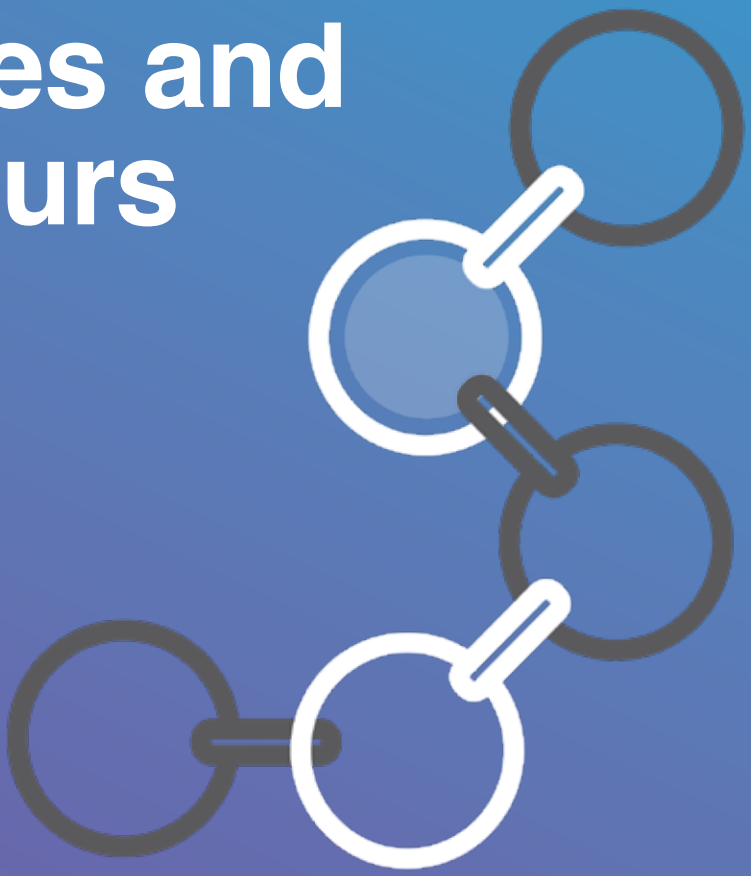
HFMA briefing
November 2021

Supporting system working through finance: principles and behaviours



NEWTON

Contents

Introduction 3

Background 3

System financial framework principles 4

System behaviours 5

System stories 6

- Integrated care in Humber Coast and Vale ICS 6
- Lessons from Mid and South Essex ICS 7
- Capital prioritisation in Nottingham and Nottinghamshire ICS 8

Conclusion 9

Introduction

The shift from competition to collaboration in the NHS aims to deliver better outcomes across the whole heath and care system. However, while significant time and energy is being focused on the changing NHS architecture to facilitate this, attention on ensuring the right underlying culture and behaviours are in place is essential.

HFMA and Newton together explored the key principles of a system financial framework and the behaviours needed to make it work, starting with a roundtable in May 2021[1].

Based on the roundtable discussion and subsequent interviews, this briefing sets out the key principles and behaviours required for effective system working. It also shares stories from across integrated care systems (ICSs).

"There is widespread support for the move to integrated care systems and a more collaborative approach to healthcare and improving the health of the population. But the simple creation of new organisations and structures won't deliver the desired outcomes. Instead, it will need a set of behaviours across health and partner organisations and a financial framework that encourages this partnership approach rather than acting against it."

HFMA and Newton, Supporting system working through finance roundtable, May 2021[1]

It is true that 'no one size fits all for an ICS', yet sharing experiences provides a valuable source of learning.

Further stories will be added as system working continues to develop. If you are grappling with a system working approach, this short briefing is intended to be a helpful starting point.

Background

The move to ICSs 'will play a critical role in aligning action between partners to achieve their shared purpose: to improve outcomes and tackle inequalities, to enhance productivity and make best use of resources and to strengthen local communities'.[2] Once the *Health and Care Bill*[3] is enacted, it will bring into effect the proposals for ICSs set out in the white paper *Working together to improve health and social care for all*[4].

Legislation, including the duty to co-operate, is an important enabler to change. However, making this a reality relies on having the right workforce, culture, leadership and incentives.

