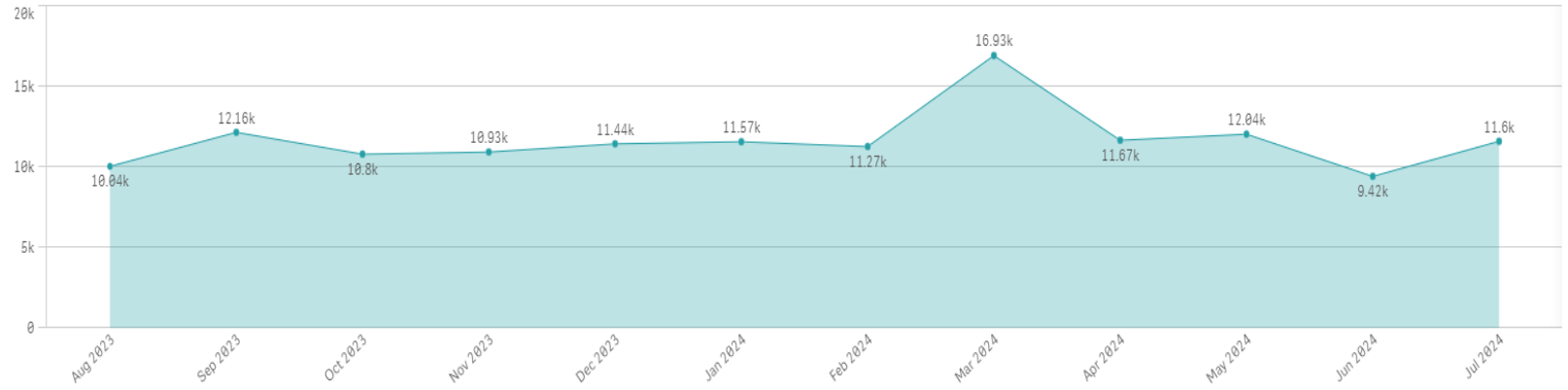
Cost of Medically Safe Days
88.86M

Days Past Medically Safe Date
139,876

Cost of Medically Safe Days by Activity (FCEs) end month



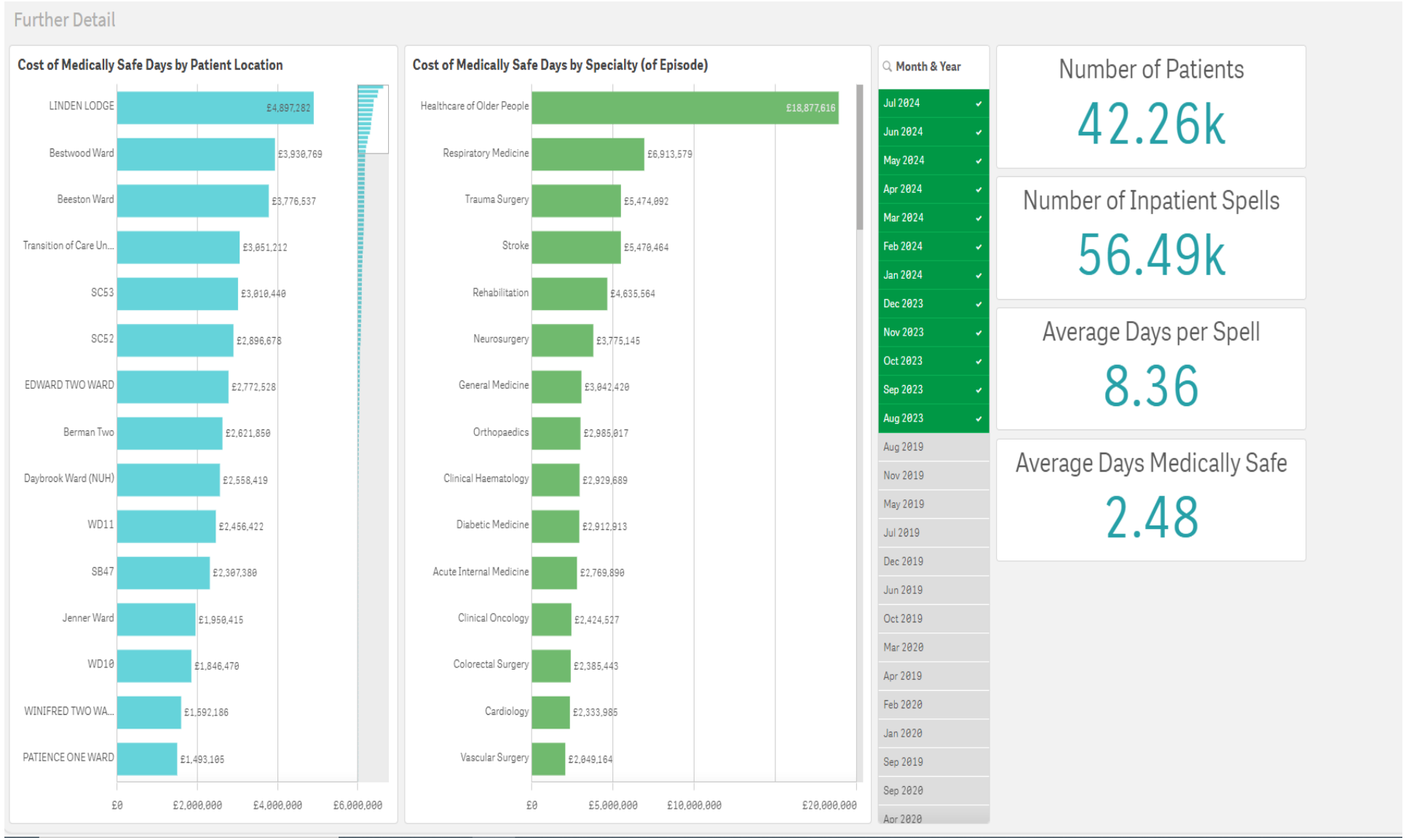
Sum of Medically Safe Days by Activity (FCEs) end month



