DELIVERING EFFICIENCIES

What is finance's role in the current push to deliver efficiencies? And what systems are needed to support this work? Steve Brown reports on a recent HFMA roundtable supported by Unit4

Delivering efficiencies is an ongoing challenge for NHS bodies. But right now the pressure to deliver improvements is particularly intense as inflation has massively reduced the purchasing power of the NHS settlement and industrial action has increased costs.

While changes to pathways and clinical services offer the most significant opportunities to improve productivity, what contribution could finance teams make to support these efforts and realise efficiency in their own operations?

This was the question taken on by an HFMA roundtable, supported by finance and enterprise resource planning software supplier Unit4, towards the end of 2023.

The group of finance leaders, planning managers and analysts got together to explore, in particular, how financial systems could be used to help identify efficiencies and to discuss the case for investing in new, more powerful financial systems.

The overarching efficiency ask for the NHS in 2023/24 was 2.2%. But systems have had to dig far deeper to find much more significant savings.

For a start, inflation in both 2022/23 and the current year has been far higher than the level assumed when budgets were set and allocations were made. On top of this, industrial action has increased costs beyond the level covered by the increased system allocation announced in autumn 2023.

As well as renewed calls to focus on winter pressures and deliver within planned spending levels, there has been an increased focus on productivity, with concerns that rises in funding and staffing levels in recent years have not been reflected in sufficient increases in activity. A 24% fall in productivity over the pandemic period underpins raised interest in why productivity has struggled to bounce back.

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Nicky Lloyd, chief finance officer at Royal Berkshire NHS Foundation Trust said that, ahead of discussing the efficiencies that could be made, it was important to understand the data behind the measures of NHS productivity.

'There has been an important shift in the way we deliver services,' she said. 'And this is not always obvious when you compare current activity to pre-pandemic activity and count traditional points of delivery or units of activity such as the number of non-electives or appointments or attendances at A&E.

'Our clinicians are working in some of their clinical sessions giving expert advice and

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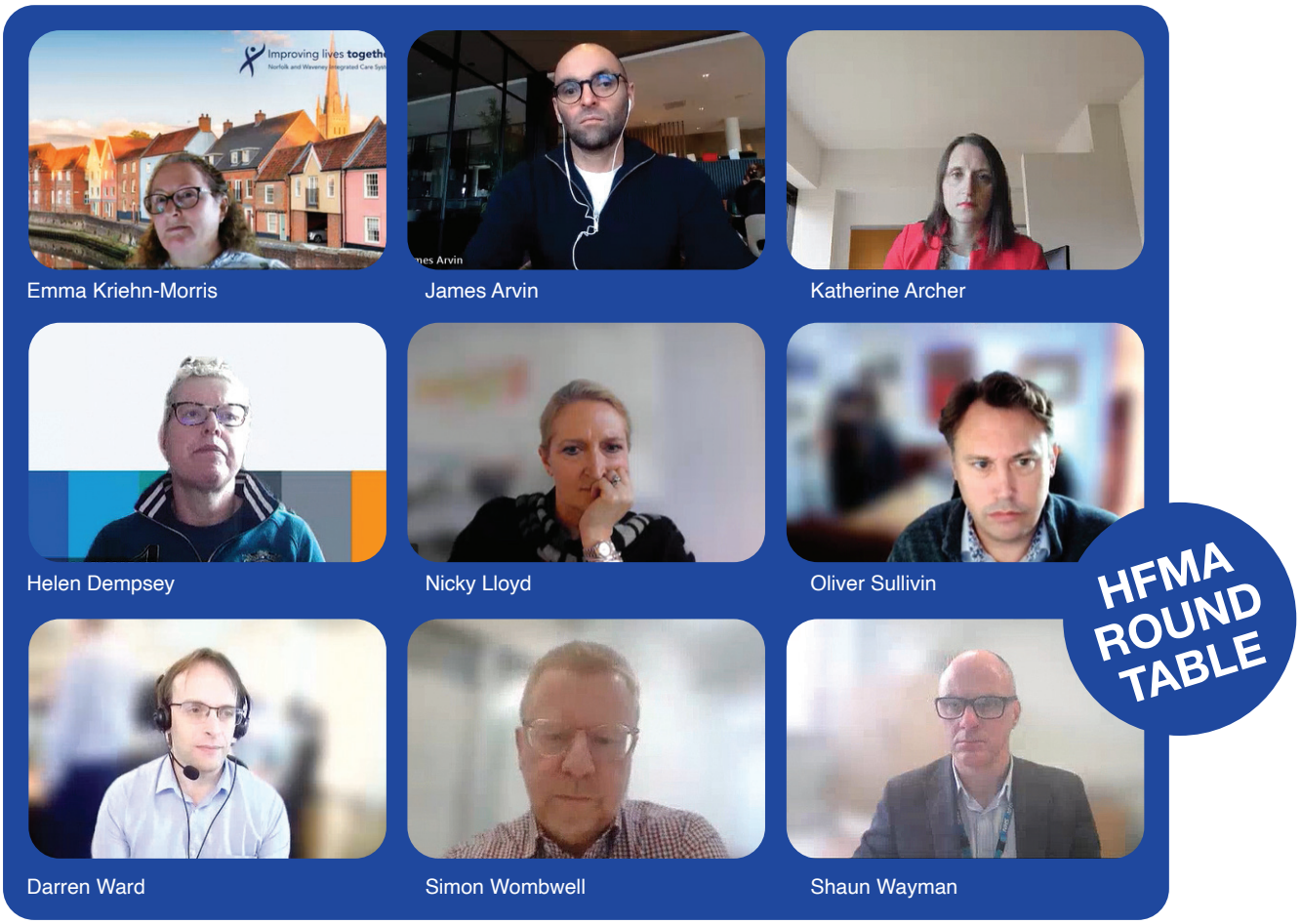