During the Covid-19 pandemic, the usual NHS financial regime has been paused and much simplified payment mechanisms and contracts have been put in place. As the NHS returns from working within a block contract mindset and develops frameworks for the new NHS architecture, there is the opportunity to design a new financial regime that supports integrated care and system working.

Building on the HFMA's *The future NHS financial regime in England: recommendations*[5] and *Developing system finance and governance arrangements: key considerations for 2021/22*[6], the HFMA and Newton invited those working in ICSs to a roundtable focused on supporting system working through finance[1]. Two key questions were considered:

- What principles and mechanisms should be the basis of a successful financial regime?
- What behaviours are needed to make effective system working a reality?

The key principles and behaviours identified are explored in this briefing.

1 HFMA and Newton, *The missing link*, June 2021

2 NHS England and NHS Improvement, *Integrated care systems: design framework*, June 2021, summarised in HFMA, *Summary of integrated care systems: design framework*, June 2021

3 UK Parliament, *Health and Care Bill*, July 2021, summarised in HFMA, *Summary of the Health and Care Bill*, July 2021

4 Department of Health and Social Care, *Working together to improve health and social care for all*, February 2021, summarised in HFMA, *Summary of integration and innovation: working together to improve health and social care for all*, February 2021

5 HFMA, *The future NHS financial regime in England: recommendations*, December 2020

6 HFMA, *Developing system finance and governance arrangements: key considerations for 2021/22*, March 2021

System financial framework principles

Big questions remain around what the financial regime will look like, and what arrangements are needed to make system working a reality. Systems vary across England, based on size, geography and demography. This means different ICSs will need to take different approaches to integrating care, yet the financial framework needs to support each approach. There are a number of key principles that must form the foundation for a system finance framework, as set out below.

1. Strategy first

The system strategy should come first, supported by the financial framework. Joint ownership of agreed system objectives should form the basis for decision-making and be used to dictate the way finances flow rather than vice versa.

Money should then be allocated to organisations based on agreed system objectives, rather than trying to retrospectively move money around to meet system needs. This also has the benefit of reducing unnecessary transactional costs. This approach could enable funding to be allocated to support the workforce to work across organisational boundaries more easily or could support the allocation of resources to address prevention needs. Good financial management of the agreed financial flows then becomes a strong tool in ensuring outcomes are delivered and system objectives are met.

Using this approach will also allow systems to incentivise empowerment of place, which is where most integration of services will be delivered across wider health and social care. This will differ across ICSs – there must be flexibility for local systems to make this work based on local knowledge.

2. Keep it simple

There must be complete clarity about resources available for the system. Simplicity in financial arrangements will make them easier for everyone to understand, avoid funds being accounted for several times and aid transparency. For many, there has been a clear benefit in moving away from payment by results and enabling the focus to be on the system pound. Overcomplicated payment regimes, often with many templates to complete, require time and resource to manage, and reduce capacity to focus on delivering outcomes. A simple approach allows everyone to understand each other's risks better and for them to be managed across the system.

> "I've worked with different finance systems and it can sometimes be like pushing water uphill. You often have to put lots of effort into working around the system rather than the system working for you."
>
> *Ric Whalley, Newton*

3. System incentives

Any financial framework needs to incentivise system behaviour and performance. Locally a clear and agreed system of holding people to account is needed. At a national level, oversight should focus on rewarding excellent performance and supporting improvement. System oversight needs to focus on overall system performance and the wider benefits of decisions made. Increasingly one partner from the system will 'lose' to enable a greater system 'win'. There needs to be a mechanism in the financial framework where actions to support the system potentially to the detriment of a single organisation are encouraged and appropriately incentivised.

