Standard setters

Standardised finance systems could improve the quality of financial reporting across the NHS. Delegates at an HFMA roundtable, supported by NHS Shared Business Services, agreed that the time is right to make a change. Steve Brown reports

The Getting It Right First Time (GIRFT) programme has been addressing unwarranted variation in clinical care for years. Finance managers at a recent HFMA roundtable called for the same focus on standardisation to now be applied to NHS finance departments, systems and processes. And they identified the move to integrated care system working as the perfect opportunity to put this ambition into practice.

NHS finance is subject to some standardisation. Financial accounting standards mean there should be limited variation in year-end financial reporting. And clinical commissioning groups all used a common integrated single financial environment (ISFE) until they were abolished in July. This provided them with a common accounting platform with a single chart of accounts – and their successor integrated care boards continue using the same model.

However, outside the commissioning sector, NHS providers use a range of different systems and charts of account, often arguing that a unique local context demands flexibility that cannot be provided by common systems.

Attendees at the roundtable, held ahead of July's system start date, challenged this view and argued that the benefits of greater standardisation outweighed the downsides and challenges of implementation.

The roundtable was supported by NHS Shared Business Services, a joint venture between the Department of Health and Social Care and Sopra Steria. NHS SBS has delivered the ISFE since its inception in 2013 and will continue to do so until at least 2024. Arrangements beyond this date currently depend on a tender process.

The roundtable's first job was to agree what it meant by standardisation. Simon Currie, director of financial planning and delivery at NHS England, got the ball rolling. 'From a national perspective, when we collect data, it is really important that everybody interprets that in the same way,' he said. This wasn't always the case. 'This is about some basic aspects of our reporting – quite basic definitions of how we categorise things and how we add them together. But it also gets into some of the cleverer things that we might do, such as model hospital and NHS Rightcare.

'The more we can do in terms of having everybody report the same things in the same way, the better,' he said.

He recognised that the NHS was not 'one size fits all'. 'It is about striking a balance between people having the flexibility to do things differently locally because they face different circumstances and doing things differently just because that is the way they've always been done.'

HFMA ROUND TABLE

Adrian Snarr, then NHS England director of financial control, said the validity of local variation should be challenged. 'What we tend to do is to work with that local variation and then try to standardise it at a regional or national level, instead of going back to the root and standardising it at an organisational level,' he said.

'We've had a fixed chart of accounts for commissioners and, through lots of pain, we haven't flexed it. CCGs constantly came to us asking us to change the chart of accounts locally, but it doesn't work if you do that.'

Commissioning edge

This enabled the centre to get a good, consolidated position for the commissioning sector in a way that can't be produced across the provider sector because of the lack of standardisation. 'That really pays dividends in terms of consistency of reporting,' he said.

He encouraged providers to see the bigger picture as systems started to look at the possibility of system-wide standardisation.

At the time of the roundtable, Norfolk and Waveney Integrated Care

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System was exploring the potential for standardisation of systems and reporting across all its component organisations.

Norfolk and Norwich University Hospitals NHS Foundation Trust deputy finance director Stephen Beeson said the aim was to drive efficiency and value. 'We do lots of things where we spend time trying to make it work and fit together so that we can report in a way that is useful,' he said. 'If we have got good systems, automation and standardised ways of doing and capturing things, then we should be able to use groupings and other mechanisms to do the individual bespoke bits of reporting that we need to do at a local level, while still being able to meet national requirements.

'So I don't see them as independent issues,' he added. 'It is very much about the sophistication of the business intelligence process that fits on the front end.'

Providers are often protective about their own chart of accounts, arguing that they need their own unique coding structure to be able to report accurately and manage their activities. But Mr Beeson rejected this. 'We need to be a bit more mature about accepting that sometimes things won't be perfect,' he said. 'If we have something that has a reasonable categorisation that allows us to compare locally and across our system regionally, it will help drive efficiency. It will make sure that all the GIRFT and benchmarking actually don't lead us to dead-ends.'

