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Future Focused Finance

National Inquiry Into Innovation

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Contents

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Section 1: Future Focused Finance National Inquiry Into Innovation

Introduction

This inquiry commissioned by NHS Future Focused Finance, 'Great Place to Work' workstream, sought to investigate the cultural opportunities and barriers to innovation in Finance professionals, and the role NHS Finance can and could play in leading and generating innovation within the finance function, and across organisations and systems.

The aims of the study were to:

1. Generate clarity within the finance community of what constitutes innovation, and determine a language that the function can comfortably engage with.

2. Understand the nature of innovation in finance and how/ if that differs from other professional groups.

3. Identify what it takes for finance leaders to innovate individually as well as organisationally. Specifically, what cultural issues are a feature across the whole of the NHS and what issues are particular to finance in terms of generation and spread of innovation?

4. Identify what is needed in order for NHS finance teams to become more innovative, and whether the need varies depending on the nature of the organisation (commissioner/ provider; large/small).

The Inquiry generated intelligence on the culture of innovation in the NHS, the contextual constraints on innovation, the range of innovations being generated by finance leaders, and the requirements for innovation across the NHS in the future.

The Context for Innovation in Finance

Long-term sustainability of the NHS depends upon innovation. The Five Year Forward View[1] forecasts a funding gap of £30 billion, the solution to which depends on new ideas and practices through innovation within six areas: models of care delivery; leadership; modern workforce; information revolution; efficiency and productive investment; and technical and scientific health innovation. The finance function in the NHS has a relationship with each of these areas.

Innovation refers not only to technical innovation through the bench to bedside development of drugs and devices; but also to social innovation – creative ways of working and communicating, cooperating and collaborating to generate social value

(Jiang and Thagard, 2013)[2]. Social innovation seeks to meet societal challenges, that for the NHS requires innovation in the interplay between health, the causalities of poor health and inequalities, through new ways of organising; and is characterised by a high-degree of complexity (Vinals and Rodriguez, 2013)[3]. The Forward View mentions (in the context of finance) 'innovations such as prime contracting and/or delegated capitated budgets' (p23), but social innovation goes beyond structural changes to changing the relationships between citizens, providers, commissioners and policy makers, and the finance function has a role to play here. It is the interdependence between professionals, managers and citizens that is the foundation for innovations to meet the current population health challenges, and this is going to require a focus on 'place' and communities (NGLN and Collaborate 2016)[4], generating capacity in communities to create health (Caroll and Kelly 2015)[5]. It is this context of systems innovation, that this Inquiry takes place.

The Background for this Inquiry

There were a number of observations and assumptions that generated this inquiry from the work to date by NHS Future Focused Finance:

1. There is enthusiasm for innovation.

   In the NHS Future Focused Finance engagement exercises across the country, of over 1000 people, there was a great deal of enthusiasm to look at 'encouraging individual innovation'.

2. It appears that in those teams that are great places to work, there is opportunity to innovate.

   Reviewing the 'Great Place to Work' NHS finance team assessments, it appeared that there was a correlation between those teams which scored well and the individuals who reported that they felt able to innovate and their ideas were valued and included.

3. The culture of NHS Finance does not naturally align with being comfortable in declaring itself to be 'innovative' or 'best', but is very open to sharing 'good practice'

   Finance is perceived as risk averse and there is a cultural norm of not sharing innovation until it is rigorously proved to be effective.

4. There is the potential for innovation in Finance.

   There are more and more opportunities to innovate in finance, and the future NHS depends on finance leaders generating a culture of innovation.

This paints a picture of NHS Finance as a 'contained' leader of innovation, constrained by perceptions of its role and potential, where there are signs of finance innovators working in great teams breaking out of their silos to partner with other disciplines to secure better services for citizens.

The Inquiry sought to build on the engagement work in NHS Future Focused Finance, taking an appreciative approach to investigate where there is innovation led by or catalysed by finance leaders, to understand the conditions that generated this innovation culture.

Method

A brief review of the existing literature (Section 2) in relation to NHS finance and innovation was undertaken to generate evidence to inform the aims of the study, and then to elicit evidence-based statements and themes where further evidence was required, that were tested in the inquiry through the interview process.

We approached Finance teams across England and Wales that were known for innovative practice, frequently because they had won awards, to participate in the Inquiry. This method reflected one of the major aims of the Inquiry: to highlight successful work already existing in the system, and to discover emergent approaches to innovation.

Seven sets of witnesses[a] were interviewed using a semi-structured appreciative model, beginning with a request for a story of successful innovation led by the NHS finance function, followed by questions that had arisen from the literature review, by an expert panel of at least four people. Each session lasted approximately 1 hour and was recorded and transcribed. Panel members read two or more transcripts, one in which they were present and another one or more in which they were not.

Panel members drew out major themes and quotes, linking them to the framework of questions above. They convened for a half-day sense-making workshop to synthesise the themes and identify main messages.

a A larger number was scheduled for interview but there was some attrition in numbers.

Summary of Results

The results against the requirements were as follows:

1. *Generate clarity within the finance community of what constitutes innovation, and determine a language that the function can comfortably engage with.*

   Innovation is 'new to here'[9] not 'brand new' (invention). Although the inquiry focused on the term 'innovation', some of our witnesses declared that it was not a word that they often used. Their mental models or tropes were based around motivation, e.g. "the art of making people bothered" or around habitual structures, e.g. vision, infrastructure, people (VIP). What mattered was that any innovation achieved results and generated value.

2. *Understand the nature of innovation in finance and how/ if that differs from other professional groups.*

   Finance has the potential to have an in-depth understanding of every part of the health system/ organisation, which gives it a unique role in seeing the 'whole' of the system, and has the further potential to generate new insights into those factors that cause difficulties, or areas where attention could be focused to make a significant difference in services.

   There are two ways Finance can generate innovation:

   a) Through resourcing headspace (providing time, processes, people, funding), and the testing of ideas in action.

   b) Through providing data and intelligence to teams to disrupt the status quo and generate ambition for a better future, supporting development and innovation for new ways of working, to generate social value.

   It is the latter which is a growing area for NHS Finance teams.

3. *Identify what it takes for finance leaders to innovate individually as well as organisationally. Specifically, what cultural issues are a feature across the whole of the NHS and what issues are particular to finance in terms of generation and spread of innovation.*

   Securing innovation requires the finance function to:

   - Work at pace and be ambitious – being relevant to the immediate issues of variation facing the service, and committed to a better future.
   - Generate metrics to support inquiry and innovation processes bringing finance, business intelligence and IT together.
   - Generate readiness to change between functions using its insights into the whole organisation/ system.