4. System costs not income

Decision-making has to be based on the costs of delivering care and improving outcomes, not the income that is attracted. To do this systems will need a shared understanding of system costs and resources. An understanding of fixed and variable costs allows for modelling which can inform system decisions. Service line reporting at a system level can support this understanding. In some cases, ICSs are developing a system 'budget book' setting out resources by service line and aligning accountability to services rather than organisations.[7]

5. Longer term planning

The financial framework must encourage organisations and systems to plan and take decisions for the longer term. This allows consideration of benefits that need a longer timeframe to be realised – particularly key as fundamental service transformation is made. The annual focus on allocations work against this. With the current backlog to address too, long-term planning and short-term firefighting is hard to balance. Mirroring the local government medium-term financial strategy process would be a step in the right direction. Each system will need to be clear on:

- What does the current service look like? (A)
- What do we want the service to look like, centred around the person? (B)
- What is the operational roadmap to get from A to B?
- How can the money follow this path?

[7] HFMA, webinar – *ICS stories: Mid and South Essex service line approach*, November 2021

System behaviours

Whatever financial framework is in place, without all the system partners exhibiting the right behaviours, it will fail. A shared vision, trust and transparency are pre-requisites for any arrangements. The key behaviours that must be in place across systems if the new structures are to achieve their goals are set out below.

1. System leadership

System leadership is crucial in setting the culture from the top and throughout NHS bodies. It is important to recognise that the NHS has been working in a competitive manner for a number of years.

The leadership approach needs to enable all – boards, operational teams and support services – to move to a more collaborative partnership approach.

Finance professionals can be ambassadors for a collaborative approach, bringing together both individuals and information to support trust between partners.

2. Mindset and language

Culture is key to ensuring that the move from clinical commissioning groups (CCGs) to integrated care boards (ICBs) is not a simple shift to a larger commissioning unit. Putting the system first is as much a mindset as the byproduct of payment systems and oversight mechanisms.

It requires trust, transparency and a commitment to partnership working. Applying a system first approach to all decisions needs to be the starting point. Training and time for conversations are key tools in ensuring individuals are able to think beyond the impact on their individual organisation, focusing on enabling the right care at the right time and in the right place.

Language can strongly influence conversations, both positively and negatively. Some language has strong connotations to old ways of working, such as providers and commissioning, and the terminology used can differ between sectors, leading to the potential for misunderstanding and confusion.

3. Cross-sector working

Behaviours need to encourage greater cross-sector working. It is easy to allow silo behaviours to become the norm but this will have a negative impact on effective system working.

All parties need to be clear on how they can engage with each other to ensure they feel they are able to contribute to a common system purpose. This is not easy with so many parties to involve – patients, mental health, community, acute, primary care, public health, social care, ambulance trusts, voluntary sector, private sector, non-executive directors and lay members and more. The key is to have clear channels of communication and not to avoid difficult, yet constructive, conversations.

4. Focus on population health

Collaborative behaviours are much easier if there is a clear and common goal. Focusing on population health and addressing health inequalities is both a system priority and a topic that can bring people together. If you talk about the outcomes for your area and how best to spend each pound to achieve this, it engages all parties.

5. System action

Actions speak louder than words. Over recent years, there has been a lot of work to build relationships across systems. For many, now is the time that difficult decisions need to be made in the interests of the population and system, rather than in the interests of individual organisations.

Systems need to be prepared to take decisions that require people to act differently than in the past and demonstrate to each other that they will actually put the system first. This needs to start with open conversations that turn into decisions that are put into practice.

For many, the best way to achieve this is to break things down into manageable projects and agree an initial focus, rather than trying to do everything at once.

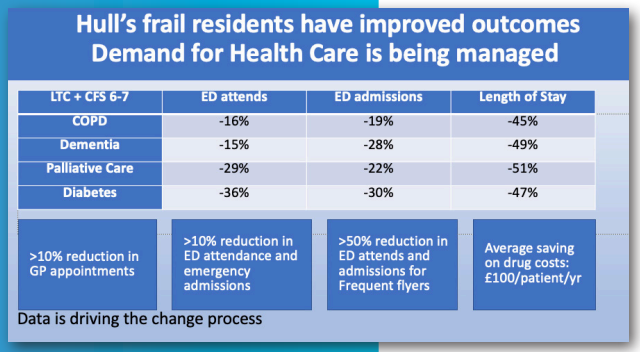
System stories

The following stories, shared from ICSs across the country, show just how important these system principles and behaviours are to effective system working. We will continue to share experiences from ICSs as a valuable source of inspiration and learning. If you would like to share your ICS story, please get in touch at **policy@hfma.org.uk**

ICS stories: integrated care in Humber Coast and Vale ICS

Context
Working collaboratively, clinical leaders, the CCG and health and social care providers have delivered a new and award-winning anticipatory and responsive community frailty model, including the opening of the Jean Bishop Integrated Care Centre. This has resulted in a sustained and significant reduction in unnecessary emergency admissions, ED attendances, drug costs and length of stay, as well as 'patients, their families and carers, saying the care they've received has changed their lives'. The improved outcomes are pictured below.

