HFMA briefing
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Obstacles and opportunities

A write up of a roundtable held in May 2023 on the productivity and efficiency challenge

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Introduction

Fáilte go Dún Éideann - welcome to Edinburgh: this was the venue for a roundtable discussion held in May with Scotland's national and regional finance leaders together with HFMA trustees from the other three home nations. The candid and open discussion sought to explore the realities of improving productivity and efficiency in light of a 25.6% drop at the end of 2020/21 as set out by the Office for National Statistics, the most recent period available.

Stark in scale, the ONS assessment reflects the first full year of the pandemic and includes centrally incurred costs like test and trace and personal protective equipment. The figure also takes account of labour cost increases (5%), a drop in output of 7.6% and an increase in goods and services costs of 24.2%. Future assessments will undoubtedly show an improving picture.

To frame the discussion, participants drew on the Health Foundation's 2021 publication *Five things we learned from our work on NHS productivity*[1]. With both obstacles and opportunities for improving productivity and efficiency in mind, contributions were collected around workforce and skills optimisation, digitalisation of service delivery and preventative and population health management. The capacity and capability to implement change, particularly the skills finance professionals would need, was also covered.

The session started with opening remarks from Richard McCallum, director of health finance and governance, the Scottish Government and Robert White, chair of the roundtable and former NAO director of health value for money audit. Richard welcomed a discussion covering both health and social care, especially as Scotland is looking at productivity and efficiency alongside its preparations for a National Care Service. The challenges are familiar ones and don't start and stop in acute hospitals nor are they confined to the boundaries of the NHS. This makes the system challenges for improving productivity and efficiency wider and overcoming these could be helped through an improvement in the quality of data, a necessary ingredient for integrating services. Not uncommonly, acute hospital data quality is better than that found in community, primary and social care services. A key driver for the National Care Service is to improve lines of accountability across the system to the benefit the population of Scotland.

Naturally, in any improvement endeavour, there are obstacles to overcome:

- Workforce – there are immediate challenges associated with current pay discussions, both in terms of service implications and costs associated. Beyond this however, Scotland has proportionately more staff and higher pay and, notwithstanding recruitment and retention challenges, these factors will naturally play into this debate.
- Revenue versus capital – there is a natural focus on revenue trends, but capital investment must be considered for its long-term benefits. This is fundamental to support the shape of future service models and should avoid an overly strong focus on replacing the current estate. Certainly, there are advances to be made in diagnostics such as faster/ more accurate MRI scans, but investment needs to be prioritised and the benefits measurable.
- Culture – a shared endeavour is needed for improving productivity, but it must be realistic and leaders need to be buoyed up. A 3% cash releasing efficiency saving is challenging given 2% in the past felt difficult. How do you gear up for that and avoid a sense that it is too difficult? If it is perceived as too high, the task can feel regressive. What is clear is that new approaches to productivity and efficiency are needed. The finance function has an important role to help make this work in conjunction with chief executives, medical directors and clinical and managerial leaders.

Robert White noted that 'productivity' and 'efficiency' are often interchangeable terms. Productivity measures feature heavily when describing overall sector performance and particularly in central government funding settlements. In turn, HM Treasury uses these measures to determine what level of efficiency the NHS should be capable of. 'The NHS can be more productive' is often said, but that national message is rarely expressed in a way that is meaningful to clinicians, management teams and those charged with planning and paying for care. As we know, national funding settlements

[1] Health Foundation, *Five things we learned from our work on NHS productivity*, October 2021

inform efficiency targets and they in turn inform cost improvement programmes, transformation schemes, and technical and allocative spending decisions. Locally, this is where the rubber hits the ground and however unpalatable, is in a language people understand.

The Office for National Statistics (ONS) is the official source of public service productivity[2] statistics. There are other bodies that publish healthcare productivity including the University of York's Centre for Health Economics, The Productivity Institute and the Economic and Social Research Council. Although there is variation in methods and timeframes, by all measures the 2020/21 drop in productivity is unprecedented.

