HFMA briefing
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Balancing act: supporting finance leaders to deliver on short- and long-term priorities

Newton

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Introduction

The context

Meeting today's challenges while building towards improved financial sustainability and delivering better outcomes for people.

The ask of the NHS today is clear – to improve quality and reduce costs so that each pound spent in the NHS delivers best value, outcomes and experience for patients, the population and NHS staff.

However, the financial and operational challenges facing the NHS are well documented, and in-year cost control approaches challenge the flexibility required to deliver the more financially sustainable reforms required.

In July 2024, the National Audit Office (NAO) report on NHS financial management[1] described a worsening underlying financial position due to issues such as a failure to invest in its estate, inflation, cost of post-pandemic recovery, industrial action, and increased sickness absence, as well as a decline in NHS productivity. The report also recognised that although the NHS delivered record levels of activity in many areas last year, performance is well below what patients should expect, and patients are waiting longer than they should for treatment.

Lord Darzi's review of the state of the NHS[2] in September 2024 assessed it to be in 'serious trouble', starved of capital and delivering unacceptable waiting times in a system too focused on acute care, making too little use of technology, and not paying enough attention to prevention. His diagnosis is intended to form the basis of a 10-year health plan[3] framed around three big shifts: moving from analogue to digital, hospitals to communities, and sickness to prevention.

Although the overall financial position improved from the 2023/24 system deficit of £1.4bn to a 2024/25 forecast of £604m overspend at month 11[4], the financial standing of the NHS is still at its most precarious in recent history. The first draft of integrated care system (ICS) financial plans for 2025/26 suggested a combined deficit of £6.6bn[5].

Consequently, in March 2025, NHS England announced a 'fundamental reset of the financial regime and accountability', telling trust and integrated care board (ICB) leaders that there needed to be a major focus on the financial position and financial grip both immediately – for 2025/26 – and for the longer-term. Alongside this, leaders have called for systems to tackle unacceptable variation in quality[6]. As set out in the letter sent to all NHS chairs and chief executives on 1 April[7], significant efforts have led to a much stronger position at the start of the financial year of £2.5bn deficit (before £2.2bn deficit support). However, there are major risks within the 2025/26 position including pay settlements and the requirement for material efficiency plans that need to be worked through to ensure they are turned into deliverable actions.

The March 2025 NHS England performance update also recognised that although there have also been improvements in performance there is still a long way to go to meet targets. For example, in January 2025, 58.9% of elective referrals met the 18 week target compared to the constitutional standard of 92%. Other areas of particular challenge include long waits for mental health and community services, high numbers of people continuing to experience unacceptably long waits in emergency departments, and access to dentistry[8].

[1] National Audit Office, *Financial management and sustainability*, July 2024
[2] Department of Health and Social Care, *Independent investigation of the NHS in England*, November 2024
[3] Department of Health and Social Care and NHS England, *NHS change*, October 2024
[4] NHS England, *Financial performance update*, March 2025
[5] NHS England, *Update on 2025/26 planning round*, March 2025
[6] HFMA, *More ambition needed on productivity in financial reset*, March 2025
[7] NHS England, *Working together in 2025/26 to lay the foundations for reform*, April 2025
[8] NHS England, *Review of NHS performance and delivery: data annex*, March 2025

The aims of this project

Practical support for finance leaders in balancing work across three transformation horizons.

To achieve the ask of an NHS that delivers long-term operational and financial sustainability requires significant change across short-, medium- and long-term horizons. However, the current focus on agreeing, and then delivering on, a tight 2025/26 financial plan (including a plethora of returns), along with the immediate workload and distraction of the abolition of NHS England and delivery of local running cost reductions, leaves little (or no) management capacity to think about anything other than the short-term. This sentiment was strongly felt by many of the finance leaders engaged throughout this project.

As set out in the HFMA's statement on the role of the NHS chief finance officer (CFO), the CFO in today's NHS is at the heart of an organisation's management structure and plays a key role in both corporate decision-making and leadership[9]. Working closely with board members and clinicians, finance leaders are required to balance quality and finance targets within year for their own organisation, in addition to delivering quality and finance targets across multiple years across multiple organisations.

However, for many in the finance community, the focus on in-year initiatives leaves no headroom to come together as leaders to discuss and progress multi-year schemes.

In response, the HFMA and Newton have together undertaken a series of engagements with NHS leaders. These engagements have sought to identify practical approaches that can create headroom (both in terms of time and money) for longer-term change, helping to avoid getting caught in the short-term only. The methodology is set out in **appendix A**.

This paper summarises the common barriers and success criteria identified in balancing work across three transformation horizons:

- **horizon 1:** optimising the current system
- **horizon 2:** designing, testing and scaling new service delivery models
- **horizon 3:** fundamental service redesign and normalising new operating models.

It provides practical tools and resources that we hope will support finance leaders today, including links to existing resources as well as case studies to share the methods and mindsets being applied across the country. The messages are applicable across the four nations of the United Kingdom.

The aims of this project

- **Create headroom:** provide practical approaches that can create headroom – both in terms of time and money – to plan and deliver multi-year structural change and avoid getting caught in the short-term only.
- **Provide a framework for planning:** support finance leaders to develop plans for long-term financial sustainability and improved outcomes, at the same time as operationalising current plans.
- **Clarify the role of finance leaders:** set out the role of finance leaders within multi-year, multi-organisational system change.
- **Share experiences and tools:** summarise the common barriers and success criteria identified in balancing work across different change horizons, sharing examples, practical tools and resources that can support finance leaders today.
- **Inform strategy discussions:** provide the basis for further discussion on the role of the finance profession within wider NHS plans, including the 10-year health plan.

[9] HFMA, *The role of the NHS chief finance officer*, October 2024

Finance leading across multiple horizons

Finance leaders have a key role – working with their executive director colleagues – to develop plans for long-term financial sustainability and improved outcomes, at the same time as operationalising current plans. Finance leaders are well placed to both drive and support change, with the ability to: harness multi-disciplinary knowledge to provide evidence-based options for decision-making; think and lead across a system; role model collaborative behaviours; and identify financial barriers and levers to change. Through this programme it was evident that there is a clear excitement and determination to deliver longer-term financial sustainability and value for the patient, the commissioning organisation and the taxpayer.