guidance to GPs over the phone, which can avoid the GP needing to immediately refer a patient to the hospital.

'We also have consultants triaging referrals to prevent unnecessary first outpatient attendances, saving patient time and clinical time by recommending a different pathway.'

She added: 'However, we continue to measure, and be measured by commissioners, across activity delivery of electives, non-electives, outpatient attendances – new and follow-up. These are the units of currency the NHS has traditionally used. But there are ways that healthcare is being delivered now that don't neatly fit into those units.'

So certain categories of non-elective activity might go down from one year to another, but that doesn't mean clinicians are working less intensively. They might just be working differently in an area providing care that is better for patients, such as same day emergency care, or patients being cared for through a virtual ward rather than being admitted as a non-elective patient and then discharged in less than 24 hours. However, sicker patients as a result of the pandemic are also having an impact on reported productivity.

At the time of the roundtable, Katherine Archer was deputy director of finance (performance and reporting) at Oxford University Hospitals NHS Foundation Trust, but she has subsequently moved to Buckinghamshire Healthcare NHS Trust as deputy chief finance officer (financial management). '[At Oxford] we are measuring the number of non-elective patients that have gone through the system,' she said. 'But we have found that each patient is staying longer, which means we haven't got the space or capacity to deal with [as many] elective patients.

'But we are not less busy and, having looked at the data, it is not to do with delayed discharges – it's to do with acuity.'

She suggested this was typically adding a day to non-elective patients' time in hospital, which over the hospital's total bed base was a significant reduction in flow.

'Measuring productivity just on patient throughput is probably not an accurate way of doing it,' she said.

Participants

- Katherine Archer, Oxford University Hospitals NHS Foundation Trust
- James Arvin, Unit4
- Helen Dempsey, Staffordshire and Stoke-on-Trent Integrated Care Board
- Emma Kriehn-Morris (chair), Norfolk and Waveney Integrated Care Board
- Nicky Lloyd, Royal Berkshire NHS Foundation Trust
- Oliver Sullivin, Unit4
- Darren Ward, East of England Ambulance NHS Trust
- Shaun Wayman, South Tyneside and Sunderland NHS Foundation Trust
- Simon Wombwell, transformation consultant

Efficiency opportunities

However, there was agreement that there were opportunities for finance teams to support efficiency improvement, mostly based on analysing data and supporting clinicians and operational teams to revise working practices and pathways.

This brought the conversation on to the use of finance systems and their interaction with other key data systems.

Two main points were raised. How could finance teams find the time to do more analysis and help operational teams understand what

the data was saying and support changes? And what systems did finance teams need to support robust decision-making?

Simon Wombwell, a former trust finance director and now a consultant specialising in transformation and turnaround, said there was a definite question about the potential for new finance or enterprise resource planning systems to support future transformation.

But this would take time. And given the significant challenges facing the NHS right now, he said the key was how the NHS could leverage the systems it already has to drive efficiencies in the short term.

'When I think about areas of waste, I think our current finance systems can definitely help us – whether it be the management accounts system or the procurement system,' he said. 'But we need to think about how we use those systems to engage in the right conversations.'