Before this, services were being commissioned and delivered across a number of organisations with an overwhelming level of duplication and a clear need to join all the different elements up for patients. This required thinking as one system rather than as individual organisations. The starting point was working with clinical leaders to create a clear vision of the goal, providing a clear and compelling rationale through which to engage executive teams across all organisations.



Challenges
Emma Sayner (pictured top), chief finance officer, and Lesley Windass (below), head of transformation at Hull CCG emphasised that this was not easy. As Lesley said: 'It was a great leap of faith – I knew we were doing the right thing but I was nervous about whether we were really going to get the results.'

The sheer number of people involved created challenges. The financial side of the development was the simple part and the project required little additional funding but did require using the existing workforce differently. The particular hurdles were in integrating ways of working; the care records and most importantly the workforce.

Critical success factors
- Leadership – dedicated to the delivery of the shared vision, resilient and with credibility
- Relationships – mutual respect for different professions/code of practice/legislation/roles and responsibilities
- Trust – systems, processes, sharing information, each other
- Involve and include everyone – many professions, several organisations, one team
- Stop thinking organisations and think people
- Create a shared purpose and goals that meets principles of health and social care
- Be brave, be involved, be confident
- Honest, transparent communication at all levels, make sure everyone is heard
- Start with small steps build on success before expanding
- Embrace digital solutions

What's next
This is seen as only the start and something that can be replicated across many service areas. The move to statutory ICSs, with its system-wide approach to resource allocation, supports the culture that has developed in setting up the integrated care centre within the Humber, Coast and Vale ICS.

For more detail, watch the webinar here – ICS stories: integrated care in Humber, Coast and Vale ICS

ICS stories: lessons from Mid and South Essex ICS

By Dawn Scrafield, Chief Financial Officer, Mid and South Essex NHS FT

Context

Across Essex, we give thousands of people great care every day. But in 2019, we identified people sometimes finding themselves with the wrong kind of support. To understand the scale of the challenge, we conducted a system-wide diagnostic, which involved reviewing 340 cases and 2,147 beds with 95 practitioners. This identified specific opportunities for us to work better as a system to deliver improved outcomes for our residents. We found:

- An opportunity to improve outcomes for 44% of older people supported by social services
- 28% of acute hospital admissions could be avoided for older people
- Only 27% of older people go home from a temporary placement
- An opportunity to improve outcomes and achieve savings of £21m-£26m per year for the system.

As a result, and alongside Newton, we initiated the Connect programme to transform care for older adults and ensure they get the best ongoing care in the best setting. Ultimately, the programme has been about health and care partners across Essex moving from working in quite a fragmented way to joining up care and making Essex a great place to grow old.

The programme has comprised five interrelated projects all focused on achieving better outcomes for older adults in Essex – identified at system-level and delivered at place-level. These are: admission avoidance; making discharge outcomes more independent; improving community hospital bed flow; increasing the efficiency and effectiveness of reablement; and supporting independence by improving long-term care assessments and decisions.

Challenges

As to be expected on such a complex programme, we have faced many challenges along the way. One of the greatest challenges has been getting the transparency and visibility of data, and then bringing it to life as management and operational information. However, by overcoming this as a system, we now have a very rich evidence base to inform our conversations, rather than relying on emotions or anecdotes.

This approach has been a key enabler of the whole programme – it meant we could align on a shared vision with a focus on delivering outcomes, agnostic of any system partners' goals. It also underpins how we articulate the system benefit for any change made. As we have continued through the work, this use of data has also enabled us to drive continuous improvement – we are now clearer on our performance and can pinpoint the areas we need to address to achieve measurable impact.