In England, productivity challenges continue as set out in NHS England's finance and performance reports. The forecast of the position (and now outturn) for 2022/23, always showed compliance with the NHS financial settlement with the real pressure evident in meeting targets for cancer services, electives, A&E, ambulances, diagnostics and discharges. The growth in waiting times contributed to the UK's fall to fourth place in the Commonwealth Fund's *Mirror, mirror 2021: reflecting poorly*[3] down from first in 2017[4]. The situation within social care, both domiciliary and residential, is just as challenging and together with the NHS, paints a familiar picture in all four nations. For the national finance leaders in each system, it is understandable that defending a rise in staff numbers, increasing expenditure, falling output and missed targets is far from easy. Care is needed when comparing efficiency planning figures in 2023/24, but nevertheless, a range across the four nations of 2.2% to 3.5% exists potentially extending to 10%. This is a challenging ask and one that should in theory, benefit from getting activity back on track within available resources.

The principal pressures, challenges and barriers affecting efficiency and productivity

Whether it is serving a rural geography or having a hospital that is unable to meet demand, delivering services in Scotland carries unique challenges.

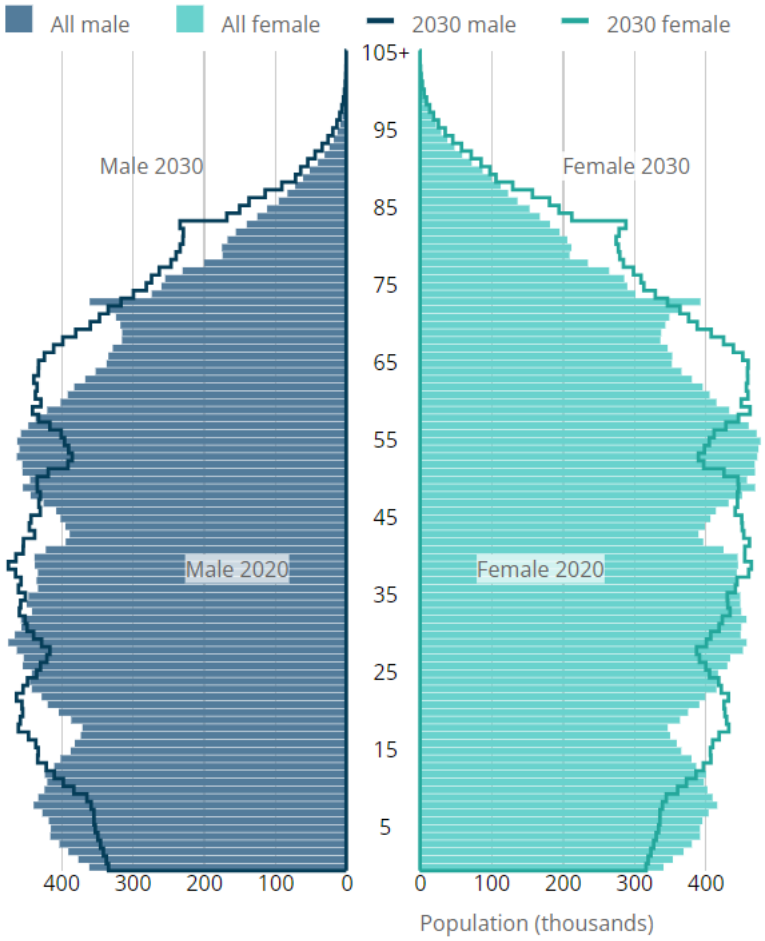
> *'Serving a rural geography presents its own challenges in service delivery and staffing, especially one with an aging workforce population'*
>
> *Andrew Bone, director of finance, NHS Borders*

Getting fixated on the size and scale of the problem can get in the way of addressing it, especially when faced with a shrinking working-age population, limited access to capital monies and an aging and inefficient estate. We have become used to the shape of a standard age chart for the UK (Chart 1), but in parts of Scotland this is shaped like a mushroom, the situation not being helped by a workforce that gravitates towards Glasgow and Edinburgh.