- Be in-service to colleague professionals' work, securing better relationships between professionals, being active participants with other professionals and citizens.
- Ensure the appropriate balance and interplay between innovation and performance management for change.
- Tackle unwarranted variation.
- Have a deep understanding of the capabilities in the organisation and develop strategic resources within the organisation.
- Be focused as much on the long term as the short term so the organisation/ system can adapt.
- Ensure that innovation adds value, and that this isn't overshadowed by processes to secure assurance.
- Secure structural innovation in funding and payment mechanisms.
- Develop a wider understanding within colleague leaders of risk and how to manage risk.

The inquiry surfaced a number of cultural issues which were features of the wider health system:

- The politicised nature of the NHS generating a culture of risk aversion
- The role of the centre in enabling and being in service to local change, with a more nuanced relationship between fire fighting and innovation/planning for the future; and in balancing measures to control versus headroom to change.
- The need to look outside the boundaries of the organisation (both locally and nationally) for ideas and to share and learn collaboratively

The conditions for innovation across the whole of the NHS that are no different in the finance function:

- Innovation as the day job.
- Outward looking, open to learning from others and to share learning.
- Clarity of purpose and ambition, and not being distracted away from this – particularly at the top of the organisation/ system.
- Diversifying views – bringing in a wider set of views into any problem/issue.
- Openness and transparency between partners (in clinical teams, between directorates, between organisations, between the centre and the field).
- Fail in order to learn.
- Demonstrating impact and value.
- Focus on the longer term as well as the short term.

4. *Identify what is needed in order for NHS finance teams to become more innovative, and whether the need varies depending on the nature of the organisation (commissioner/ provider; large/small).*

The inquiry didn't generate enough data to distinguish any difference between organisational forms. However there were some key developments required in finance:

a) Ability to work as a facilitator of change across the whole rather than an authoritative ambassador.

b) Ability to work in service to clinical improvements and innovation.

c) Securing the combined capacity of finance, business intelligence and information technology to support innovation.

d) Ability to work at pace to provide real-time data for business function, improvement and innovation.

Recommendations

Whilst this report was primarily to generate insight into the finance role in innovation a number of key issues emerged which we recommend the finance community address.

Data and Intelligence

1. Ensure teams (clinical, operational and MDT) have access to data and intelligence to support innovation and improvement across the patient's journey, and access to support for making sense of that data.

2. Support the development of metrics for innovation and improvement, bringing intelligence on value into teams.

3. Bring business intelligence, information technology and finance together in service to securing real-time data for innovation across all functions in the organisation. Inject pace into the availability of data so that decisions can be effective.

4. Use data to ask questions of teams that ignite their ambition and interest in change.

5. Manage the data demands of performance management, to ensure there is room for innovation.

Skills and development

1. Develop in-depth understanding of the functions within the organization and system, and insight into the intended and unintended consequences of change in any part.

2. Develop understanding of 'readiness to change' and support the conditions for this across the organization and system.

3. Develop skills in facilitation of change across the system.

4. Provide development for other disciplines in the nature of and management of risk

Focus

1. Bring intelligence from the finance team's exposure to every function within the organization and system into organization/system change programmes and strategy, working with other discipline specific leaders.

2. Focus as much on the long term as the short term.

3. Ensure that innovation adds value, and that this isn't overshadowed by processes to secure assurance.

Resources

1. Generate commitment to the headroom required for innovation through (a) team reviews (b) providing intelligence/ data to enable review.

2. Generate an understanding of the resources in the organization (people, intelligence).

3. Secure structural innovation in funding and payment mechanisms (e.g. tariff) to support clinical and systems innovation.

Relationships

1. Be active partners with clinicians and citizens, working in service to the clinically facing work of the organization and system.

2. Seek common goals to promote risk-sharing at commissioner/provider interface.

3. Identify champions of innovation vertically through the hierarchy who will motivate and celebrate success.

Inquiry Interview Findings

Using an appreciative stance participants were asked to describe their innovative practice (see Appendix 1 for detailed question schedule), drawing out the features that helped or got in the way. They gave their interpretation of the term 'innovation' and considered what was distinctive about finance.

Innovation

Innovation is any change in practice or behavior which is "new to here" (Rogers 2003)[9].

> *"Innovation is just being open to doing something different that will offer a better outcome and being, I suppose, free and flexible in what that is"*

> *"Innovation is the area between inventing something and implementing it. Innovation involves putting into practice inventions through development and testing. Implementation follows through scaling up or rolling out on a wider scale."*

> *Innovation means "looking at something and trying to make it better". "There's got to be a focus on what's the achievement, what are you trying to get out of this. It's really results orientated for me."*

> *... "new ideas and a different way of doing things"*

Innovations took place, for example, at the level of the patient journey, using data and dialogue to improve patient experience and reduce costs through increasing flow and shortening length of stay. They also involved improved and speedier reporting of financial results to budget holders to enable more effective decision-making and to catalyse clinical and operational innovation. At a system level, innovation involved working across sectors to get the best value out of available resources. All of these developments depended on strong partnership working with other disciplines, especially clinicians, facilitated by mutual respect and shared goals.

Example 1: Securing the best through information and engagement- Bolton Foundation Trust

A finance function based in a troubled and scandal-hit hospital was at a low point. It turned itself round by adopting a new vision: to be the best finance function in the NHS. An annual finance improvement plan was developed across three areas: financial sustainability, financial governance and financial skills development.

'Working Day One' was a major innovation that aimed to get the results out by five o'clock on the first working day to the organisation. In the past, reports had gone out on work day 12 or even as late as 30th of the month.

The Working Day One project was delivered in eight weeks, from pitching the idea to staff to final output. The first four to five weeks was mainly spent in consultation - talking to the team, one to ones, group sessions – to ensure everyone understood the reason for change.

> *"Getting the staff on board with that was really quite challenging ... we'd been in the past, ... very risk averse in terms of 'Oh well if we do that it won't be accurate'. So really getting over that was a challenge."*

There was little confidence in the organisation that it would be sustained. But Working Day One has been functioning for nearly three years now. The finance team has been voted 'Corporate Team of the Year' within the trust. This is a significant shift because when the trust had been in difficulty the finance function had been held to blame.

Working Day One sits within a wider raft of change, bent on improving impact. It addresses the question: "What is it you've done, what is the technical thing you've done?". But within the innovation is a perhaps bigger story about leadership and engagement, 'making people bothered', talking to staff, giving them a reason to feel confident and proud of their role. The initiative was based on a new purpose, that budget statements and information were "a call to action to the organisation rather than a reconciliation". Since impact depends upon accountability, engagement with clinicians was part of a strategy to make clinicians feel more accountable for financial performance and to make cost improvements. A process described as the 'Model Hospital', invented within six weeks, generated the sort of reports that external management consultants are frequently commissioned to produce, analysing performance and scope for change within clinical divisions. "We had done nine reports in three months", undertaken by three divisional accountants. The reports provide a vehicle for bringing all hospital consultants round the table to discuss their practice. A third initiative, described as the "Alternative Site Valuation Model", involved an idea that came from other trusts through a site visit. This was fully implemented in Bolton in under three months. The key to impact was said to be speed – which comes back to the Working Day One rationale.