The other, unsurprising, challenge has been the impact of Covid-19. We had not long started the scoping of the programme when Covid hit. However, we were able to take the opportunity to understand how we might accelerate the findings from the diagnostic. This has particularly been the case for the community workstreams, which have benefited from an evidence base pre-, during and post-Covid. The evidence base has also helped equip us better to face some of the current domiciliary care market challenges, which we wouldn't have been able to do before.

What's next

While we are still delivering the Connect programme, I am proud of its impact and the tangible improvements it has made. The drive in our Urgent Community Response Team – which has seen referrals increase twofold – will leave a legacy for the system about how we work with different partners. In addition we have seen:

- Community flow improving clarity of patient next steps to reduce length of stay by 4.3 days per patient, allowing us to close a 24-bed ward.
- Discharge outcomes have introduced early identification and multi-disciplinary working to support a 20% reduction in placements to bedded settings post-discharge from acute.
- Supporting independence work has aligned social work teams to primary care network footprints, with new ways of working helping 25% of people be supported more independently.
- New ways of working with ECL (reablement provider) in the south west Essex pilot has shown a 20% reduction in length of stay and a 20% increase in effectiveness, lowering onward demand for care. These ways of working are currently being scaled up county-wide.

There is always more work to do around integration and system working but I see Connect being with us for many years to come, and really becoming the blueprint for how we develop future programmes across the system – such as our financial sustainability programme.

Furthermore, because Connect has improved the level of skills and capabilities across the system – for example, we have a much more structured approach to measuring benefits and reviewing actions and improvements – we can apply this to other programmes of work.

In addition to the improved outcomes we have achieved for our residents, and the financial benefits we have seen, more importantly we have proved that we are stronger together as a system rather than as individual organisations. I am proud of the strong and lasting relationships we have formed with one another, while, despite the significant challenges, having some fun along the way.

My advice for other systems is to find like-minded colleagues across the system. Finding people to lead the way who have passion and commitment is much more important than job titles!

- **To hear more about Connect see: https://youtu.be/YdRObqqdBvk**
- **Join Newton and Dawn at the HFMA Annual Conference at 12.45 on 7 December – click here for details.**

ICS stories: capital prioritisation in Nottingham and Nottinghamshire ICS

Context

For the past two years, Nottingham and Nottinghamshire Integrated Care System (ICS) has been working on a system-led capital planning approach. Within the ICS, particularly focused on the three acute provider trusts (Sherwood Forest Hospitals NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust and Nottingham University Hospitals NHS Trust), there are a number of substantial and varied estate challenges. The ICS has been working on how to prioritise these needs within a constrained capital envelope.

Overall capital funds are allocated to the ICS. The ICS estates strategy forms the basis for allocations to individual programmes. In a nutshell, the ICS estates strategy is to fully utilise existing estate; rationalise poor-quality estate; and invest in additional capacity where required to improve service provision. Initially, the aim was to use a bottom-up approach to prioritisation with plans on a page developed for a chief executive-led review process with the following critical success factors:

- Strategic fit
- Patient/staff safety quality and experience
- VFM (financial and non-financial benefits)
- Deliverability

However, it was established that this approach was impractical in comparing schemes across organisations and type of spend – for example, digital v estate v equipment. Instead, the ICS agreed organisational splits based on the funding formula and local priorities, with finance directors coming together to decide how funding would be allocated between them.

Marcus Pratt (pictured top), programme director at Nottingham and Nottinghamshire ICS, and Dominic Thornton (right), deputy director of finance at Nottingham University Hospitals NHS Trust, shared their thoughts on the challenges and lessons learnt.

Challenges

One of the key challenges faced was how to establish mechanisms to objectively compare capital schemes for prioritisation. This makes a whole programme bottom-up prioritisation an impossible ask. Marcus said one of the key lessons learnt was that in addressing challenges, 'we need to go down the route of mature conversations, good relationships and understanding where we need to get to as a system and make sure we are addressing critical issues first.'

As well as the overall capital limit being a challenge, other challenges include cash availability; lack of a multi-year settlement; and slippage exacerbated by material and labour shortages.