It was recognised that the actions needed will vary across systems that are likely to have different levels of opportunity in the short-, medium- and long-term. For some there will be immediate productivity opportunities to tackle, while others might need to focus on significant pathway redesign. These are not mutually exclusive; indeed many require short-term productivity and efficiency gains to pay for the longer-term transformation and ultimately deliver sustainability. A clear local understanding to inform where best to intentionally spend the limited management capacity guided by the local context is key.

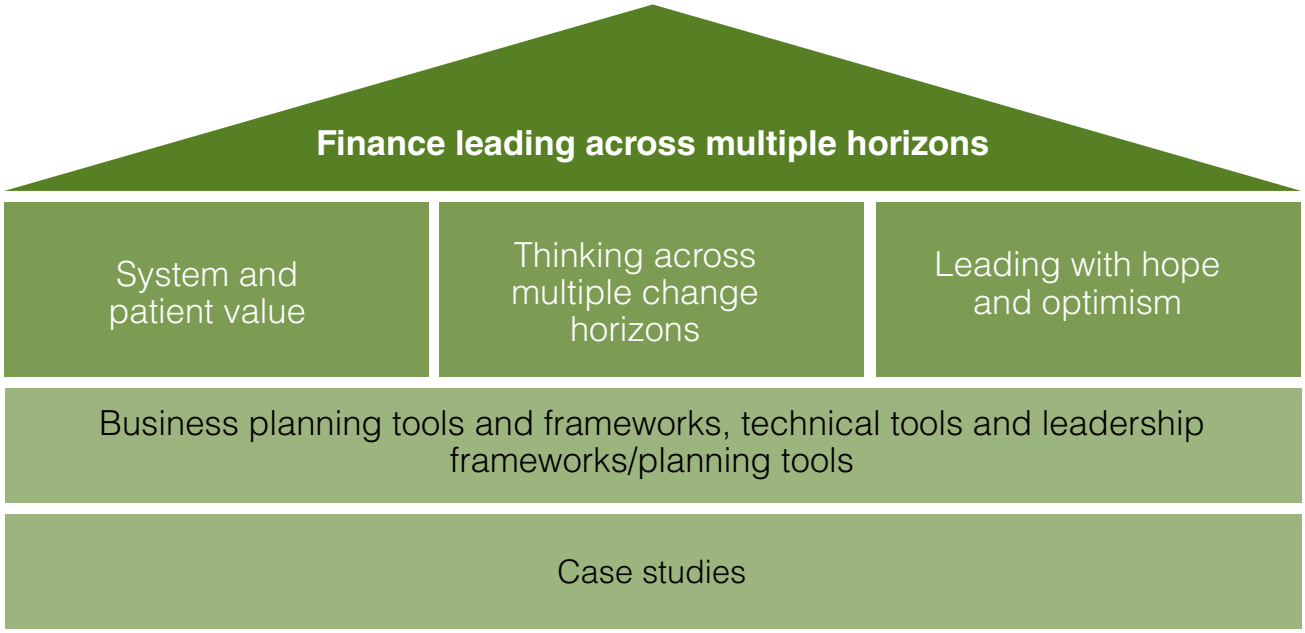
Interestingly, the engagement and roundtable discussions identified a range of common challenges and opportunities that many finance leaders are experiencing no matter their local context.

Leaders articulated the requirement for thinking proactively across both the short-term and the longer-term, and the need to equip finance teams with the skills to think and plan across these different challenges. They also reflected on the need for finance leaders, working closely with executive colleagues, to be equipped to drive planning decisions. Discussions repeatedly centred around three themes:

- **Thinking across multiple change horizons:** understanding local opportunities and being able to think and plan simultaneously across the short-, medium- and long-term.
- **System and patient value:** acting with true value in mind – delivering better care and outcomes for individuals and thinking with a system mindset financially.
- **Leading with hope and optimism:** knowing how to form a compelling change narrative.

The output of this engagement has been structured to encourage practical use to support the role of a finance leader. Each of the three key themes is explained in detail and complemented with relevant tools and frameworks to help leaders to enact that theme. Finally, case studies bring to life how other finance leaders have carried out their role to deliver across these objectives.

Figure 1: a summary of the research outcomes



1. Thinking across multiple change horizons

Overview

It is helpful to reflect on current arrangements and opportunities for improvement by thinking across three horizons:

- optimising the current system
- designing, testing and scaling new service delivery models
- fundamental service redesign and normalising new operating models.

These horizons are not about the timescale for change as much as the nature of the change being considered – in reality the different horizons are considered concurrently, with some initiatives delivered concurrently and some delivered one after the other, dependent on the type of change.

The starting points differ across the country, with many feeling trapped in the short-term, with no headroom to think about important long-term elements.

The key to these horizons is not to think of them as entirely sequential and to use them to inform an organisational/ system-wide view of improvement.

Practical actions are set out at the end of the section. A supporting transformation roadmap and case studies are included in the appendices.