Example 2: Catalysing clinical innovation – Nottingham University Hospitals Trust

NHS-wide processes (PLICS, i.e. patient level information costing system, service line reporting and service line management) have been exploited to improve clinical engagement, transparency and understanding of services, leading to service redesign. Much of it was facilitated by "demystifying the information" and "winning hearts and minds" by embedding business partner roles.

The emergency care pathway and use of the general medical take was redesigned. Evidence from the PLIC system demonstrated that three days length of stay in the emergency admissions was a financial break-even point, which the trust routinely exceeded. Clinicians engaged with the evidence and visited other trusts to learn how to deal better with pathways for individuals and cohorts of patients. They developed standardised packages that treated patients differently in the acute setting, changed pathways and supported the junior doctors. It was well-resourced and successfully reduced length of stay. The navigation service has also been improved by introducing a direct telephone line between GPs and clinicians at the front door, building relationships

and working out the most appropriate pathway: "should they come in to the ED, to the general admissions area, surgical admissions area or can they go in out-patients or can we manage them at home?"

In the same trust PLICS is being tested by an epidemiologist to see whether it changes clinical decision-making. A controlled trial is being pursued in the respiratory service and the gastroenterology service, giving them the PLICS information and seeing whether it makes a difference. Three months into the process the feedback is that the data is too detailed. Presentation has been changed into a fantasy football style league table of how many patients they've seen, how many diagnostic tests etc. Success stories build momentum, enabling data to be introduced to more areas.

Example 3: Generating value across a system – ABM University Health Board, Wales

A holistic approach has been used to identify how limited resources could be used to maximum effect. A 'Regional Collaboration for Health' brings together Swansea University, the Abertawe Bro Morgannwg Board centred around Swansea, the Hywel Dda Board, which goes further west into Pembrokeshire, and neighbouring local authorities as associate partners. They look at how to maximise resources and use collective influence for the benefit of residents across health and wellbeing and wealth creation. The partnership focuses on the language of 'value' as a way of bringing cost, performance and quality together. Assets, skills and investment opportunities have been identified through dialogue, creating lines of communication with ministers in all sectors: Economics, Health, Finance, Education and Skills.

The initiative has created 'Talent Bank', linking gaps in employment, education, training and workforce. The logic is: 'we've got people who are looking for work; we've got universities and sixth form colleges which are capable of training and educating them. There are areas of deprivation and we've got gaps in the workforce and we can't recruit.' The Talent Bank is a pipeline to help address problems, both from a health perspective but, also, a social economic perspective while supporting educational institutions at the same time. Wales has set up a finance academy which is attempting to drive innovation.

Key Theme 1 – Facilitator of the Whole

Several strong themes emerged from witness accounts that explained how Finance could lead and secure innovation. The first describes the finance function as 'facilitator of the whole'.

Seeing the Whole

The Finance function is uniquely placed in healthcare organisations. It works in and has knowledge of, and relationship with all parts of the organisation and system, giving finance an overview of operations, and a potential to 'join the dots'.

> *"A key benefit in working in finance which I think is really important is that you're working across lots of different forums, so you can see where the dots aren't joined."*

> *"Finance, in a professional sense, we touch everything and, therefore, the network we've got under people, literally, if you combined it, we know everything. And I think, 'How do we come together to, therefore, make the joins that other people may not be in a position to see?'"*

Understanding Cause and Effect

Engagement with all types of functions is distinct from clinical disciplines which are specialist or location-specific. Knowledge across functions, and the patient pathway gives an insight into cause and effect. This means that finance has the potential to generate a better picture of the 'whole' and to see the underlying causalities to problems, which any partial view can easily miss.

> "So I think if you work in a particular discipline, maybe a clinical one, it's quite isolated in some respects, whereas I think the finance function is multidisciplinary - it works across. So you're engaging clinicians, you're engaging with senior management, you're engaging with strategy, you're engaging with planning. So that allows you to gain a broad understanding, I feel, of what could work and what's not working and what's worked before in the past."

Partnering with Clinicians

The finance function's holistic view fosters a process of engagement and co-production with clinicians. Joint-working provides a strong sense of purpose and satisfaction among finance staff, generating shared ownership for better services. Their reach across the organisation can produce significant changes to operations, which go beyond narrow budget-allocation processes.

> *"Finance's way is about supporting innovation, supporting the clinicians to deliver the innovation and not being a barrier to innovation"*

> *"...create that time to talk because that's where we find the real insight in striving for performance change; spending time with what is a great bunch of consultants and clinicians"*

"...we sit down with them and we work through in terms of 'right, how often do you run a clinic, how many people are on those clinics?' ... We build up their cost data and then we work with them. We benchmark that to say 'right, these are where you can potentially save from that'. And then they own it and they will deliver it because they have produced it ... They have really engaged in it and they are part of this process."

"So, obviously, there's different languages you speak to in terms of maybe the medicals really focused on the outcomes and the operationals really focused on efficiency. But that's where the finance leadership can see them both and bring them together"

"...it's a shared journey, it's shared ownership, we're all in it together"

Understanding and being in service to aspirations of professionals

Finance staff had a strong appreciation of the challenges facing clinicians and their aspirations, and worked in service to those aspirations. Innovation worked well where "there's a clear shared purpose and direction". The finance function, when collaborating well, sees beyond money and "into other people's aspirations, other people's ideas". At times clinicians felt that the opposite was true, telling finance staff that "you're not speaking the same language as us because we're aspiring". At this point finance staff and clinicians needed to coalesce around a shared set of values to work together and improve relationships. A practical way of achieving this was to have "a very strong devolved finance presence integrated into the service units'.

"I don't think [innovation] is harder in finance. I think it's probably easier because we've got some evidence that supports it whereas I want to meet the person that did the first day case procedure, because moving from doing something as planned care that's in for three or four days to "no, I'm going to do it in a day and you're going to go home", that must have been hard to do."

"We don't have that much power over them. We want to work with them."

A collective aim is needed to bring people together:

"Unless there's a target to head towards, people will be going on their own paths, and then it really takes local leadership and a lot of goodwill to drive it forward."

"A way of facilitating work with clinicians is to engage in dialogue, asking for feedback from budget holders with the aim of thinking about 'how we can help'."

"We do it on a three-times-a-year: every budget holder gets asked once a year about the service they receive and what they want to see changed and improved."

The role of financial innovation in healthcare is aligned to clinical innovation, in contrast to the role of finance in the wider economic environment:

"Finance can lead financial innovation and financial innovation can enable clinical

and operational innovation in terms of the health sector, and obviously there's lots of financial innovation out in the world to make money out of money."