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He also anticipated a renewed push on service line reporting and using patient-level costing to find efficiencies – and current systems could help with these areas.

However, he suggested the future would be about value-based healthcare and addressing health inequities by moving funds between sectors – out of acute and into mental health, for example. And here he felt current systems were less useful.

'Enterprise resource planning is a great opportunity – linking finance, workforce and other resource information – but my big worry would be where the funding is going to come from to pay for it.'

He added that finance teams needed to understand what potential the new federated data platform offered, given that the system is being procured centrally for the whole service to access.

As a final point, Mr Wombwell added that there would also be pressure on finance departments to downsize. Integrated care boards already face 30% reductions, which are likely to hit all functions, but he suggested the demands would hit providers too.

'We are going to have to be more productive as a finance department,' he said.

This would mean greater use of artificial intelligence and robotic process automation and a move to more real-time reporting. There would need to be fewer people manually producing reports – and those that remained would be engaging in higher value activities and supporting clinicians and budget holders.

Ms Lloyd noted that moving to automated data processing approaches wasn't straightforward. Royal Berkshire had introduced a new finance ledger/procure-to-pay system about 18 months ago.

In theory, this cuts out a lot of manual data entry effort. An optical character recognition process electronically matches received incoming invoices with purchase orders and then notifies the requisitioner to record when the goods or services have been received. However, higher levels of rejections of incoming invoices had occurred with the new system.

'We became aware that our accounts payable team had been carrying out significant manual interventions previously to enable invoices to be matched, especially for non-catalogue

Redeploying resources

Royal Berkshire's Ms Lloyd said there is an overarching intent to promote helping communities to 'stay well', including screening, health checks and early interventions, as well as treating patients when they become ill. Moving resources out of acute trusts had to start with considering re-allocating the time spent by clinical staff towards activities that deliver the mission of the health-promoting hospital.

For elderly care physicians, this might mean moving two programmed activities a week outreaching to nursing homes and GP practices. 'This does not destabilise teams or organisations, which have fixed cost bases, and allows an orderly look at the resources currently being consumed to see how we can actively start to redeploy parts of resources towards a population health approach,' she said.

The left shift needed to be smarter than that. 'We have to look at the resources that are currently being consumed and understand how we can actively redeploy them towards a population health approach,' she said. The attendees agreed that the role of the finance function was to understand the costs of providing healthcare to an individual – but suggested that this could require accountants to develop additional skills with a greater emphasis on health economics.

Staffordshire and Stoke-on-Trent's Ms Dempsey said that there was an understandable focus on productivity at the moment but she was worried the focus was mainly on the acute sector.

'One of the areas we are crying out to get back into is mental health, community and primary care productivity,' she said. One of the issues in understanding productivity in these sectors is less rich data to make the judgement – the lack of payment by results or consistent currencies mean there is a more limited data set.

But she also suggested that this made it difficult to understand the impact of investment or changes in productivity in individual sectors on other parts of the NHS. 'I think that one of the things we've really lost during Covid is programme budgeting,' she said. 'When it was done well it provided really great data.'

She suggested that the data had the potential to show links between sectors – for example how investment in community services could have an impact on the acute sector in terms of reduced referrals – or reduced waiting lists.

'Now, we have vast sources of activity, finance and human resource information, but we don't have smart ways to join it up,' she said. The more general move away from payment by results in the acute sector – ending activity-based contracts had the benefit of reducing the time spent on transactional activities. This potentially created some of the time finance staff needed to support their operational teams.

But she also warned that PBR had produced a lot of data that was useful outside of the contractual process. 'We don't want to lose that intelligence just because we are no longer contracting on that basis,' she said. She had a particular concern that, given the current financial constraints, there might be a temptation to disinvest in business intelligence and financial analysis just at a time when it was most needed.

"We shouldn't get hung up on everyone needing to be on the same data collection system. What is more important is being able to cohort the sort of data you are collecting"
Nicky Lloyd

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orders. So, we have saved huge amounts of time on one level, because we no longer have our team manually keying in invoices or scanning invoices into ledgers,' she said.

'However, we have needed to ensure that budget holders are much more precise at the point they raise a requisition, otherwise transactions may not match automatically.'

Using AI

In terms of management accounts, she observed the benefit of greater automation and use of artificial intelligence (AI) in data processing. 'The more we can use AI getting to 'the what' – what is the financial position? – the more we can add value. By freeing up our skilled people to analyse the 'so what' and advise on the 'what next' to make interventions, we will make ourselves more efficient or reduce our run rate of expenditure.'