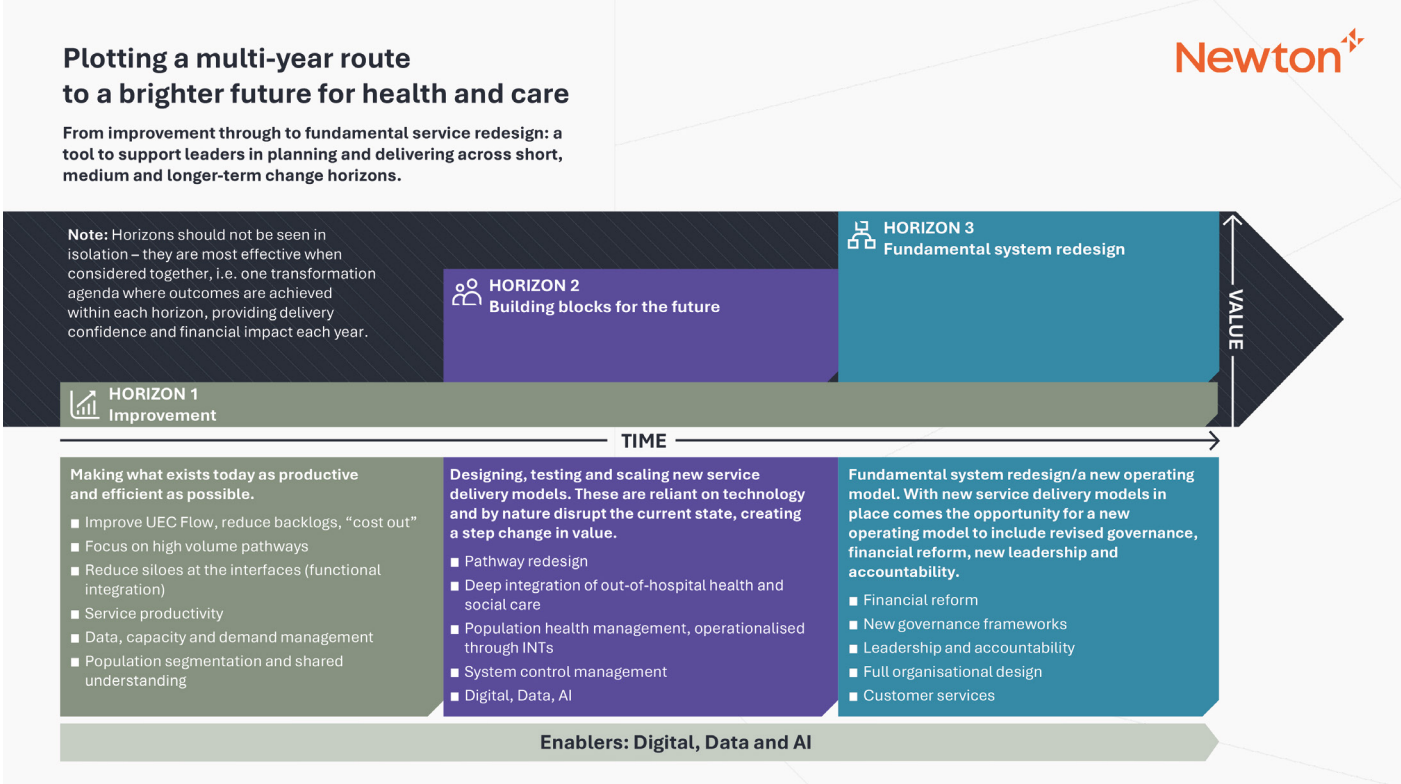
Finance leader reflections and experiences

When faced with immediate short-term demands combined with the longer-term shifts required to deliver on medium-term financial sustainability, finance leaders reflected on how and where they currently operate across these multiple horizons, or how they wish they could do this better. The critical success factors for enabling multi-horizon thinking were also discussed, as well as the role of a finance leader in setting up some of the required enablers.

The three horizon model set out in **figure 2** was used as a discussion prompt during the roundtables and is a helpful framework for finance leaders to use with colleagues as they think about their own current areas of focus and opportunities. This will differ across each organisation and system.

These horizons are not about the timescale for change as much as the nature of the change being considered. Equally, they should not be seen in isolation – they are most effective when considered together – one transformation agenda where outcomes are achieved within each horizon, providing delivery confidence and financial impact each year.

Figure 2: the three horizon model



Horizon 1: Making what exists today as productive and efficient as possible

Some leaders shared examples of embracing the 'brilliant basics' ethos in their ways of working within horizon 1. While often these examples were openly shared as not leading the way with innovation, a focus on 'brilliant basics' in some areas has potential for large scale impact. Examples shared included having a refreshed focus on length of stay and quality board rounds; standardising rotas; and having a coordinated push on agency and bank usage. In several cases, leaders called out the importance of the cultural change that took place alongside any technical change, and the need to engage teams on patient and operational value rather than specifically money. Another consideration raised was where opportunities exist for finance teams (or wider support services) to improve their own efficiency and lead by example on the productivity challenge.

Further examples of horizon 1 opportunities are included in additional HFMA resources[10].

Horizon 2: Designing, testing, and scaling new service delivery models

Roundtable participants shared examples of designing, testing, and scaling new service delivery models. These included working in a more integrated manner across existing service or pathway interfaces, and identifying opportunities for better service provision. Specific examples ranged from integrating several community services into a single team, through to new models for urgent response to mental health crises. These were seen to have generally supported both shifts from acute to community and from treatment to prevention. Key discussion points included the challenges in designing and funding new services alongside day-to-day running, the need to design with overall system value in mind and the importance of engagement and alignment with system partners throughout.

Horizon 3: Fundamental system redesign

Participants shared aspirations to work on the longer-term elements which would lead to a more personalised, sustainable approach to health and care in the UK. This included examples ranging from funding models which align incentives, through to more blue-sky discussions on potential future models of care (for example accountable care organisations). By their nature these often seem outside of the current grasp of any one organisation, but in applying a multi-year approach and recognising the different improvement horizons within the change journey, it was felt that many of these ideas would become accessible. However, it was agreed that there is a risk that without any headspace and capacity to begin working on these, they remain several years away.

[10] HFMA, *Common themes from the investigation and intervention regime reports*, February 2025 and HFMA, *The NHS productivity challenge*, November 2024

Applying the horizon model

Resonating with many of those involved in this work, one roundtable participant commented.

> ‘It’s not just do we have financial headroom, it’s do we have the time to stop and think?’

The role of finance leaders beyond the traditional boundaries is a key factor. This cultural understanding forms a helpful start point to determine the most impactful improvement approach (as per the three horizons) for each improvement outcome within an organisation/system. It helps to define which horizon is the most appropriate start point and the improvement journey over time in order to stretch each opportunity sufficiently, building a comprehensive improvement portfolio that balances short- and medium-term service delivery requirements.

For example, those organisations with a history of large cost improvement programme (CIP) delivery should focus on more allocative efficiency gains (such as more activity in horizon 2 and 3), while those that have a lesser track record of CIP delivery and have more ‘brilliant basics’ opportunities should have the balance of productive and allocative efficiency (such as more activity within horizon 1, supplemented by key focus areas in horizon 2 and 3).

When considering current performance and savings plans, many leaders reflected that they operate more in ‘horizon 0’: surviving an annual churn, with many non-recurrent savings, uncertain sustainability, or shifting pressures into future years.

Key questions include:

- Do we have the right balance of ‘fix today’ versus ‘change tomorrow’?
- Do we know our organisation well enough to know which horizon is the appropriate starting point for each individual service?
- Which opportunities do we want to focus on to maximise value over time?
- Are we connecting our improvement ambition across horizons to maximise impact over time? For example:
  - urgent and emergency care (UEC) efficiency gains in horizon 1 (for example reduced length of stay via ‘brilliant basics’)
  - launching new models of care within horizon 2 (for example virtual wards, frailty same day emergency care (SDEC)
  - designing a fundamentally new model of care for horizon 3 (for example single point of access (SPOA) and integrated neighbourhood teams).