Critical success factors

Marcus and Dominic agree that good relationships and trust are the key. Everyone needs to know that all are coming to the conversation with the goal to achieve the best for the patient and utilise resources in the best way, with no organisational protectionist thinking. Because of the groundwork and good relationships, the ICS has been able to have the necessary challenging conversations in prioritising its capital.

Another critical success factor has been clear and transparent reporting of capital expenditure. The ICS uses a capital database shared across the system enabling conversations such as what slippage might be used for.

What's next

Building on the work to date, the ICS aims to develop three- to five-year capital plans as a basis to pursue funds. These should include a wider understanding of ICS capital and estates such as local authority and primary care estate risks and issues. It would also like to establish a better link with estates plans at a place level to feed into the overall ICS capital plan.

For more detail, watch the webinar here – ICS stories: Capital prioritisation in Nottingham and Nottinghamshire ICS

Watch out for further upcoming webinars in the ICS stories series[8].

[8] All HFMA webinars have CPD accredited status with the CPD Standards Office. Delegates who attend will receive an accredited CPD Certificate of Attendance

Conclusion

As the NHS emerges from the Covid-19 pandemic amidst a significant activity backlog, workforce shortages and ongoing financial constraints, it is clear that the challenges will continue for some time.

To rise to these challenges, the NHS will need to build on the transformation plans developed and ensure that the benefits arising from system working are delivered.

All parties involved want to do the right thing for the patient. It can often seem difficult within existing arrangements, but there are opportunities to do things differently.

As explored in this briefing, and brought to life with stories from across ICSs, there are key principles and behaviours that need to be in place to make this happen, in particular ensuring that the money simply and transparently follows the agreed system strategy.

Acknowledgements

This briefing was written by Lisa Robertson, policy and research manager, HFMA and Rosanne Furniss, director, Newton. With thanks to:

- Malcolm Ace, Hampshire Hospitals NHS Foundation Trust
- Karen King, Bath and North East Somerset CCG
- Robert Holcombe, Aneurin Bevan University Health Board
- Marcus Pratt, Nottingham and Nottinghamshire Integrated Care System
- Kathy Roe, Tameside Metropolitan Borough Council and Tameside and Glossup CCG
- Su Rollason, University Hospitals Coventry and Warwickshire NHS Trust
- Chris Sands, Derbyshire Community Health Services NHS Foundation Trust
- Emma Sayner, Hull CCG
- Dawn Scrafield, Mid and South Essex NHS Foundation Trust
- Dominic Thornton, Nottingham University Hospitals NHS Trust
- Jonathan Webb, West Yorkshire and Harrogate ICS
- Lesley Windass, Hull CCG
- Ric Whalley, Newton
- Claire Yarwood, Manchester Health and Care Commissioning
- HFMA's System Finance Special Interest Group

The CPD Standards Office
CPD PROVIDER: 50137
2020-2022
www.cpdstandards.com

Accredited cpd Activity

About Newton

Newton supports health organisations and health and social care systems to redesign ways of working and implement measurable and sustainable change which is better for people, better for staff and delivers real financial benefit. It specialises in tackling highly complex challenges, by designing and implementing the operational, digital and people-centred change that needs to happen to solve them.

Newton's clients value it for its ability to embed sustainable change by working from the ground up – uncovering the root causes of the trickiest problems, supporting leadership to act on this information and working as part of their frontline teams to deliver real change.

It has worked with more than 100 public sector organisations, including several of the largest health and social care systems, delivering in excess of £300m annualised savings. In addition to the Essex programme outlined in this briefing, it has also worked alongside the Birmingham health and social care system on the Early Intervention Programme. You can find out more about the programme here: https://www.livehealthylivehappy.org.uk/early-intervention/

www.newtoneurope.com

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.

HFMA

1 Temple Way, Bristol BS2 0BU

T 0117 929 4789
E info@hfma.org.uk

Healthcare Financial Management Association (HFMA) is a registered charity in England and Wales, no 1114463 and Scotland, no SCO41994.
HFMA is also a limited company registered in England and Wales, no 5787972. Registered office: 110 Rochester Row, Victoria, London SW1P 1JP

HEA.FIN.067 03/17

www.hfma.org.uk