Month & Year

- Jul 2024
- Jun 2024
- May 2024
- Apr 2024
- Mar 2024
- Feb 2024
- Jan 2024
- Dec 2023
- Nov 2023
- Oct 2023
- Sep 2023
- Aug 2023

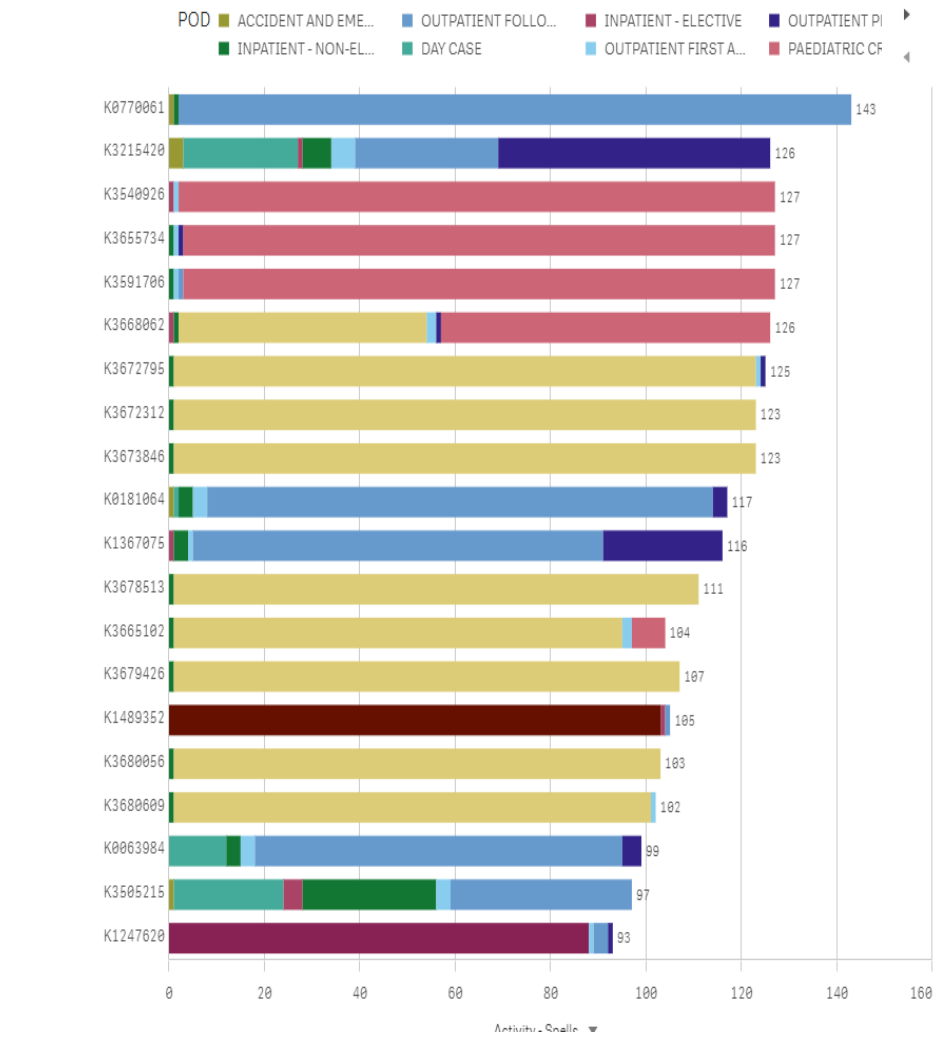
Cost of Medically Fit patients (2)