Engaging

The first stage of securing energy and commitment to innovation and change was to get people 'bothered' about the issues.

"We've got that recognition that it's behaviours, people's behaviours, that need to change. So we talk about the art of making people bothered. ... we've made people bothered, we've got the accountability, we've got commitment." "... people in Bolton are very bothered about how we finance the organisation as well as the performance"

In a hierarchical system it is necessary to secure change by engaging vertically at every level:

"We shared it regionally within our Greater Manchester network, and one of the people in that network is a representative on a national user group, so then that got shared with him and NHS England took it on board. They adapted it slightly. It didn't have as much freedom as we had. But then that was shared nationally."

Using data to engage

The knowledge and overview possessed by finance is dependent on creation, flow and application of data. A pragmatic approach was cultivated with clinicians, allowing decisions to be made on data that was 'good enough'.

"...our organisation has got the confidence to use our data to drive the improvement programmes"

"...we accept the data. It's not going to be perfect"

As data is the platform for decisions, there remains considerable scope to improve its quality and accessibility:

"Dashboards have helped us because they're quite graphical, more visual representation and, as we know, a lot of people find that easier to look at than just a sheet of numbers. So I think if you can go in with a flexed style, trying to understand, putting yourself in the shoes of the end user which is what I've already tried to do and said 'we think this will help you, we think this will enable you better to understand something or take it forward or have a joint ownership'."

Part of the finance department's responsibility is to support the rest of the organisation to be able to engage with data. Training and development initiatives promote use of data:

"So we've just opened up a discussion with Swansea University informatics and information department, about a training programme for the unit directors to understand a little better data and informatics as a source of evidence and evaluation and to then think about how they can structure their teams to be resourced to facilitate that."

Key Theme 2 – Leadership approach

Ambition and pride

A strong sense of pride emerged from many witnesses, and a driving ambition to be a respected part of a successful organisation. There was explicit rejection of the 'busted model' of inviting external consultants in to turn around an organisation. Instead, leadership instilled an *esprit de corps* that generated confidence in staff and commitment from them.

> *"Give me a room full of NHS finance people with the right ambition and the right attitude and we can do anything they can do, I guarantee it."*

> *"Everybody I think is extremely proud, they are proud to be part of finance"*

> *"We came up with the finance vision to the best finance and procurement department in the NHS... But the reason why we picked Work Day One was if we get ours out on the first working day nobody can beat it ... You could see the change in people in terms of the confidence and they're proud to be part of that change. It really has I think brought everybody together, they feel part of it."*

Agile to deal with priorities

The context of innovation and change will inevitably shift. Respondents highlighted the necessity of changing with purpose, rather than flitting from scheme to scheme without focus.

> *"Maybe all those schemes that have worked really, really well, they kind of drop off the radar and then we get hung up on the next thing."*

Part of the solution lay in having a systematic approach to dealing with innovation, e.g. through creating an innovation pipeline.

> *"...remove the localist element ...create an innovation pipeline .... Break away from the local shackle."*

We observe a possible tension here between innovation as a local response to specific conditions (micro) and as a high-level and top-down initiative (macro).

Outward looking and learning

The local-national spectrum did not on the whole create a problem for innovators. Being outward-facing and willing to share learning, and to learn from others was an important source of intelligence and motivation:

> *"It is collaborative. It's okay to share good practice and say 'look what we've done and we've innovated and actually you can come and see' or 'you can have this and we'll support you'. And I think that is a really powerful thing. If we can tap into that and actually bring out those pockets of good practice and share that across the piece that will help us move forward as well in terms of getting the best of the innovation out there and not just in pockets and isolated."*

Pace and Speed – rapid feedback

Emphasis upon speedy production and dissemination of data was a common theme. "How do you make that process fast?" A dynamic cycle of reporting and decision-making left no room for sitting on data or refining it until it became historic. Innovation requires 'real time' data and decision-making. Improving clinical decision-making and flow requires relevant and timely data.

> *"...getting information out of the organisation quickly"*

> *"So it's about speed and because you can get things done quickly and you can see the change and we could see the benefit to the organisation."*

> An example of poor practice: *"the Finance Director then sits on [the results] for two weeks considering them and presumably coming up with a spiel of how to explain them. And basically the results are teamwork. But that just basically misses the point of having to take action on results as soon as they are done."*

Some innovations were specifically about ramping up speed and momentum or about streamlining laborious processes through automation. A mantra used by one trust could be applied to multiple innovations: "If it's taking too long we're doing it wrong! "

> *"[Our innovation] took what was possibly a day's worth of staff time every month down to just an hour. We are very proud of it."*

Introduction of Working Day One, i.e. getting results out by five o'clock on the first working day to the organisation, exemplified "a call to action to the organisation rather than a reconciliation". Speed was a corollary of trust in the data and a sense that everyone in the organisation was moving in the same direction and 'trying to do the right thing'.

> *"You need the care model, you need the leadership, you need the data and understanding behind it, and so the challenge really is to move it all at the same time I think."*

Clarity of ambition

Innovation for its own sake did not feature among the witness statements. Rather, they exhibited a clarity of purpose and ambition, building on the fundamentals of the finance service, and working out what was important to people.

> *"We do those basics and if you have got those basics in place then you can do the innovative stuff."*

> *"Do you understand that we need to deliver what we say we need to do? Is this important? Yes. Do we need to do it? Yes. Are you on fire to make it happen? Yes we are."*

Doing the right thing

Allied to this clarity of purpose is a strong orientation towards "doing the right thing". The phrase was used repeatedly by the witness. It set the compass for individual finance staff,

determined organisational priorities, and forged an alliance between disparate parts of the service, e.g. finance staff and clinical professionals. It reflected values and operational realities.

> *"It's how you relate to the other party and trying to make sure you are both focusing on the right thing."*

> *"People were trying to do the right thing, and professionals want to be involved in that."*

> *"There is no fear of failure because we cannot fail because it's the right thing to do... they say 'we need to do this because it's the right thing to do to get us where we need to be.'"*

Key Theme 3 – Team makeup

Individual qualities and professional development

There was a highly personal dimension to innovation. Witnesses described their 'journey', the importance of individual qualities, e.g. 'dogged determination', and the motivating effect of 'celebrating success'. Use of mentorship ("really inspiring") and coaching appeared to be a common thread, showing a commitment towards professional development among our innovating sample. Team-building initiatives were defended.

> *"We have quarterly time outs and we take the entire directorate out. It's only half a day but we take them through, we look at performance and everything else, various innovations that we're doing and at first we got criticised for it – 'you're taking them all off on a jolly and giving them sandwiches'; 'no we're not, this is about team building'".*

Bringing IT/Business Intelligence and Finance together

Information technology underpins good finance and accounting systems. In Wales, we learned that collaborative working between organisations, including pooling resources (e.g. between education, social services and health), could drive innovation and improvement in services through the adoption of modern technology solutions.

