Automatic for the finance people

A spreadsheet-based automation tool aims to reduce the time it takes to fill in provider finance returns, freeing up finance staff for value-added tasks. Steve Brown reports

People are attracted to accountancy and working in NHS finance for lots of reasons. But it is fair to say that filling in regular finance returns and submitting them to the centre is not one of them.

NHS providers' provider finance returns (PFRs) may be essential if NHS England is to see how providers are performing against financial plans and to highlight where pressures are emerging – on staffing, for example. But they take considerable time to complete – time that could be better spent on analysis or supporting budget holders and clinical teams to add value to patient care. They are also vulnerable to human error – a lot of damage can be done with a simple cut and paste.

The *Becoming One NHS Finance* report, the output of a conversation with the NHS finance community commissioned by the Finance Leadership Council, made it clear. Finance staff wanted greater use of automation, leaving them with more time to analyse figures and use the data to drive improvement. The PFRs seemed a good place to start.

So this year, the One NHS Finance Finance Innovation Forum has been working with NHS England's returns team to see if this manual burden can be reduced with a simple and shareable Excel-based automated solution.

Edd Berry, director of finance innovation at Manchester University Hospitals NHS Trust and a member of the Finance Innovation Forum, says completing the returns can be a big burden, particularly when there are changes to the template and the data requested each month. For example, this year NHS England has added requests for information about providers' utility costs. The returns resemble a mini set of accounts including details of income, balance sheet and cash flow, with lots of additional detail required on aspects such as staffing and staffing costs.

They are typically made available by working day 1 of each month, with trusts having to make partial submission for their system on working day 6, based on a minimum data set. Then the full submission to NHS England is on working day 11. Some 25 tabs in the workbook require some degree of input – ranging from a few cells to hundreds of elements needing to be completed.

'In a big organisation, there will be a team of people involved in compiling the information. But in a smaller trust, it could be one person doing the whole return,' says Mr Berry.

Half a dozen people are involved for a few days each month in the Manchester trust, he says. The spreadsheets have been aligned with the planning template, so the monthly returns feel familiar, but it's still a lot of work, even when the details being requested haven't changed.

Different requirements

All organisations run different ledgers, which are set up to meet their local needs. For example, a ledger may be programmed to provide data at the level of detail that the board wants to see it, which may be a slightly different view than that required by NHS England.

A trust might identify all its nursing and midwifery costs by agenda for change bands, while NHS England only wants to see the costs split into substantive, bank and agency. Some ledgers may be able to provide this output, others would require a manual intervention.

Once the month-specific workbook is issued, a trust would typically need to convert it into a shared file to enable multiple people to access and work on it at the same time. It is pre-populated with a trust's

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planned figures and with numbers from previous returns; trusts then input their actual year-to-date figures and their full-year forecasts.

There are multiple worksheets. For example, one looks at staff cost detail. 'What you would normally do is pull off a trial balance from the ledger and it would hopefully be summarised at the NHS England category level correctly,' says Mr Berry. 'That can take some checking, especially if someone has created new codes and there is misalignment with the required categories. Then, basically, it is just a case of typing all those figures directly into the return, line by line.'

The problem is that the sheets can be huge. 'It's not a difficult process,' comments Mr Berry, 'it's just time-consuming – and there is a lot of scope for manual error and putting figures in the wrong boxes.'

"It is an automated filling-in process, not an automated submission. It doesn't submit the information without you looking at it first"
Edd Berry

The main benefit of automation, he says, is the time it can save. His trust switched to working day 1 reporting a couple of years ago. The thinking is that the sooner you know your position, the sooner you can do something about it. And, in a similar way, reducing the time spent on transactional processes, such as those involved with filling in the PFRs, frees up people to analyse the data and make decisions.

Rather than taking time to compile data for the centre showing, for example, a big variation against plan, finance staff could be spending their time understanding why there is the variation and putting mitigating actions in place. 'Anything that puts more time back into locally supporting the decision-making is a good thing,' says Mr Berry. 'Feeding the central beast is an essential part of what we do, but we need to do it as efficiently as possible.'