Frequent Attenders

IQVIA Frequent Attenders - Report relates to the period 01/04/2024 - 31/07/2024

Top 20 Patients by Activity Volume



Division	Point of Delivery	HRG Sub Chapter	HRG	K Number
AMB: AMBULATORY CARE	ACC: ADULT CRITICAL C...	AA: NERVOUS SYSTEM P...	AA22C: CEREBROVASCU...	00F00020
CAS: CANCER SERVICES	AE: ACCIDENT AND EME...	AB: PAIN MANAGEMENT	AA22D: CEREBROVASCU...	00F00075
CEN: CENTRAL	C: COMMUNITY ATTEND...	BZ: EYES AND PERIORBI...	AA22E: CEREBROVASCU...	00F00076
	DA: DIRECT ACCESS	CA: EAR, NOSE, MOUTH, ...	AA22F: CEREBROVASCU...	00F00278
Service Line	DC: DAY CASE	CB: EAR, NOSE, MOUTH, ...	AA22G: CEREBROVASCU...	00F00283
TFC Description	DIALYSIS: DIALYSIS	CD: DENTAL AND ORTH...	AA23C: HAEMORRHAGI...	00F00314

Top 20 Patients by Activity Volume

K Number	HRG Description	TFC Description	Activi...	Activi... - Spells	Total Cost
Totals			**2,346**	**2,287**	**-£5,706,262.25**
	OP FOLLOW UP FACE TO FACE SINGLE PROF	350: Infectious Diseases	49	49	-£2,059.93
	OP FOLLOW UP NON FACE TO FACE SINGLE PROF	370: Medical Oncology	16	16	-£3,073.18
K0	DATA INVALID FOR GROUPING	800: Clinical Oncology	6	6	-£9,505.31
K0	ATTENTION TO CENTRAL VENOUS CATHETER, 19 YEARS AND OVER	800: Clinical Oncology	5	5	-£926.49
K00	DATA INVALID FOR GROUPING	370: Medical Oncology	3	3	-£664.05
K006	OP FOLLOW UP FACE TO FACE SINGLE PROF	101: Urology	3	3	-£351.72
K00	OP FOLLOW UP FACE TO FACE SINGLE PROF	370: Medical Oncology	2	2	-£459.29
K00	OP FOLLOW UP NON FACE TO FACE SINGLE PROF	503: Gynaecological Oncology	2	2	-£590.13
K 06	SAME DAY CHEMOTHERAPY ADMISSION/ATTENDANCE	800: Clinical Oncology	2	2	-£510.10
K 0	ADMISSION OR ATTENDANCE FOR DIAGNOSTIC IMAGING	812: Diagnostic Imaging	1	1	-£6.88
K	MALIGNANT GYNAECOLOGICAL DISORDERS, WITHOUT INTERVENTIONS, WITH CC SCORE 4-6	800: Clinical Oncology	1	1	-£179.87
K00	MULTIPLE VERY COMPLEX GASTROINTESTINAL TRACT PROCEDURES, 19 YEARS AND OVER, WITH CC SCORE 7+	502: Gynaecology	1	1	-£4,701.46
K0063	OP FIRST ATT FACE TO FACE SINGLE PROF	350: Infectious Diseases	1	1	-£39.21
K00639	OP FIRST ATT NON FACE TO FACE SINGLE PROF	654: Dietetics	1	1	-£67.32

What does good costing look like?

Ten tests for what good looks like for costing in the NHS

1. Cost data is regularly used in decision-making to drive improvements in value in the NHS.
2. Costing supports the future information requirements of the NHS.
3. Cost data from the national cost collection is fed back in a timely manner to local health economies in a way that supports them to improve value.
4. There are a set of national costing standards to ensure a consistent approach to patient-level costing. The standards are proportionate, achievable, and easy to understand.
5. There is a single version of cost data that can be used both locally and nationally.
6. Local leaders ensure that there are robust data governance processes in place for the non-financial data required for costing.
7. The role of cost accountants includes creating cost data and supporting their local health services to use the data to improve value.
8. Local and national costing teams are adequately resourced with staff who have the right skills, knowledge and experience.
9. Decisions made about changes to the national costing approach are transparent.
10. The development of the national costing approach is done in close partnership with local teams.