We heard from many finance leaders that while change was happening in their systems, to really impact the future of financial sustainability of their services, a rebalancing of these timescales and types of work was required. The starting points differed across the country. Many feel trapped in the short-term, with no headroom to think about important long-term elements. Others reported lots of discussion on ‘bigger picture’ ideas but lacked confidence on the benefits realisation timelines and current foundational ways of working.

When thinking about larger scale transformation in horizons 2 or 3, one of the overriding themes was how to break out of the cycle of current performance churn and find time for those long-term important elements. It can currently feel like there are always fires to fight, and the more that senior leaders end up firefighting the less time there is available to prevent future fires. This is of course also true outside of the finance function. Participants were keen to explore how best to support and empower their teams, and once enabled then encourage and expect them to resolve what’s within their remit, rather than feeling the need to escalate.

When discussing application of the horizon model, the following two key requirements were discussed.

- **The key to these horizons is not to think of them as entirely sequential**, but rather to work with operational and clinical colleagues to understand the opportunities and time to deliver within each. A single work element may progress from horizon 1 to 2 to 3, or you may decide to jump directly to horizon 2 as improving the current model has limited returns. Conversely you may improve in horizon 1 and decide the further (more disruptive) transformation in horizon 2 or 3 is not required after all.
- **The horizons model informs an organisational/ system-wide view of improvement** with finance teams helping to navigate the relative paybacks and expected values of working in these different horizons. If you zoom out to look across your efforts, there will be a mix of horizons across your improvement agenda. Having a shared view of improvement (and expected improvement trajectories) across finance, transformation, and operations can prove incredibly valuable.

In reality, delivering against these horizons is not linear and will be informed by a number of existing processes and plans (such as month-end, control totals, executive boards, strategies, performance measures and so on). This is inherently complex and there is a role for finance leaders to hold strong on the multi-year objective framing, leading the way (through the complexities) to balance the conflicting pressures and keep their change journey on track.

The use of digital solutions applies across each of the three horizons. This is explored further in the HFMA's briefing on the role of digital technologies in financial recovery[11] as well as the example set out in using predictive analytics to improve mental health services[12].

Appendix B sets out the key areas of focus within each of the three horizons. It can be used as a discussion tool to develop your own individual transformation roadmap.

Practical next steps

Know your own organisation/system and where to focus:

- Where are the services where the 'do-nothing' situation is untenable? These are 'no-regrets' areas to focus on.
- Complete an honest appraisal of which horizon you are in to determine where to focus (such as if you are just in 'horizon 0' and stripping non-recurrent savings – find a service area where you can plot improvement initiatives across the horizons).
- Work with clinical, operations, and finance teams to set time horizons; define value; explore options; and manage short-term demands, medium-term sustainability and long-term planning.
- Prioritise pragmatism over perfectionism in tracking system contributions and impacts, include anticipated impacts and assumptions in transformation plans, and identify success factors for multi-horizon thinking.
- Collaborate with clinicians to understand unit costs and the value of activities influencing resource use.
- Find delivery opportunities within each horizon and promote transparency between partners considering health and social care interdependencies.
- Develop system leadership focused on collaboration, accountability, improvement, and help finance business partners (FBPs) balance reporting with transformational support.
- Focus on cultural change as well as technical change.
- Engage teams on patient and operational value rather than money and allocate time for larger transformations in horizons 2 or 3.
- Balance a mix of horizons across the improvement agenda.

[11] HFMA, *The role of digital technologies in financial recovery*, October 2024

[12] HFMA, *Update - using predictive analytics to improve mental health services*, January 2025

2. System and patient value

Overview

Finance leaders recognised that long-term success relies on a focus on underlying value, and not just on cost.

Working with multi-disciplinary teams is needed to understand the underlying value of decisions and behaviours and build a broader picture of service value that encapsulates the potential of new delivery models and the risk of failure demand, over and above short-term running costs.

Finance leaders reflected that real progress has been made in partnership working and integration, with much more discussion of impacts in both health and social care.

A system mindset is essential to success and while progress has been made in partnership working and integration, there is further room for improvement – an increase in transparency and openness between partners.

Practical actions are set out at the end of the section and case studies are included in the appendices.

Finance leader reflections and experiences

Focus on underlying value and not just on cost

Finance leaders recognised that long-term success requires a focus on underlying value and not just cost. This will require better definition and assessment of value to make service improvement decisions. To do this, systems need to have a more sophisticated framework for measuring value across disciplines and organisations. Finance leaders reflected on their evolving role, the need for deep engagement with colleagues, and the wider skillset and mindset shifts required.

‘Are we doing the things we’ve always done and expecting different results?’

‘We have to enter an era of doing better things.’

There was a general opinion that during times of financial challenge it is easy for finance teams to focus on the costs of how we currently deliver healthcare, rather than necessarily on the underlying value to the patient and the behaviours which drive inefficient use of resources. Participants discussed needing to take time to work with clinicians to understand not just unit cost, but the underlying value of activity, and the impact of failure demand when we don’t deliver the right care in the right place.

‘We understand unit costs, but the challenge is in the behaviours that determine what things cost.’

In order to understand the underlying value of decisions and behaviours, finance teams need to build a broader picture of service value that encapsulates the potential of new delivery models and the risk of failure demand, over and above short-term running costs. This requires working with multi-disciplinary teams (clinical, operations, and finance) to fully understand the operations of a service and setting an appropriate time horizon to define value and to assess the options available.

Two examples referenced were the dependencies between complex discharges, intermediate care, and social care outcomes, or focusing on the total bed days required and improving this through admission avoidance and length of stay reduction, rather than just focusing on the cost per bed day.

‘The role of finance leaders has evolved – we are thinking more about delivering service efficiencies as a system and considering the welfare of all organisations within that, as opposed to savings within individual organisations.’

The Healthcare Value Institute[13] has further resources to support how value-based healthcare can encourage multidisciplinary system-wide approaches to deliver financially sustainable outcomes. Examples include *A value-based healthcare approach to driving improved productivity*[14] and *The vital role of outcome measurement in maximising healthcare value*[15]. The One NHS Finance *Best possible value toolkit*[16] is another source of support in making value-based decisions for healthcare services.