The 32 integrated boards in Scotland have delegated responsibility for local authority social care. Making this effective is frustrated by acute operational pressures and an inability to release capacity. Regional areas can learn from one another's strategic plans with good examples of delayed discharges in Aberdeen and hospital at home schemes offering solutions. There are also options available to address workforce shortages by looking at clinical models, for example, the enhanced use of community link workers in each of the GP practices.

[2] The Office for National Statistics, *Public service productivity, healthcare, England: financial year ending 2021*, March 2023
[3] The Commonwealth Fund, *Mirror, mirror 2021: reflecting poorly*, August 2021
[4] The Commonwealth Fund, *Mirror, mirror 2017*

Chart 1: Estimated and projected age structure of the UK population, mid 2020 and mid 2030[5]



Source: The Office for National Statistics

Covid-19 altered many things including underlying expenditure trends as conversations focused on safety and quality with less regard for the money. Now, the finance voice needs to be clear that 'this is the resource available, so we must look at the opportunities for productivity'. Roundtable attendees highlighted the need for action rather than further analysis of the size of the problem.

'At times, there is a depth of analysis that frustrates change leading to "paralysis by analysis"'

Wendy Thompson, director of finance and estates, HSC South Eastern Health and Social Care Trust, Northern Ireland

Unlocking technology to make stepped changes is required, but the case for change must have more scrutiny. Productivity opportunities are often pursued without a more critical assessment of the benefits, for example, robotic surgery. More should be done to put options in front of decision makers and politicians and to be braver when it comes to change.

All agreed that aging buildings and workforce recruitment and retention are major barriers to improved efficiency. Local politics can also make changes difficult for reasons beyond the improvement of service delivery. In Northern Ireland for example, separate entities are making small changes, but they are doing so in the absence of an overarching plan. This does not address the risk of service collapse despite individual organisations making the best of things. The country has unique challenges as there is no formal commissioner in place. Grip and financial control is needed back

[5] The Office for National Statistics, *National population projections: 2020-based interim*, December 2023

within the system and reports by the Northern Ireland Fiscal Council[6] back this up, highlighting the workforce shortages and efficiency challenges. Social care staff, in particular, are difficult to recruit when people are paid more with less stress in other parts of the economy. There needs to be a proper career structure in order to alleviate hospitals getting clogged up, particularly emergency departments.

'Although there are integrated health and care trusts in Northern Ireland, it doesn't remove the challenges'

Owen Harkin, HFMA past president and deputy CEO, HSC Northern Health and Social Care Trust, Northern Ireland

When it comes to falling output, more is known about acute activity than primary care and community owing to limited data. The big issues are not unique to Covid-19. For example, urgent care pressures, 'no criteria to reside' bed days, quality, grip and control as well as additional staff payments. This raises the question of 'how much can be recovered and over what timeframe'?. Some solutions and their business cases, for example virtual wards, are not demonstrating value at 50% occupancy nor is the investment standing up to scrutiny. Better data metrics across systems will help address this, provided that day to day pressures do not get in the way of developing them. Whatever the efficiency and savings plans are, clinicians need to be engaged and management teams mindful of the load and burnout experienced by staff. Looking longer term, the answer may lie in more investment in preventative initiatives.

Opportunities in workforce and skills optimisation

Richard McCallum pointed to the significant work undertaken regarding future workforce projections, but he highlighted the challenge of a model of continued growth when there is working age population stagnation. The current modelling assumes a higher proportion of the population working in health and social care and this will inevitably lead to sustainability challenges in the future.