He recognises that some people are nervous about automation, in case they lose control of the numbers being reported. But he believes this is born of a misunderstanding of how automation works. 'You are actually making the system far more reliable,' he says. 'You design and build it and then thoroughly test it until you have an automated process that will always do exactly the same thing. It won't get disturbed when someone interrupts you and it will eliminate human errors.'

The automation process works on the basis of describing a standardised data set in the same way that data sets are produced for outpatient or accident and emergency activity. The idea is that all organisations can set up their ledger systems to output data in a set order. Depending on the ledger, it may be able to output data at the NHS England category summarised level or the trust may need to do a little local mapping.

This list would have three columns – subcode, main code and value – with the codes making it clear that this was, for example, the year-to-date costs for substantive registered nurses. With a list output in this format, all the trust finance manager has to do is cut and paste the long, three-column list into the provided spreadsheet tool and the tool then populates the rest of the workbook.

Use of the tool is completely voluntary. And while it does involve some initial set-up work with the ledger, that only needs to be done once. And trusts don't need to codify everything straightaway. They might start just with the income and expenditure and continue to do the balance sheet and cash manually. Or they might just start with staffing costs and then gradually improve their automation.

Steve Hubbard, deputy director of financial reporting at NHS England, says trusts do need to put a small amount of time into the tool up front. 'It will take perhaps four to five hours to set up,' he says. 'You have to invest that time. But then you have something that will save time on a monthly basis.' Feedback from NHS providers suggests that the tool is saving as much as five hours work each month.

But it has other benefits. Some trusts have reported that using the tool has prompted a wider review of the efficiency of their reporting processes. 'It can make everyone's process leaner,' says Mr Hubbard. 'And that can open up other doors.'

Claire Ridgway, senior financial reporting lead at NHS England, says there is a small increased admin burden for the central team. But this is minor compared with the benefit, even for an individual trust, and is incurred just once, rather than in every NHS provider finance team. She adds that the tool was designed by practitioners in frontline finance teams and then built by NHS England.

The tool did not start from scratch, but drew on existing local solutions already in use across a wide-ranging user group. However, she says that some local automation solutions still resulted in an Excel spreadsheet with data that needed to be copied over to the formal returns. The new tool takes the automation a step further.

Take-up rate

Up to 20% of NHS providers have started to use the tool to some extent and NHS England is keen to encourage other organisations to follow. It insists the sole motivation is to reduce the burden on finance practitioners. 'We've built the tool, but it has been designed by the service. In particular, it should help smaller providers to make their process more efficient and to free up their time,' says Ms Ridgway.

Mr Hubbard adds that the whole returns team has worked in frontline finance roles and has experience of the returns process. 'There is some benefit to NHS England,' he admits. 'If we've created more time for trust finance teams, the product we receive should have fewer queries or problems,' he says.

Back in Manchester, Mr Berry agrees that reducing the burden of form-filling should allow more time for checking figures before submissions. In the manual process, about 80% of the time is taken up actually filling in the return, he says, leaving just 20% of the time for checking. Automation should flip those numbers on their head.

'The point is that it is an automated filling-in process, not an automated submission,' says Mr Berry. 'It doesn't submit the information without you looking at it first. So, you can look for any variations or surprise changes.'

There is a clear direction of travel towards earlier financial reporting. Several organisations have moved towards adopting working day 1 reporting and more are showing interest. A recent One NHS Finance webinar on the topic attracted more than 150 delegates. It also seems likely that system working and reporting will push organisations to harmonise their reporting practices across systems. Systems are unlikely to want some organisations reporting the most recent month's figures while others are quoting the previous month or have reporting dictated by the slowest in the system.

Automating the PFR process clearly aligns with this move to faster reporting. But there are no current plans to bring the PFR timetable forward. For Mr Berry, the automation tool is a no-brainer. 'People manually typing in figures, and potentially not getting it right, is not adding value,' he says. 'The bit that adds value is the analysis of what the figures are saying.'

And the tool frees up finance managers up to do exactly that.

Integrating care: policy, principles and practice for places

Dr Eleanor Roy, CIPFA Health and Social Care Manager

Health and care integration is not a new phenomenon but has been a constant and significant policy theme for many years.