Partnership working and integration

Participants reflected that it does feel like real progress has been made in partnership working and integration, with much more consideration of impacts in both health and social care and across organisational interfaces such as the community provider and acute hospital. Several examples of this were shared, such as considering what happens if a local authority is financially challenged and drives more demand into the health system. Or, where work in a single organisation effectively 'squeezes the balloon' and moves pressure elsewhere in the system – for example, a focus on prompt discharge in acute beds achieved through using additional beds in the community with inadequate therapy support, leading to reduced independence for people and associated social care costs.

Some participants did emphasise there was further room for improvement – an increase in transparency and openness between partners; more consideration of not just health and social care, but the interdependencies between primary and secondary care; and the relationship between elective care backlogs and urgent and emergency care demand.

It was discussed that protectionism can raise its head at times. Everyone acknowledges they would ideally move the right care to the right place, but that funding to make the transformation happen, and the changing of commissioned contracts around this is not flexible and able to keep pace. Often systems don't have the financial headroom, whether capital budgets or revenue funding, to pump prime or double run initiatives. This leads to a dissonance between the ultimate goal being entirely logical and high-value for patients and the system, but the resources required to get there being unavailable. This is explored in the HFMA briefings, *Moving money around the system*[17] and *Bringing it together: financial strategies that address health inequalities*[18].

If organisations are in stalemate because no one wants to 'lose out', then it is the pace of change and ultimately the positive impact on patients which suffers. The use of block-based contracts was raised as having cut through some of the activity and tariff-based challenges in making changes or cooperating to respond to pressure. Protectionism can also be found in operational constraints put in place by partners or deep rooted in commissioning agreements. Some of these constraints are in place for good reason, but others are in place as that is the way things have always been done – not necessarily because that is how things need to be done going forwards. To operate in a system leadership capacity, organisational leaders have to both embrace transparency and openness, and a willingness to collaborate for the greater good. But they also have to be willing to be potentially vulnerable and held to account by system partners for performance and improvement.

A toolkit for leaders and individuals engaged in the design and delivery of integrated care at a local level can be found in *Integration at place: from ambition to delivery*, published by NHS Providers and Newton[19].

Value – mindset, measurement, and realisation

What do finance functions need to do to be able to think in these value terms and influence others? Participants shared that there are undoubtedly opportunities to develop new skills, or recruit new roles which bring complementarity and diversity of thought into the finance team. It may also be time to look at business partnering models and support finance business partners (FBPs) to rebalance their activity from the 'churn of reporting' to more transformational support. One roundtable group discussed how as senior finance leaders, their support of other functions should be a key evaluator of performance – the acid test being how often colleagues come to them for advice or help.

[13] Healthcare Value Institute, webpage

[14] Healthcare Value Institute, *A value-based healthcare approach to driving improved productivity*, December 2024

[15] Healthcare Value Institute, *The vital role of outcome measurement in maximising value*, November 2024

[16] One NHS Finance, *Best possible value: decision toolkit*, webpage

[17] HFMA, *Moving money around the system*, January 2025

[18] HFMA, *Bringing it all together: financial strategies that address health inequalities*, August 2024

[19] NHS Providers and Newton, *Integration at place: from ambition to delivery*, January 2024

The practical measurement of value was raised as a frequent obstacle. This covered a breadth of topics, from the macro challenge of not considering wider value such as healthy people's contribution to the economy, through to the more granular challenge of tracing directly from a change implemented in one part of the system to which finance pot or budget line will be impacted elsewhere.

Operating with a degree of pragmatism over perfectionism is often challenging when reporting cycles take precedence, but a move in this direction is likely to be required to support shifts into the community.

Participants also raised experiences of transformation schemes with benefits that are below a realisable scale. For example, releasing 1,000 bed days a year, but with no ability to aggregate similar impacts to enable the closure of an escalation ward. It was suggested that there should be increased discipline in the clarity on the route to value in initial programme planning documentation, supplemented by FBPs being able to support and challenge on the underlying value.

Practical next steps

Define 'value' to align incentives and balance short- versus long-term trade-offs:

- Broaden the calculation of service value to include new delivery models and failure demand impacts.
- Create a framework for multi-disciplinary teams to decide on service improvements.
- Set a clear but meaningful timeframe to expect to deliver on the value you have defined – being brave about multi-year solutions where the expected value impact is greater where a multi-year approach is taken.
- Work with clinical, operations and finance teams to align across these decision points.
- Prioritise pragmatism over perfectionism in tracking economic contributions and budget impacts.
- Include anticipated impacts in transformation plans to support community shifts.

Adopt a system mindset and lead collaboration:

- Work with clinicians to understand unit costs and activity values affecting resources.
- Foster transparency between partners, considering health and social care interdependencies.
- Embrace system leadership, focusing on collaboration, performance and improvement accountability.
- Consider the role of finance teams and be conscious in the skills you value.
- Develop new skills and recruit diverse thinkers to support transformational activities.
- Enable finance business partners to balance reporting and transformational support.

3. Leading with hope and optimism

Overview

Finance leaders have an important leadership role to coalesce teams around a common goal, bring people together, and drive evidence-based decision-making.

There needs to be a clear change narrative that is engaging, optimistic and relevant to clinicians and other healthcare professionals, operational colleagues and the finance community.

It can be challenging to lead with optimism in times of such uncertainty and change. Authenticity, consistency and conviction will be essential in how the narrative is communicated.

Practical actions are set out at the end of the section and case studies are included in the appendices.

Finance leader reflections and experiences

Finance leaders reflected on the need to have a change narrative that is engaging and optimistic. Given the diverse range of people and roles involved in large scale transformation and improvement, the narrative needs to be engaging and relevant to clinicians and other healthcare professionals, operational colleagues, and the finance community.

> ‘We need to find time to think about doing things differently – to make clinicians aware of the financial position and the alternative ways of doing things. We need time and space for creative conversations.’

Roundtable participants reflected on finance functions often being seen as the ‘honest broker’, able to help convene across disciplines and/or organisations. How can finance leaders step further into this role, bringing others together and using evidence-based decision-making, strong value cases, and alignment with the long-term change plan? Within this context it was agreed to be particularly important to engage clinicians early and take them on the journey in terms of where you are aiming for and why, and what it means for patients.