Wider benefits

Organisations spending time defending their data and the specific way they counted it did not contribute to delivering transformational change, Mr Beeson said. Norfolk's new standardised approach is expected to go live in October and he said there was agreement that it would deliver wider benefits.

Robert Forster, chief finance officer and deputy chief executive of Liverpool University Hospitals NHS Foundation Trust, has recently overseen the merger of two finance teams and ledgers as part of a major trust merger. Chairing the roundtable, he said Mr Beeson's comments would ring true across most organisations. 'The amount of time sometimes spent on proving that something doesn't mean what it actually says is surely wasted,' he said.

Some organisational barriers need to come down in favour of working as a single NHS, according to Stephen Sutcliffe, chief finance officer of NHS SBS. 'Are we spending time adding value to clinicians and patients and improving the use of taxpayers' money? Or are we spending a lot of time just moving the deckchairs about?' he asked.

He also challenged the view of standardisation as a compromise on quality. 'It is often seen as a route to the bottom and a negative concept,' he said. 'But I genuinely believe that standardisation is about best practice. You standardise at the best level and then help everybody to move up to that.'

He agreed that the chart of accounts question was something that could be addressed, especially given the power of technology and new reporting solutions. However, he said that while standardisation in general made a lot of sense, there would still be the need for flexibility to accommodate nuances in organisational type and specific circumstances. 'About 80%-90% is common to the whole NHS. We've not quite got the balance right at the moment,' he said. 'It feels more 50:50 than it does 80:20.'

Portsmouth Hospitals University NHS Trust has recently been through a process of challenging established working practices when it moved to working day one reporting in April 2021. While clearly a technical process, this was in fact more of a cultural challenge – with the finance team having to become more comfortable with a slightly higher level of assumptions.

Participants

- Stephen Beeson, Norfolk and Norwich University Hospitals NHS FT
- Simon Currie, NHS England
- Gerard Enright, Leeds and York Partnership NHS FT
- Rob Forster (chair), Liverpool University Hospitals NHS FT
- Kevin Nederpel, Portsmouth Hospitals University NHS Trust
- Chris Plant, Herefordshire and Worcestershire CCG
- Adrian Snarr, NHS England
- Stephen Sutcliffe, NHS Shared Business Services

> **"The amount of time sometimes spent on proving that something doesn't mean what it actually says is surely wasted"**
> **Rob Forster, Liverpool University Hospitals NHS FT**

Kevin Nederpel, the trust's deputy director of finance, was one part of the team overseeing the changes. He told the roundtable that there was an argument for just getting on with the standardisation process.

'The chart of accounts is a really basic thing to get right,' he said. 'But it is the hierarchy that sits above it that is almost as important. I find that I'm having conversations in my own team about which hierarchy is being used to service different audiences – fundamentally the underlying data is the same.'

But while this might be viewed as 'flexibility', in reality it involved the finance teams validating the numbers rather than acting on the intelligence. So, he suggested that a common chart of accounts should be a relatively easy hurdle to clear, with the business intelligence software that sits on top of it being the key to extracting information to support the management of the organisation.

'Fundamentally, the chart of accounts only provides information on what you have spent rather than why and what the drivers are. All provider organisations have moved beyond reporting on the chart of accounts when providing analysis to the organisation.'

He added that getting everyone reporting the same thing in the same way was vital to understanding broader variation.

'We talk about triangulation – about finance, activity and workforce,' he said. 'But we need to get this right for finance and be seen to have mastered it if we then want to ask clinicians and others to do the same thing for activity and workforce.' There was a feeling that standardisation should also move beyond finance to rostering and staff systems, given the level of spend on workforce.

Mr Forster agreed that the business intelligence side of things was important. 'It feels like we don't always make the most of the data we have,' he said. 'There is a big drive in my organisation towards making data count and the use of statistical process control charts to identify unwarranted variation. I'm not sure finance is at the front of the curve on that, despite banging the drum loudly for our colleagues to address it in their areas.'