Structurally, there appeared to be advantages to bringing functions together.

> *"It's important to have a good network and definitely to bring IT and finance together."*

The mix of skills between IT and finance can lead to innovation through improvement of routine manual processes. A fresh set of eyes, collaboration and technical insight has proved fruitful.

> *"We brought IT in. I think what we find with a lot of things is that nobody thinks about that bit over there, the IT that can do it. They have a process, but it's very manual. So when we get these things we look at them together and we try and develop something."*

Key Theme 4 – Conditions and process that enable innovation

Innovation as the day job

Innovation was mainly characterised as a form of incremental improvement that was built into the day job. It was often a response to frustration with the status quo and "part of the reason why you can function with less money". Where innovation was not the day job but was instead treated as a project, then it was less likely to have impact.

> *"[in some places] people treat the new care model piece or the innovation piece as a project rather than business as usual, whereas in places where it's really driving forward is that it's literally someone's day job to do it."*

> *"Innovation for me is the day job .... For me innovation is what we need to do and why I come to work."*

Diversity of views and networks

Lack of capacity to think freely and creatively, i.e. 'headspace', was a limiting factor. Where this headroom was available, innovation was stimulated by collecting ideas from other people, using informal networks.

> *"Innovation is about making the time to talk to people, that's the thing that makes the difference, that's the thing that gets the ideas started, that's the thing that gets people motivated."*

> *"When you don't know something, you go and find somebody that knows a lot more than you .... If you have a strong informal network you're more likely to deliver better products ... going downstairs and saying 'let's have a cup of coffee'".*

Look outside for ideas

Search for good practice leads finance departments to visit other organisations and collect new ideas, using a strong outward focus.

> *"If someone out there is doing better than us we'd want to go out there and find a way to beat it."*

> *"We're really encouraged to go out and find out how other people have done it better than us and then learn from it and bring it back."*

Openness and transparency creates an atmosphere of trust

Trust can be fostered within organisations, e.g. between finance and clinical professionals. At the boundaries between organisations, however, the incentive to hoard knowledge is stronger in order to protect budgets and resource allocations. Lack of openness was identified as a barrier to innovation within the system. Absence of trust creates a barrier that prevents good working relationships.

> *"We're having to unpick that. It's causing us massive problems with trust, and all trusts are cross subsidising, but they're not declaring it in the ledger, I would argue."*

> *".....because we don't have that transparency and trust and people are saying 'I've got to make things balance' and not say 'I've made a massive loss on this service line this year', but openly 'this service line here, my activity has not quite been what it used to be so I've managed to plug that hole', instead of saying 'everything is rosy' ".*

> *"...problem with trust between health and social care is going to be the biggest stifler of innovation ... I think trust is a massive issue."*

Transparency or lack of it defines relationships between organisations. It is seen as a leadership issue, which has technical consequences for the system.

> *"The other thing that's getting in the way is the relationships and I think that comes down to leadership and the set-up of the system overall that we need to overcome."*

> *"It will start conversations which haven't historically happened because people are being more open about what they're doing. Therefore, once they start doing that you can start a transitional journey to full capitation or partial capitation."*

Focus on value and able to articulate impact

There was a strong aspiration to add value to the organisation, consistent with the service-ethos and values described earlier. Moreover, value as a clear and understandable goal for clinicians and managers together can create a common language for engagement, joint working and innovation.

> *"If you look at where we [Finance] have come from and where we're going, we want to change, we want to improve, we want to add value as a body and in our organisation. I think we've got to justify our worth, we're not the frontline. People don't see us every day so some people think 'why is there 25 of you sat over there, what are you all doing?'. So you've got to show that to them and part of that is adding value to them and adding value to the organisation."*

> *"Data processing and timeliness is about also adding value and being as efficient as we can as well as supporting the business and giving them the right information at the right time."*

> *"I have to feel that I'm making a difference and adding value."*

Where it is difficult to articulate impact, due to complex systems, then it is difficult to effect change.

> *"There is a level of distrust between 'will this care model actually have that impact?' And when we go and talk to them about 'how would you pay for that?' the conversation often rears back to 'oh, that impact won't arise'."*

Finance leaders are beginning to grapple with the challenge of developing financial 'rules' that structurally enable innovation and value creation.

> *"How can an organisation's Financial Framework or "Rules" for Planning and Delivery support structured and widespread Innovation and Improvement (let me call it Value) across the organization? This is a systematic question about how the "Rules" effect behaviour and decision making. It also references the role of accountability and incentives in organisational systems. We are grappling at present with this challenge... of putting value creation into the heart of the organisation's financial "rules" and for this to align clearly with the organisation's values and quality aspirations. This is a difficult challenge."*

Fail and learn

Interviewees described the no-blame culture within their organisation that was helpful to innovation and provided a safe environment.

> *"Our FD and deputy are very much supportive of innovation and letting us have a go, as it were, in quite a safe environment on a small scale."*

> *"The leadership and the culture is a big part of enabling some of that innovation to take place."*

> *"I suppose the self-confidence in that sense not to just keep doing what was seen as the safe thing."*

The emphasis upon learning from failure gives confidence to be bold and take responsibility for new ways of working.

> *"Failure is not a problem. We put too much stead on failure being an issue. Failure is only an issue if you don't learn from it."*

> *[Reference to a Trust that got into difficulty]: "'it was somebody down there, somebody down there's fault, find what's down there and blame them". - That's just the antithesis of what's actually required."*

> *"When you do make a mistake people rally round you and help you through it rather than just hang you out to dry, and I think that goes back to the culture and the leadership that we've got embedded in our organisation."*

Sustained attention from the top

The NHS, as a hierarchical organisation, is capable of stifling innovation. Lack of responsiveness at the top (of the function or organisation) was thought to be a barrier to transfer to spread of innovation opportunities. Successful change-agents made special efforts to secure buy-in and attention from the top.

> *"The worry is moving somewhere else is that you don't have that person above you that lets you be open."*

Celebration of success bestowed recognition from the top of the organisation and encouraged further innovation.

> *"...you really need success to inspire other people to then take that forward"*

> *"For me the key word is listening. You've got to listen to people and people have got to listen to you."*

As an example, leaders in Wales have set up a Finance Academy which is attempting to catalyse innovation and finance across Wales.

Productive relationship with the Centre

The Centre has a critical role in generating the conditions for innovation providing intelligence and resources without stifling local autonomy by over-management of risk.