This is at the crux of the value discussions, being able to engage on the underlying behaviours and decisions, as opposed to just cost implications. People shared experiences in the challenge of trying to find a narrative that works across different groups, without becoming generic and losing impact. For example, engaging with the general clinical base is very different from communication with one very sceptical but very key clinician.

The roundtable discussions echo the key themes identified in HFMA’s briefing, *Common themes from financially stable systems*[20]:

- building good relationships
- encouraging openness and transparency
- clearly communicating the strategy
- using the available levers.

It can be challenging to lead with optimism in times of such uncertainty and change. In the roundtable discussions there was a real sense that not only does change have to be delivered this time, but that under the right conditions it truly can be delivered. Authenticity and conviction were agreed to be essential in how the narrative is communicated. Hope and optimism will also be key to inspiring the change required to achieve the long-term strategy, all while meeting the short-term demands.

Further leadership support can be found on the HFMA website (both on the events page and online learning and qualifications)[21] and further opportunities to network with other leaders can be found on the HFMA events page[22].

[20] HFMA, *Common themes from financially stable systems*, November 2024
[21] HFMA, *Career development*, webpage
[22] HFMA, *Events* and *CFO Network*, webpage

Figure 3: crafting a compelling narrative

Some areas of good practice shared in crafting effective narratives

- Distil down the core messaging that covers the purpose of the work – why, what and how – then select the most relevant elements and tailor for different audiences while anchoring on consistent core language and terminology.
- Ensure your narrative leads with the patient at the heart – while not shying away from the fact that money is important, can you also articulate the benefit in terms of patient outcomes or experience?
- Ensure your narrative resonates with colleagues who will be involved in the change – a simple three point checklist based on a well-established change equation:
  - does it spark dissatisfaction with the current state, importantly not just of the wider NHS position, but of that person's specific service, pathway, or ways of working?
  - does it excite them about what's possible in the future and can you articulate why this will be better for patients as well as finances?
  - do they understand what is being asked of them initially? They don't need the whole journey (and you may not know it!), but without clear first steps will they be willing to set off on the journey to sustainability?
- Share this narrative with relevant partners and communicate across all levels.
- Ensure the narrative is available in a form that can be communicated with patients and families too.
- Understand how the narrative is used – is it actually used regularly and if not, why not?

Practical next steps

Understand others to convene effectively:

- Identify who you need around the table to define the appropriate change ambition and what you need from others to succeed.
- Consider how you are going to appeal to others and what the uniting ambition is across clinical, operational, and finance teams.
- Provide consistency, leading through the ambiguity and short-term distractions with a clear definition and measurement of what good looks like and the timeframe for assessment.
- Act as the honest broker over multiple change horizons.

Next steps

There is no doubt there is increased uncertainty, turbulence and pressing asks of leaders throughout health and social care. This makes it as important as ever to maintain one eye on the longer-term, have a shared ambition, and hold true to the conviction to deliver on both long- and short-term priorities.

The complexity finance leaders are facing is clear. The success criteria and requirement to balance quality and finance objectives over multiple time horizons are continually changing, and delivery is increasingly dependent on multi-disciplinary and/or multi-agency collaboration. Clarity on NHS funding (both capital and revenue) is paramount in supporting proactive and reactive behaviours. Success can only be achieved in this environment by establishing trusted working relationships with system partners and having a shared mindset around collaboration and shared success.

As the financial pressures increase, one thing is increasingly evident – there is a critical role for the finance leader, and they will need to be equipped with the appropriate tools, frameworks, and financial criteria to set them up for success in support of the health outcomes of the United Kingdom.

The engagement with finance leaders throughout this project has surfaced a wealth of positive thinking and best practice examples, as well as proving a welcome opportunity for the 'headspace' required to navigate the complexity of this topic.

It is hoped that the materials made available in this publication will be of use in the coming months and beyond as trusts and systems develop their plans for the delivery of the 10-year plan while delivering on short-term priorities.

Leaders have also valued the opportunity to come together and share experiences throughout this project and both the HFMA and Newton are committed to continuing to support these conversations – locally and nationally. Further opportunities for support in applying the tools, frameworks, and thinking to individual system or organisational contexts and to share experiences of doing so with peers will be made available through various upcoming HFMA events and forums.

Appendix A: Methodology

This publication is the result of a programme of work led by a partnership between the HFMA and Newton which involved input from several sources to truly understand the pressures faced by finance leaders today and the opportunities and tools they could consider in support of their local residents, patients and staff.

Understanding

At the centre of this is rich insight provided by engagement with over 40 chief financial officers and other finance leaders from around the country. This was sourced from several of the HFMA's existing forums including the Financial Recovery Group, Policy and Research Committee and ICB Finance Group along with five roundtables held online and at HFMA events between November 2024 and February 2025.

During these engagements, participants were asked to share their experiences of driving multi-year change in their systems and organisations within the current financial climate, including the things which were impeding or enabling progress with these endeavours. The publication is designed to reflect the breadth and depth of their views, experiences and examples of good practice.

Practical application

Key messages from the engagements are supplemented with the following to support the practical application of principles:

- **Case studies:** examples included in this publication have been sourced from a combination of the roundtables, subsequent one-to-one conversations with finance and operational leaders who delivered the programmes, as well as change programmes undertaken by Newton.
- **Further resources:** to support finance leaders to take further practical action from the insights within this report, where relevant, industry tools, frameworks and models are linked.

Collaboration

The approach to this project was shaped by engagement and co-design with key HFMA forums as set out above. National, regional and local finance leaders have been involved in this work through attendance as part of scoping, roundtables and review.

The project aims to support discussions on NHS reform and the 10-year health plan and we would welcome the opportunity to engage further with the Department of Health and Social Care (DHSC) and NHS England colleagues as delivery plans are developed.

The HFMA and Newton would like to thank all of those who have kindly contributed to this project.

Appendix B: Transformation roadmap

The table below sets out the key areas of focus within each of the three horizons. It can be used as a discussion tool to develop a transformation roadmap.