Inevitable change

NHS providers may have resisted standardisation in financial systems, but there are forces that are likely to push them more in this direction. The movement of software providers to cloud-based solutions and the provision of software as a service (SAAS) is a good example. Under SAAS, software is accessed online via a subscription, rather than being bought and installed on individual computers.

Mr Beeson said the industry's move to SAAS and the NHS adoption of it were inevitable. 'Pretending we can do it another way is probably quite naïve,' he said. 'We simply need to accept it and move on.'

Mr Snarr agreed this was the clear direction of travel and the NHS could not swim against the tide for finance or other core systems. 'The ability to customise those cloud-based platforms is severely limited, so by default we will have to get used to a level of standardisation,' he said.

The reward would be potentially having the whole NHS on a 'near identical platform'. And he reinforced the importance of business intelligence solutions outside of the core system to slice the data in ways needed for local management. 'I think it might give us the opportunity to drive standardisation,' said Mr Snarr, 'but also offer the bespoke functionality around reporting. So you'll get the best of both worlds.'

Mr Sutcliffe said that maintenance and support for existing non-cloud legacy systems would also be reduced or withdrawn. 'But with SAAS, you'll get regular updates, as you do with Apple software, for example,' he said. 'There are benefits the large enterprise resource planning providers bring, such as Oracle and SAP. They can deliver continual improvements in functionality month by month, quarter by quarter. So, we shouldn't see it as a constraint.'

An additional benefit would be that standard technology should encourage standard processes. Mr Sutcliffe said this would help finance professionals to move more easily between organisations, reducing familiarisation times and training requirements when people take on new jobs.

Mr Nederpel said NHS organisations should ask themselves why they weren't using the same solutions as commercial organisations for core activities such as general ledgers, accounts payable and accounts receivable. This would allow them to focus on areas where the NHS is genuinely different – patient-level costing and capital accounting, say. 'Standard practice and standardisation of how you process invoices and report the general ledger should be fairly easy,' he suggested.

Convince or compel?

Mr Forster asked whether the move to greater standardisation should be achieved by convincing or compelling people. Despite general encouragement to increase the use of technology and standardise the accounts set-up, there had been minimal response.

However, he recognised finance teams were under a lot of pressure to deliver other priorities. And cost and the time needed to implement more standardised systems were both legitimate considerations.

Mr Snarr pointed out that a mandated system was in place for commissioners. 'We've discussed at various points throughout the past years as to whether we should mandate it for providers,' he said. 'But we've always decided against it for two reasons. First, there is the foundation trust regime, so you can't mandate it for them. And mandating doesn't tend to get the right buy-in.'

He suggested a cultural mind shift was needed to do some of this work, and ordering people to do it doesn't start from the right place. He again highlighted the work in Norfolk and Waveney as a template for greater standardisation at system level. 'I suspect they didn't all start in the same place but they've quite quickly developed a consensus,' he added.

HFMA ROUND TABLE

With partner organisations thinking through what system working really entails, Mr Snarr suggested that system mandation might not be necessary – they could work it out for themselves.

However, he accepted there was a danger that the NHS would end up with 42 different systems doing something different rather than a standardised approach across the whole service.

Gerard Enright, financial controller at Leeds and York Partnership NHS Foundation Trust, agreed that the messaging was very important. 'It is about getting everybody to commit to standardisation or to using the same tools,' he said. 'Using terminology like "mandating" just sends the wrong message.

'It's a balancing act. Perhaps getting standardisation at ICS level is a good first step.' He added that Norfolk and Waveney's experience and feedback later in the year could help others to follow their lead.

Chris Plant, deputy chief finance officer at Herefordshire and Worcestershire Clinical Commissioning Group, said that before July's move to system working, there had been benefits to using a mandated

chart of accounts across all commissioners. 'We merged CCGs about two years ago and it made the process a lot easier, because obviously we were all starting from the same base,' he said. 'There were slight nuances, where things were done slightly differently, but on the whole, everything aligned – so standardisation across commissioners did make things easier.'