Over time, integration has moved from specific pilots and programmes, through voluntary partnerships with no formal accountabilities. The *Health and Care Act 2022* (the Act) put integrated care systems (ICSs) on a statutory footing, and provides a legislative framework that moves away from competition in the NHS and aims to better support collaboration and partnership working.

There has also been a widening of the scope of what integration is trying to achieve. From closer integration within the NHS and between the NHS and social care to a broader view including the wider determinants of health and wellbeing, to positively impact on population health with a focus on prevention and reducing health inequalities. This is reflected in the 'triple aim' in the Act.

While the Act established integrated care boards (ICBs) and integrated care partnerships (ICPs) on a statutory basis, it made no provision for local level: the place-based partnerships where health and care organisations, with understanding of their local area, come together to deliver services and solutions for residents.

In February 2022, the government published '*Health and social care integration: joining up care for people, places and populations*' which recognised place as the engine for delivery and reform and the need for formal place-based arrangements. However, it raised many challenges, including outcomes, accountability and finance at the level of place. These are key components of good public financial management, and critical elements for effective collaboration across organisations with such different systems and cultures.

CIPFA believes that for integration to be a success, a whole systems approach to public financial management is essential. This means understanding that outcomes can be improved by working across organisational boundaries, recognising the inter-dependence of services and the greater impact they can have through closer collaboration while working towards a shared vision.

Our recent publication, '*Integrating care: policy, principles and practice for places*,' aims to support such an approach. It provides an overview of the changes as a result of the Act and what integration is seeking to achieve. It considers the wider health and care landscape in the current climate and addresses the remaining challenges at place level. The publication, and the recommendations and case studies it contains, are intended to influence the development of further policy and guidance by central government, and to provide support for practitioners working at the local level.

To learn more: visit cipfa.org/services/integrating-care

Importance of place, partners and prevention

- The renewed focus on integration presents a new opportunity for partners across the health and care sector to work differently. Taking a place-based approach focused on the wider determinants of health and wellbeing, with an emphasis on prevention, could make a huge contribution to achieving the aims of integration and improving population health.
- Local government, both upper and lower tier councils, have a vital role to play in integrating health and care. They hold many of the levers that are key to influencing the social determinants of health and wellbeing, as well as a deep understanding of the places and neighbourhoods they serve.
- Achieving the vision for integrating health and care requires long-term commitment and certainty of funding. A twin-track approach is necessary to ensure that health and care services can deal with immediate pressures, as well as making the long-term preventative investments to ensure services are sustainable for future generations.

Importance of a whole systems, outcomes-based approach

- A whole system, outcomes-based approach can highlight interdependencies between services and help foster a common vision and shared understanding between partners. Good public financial management requires making evidence-based decisions on the allocation of public money to outcomes and provide value for the public pound in place.
- Against the backdrop of wider policy reforms and huge pressures on the NHS and local government, a national outcomes framework could provide a single, coherent set of shared priorities across health and care. This should allow for autonomy with an emphasis on local priorities reflecting national outcomes – not national prescription driving local activity.

Importance of public financial management – putting the principles in place

- Governance, accountability and finance are key components of good PFM. Taking a one-size fits all approach to governance or focusing on pooling budgets alone does not account for the huger variation between places and their local circumstances.
- A principles-based framework for place that incorporates robust governance, accountability and finance arrangements would provide flexibility to allow for adaptation as places mature and evolve. Such a framework should be for local determination and aligned to the 'national ask.'
- Bringing together services to improve population health needs to be supported by long-term planning and removal of the barriers that prevent closer alignment of services. The finance profession is a critical enabler of closer integration, supporting long-term planning and closer alignment of services – enabling resources to move freely and empowering change.

A focus on place is vital if we are to make the most of the opportunities that integration provides and deliver the changes that will ultimately benefit the service user. The issues around integration are significant, but not insurmountable. CIPFA stands ready to support and empower local government and its NHS partners to find solutions to the financial, governance and place-based challenges around integration.

CIPFA's '*Integrating care: policy, principles and practice for places*' is available as a free download on the CIPFA website.