Case Study: Cambridgeshire and Peterborough

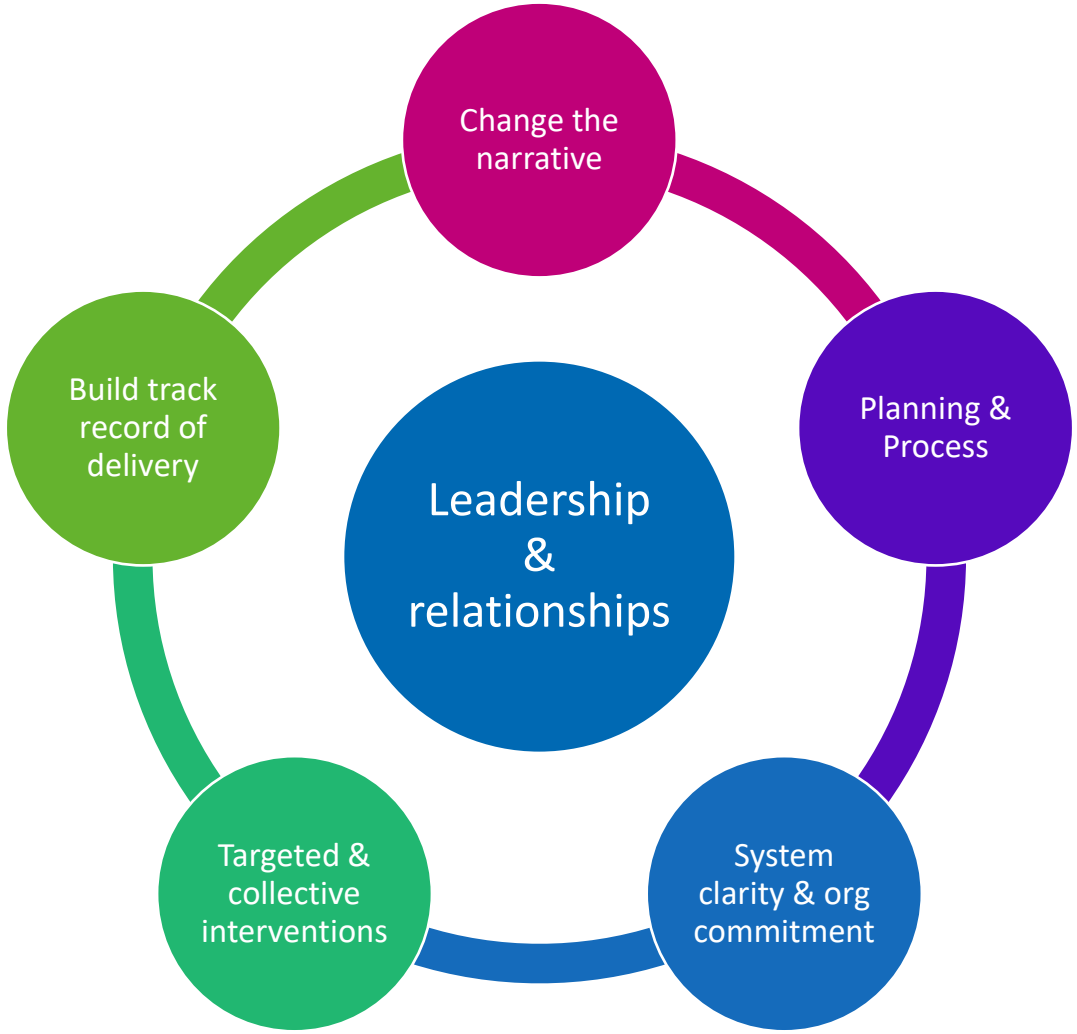
Nicci Briggs, Chief Finance Officer at Cambridgeshire & Peterborough ICS