	Horizon 1	Horizon 2	Horizon 3
Shift left such as reduce acute bed days	Optimise urgent and emergency care. Drive out of hospital care improvements.	Shift acute care (diagnostics, pharmacy, outpatients) into the community. Reduce hospital bed base.	Personalised and preventive health.
Local assessment and proposed actions:			
Maximising independence after crisis such as intermediate care costs and outcomes	Streamline intermediate care and discharges.	Integrated delivery models across health and social care.	Integrated community team(s) with joined up journeys and continuity of care.
Local assessment and proposed actions:			
Maximise healthy life expectancy and prevent crisis	Enhance primary care access.	Multidisciplinary care teams around GP populations. AI and data for predictive care. Empower patients and link with voluntary sector. Unified 'one-stop-shop' access.	Reform financial incentives to support outcomes-based care. Adopt accountable care organisations (ACOs). Integrate genomics and personalised medicine. Use advanced data for prevention and tailored interventions.
Local assessment and proposed actions:			
Back office cost efficiency	Consolidate HR, finance, IT at system level.	Sub-regional scaling of corporate functions.	
Local assessment and proposed actions:			
Front line productivity (provider efficiency and staffing)	Improve elective care throughput. Digital tools to support workflow.		
Local assessment and proposed actions:			

Appendix C: Further reading

Further resources referenced throughout this paper are set out below:

- National Audit Office, *Financial management and sustainability*, July 2024
- Department of Health and Social Care, *Independent investigation of the NHS in England*, November 2024
- Department of Health and Social Care and NHS England, *NHS change*, October 2024
- NHS England, *Financial performance update*, March 2025
- NHS England, *Update on 2025/26 planning round*, March 2025
- HFMA, *More ambition needed on productivity in financial reset*, March 2025
- NHS England, *Working together in 2025/26 to lay the foundations for reform*, April 2025
- NHS England, *Review of NHS performance and delivery: data annex*, March 2025
- HFMA, *The role of the NHS chief finance officer*, October 2024
- HFMA, *Common themes from the investigation and intervention regime reports*, February 2025 and HFMA, *The NHS productivity challenge*, November 2024
- HFMA, *The role of digital technologies in financial recovery*, October 2024
- HFMA, *Update - using predictive analytics to improve mental health services*, January 2025
- Healthcare Value Institute, webpage
- Healthcare Value Institute, *A value-based healthcare approach to driving improved productivity*, December 2024
- Healthcare Value Institute, *The vital role of outcome measurement in maximising value*, November 2024
- One NHS Finance, *Best possible value: decision toolkit*, webpage
- HFMA, *Moving money around the system*, January 2025
- HFMA, *Bringing it all together: financial strategies that address health inequalities*, August 2024
- NHS Providers and Newton, *Integration at place: from ambition to delivery*, January 2024
- HFMA, *Common themes from financially stable systems*, November 2024
- HFMA, *Career development*, webpage
- HFMA, *Events* and *CFO Network*, webpage

Appendix D: Case studies

Case study one: Coventry – improving lives

Overview of scheme/programme	
Summary: what is the specific outcome/ improvement area that this scheme sought to tackle?	Coventry, one of four places within the Coventry and Warwickshire Integrated Care System, like much of the country, found its urgent health and care services under significant pressure meaning that the residents of Coventry were not always receiving an optimum service or the best possible outcome. The *Improving lives* programme is about fundamentally changing the way in which people with urgent need in Coventry are supported.
Which of the 'Darzi shifts' does this relate to?	Hospital to community and analogue to digital.
Key organisations/system partners involved	A place-based partnership consisting of Coventry City Council (CCC), University Hospital Coventry and Warwickshire (UHCW), Coventry and Warwickshire Partnership Trust (CWPT) and other system partners including primary care networks and the West Midland Ambulance Service, with support from Newton.
Lead organisation	Acute trust, supported by the ICB.
How was the programme funded?	Shared contributions between the ICB, trust and council.
Programme governance	This was an ambitious, complex programme which required robust supporting mechanisms and tools to be in place order to realise the potential of a new urgent care service model and for it to become sustainable. Specific programme governance was established including sponsors from each of the partner organisations and the ICB forming a programme board, leads for each of the programme's workstreams and a benefits realisation group.
What was changed/ transformed through the scheme?	The *Improving lives* programme introduced many significant changes, from the creation of a locally integrated model that effectively supports residents, the introduction of a pull model which allows patients who are being discharged from hospital to have their care plan before they are medically optimised, and improvements to the visibility of the services within the system.
Making the case and getting started	
How did you make the case to take this scheme forward?	The programme builds on the findings from an assessment of Coventry's urgent health and care services which found significant opportunities to improve along the entire pathway. The assessment, led by Newton, found that there was a tendency to make hospital conveyance the default option for people with urgent need. The assessment not only made the case for change very clear but identified with precision which changes across the whole urgent and emergency care (UEC) pathway were going to be most impactful, enabling system partners to move forwards with confidence and alignment.
What created the main impetus/momentum to take it forward?	Following the assessment, the partnership also conducted a short design piece of work to start to bring to life an evidence-based vision of what the future model could look like. This was important to continue to build the excitement and confidence of the different organisations involved – it needed to be clearly different to the sticking plaster solutions that had been delivered in the past. Crucially, at the heart of the changes being made was a real focus on doing the right thing for the patient which is something that everyone can get behind.

What challenges did you encounter in getting things off the ground and how did you overcome them?	It wasn't a linear trajectory towards success, with several bumps in the road. There was constant tension between juggling the pressure to meet in-year targets, while tracking progress on a multi-year programme. This was particularly challenging when the time to deliver benefit was quite protracted – it required the benefits realisation group to hold its nerve at a time when it would have been very easy to be distracted by lots of 'in-year' noise. Benefits tracking can be challenging, particularly with a programme of this size and complexity. The difference here was that the assessment provided a baseline for each of our metrics, and agreement from every organisation involved to provide the data that was required to track progress against these. The combination of accurately tracking benefits, alongside case studies of the impact changes were having on patients, provide a powerful driving force to continue.

Impact

What financial benefit was achieved?	As of January 2025, the outcomes achieved as a result of the programme translate to around £17m annual financial benefit for Coventry. This benefit was split across UHCW and CCC spend.
What was the impact on patient outcomes/quality?	As of January 2025, the programme is having the following impact on outcomes across the UEC pathway in Coventry: • 18% reduction in older adult admissions to base wards with people being better supported by primary care or the urgent community services • a reduction of 1.1 days in length of stay for patients who return to their usual place of residence (20%) • 50% reduction in the number of people moving to a long-term bedded setting • reduced demand for short-term bedded care from 85 beds to 39 beds, with this group having more independent outcomes in their own homes • successfully moved 158 members of staff from 8 different services into one new organisation • built a care record that hosts a case load of 700+ people and connects community, adult social care, and acute data.
Was there any other impact (for example, on staff, system partnership)?	The programme provided a platform for the Coventry place partners to unlock organisational boundaries, improve relationships across the system, and create a more integrated model of care.
In what timeframe were these benefits realised?	The programme started in January 2023 and reached target run rate in November 2024.