An increase in career grade staffing roles could help along with expanding multidisciplinary teams to support integrated care together with specialist roles and technical roles. This may start to reverse the trend in social care staff being enticed to work in hospitals. It was noted that there is interesting work going on in Scotland around career grade professions for unregistered staff and multi-disciplinary teams. This moves towards innovation with benefits that won't cost more and which provides better care. At present the production line for specialist and technical roles is not there and this dial won't shift without involvement from universities and other education providers. Scotland's workforce plan is not expressed in this level of detail, but we can learn now from opportunities for adapted workforce models such as those observed during consultant cover for junior doctor strikes. Does medical sub-specialisation need to be increased or could service provision be replicated in other ways? To optimise the work of a stretched nursing workforce, one option is to provide relief from the burden of administrative duties through introducing support staff.

Understanding the impact on the workforce from the past few years is important. It has been severe and having any large efficiency programme requires a change of language. Working with staff to reduce 'waste' is far more engaging than programmes design to 'cut budgets' or 'save money'. Behaviours should focus on human capital investment as happiness and wellbeing can translate into improved productivity. New approaches can work as young people's attitudes change leading to shifting models of care. For example, face to face versus video/telephone calls and patient initiated follow-ups are also showing promise. Standardising bank rates will help as will altering roles, particularly within medical grades. As it stands, current practices have a built-in level of inefficiency. The junior doctor strike showed an interesting reduction in admissions and more discharges. Nurses with extended skills were stepping up.

'Clearly junior doctors are the consultant workforce of the future, but roles need looking at as the training does not always feel like it is as aligned to service need as it once was'

[6] Northern Ireland Fiscal Council, *The NIO's 2022/23 budget for Northern Ireland: an assessment*, March 2023

Dawn Scrafield, chief finance officer, Mid and South Essex NHS Foundation Trust

The junior doctor contract entails less rotation time on site and better worklife balance, but feedback from the strike should be captured.

'With the current medicalised models, new extended roles for emergency nurse practitioners could help along with more flexible working patterns'

Scott Urquhart, director of finance, Forth Valley Health Board

Participants agreed that public and staff expectations are changing and networked care offers efficiency opportunities rather than the current linear pathways. Pathways for conditions such as frailty will have better links with primary care if they are planned in an integrated way so that specialist opinions are drawn in only when needed. This is the essence of value-based healthcare with further opportunities for GPs looking at high risk complex patients and ways of avoiding inappropriate hospital admissions.

'Workforce planning must be done on an integrated basis as too much is currently done in silos'

Dr Kavita Gnanaolivu, Chair – HFMA Wales

Digital technologies, integration and shared care records

Our lives are dominated by app based solutions, but where are the digital opportunities in health? Are there examples of shared care records transforming care delivery, self-managed care and reducing duplication and inefficiency? These are big questions deserving of more time, but knowing where you are starting from is important.

Scotland is not unique in undertaking a digital maturity assessment within the NHS to determine progress and set out aims.

'*A historical lack of investment in NHS digital infrastructure creates challenges and a potential unattainable financial spend to get to the level of "cutting edge"'*

Alex Stephen, director of finance, Grampian Health Board

E-referrals offer efficiency opportunities, but you need the right culture and behaviours to make it work. For example, everyone must engage with the technology and not use support staff to circumvent the benefits through workarounds. Proven care models should be supported by digital technology, rather than digitising inefficient pathways. Innovation gains made during the pandemic shouldn't be lost through reverting to previous cultural practices. Investing in digital solutions is fine, but training must be improved to avoid only a fraction of the number of people who know how to use it. Greater collaboration on procurement will help by avoiding bespoke tailoring that influences cost. Although the health boards are regionally based, digital processes offer opportunities to access care remotely and across borders. For example, if a video consultation is effective for a specific condition, access could be widened. It was accepted that for a country the size of Scotland, systems procurement across the various boards ought not to result in a wide variety of core systems.

Digital solutions must be comprehensive to avoid duplicate processes. For example, transformation schemes where new care models sit alongside existing ones in some cases leading patients to receive results and advice by phone and also being asked to attend. Moving to a single health and social care record system in Northern Ireland will bring improvement and giving patients control and personal responsibility, for example booking their own follow-up appointments, can yield benefits. These solutions will succeed based on the ease with which they can be used by patients and staff.