James Arvin, public sector director at Unit4, said there were increasing examples of NHS finance teams using bots and AI to automate some of the manual activities undertaken in finance departments – for example, bank reconciliation.

'I think there is a huge opportunity to use some of that new technology and some fairly standard AI tool sets to automate things like invoice processing and those more repetitive tasks,' he said.

'And that might feed the more strategic business partnering that we discussed, for example, and really help to drive efficiencies in the sector.'

There was agreement that organisations and systems could not look at finance data in isolation but needed to be seeing it alongside workforce and activity data to be able to find opportunities to improve services and efficiency. There can be challenges in getting different systems to talk to each other. But Ms Archer said there was no need for NHS bodies to buy an all-singing, all-dancing IT solution.

'We have an Oracle ledger, but we are also already paying for Office 365. So, what we have done is to make use of Power BI [Microsoft's data visualisation platform],' she said. 'Initially this was just to support financial reporting and letting budget holders log in to see their own reports online.'

But the trust has now moved way beyond this to use the software to pull in data from various trust systems including the general ledger, contracting and activity data and workforce information, including bank and agency staff.

It can also pull in stats on drugs usage and additional sessions. In addition, the costing team has built its own platform.

'The point is, we haven't moved away from our old systems,' Ms Archer said. 'It is like throwing all the data in the hopper of a big cloud server and then it spits it out in whatever shape or form you want.'

"When you have all the data on an easy-to-read chart, you can just run your eye over it and see your problem areas"
Katherine Archer

It was far more than a 'big data dump with automated statistical process charts', she added. 'It is using what we already have and it is certainly adding value.'

Ms Archer said the system provided a perfect starting point for expenditure analysis – for example, looking at use of the more expensive bank or agency nurses and what additional sessions were being run.

'When you have all the data on an easy-to-read chart, you can just run your eye over it and see your problem areas. It really helps us to drill down to the problems faster,' she said.

'We are being challenged to move from diagnosis to treatment and having the data in this format enables finance to do the initial diagnosis and then talk to the services about what changes could be made to improve performance.'

The system currently has some 700 budget holders using it and the trust was highly commended for the work in the 2023 HFMA Awards' Delivering Value with Digital Technology category.

Ms Archer said it was a big leap forward from the old spreadsheet reports that used to be sent out to budget holders. The new reports are not bespoke to individual budget holders, but the system is flexible, providing lots of different ways of looking at the data so that clinicians and budget holders can see things quickly.

Ms Lloyd underlined the point that organisations did not need to have the same branded systems to be able to share data across system partners, but could achieve the same result using a data warehouse approach.

'For example, we have a system called Connected Care in Berkshire, which takes patient data from a number of different systems – primary care and acute trusts – and allows clinical colleagues caring for the patient to link and see shared data,' she said.

'So we shouldn't get hung up on everyone needing to be on the same data collection system. What is more important is being able to cohort the sort of data you are collecting together, keeping it secure, and making it available to care givers, so that everyone has a consistent and full patient history, whether in primary or secondary care.'

Shaun Wayman, associate director of finance (financial services) at South Tyneside and Sunderland NHS Foundation Trust, said that, even from a benchmarking point of view, having the same core system across different organisations didn't necessarily mean everything worked together seamlessly.

'We are also using Oracle, provided by NEP,' he said. (NEP is the shared service provider set up to provide a common finance and procurement solution across the North East.)

'But I'm not totally convinced that we get all the potential shared benefit of everybody being involved in that, because we all do things slightly differently. So we never quite get the efficiencies out of the system.

'Equally, we all deal with suppliers differently. So we won't necessarily get the benefits of automation with the supply unless we start building it into the contract.'

Organisations can also be on different systems, which means it is not necessarily straightforward to consolidate data across organisations. 'We tend to have to map things first to get consistency, which is not an ideal use of time,' he added.

Emma Kriehn-Morris, director of commissioning finance at Norfolk and Waveney Integrated Care Board, and the chair of the roundtable, said common systems were

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not really an option across the whole NHS. 'When you think about how many systems we have in place across the UK – different provider systems, commissioner systems and primary care practices too – a single system would be an unrealistic ambition now.'

But she agreed that the challenge was sharing and using systems, not just to gain historical understanding but to support future planning, including efficiency identification and delivery.