Consolidated reporting

Mr Plant said the system had also been thinking through how consolidated reports could be produced across all partner organisations. Commissioners had been used to creating a 'non-ISFE' report, with soft intelligence and narrative added to the figures. An early ICS reporting tool had looked to bring this together with provider finance returns.

It had not been without its difficulties. With commissioners reporting by working day 7 and providers working to day 11, the consolidation meant bringing provider reporting forward. 'This was a mandated approach, but it caused real problems in some of our providers because their internal systems weren't set up to do that,' he said. 'So there are issues that we could hit upon along that journey.'

Mr Nederpel said moving the reporting day shouldn't be a barrier. While earlier reporting required work and preparation, the systems themselves weren't an obstacle – it was more of a mindset change that was needed.

Mr Beeson said that it was important not to get 'hung up' on systems in initial discussions. In Norfolk and Waveney, the starting point was on the principle of a standardised approach. The upfront focus had been on the basic chart of accounts and ensuring the business intelligence systems were capable of doing the integrated care board reporting, even if the system did end up aligning to the same system and transactional services delivery.

He said there should also be recognition that some organisations were operating legacy systems and did not pay very much for them. So, change would come at a cost for some.

Mr Currie said cost concerns had also had an impact on the development of a reporting structure for ICBs and changes to the reporting cycle. The reality is that systems are in different positions in terms of their ability to deliver consolidated information across providers and commissioners. So a balance has had to be struck that falls short of what some systems are capable of delivering.

Suggestions to bring forward reporting deadlines, building on the move by some organisations to working day 1 reporting, were also met with concerns from some trusts that this would involve significant investment, which is difficult in the current climate.

HFMA ROUND TABLE

Mr Currie echoed earlier concerns that in the absence of a higher bar for unified financial reporting by systems, 42 different approaches could emerge.

'Then we'd end up in a place that isn't vastly different to where we are now, but in some ways even more entrenched because it's all devised at system level,' he said. He also rejected mandating a standard system at the outset. But he suggested that once most systems had moved to a standard approach, mandation might have a role in getting the final few organisations on board.

Mr Enright called for clarity to be provided to the finance community about why changes were being made, whether they were to reporting deadlines or standardisation of what is reported. 'We need to keep an eye on what we are trying to achieve,' he said, adding that budget holders and users of information should be on board as much as the finance team making the changes.

"Standardisation is about best practice. You standardise at the best level and then help everybody to move up to that"
Stephen Sutcliffe, NHS SBS

However, the roundtable agreed that the move to system working provided a unique window to make progress with standardisation.

'I hope we haven't missed the boat,' said Mr Nederpel, 'because this is the perfect opportunity to take this forward.'

However, he said it wouldn't happen automatically and finance leaders must champion the required changes in their own systems.

There was recognition that the finance function, like the rest of the NHS workforce, was exhausted after two years of the pandemic. Nevertheless, the service would benefit from a clearly stated goal of delivering standardisation – even if this was over a number of years – and a road map of how to get there.

In summary, Mr Forster acknowledged that there would be a range of views on standardisation around the country, but the roundtable participants were unanimous in backing the ambition.

He repeated that there was in any case an inevitability about it, with the move towards the delivery of software as a service. A common chart of accounts could be a first step, with recognition that business intelligence software was how organisations actually produced information for management and system reporting.

Mr Forster highlighted broad agreement that mandating greater standardisation was unlikely to produce the right level of buy-in. And overall he said there was an opportunity, with the introduction of new integrated care systems for the service to make a one-time change that delivered better foundations in terms of financial reporting.

While there was a recognition that finance teams were already under pressure, there was also a need for the finance profession to take a lead role in this agenda. Not only is it key to introducing new financial systems and processes, it also needs to set an example for other disciplines where the elimination of variation is also needed.

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