> *"It's pretty fair that you have to stop the house from burning down before you can improve it, but that message could be more nuanced, that it's OK to go on with planning improvements while the fire department is still hosing the house down"*

> *"One of the most value adding things that the Centre could do is to start playing back to commissioners and providers their own data, collecting it and playing it back on activity, on cost and on outcomes. And you can do that, it's not beyond the wit of man to do that."*

Key Theme 5 – Skills and understanding – that can help the system

Risk Sharing – internally and externally

The context of the review is that Finance is perceived as being risk averse and there is a cultural norm of not sharing innovation until it is rigorously proved to be effective. This was supported by the literature review, where public sector finance is risk averse due to the politicised nature of the services.

Witnesses concurred that the system fostered reluctance to take risk, but also suggested that a conservative approach to risk was appropriate when patient care was at stake.

> *"I think it's right to be risk averse when people's lives are in question, so it's quite right to be risk averse in bringing in clinical innovations and things like that and really planning them out. .... It's better to keep it steady as she goes rather than trying to change more radically."*

> *"It is my view that [the NHS and public sector] is quite risk averse and there are elements in the system design that really emphasise that perhaps natural risk aversion in finance. Things like commissioners are required by law to report a 1% surplus - there's a massive spanner in the works I think when it comes to shifting risk around and doing innovation."*

A distinction was drawn between experience of venture capitalist companies and their perception of risk, compared to public sector bodies. Private investors had greater discretion on the timescale for payback of investment.

> *"So that difference in 'How long do you wait for return?' 'How do you demonstrate?' And the huge emphasis they placed on the upfront business plan: understanding the market, understanding the risks. But, once they understood it, they had confidence ultimately ... and the overriding issue that they had is confidence in the management team."*

However the NHS Finance function does have expertise in risk that it can share with other senior leaders.

> *"it's a very simple risk share arrangement when it comes down to it, but based on a mature, 'let's sit down around the table and look at what we've done over the last three years, and do we want to spend the next three years doing the same thing?'"*

> *"If you're going to create value, you're going to have to take a different view about investment and, sometimes, you have to take a different view about timescale."*

> *"...so we're having to break it down to understand what risk truly is and Future Focus Finance have some good tools to help do that and who owns the risk."*

Business Intelligence and the relationship between performance management and innovation

Both performance management and innovation are necessary. Data is required for both, and there is an interplay between data interrogation for the process of innovation and data to demonstrate the impact of innovation in terms of performance. The value of both was appreciated and attention given to both.

> *"We use service line management, a very, very simple service line management as an active performance management tool. That is the way the division performance is done so there is no money held centrally whatsoever."*

> *"Models were identified as useful tools for applying business intelligence. For example "vision, infrastructure, people" (VIP) is a rubric that enables a finance team to check whether a scheme for innovation has potential."*

Conclusion

Innovation is characterised as a process of continuous improvement and incremental development. Although the Inquiry focused on the term 'innovation', some of our witnesses declared that it was not a word that they often used. Their mental models or tropes were based around motivation or around habitual structures, e.g. vision, infrastructure, people. Relationships are thought to trump technical challenges.

> *"For me one of the key tools that we've got is we seem to look at data report tools, have this tool that's going to do this, it's going to do that, but I think one of the most important tools is engagement, and that's on a personal level and the relationship side of things to take forward the ideas"*

Engagement in innovation was achieved through data-driven illumination of what was going on in the team, organisation or system, which in turn catalysed discomfort with the status quo, which was harnessed to generate ambition for a better service.

The witnesses gave a strong sense of pride and ambition in their role, shaped by values that were shared across the organisation. An overriding impression emerged of the finance function's broad understanding of the organisation, putting it in a powerful and influential position. At the same time, finance professionals saw their role as being in service to the clinical goals of healthcare, working best when everybody pulled in the same direction.

The macro system, with interfaces between providers and commissioners, is more fractious and less cohesive than the micro system within a hospital or a CCG. Innovation at these boundary-spanning points is likely to be more difficult to achieve. But it is not impossible, and witnesses gave examples of joint working between sectors (health, education, social care) and vertically between different tiers of the NHS.

Overall, the witnesses described a finance function of the future that offers a strong and rewarding career structure, where any frustration is outweighed by clarity of purpose.

The Inquiry has detailed the experience of finance teams with a track record in innovation. The finance community is encouraged to develop its innovation capability by addressing the recommendations – grouped around Data and Intelligence, Skills and Development, Focus, Resources and Relationships - set out in the earlier summary section of this report.

Appendix 1

Panel Interview Questions

The Panel questions were open ended to try and secure the best understanding of the nature of innovation in Finance and how the finance function contributes to an innovation culture. Each interviewee was taken through the following four questions:

1. Please tell us about an innovation you have led or contributed too. How did it start, what helped or got in the way? What worked or didn't?

2. What was it do you think that made this innovation a success? (probing for relationships, capacity, resources, context....)

3. What do you think is meant by the word 'innovation'?

4. What does it take for finance to lead or be involved in innovation? Is that different from other disciplines?

Supplementary questions, drawn from the literature, were selected by the panel, tailored to the interviewee's story:

5. "The common innovation in finance in the NHS is related to the allocation of resources." Is that your experience? What other sorts of innovation have you been involved with as a finance leader in your career?

6. "The NHS (and public sector) is risk averse." Is that your experience? Do you have any views on that? What part does finance play in that? Why do you think this is the case (if you do agree)? Why do you think this isn't the case (if you don't agree)?

7. "Readiness for innovation in NHS organisations and systems requires better communication between management (including finance) and clinical professionals." Is this your experience? Do you have any examples of that in your experience of innovation? Are there other things that matter in creating a culture of innovation?

8. "In order to innovate NHS organisations and systems need an appropriate balance between performance management and innovation, including metrics to support both." What role does finance play in securing that balance? How do you see that balance now? How did you secure the metrics to support your innovation?

9. "Innovation needs to add value." How do you ensure innovation adds value? In what areas?

10. "Innovation requires organisations and systems to be focused as much on the long term as the short term." How did you do this in your innovation? What do you think this means for the NHS and health and social care systems?

11. "Innovation benefits from headroom in resources, sometimes called 'organisational slack'." How does finance relate to the idea of organisational slack? Is there a tension with finance's role finding efficiencies?

12. Finally, does finance need to be more innovative? If so in what way and what would help?

Section 2: Brief Literature Review

May 2016

Part 1: Introduction and Summary

Approach to the Literature Review

The purpose of this literature review is to scan the innovation field, both theoretical and applied, and explore the fit with finance and healthcare. Innovation and finance knit together more closely than might be supposed. Theories of innovation at organisational level are frequently about survival, growth and adaptation in a challenging environment. Finance staff play a part in this.

Three main sources of academic literature are used. The first is a review of the innovation field directed at healthcare managers by Illinca et al (2012)[6], setting out a framework of ideas structured around questions of why, what, how, who. The second is the Web of Science database of peer-reviewed publications, using search term combinations and selecting for relevance to innovation-finance-healthcare. The third source is a scoping review of knowledge mobilisation literature (Ferlie et al, 2012)[7] that compared the generic management literature with healthcare. Snowballing techniques, following up references and leads based on knowledge of the field were also applied.