Preventative efforts and population health management enjoys comparatively lower investment and yet is cited as high priority for improving outcomes and avoiding costs. Participants were asked where investing in prevention featured in their thinking.

'Population health management is cited as a way to improve health and outcomes, but interventions offered by healthcare services only account for around 20% of outcomes with the balance linked to other factors such as housing, access to employment and the environment'

Ana Vercosa, Public Health Scotland

A holistic approach is required as seen in public health interventions on smoking and alcohol pricing. The link between obesity and diabetes is a good example of where further inroads could be made in prevention and chronic disease management. The challenge for accountants and those promoting investment, is that even after three to five years when benefits would be felt, the time horizon may be too short to incentivise investment. There is a role for finance staff in measuring whether staff deployment in areas of prevention are proportionate and if preventative strategies overlap sensibly with other plans. For example, are place-based health and wellbeing plans in- synch with population health management?

There was consensus on the importance of prevention and public health leading to suggestions of protecting more public health spending. This should offer longer term benefits as will increasing patient education. The efficiency challenge will be helped by being clear about when a patient needs to see a doctor versus an alternative health professional. The same can be said for ensuring end of life care is delivered in an appropriate palliative care setting.

'Education and engagement with the public should be a feature of population health management'

Beth Grieve, Scottish Government Health and Social Care Directorates

It was suggested that public health interventions could benefit from the introduction of a 'prevention expenditure limit'. This would be similar to the revenue and capital expenditure limits already in place in England and would restrict how funds destined for prevention are spent. Reforms in England through the introduction of integrated care systems and service integration in the other nations ought to bring more focus on the wider determinants of ill health, for example, housing, education, employment and the environment.

Leadership, improvement capacity, change skills and culture

Finance professionals can make an active contribution to change by accessing the right data and ensuring a less transactional approach in their assessment and presentation. Business cases, for example, need to be presented and managed through to implementation, rather than stopping at the point of approval. Clinical staff must support innovation within business cases through promoting new ways of delivery as any change can't be led by finance staff alone, others need to grasp that agenda, including ownership of the benefits realisation.

Finance staff are skilled at tracking variation, but the challenge is then what to do about it. A new skill set is needed by finance staff in all of the organisations comprising an integrated system.

There's an opportunity for finance staff to enthusiastically push post project evaluation and what measures are brought in to support this. This will take time, aided by a review of the number of projects finance staff are involved in which, at times, can feel like too many.

For the capability of the finance function to develop and grow, we must understand what the skills gap is at present. More can be done to create and access real time data, develop predictive models and then focus on engagement. This will significantly help in delivering best value. Understanding the role of finance professionals within new initiatives such as NHS England's single national approach to continuous improvement[7] is a must.

[7] NHS England, *NHS delivery and continuous improvement review: findings and recommendations*, April 2023

Summary

The roundtable participants set an ambitious task in covering such a wide set of issues in the time available, but the session was not designed to identify short term fixes. The post-pandemic period requires new and innovative analysis and change management skills which the NHS finance function can bring in order to maximise impact. Successful change is dependent on the enthusiasm of people as well as having a focus on outcomes and being clear at the outset how success will be measured. The emerging themes were clear and are all with the grasp of finance professionals:

- quantifying and measuring the benefits of new models of workforce
- improving data quality to understand how value based healthcare opportunities can be presented and pursued
- ensuring business cases stand up to scrutiny, have reliable measures and are seen through to post project evaluation for accountability and learning
- working with others to capture and quantify the benefits of medium and longer term strategies around preventative and public health interventions
- developing financial and economic cases for tackling the wider determinants of ill-health.

The roundtable was well timed as it described in outline the change of direction and approaches covered in more detail at an HFMA event[8].

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- Richard McCallum
- Dawn Scrafield
- Wendy Thompson
- Claire Wilson
- Scott Urquhart
- Ana Vercosa
- Alex Stephen.

[8] HFMA event, *Financial sustainability: strength in numbers across the four nations*, May 2023

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For over 70 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.

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.

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