Darren Ward, head of financial systems at the East of England Ambulance NHS Trust, said the key was that financial data had to be presented alongside non-financial metrics to add value to budget holder reports. But there were lots of different ways this could be done.

'We use Unit4's ERP and financial planning and analysis (FP&A) systems,' he said. 'We try to capture as much attribute data as we can in our finance ledger. So we capture all of our pay data, our vehicle and our site data – effectively collecting costs in their buckets within the ledger. We then analyse that a lot within the FP&A tool, where we do our budget setting and forecasting.'

However, the trust was looking for the best way to get meaningful reports out to budget holders combining financial and non-financial metrics. It had been looking at Power BI or doing it within the FP&A tool.

With all the trust's operational data pulled into a data lake, Mr Ward underlined that there was no need for a single system – just systems that could talk to each other and offer ways of linking the data together to provide useful reports.

The trust was keen for reports to support efficiency improvement by pulling in patient-level costing data (PLICS), he said. 'So we want to put in cost per activity, cost per patient, cost per vehicle and vehicle utilisation – so we can compare data across counties.

'There will be mitigating factors, but being able to see and measure performance and challenge potential inefficiencies – that is how we can get the best out of the data and the systems.'

Mr Ward added that the ambulance sector was fortunate in having just 10 services covering the whole of England. Although all the trusts reported differently internally, the sector benefited from having a common set of metrics – such as the time spent on scene – which really facilitated benchmarking and provided the opportunity to spot variation and potential areas for improvement.

Oliver Sullivin, Unit4's FP&A global growth director, asked whether organisations were using their various finance reporting systems for scenario analysis and modelling. He worried that too often this type of future planning was done outside of connected systems and undertaken in stand-alone Excel-based analysis, which raised concerns about the robustness of source data. 'Lots of organisations will look at the "how have we done", he said. 'But when it comes to the "what are we going to do" and "what should we be doing", it almost gets completely overlooked.'

Mr Ward said his ambulance trust had built rudimentary ways of modelling 'what ifs' into its FP&A system, using unit-based costings. 'That is mostly for budget setting, but it will also support modelling,' he said.

'So we have things like the pay award, which is just one number enabling us to change it within the system to replicate the effect of the pay award for our entire staff base. And we are looking to do the same for things like fuel consumption – so we can see quickly what impact, say, a 10% increase in fuel consumption would have or the impact of fuel price changes.'

Again, he stressed that currently this was primarily used for budget setting, but it allowed the trust to make other assumptions and see the knock-on effect.

'It is not really activity-based at the minute – it is more unit-cost based, but we could definitely move to an activity basis at some point in the future – the model is capable of doing that.'

But he agreed that keeping this kind of analysis or scenario planning within the system – rather than doing it externally on a spreadsheet – avoided some of the potential errors that could be introduced.

The roundtable also addressed how systems could be used for medium-term financial planning. Mr Wombwell said this was a live topic in South East London. 'The reality is that the acute sector has got to spend less in real terms over the next few years,' he said, underlining his earlier point about the need to invest in areas such as mental health.

'So we need to see some genuine cash-releasing, and finance teams need to be able to work through this with clinical and operational colleagues,' he added.

Helen Dempsey, director of planning at Staffordshire and Stoke-on-Trent Integrated Care Board, said finance reports must be restructured to support the population health agenda. 'Our ledgers are structured to count and not to give us a real insight into what we spend money on and how that money translates into health impacts,' she said.

She noted that data is required across the full patient journey, from primary care to tertiary care and across all types of services including mental health and community services.

"We need to see some genuine cash-releasing, and finance teams need to be able to work through this with clinical and operational colleagues"
Simon Wombwell

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Conclusion

Ms Kriehn-Morris said it was clear that finance had a huge role in supporting the push for efficiencies. Financial systems and data were crucial for this, but financial data was not enough on its own; it had to be looked at alongside performance and outcomes data.

Having brought together the data to tell a story, close engagement between finance professionals and clinicians, and commissioning and operational colleagues, is essential to properly understand what the data means and to identify possible opportunities for improvement.

Finance and other systems on their own are valuable, but they become really value-adding when they can 'talk together' directly or where specific reporting tools can draw data from multiple systems and present it in a flexible way. Rich reporting at an organisation, system or patient-cohort level is essential.

Finance teams need to be aware of the impacts and benefits of having the right systems and data processes in place to support the delivery of efficiencies both in the short term and the longer term. This will not only support efficiencies, but improve services and population health outcomes.

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