Websites of professional accounting associations have been accessed for material linked to innovation. They include the Healthcare Financial Management Association (HFMA), Future Focused Finance (FFF), Chartered Institute of Public Finance and Accounting (CIPFA) and the Chartered Institute of Management Accountants (CIMA).

The paper is structured by first considering innovation. It goes on to describe the framework set by Illinca et al. The remaining sections apply this framework to the areas of finance and healthcare.

Literature Review - Overview

The NHS is dependent on innovation to meet the challenges of the 21st century and beyond. Innovation is 'new to here' not 'brand new' (invention).

The review found that:

1. The finance function in its widest context (in the corporate, public and third sectors) is known to be innovative. In the social sphere this innovation has related primarily to supporting enterprise, and micro-finances (to alleviate poverty). However, in the NHS innovations in finance reported in the literature are primarily associated with the release of resources rather than in the sphere of social value.

2. The politicised nature of the NHS seems to correlate with a higher aversion to risk, and this is likely therefore to be a systemic issue.

3. Innovation to meet the challenges of the current and future context of the NHS will be both technical (new technology/ pharmaceuticals) and social (new models of care, new ways of organising). Social Innovation is a relational and creative process, requiring a deep understanding of and frustration with the status quo, creative problem solving and new ways of seeing problems, openness to new ideas, collaborations across professionals and with citizens, ability to translate ideas into local contexts, willingness to test ideas and capacity and processes for experimentation. This type of innovation requires finance leaders to:
    - Generate metrics to support inquiry and innovation processes.
    - Generate readiness to change through better communication between functions and better relationships between professionals.
    - Ensure the appropriate balance between innovation and performance management for change.
    - Tackle unwarranted variation.
    - Be active participants in innovation with other professionals and citizens.
    - Have a deep understanding of the capabilities in the organisation and develop strategic resources within the organisation.
    - Be focused as much on the long term as the short term so the organisation/ system can adapt.
    - Ensure that innovation adds value, and that this isn't overshadowed by processes to secure assurance.

4. The emerging social innovations in the NHS require Finance leaders to secure structural innovation in funding and payment mechanisms.

Part 2: Innovation – Context

This section examines the term 'innovation' and sets the context by locating it in streams of literature including strategic management and organisational studies.

Modes of Innovation

Innovation means generating change that improves products or processes and, for social innovation, creates social value. Radical innovation is said to occur when it brings something new into existence (Oroyemi, 2016)[8]. This might more accurately be described as 'invention', where innovation is 'new to here' and invention is 'brand new'. Roger's[9] definition of innovation is helpful: "an idea, practice, or object that is perceived as new by the individual or other unit" (p12).

Tether and Tajar (2008)[10] describe three modes of innovation, two of which are technical (the product-research mode and process technologies mode). The third, organisational-cooperation mode, is less well-explored and involves 'soft' innovation through organisational changes within supply-chains or networks. The paper distinguishes between specialised workforce skills and relational strengths, consistent with Kijkuit & van den Ende (2010)'s[11] notion that strong ties among friends are catalysts for ideas and innovation.

This is further strengthened by Jiang and Thagard (2013)[2] who found on reviewing social innovations in health, education, social movements, technology and finance that the conditions for social innovation included diverse relationships that generate both support and rejection, and that bring up emotions of fear, frustration, and hope. The notion that innovation comes from a place of frustration is supported by Plamping et al (2009)[14].

The social innovation literature in relation to finance roles identifies the critical impact of micro-finance, perhaps mostly widely recognised through Muhammad Yunus, awarded the Nobel Peace prize in 2006, using microfinance to relieve poverty. This creative use of the mechanism of finance for innovation to achieve social good is the most widely recognised finance role in social change.

Innovation in Systems

Plamping et al (2009)[12] look at the key elements that facilitate innovation in organisations and systems. Innovation is characterised as 'evolution' to distinguish between public and private sector challenges, where "innovation is linked to ideas of survival in a global economy and renewal in public services" (p5). They conceptualise the 'system as innovator' in contrast to the 'individual as innovator' and subscribe to Beinhocker's[13] view (2007) that evolutionary pressure within an ecosystem is a good metaphor to describe business adaptation and survival. An underpinning theme is that private services operate in a market whereas "the public service context (environment) is not a market" (p11). They use the notion of change-amplify-eliminate to describe the innovation evolutionary cycle. Change emerges in a service industry by harnessing dissatisfaction and frustration with the status quo, creating space for learning and review. Amplification (dissemination)

may be through push or pull models. The authors advocate a pull model, in which "organisations set out to build their own capacity for innovation" (p20), addressing the question "how could we do this better?" Elimination, which would happen through exiting of the market in commercial settings, translates into disinvestment in public services, which may be a result of evaluation or other evidence about relative value of activities.

Rathbone and Lynn (2012)[14] describe the conditions for transition for change as: fostering a desire for change; framing thinking around change; and enabling action from creating effective teams to cultures of improvement and innovation, to generating inward investment.

The Role of Knowledge Generation

The evolutionary model is consistent with Parent et al (2007)'s[15] system-based model of knowledge transfer capacity. Innovation is described as 'generative capacity' because it creates new knowledge locally.

A second capacity is 'disseminative', which depends on social capital or social networks. The third, 'absorptive capacity' is found in settings which already have experience of similar innovations, readiness to change, or particularly good ways of working that allow the organisation to absorb new knowledge readily. The fourth capacity, 'adaptive and responsive capacity', is described as 'second-order' and 'reflective', responding to the external environment.

Dynamic Capabilities to Support Innovation

A search of Web of Science for "innovation, performance" shows the most highly cited source to be Teece et al (1997)[16] who developed the dynamic capabilities (DC)[b] framework, focused on organisations operating in environments of rapid technological change. The framework suggests that organisations succeed by "honing internal technological, organizational, and managerial processes inside the firm" (p509), particularly knowledge processes, in order to adapt to the external environment. The dynamic capabilities framework is a refinement of the resource-based view of the firm (RBV)[17], which emphasises the importance of strategic resources within the organisation to promote innovation and growth, including knowledge as an intangible asset.

Ambidexterity

Ambidexterity describes an organisation's ability to explore and innovate through environmental change while making the most of its internal assets. Raisch and Birkinshaw's (2008)[18] highly cited paper develops a model of ambidexterity based on a review of literature covering organisational learning, technological innovation, organisational adaptation, strategic management and organisation design. The conventional view is that there is a trade-off between exploration and exploitation whereas the ambidexterity premise is that both are required. Pure exploration is betting everything on the long term, while pure exploitation, i.e. focus on short-term performance, can lead to poor responsiveness to environmental change.

b 5,797 citations at 26th April (2016). Most papers have only a handful of citations, so this is a world-ranking volume.