Cambridgeshire & Peterborough
Integrated Care System

C&P ICS NoF4 to surplus

17th September 2024

SOF 4 to HFMA Finance Team of the year



Leadership & Relationships

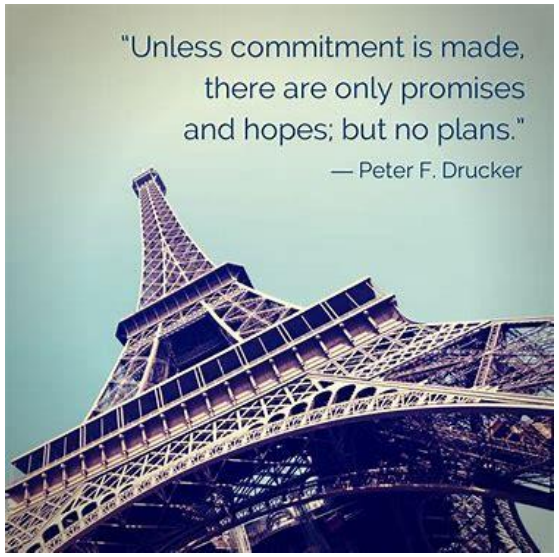
- **Unified system with unified leadership**
  - Invest time in relationships, values and behaviours
  - One fails all fail – can't succeed at the expense of another
  - Clean slate
  - Transparency and collective understanding
  - Security to be able to challenge
  - Informal space
  - Get into habit of solving our own problems together
  - Move debate out of finance and into collective system/ clinical responsibility

Change the narrative

- Moves away from 7/8 years of failing to deliver financial plans (either providers or system)
- Clean slate
- Showcase the positive achievements
- Builds confidence across the system that financial performance is achievable
- Set out the benefits – credibility, incentives, historic debt write off
- Builds sense of system performance
- Changes the external perceptions

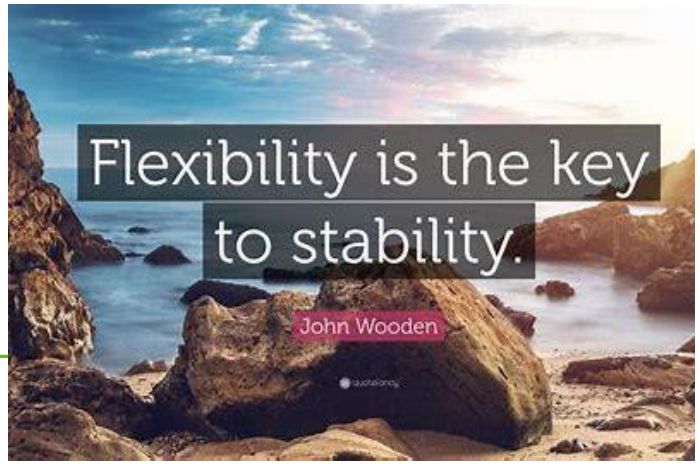
Planning & Process

- Big data, population, evidence base and data driven
- Clear focused plan
- Flat cash approach
- Focus on bigger picture & cost (collective £4bn vs arguing about the marginal changes in planning)
- Credible profile around efficiencies
- Build in time for internal challenge & wider exec discussion
- Transparency – feel equal challenge even on ringfenced areas (e.g. BCF)
- Commitment – it has to mean something and be owned



System clarity & org commitment

- System first, clear it is system funding not a collection of provider totals especially capital. Champion C&P but support providers in totality
- Clear and transparent decision making across all spend inc ringfenced
- Organisations investment is for organisation to subsidise not system problem
- Orgs only take what they need. Provider making surplus so didn't take capacity funding and provider only taking need from IA not entitlement.
- Grip and control and benchmark – org responsibility but system to share/ highlight opportunities
- Maximised elective opportunities



Targeted & collective interventions

- System first
  - Clear funding is for whole system so prioritisation must be based on system priority
  - Complexity of £4bn system vs £2bn C&P allocation (NET INFLOW)

- Recognise levers and sign off required at ICB
  - Big capital programmes
  - New Hospital programme
  - EPR

- Simplified set of priorities

- Bold decisions to drive integration (High intensity users, CVD approach, dentistry)

- Engagement vs commissioning e.g. dermatology

Build track record of delivery

- Recovery began in 2022/23 and started in earnest the flat cash cost focused approach.
- Recovery achievements, shared learning across providers
- Delivered surplus in 22/23 and 23/24 and write off historic deficit. Sold as way of protecting investment in patient services.
- When risks are raised seen as credible
- Confidence & trust
- Opportunities and freedom to make bold decisions and innovate

Governance, Risk and Audit

10 December 2024 9-12.30
via MS Teams

Topics Including:

- What does good governance look like and how does it achieve the outcomes?
- HFMA Audit Committee Handbook 2024
- System Risk Management
- What does good assurance look like?
- The new GIIA Standards
- System Audits

Confirmed Speakers
NHS England
HFMA
Institute of Internal Auditors
Good Governance Improvement

To book a free place please
email yhs-tr.audityorkshire@nhs.net
or visit www.360assurance.co.uk/events/audit/