Finance leadership mindset

What one piece of advice would you give to finance leaders embarking on a similar scheme?	'It's essential that finance leaders are involved with this sort of change from the outset – it's not something that can be joined halfway through. They also need to commit to it for the duration, holding operations teams to account on the milestones that need to be met over the course of a number of years.'

Case study two: Gloucestershire Hospitals – improving the flow foundations

Overview of scheme/programme

Summary: what is the specific outcome/ improvement area that this scheme sought to tackle?	Gloucestershire Hospitals NHS Foundation Trust has made significant improvements in ward patient flow and the efficiency of staffing models within these wards. In 2022 the hospital was running at up to 105% occupancy, at times up to 200 people boarding and around 50 people waiting for admission in the emergency department (ED). The improvement in length of stay and efficiency throughout the ward base focused on three components: 1. A joint programme with system partners based on *Working as one*, which has improved the front door and complex discharge interfaces by trialling new ways of working including better board rounds and a new integrated flow hub and then embedding the changes to drive improved length of stay. 2. Engaging staff on the wards with the challenges in patient care and improving flow – including clinicians developing their clinical vision of flow model and building ward-to-board visibility of length of stay and next step blockers. 3. Increased grip on ED staffing plans, and ward rotas and staffing templates – engaging wards on their staffing requirements, holding them to account on their plans and using performance accountability frameworks to support this grip across both performance and cost. Emergency length of stay has reduced by 21% and emergency bed occupancy by 10%, with boarding now below 30 and ED queues halved.
Which of the 'Darzi shifts' does this relate to?	Acute to community.
Key organisations/system partners involved	Gloucestershire Hospitals NHS Foundation Trust (GHFT), Gloucestershire Integrated Care Board, Gloucestershire Health & Care NHS Foundation Trust (GHC), Gloucestershire County Council.
Lead organisation	GHFT
How was the programme funded?	A combination of system improvement programme with external partners (system funded) and internal business as usual improvement through existing operational teams. The actual changes made did not require significant funding, but the transformation capacity did.
Programme governance	*Working as one* has had separate system governance which is now transitioning into business-as-usual system governance around UEC improvement. Clinical vision of flow elements were managed through GHFT internal transformation and performance governance, and the grip on staffing achieved through collaboration between business-as-usual finance support and divisions.

Making the case and getting started

How did you make the case to take this scheme forward?	A system diagnostic in 2022 supported the case for improvement in the front door model and on emergency length of stay. This supported a wider push within GHFT around performance improvement targets and a desire to really engage staff in the challenges faced.
What created the main impetus/momentum to take it forward?	The negative impacts on patient outcomes and experience, and the impact on system finances that were caused by delays and productivity challenges.
What challenges did you encounter in getting things off the ground and how did you overcome them?	System working – agreeing collaborative models in, for example, the integrated flow hub, needed senior leadership direction and intervention. Staff engagement – starting from a challenging point given the pressures in 2022, significant focus has gone into engaging and supporting staff through the changes. Clarity and ownership of the problem – Built internal visibility through the GHFT BI Team that supported the ward-to-board ownership of length of stay and the delays which could be tackled.

Impact	
What financial benefit was achieved?	The direct financial benefits have been difficult to establish as GHFT was also going through its own financial recovery programme and the financial ask was significant. What can be said is that a combination of this work and the internal work of GHFT the financial position at the end of 2024/25 resulted in a small surplus. This meant delivery of a savings plan of £37m (across the total Trust – so not all in urgent care). The key lesson to be learnt from this piece of work is to really tie down the financial baseline and how the different workstreams will impact on it and really try to drive out the cost. By making the flow better the system was able to provide better care for its patients and staff were able to provide services they are proud to provide. Agency spend came down to 2.5% and turnover improved.
What was the impact on patient outcomes/quality?	Improved flow and focusing on ED performance is seeing a reduction in long waits and subsequently delay related harm. The new integrated flow hub is seeing a shift to more people going to home based care, as well as a reduction in the time a person spends in an acute bed when they could be in their own home.
Was there any other impact (for example, on staff, system partnership)?	Positive impacts on staff engagement, areas of improved flow, seeing staff positively engage with the purpose and value of their roles in these ways of working. System working improvements have also been made – improving system transparency and resilience.
In what timeframe were these benefits realised?	After approximately 12 months of focused activity but then continued as part of the business-as-usual grip and control to ensure sustainability.
Finance leadership mindset	
What one piece of advice would you give to finance leaders embarking on a similar scheme?	‘Keep an eye on the long-term and support operational and clinical colleagues to get there, embracing the development of more strategic business cases alongside the day-to-day grip.’

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff working in healthcare. For 75 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks. Its aim is to fully represent the whole healthcare finance function and provide accessible and personalised member services that are fit for the future.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

HFMA

HFMA House, 4 Broad Plain, Bristol, BS2 0JP

T 0117 929 4789

E info@hfma.org.uk

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HFMA is also a limited company registered in England and Wales, no 5787972. Registered office: 110 Rochester Row, Victoria, London SW1P 1JP

www.hfma.org.uk

About Newton

Newton is a strategic delivery partner for health and care systems, helping to deliver change which tackles the intense pressures of today, while innovating for a brighter future. Working at the complex interfaces of health and care, it works alongside all system partners to tackle their most pressing challenges, such as improving productivity or urgent and emergency care. Looking further ahead, Newton helps to fundamentally reimagine and redesign how services are delivered, building new models of care that shift care closer to home or taking a proactive, targeted approach to prevention. To all of these complex challenges it brings robust evidence and deep insight to ensure that the impact it delivers together is meaningful and measurable: improved outcomes for people, a better experience for staff and sustainable financial benefit.

Newton

Newton Consulting Ltd, Kingston Business Park, 2, Kingston Bagpuize, Abingdon, OX13 5FE

T 01865 601300

E healthandcare@newtonimpact.com

Newton Consulting Ltd is a company registered in England and Wales, no 4279175. Registered office: 2 Kingston Business Park, Kingston Bagpuize, Oxfordshire, OX13 5FE, United Kingdom

www.newtonimpact.com

Newton