Summary

1. The NHS is dependent on innovation to meet the challenges of the 21st century and beyond.

2. Innovation is 'new to here' rather than 'brand new' (invention).

3. There are two predominant types of innovation: technical and social.

4. Social Innovation is a creative, relational process.

5. Innovation requires a level of frustration with the status quo, new ways of thinking, creative problem solving, curiosity and exploration, openness to new ideas (readiness to change), ability to translate ideas into local contexts, willingness and processes for experimentation.

6. Innovation requires a focus on the knowledge capabilities in organisations in order to be able to adapt to external environments.

7. Innovation requires both a focus on the short term and long term (ambidexterity), not either/or.

Part 3: The Why, What, How, Who of Innovation for Healthcare Managers

Overview of the Model

Illinca et al (2012)[5] propose a top 10 best reads for healthcare managers based on a Delphi study, using four dimensions of innovation in healthcare: the why, the what, the how, and who.

The 'why?' concerns the purpose of innovation in terms of necessity for organisational survival (linked to theories of competition) and of improving health. It notes that whilst the purpose might be shared, there are divergent interests, "where the interests of policy makers, pharmaceutical, and health delivery organization can conflict with those of patients" which creates conflict.

The 'what?' describes the innovation process, "spanning from the first successful practical application to the internalisation of the new technology (note: social or technological) and its embedding in organisational practices". It is an iterative, dynamic knowledge mobilisation process, not a linear progression. Perhaps one of the best examples of the unpredictability of innovation impact is the work on 'disruptive innovation' (Clayton Christensen et al)[66] cited in this paper, which relates to technological innovations that come into the market and rapidly take over.

So too is the 'how?', the innovation diffusion (adoption and spread) process, which distinguishes between innovations that become embedded and those that do not. Again, this brings to the fore the focus on organisational and system readiness and reiterates the pre-requisite of frustration with the status quo identified above.

The 'who?' identifies that spread is contingent on the relationship between the participating actors. In healthcare, the innovators are described as primarily the professionals, i.e. doctors, nurses, and health technicians. The challenge of innovation requires inter-disciplinary collaboration (not only between clinical professionals but also between these and management), whereas professional models tend to lead to the blocking of external sources of challenge. This creates a tension leading to the higher adoption of uni-professional innovation over and above inter-disciplinary innovation.

Illinca et al's paper is useful in (a) providing a reading list, (b) providing a framework for conceptualising innovation that extends to objectives, knowledge flows and power structures within healthcare as a highly professionalised service and (c) introducing a range of theoretical perspectives, spanning evolutionary economics, organisational learning, sociology. See Annex A for a fuller description.

The rest of this review covers the why, what, who and how of innovation, aiming to make a relationship with the finance function.

Why? – Purpose of Innovation in Finance

In looking at purpose, we need to consider (a) the purpose and meaning of the accounting and finance function, (b) the value of NHS organisations and systems and (c) how that relates to the purpose of organisation/system innovation, i.e. to adapt to a changing environment.

(a) The purpose of an accounting function

The accounting and finance role is differentiated. Financial accounting looks back at data to determine the organisation's value. It is a statutory requirement and must conform to mandatory standards. Managerial accounting looks forward to aid planning and organisational decision-making and is not subject to statutory regulation.

The finance profession's role across the health service, as analysed by HFMA, is becoming increasingly strategic. The following priorities have been articulated, aligning the finance function with the objectives of the NHS[19]:

a) Transforming service provision: creating new models for the delivery of affordable, sustainable and high quality healthcare

b) Building a sustainable financial future: considering new models of funding and payment

c) Knowing the business: understanding costs and developing clinical and financial engagement and collaboration

d) Getting the basics right: delivering financial control and effective governance arrangements

e) Giving a national perspective: giving an overview of the NHS financial picture and contributing to the development of the NHS finance profession

The Future-Focused Finance initiative rehearses the 'why' question by asking "what's the point of best practice?" and then answering with "it is how we get the best value for our patients, and how we will tackle the differences that lead to variation in outcomes and higher costs. Using best practice can save lives, and money".[20]

A survey by HFMA of 526 finance staff from across the NHS in England found that the majority (71%) were motivated by public sector values of the NHS. When asked what would most improve the value added by the finance team, 60% said there was a need for better communication between finance and non-finance staff to improve the understanding of the role of the function.

(b) The debate about value in healthcare

The question of value in healthcare is fundamental to the question of what motivates social innovation, and where finance staff should direct their gaze, e.g. in the balance between financial constraint and quality, short term and long term (ambidexterity) goals. We consider three arguments:

a. Public value, articulated initially by Mark H Moore (1995)[21], is citizen-revealed-preference using measures of outcomes that the public value

b. Competitive advantage has a parallel with public sector performance

c. In healthcare there has been a movement to introduce value-based competition, using the work of Michael Porter (e.g. Porter and Teisberg, 2006)[22], where value is defined as cost divided by outcome.

Public value describes the value that an organization contributes to society. The research program on public value was triggered by Moore: 'We should evaluate the efforts of public sector managers not in the economic marketplace of individual consumers, but in the political marketplace of citizens and the collective decisions of representative democratic institutions.' (Moore, 1995, p31)[23]. In October 2008 UK-based The Work Foundation[23] recalled Moore's work, observing that "public value is the analogue of the desire to maximise shareholder value in the private sector" (p4) and that public value is based on measures of outcomes: "that the public genuinely value" (p16), i.e. citizen-revealed-preferences. This participative model is very much alive in England[24], with the citizen movement driving healthcare towards integration with social care, supporting models that are 'place-based' and social rather than patient-based and medicalised[4], emphasising well-being and community resilience.

A competitive model of healthcare continues to have traction at policy level. Competition-building structures were put in place in the NHS in 1991 with the purchaser-provider split and the notions that 'money follows the patient' subsequently related to choice. Even though vocabulary has changed with successive governments and strategic shifts, the basic commissioner-provider structure remains in place, and a research stream on the role of competition has persisted (e.g. Le Grand, 2012)[25]. The NHS-market in its current form, according to the analysis of Propper (2012)[26] and Hurst and Williams (2012)[27] encourages competition based on quality rather than cost.

Parallels with private sector competition however, are limiting. Boyne and Walker (2010)[28] contrast the private sector's aim to defeat rivals in competitive markets with the public sector's aim to improve performance and provide better services, with an emphasis upon performance indicators and performance management. Klein (2010)[29], charting the history of the NHS, highlights the power distribution between professions, managers and regulators in explaining performance. Klein concludes that ultimately, "patient safety trumps balancing budgets" (p293), suggesting that value based on quality rather than financial measures, in practice, carries greatest weight.

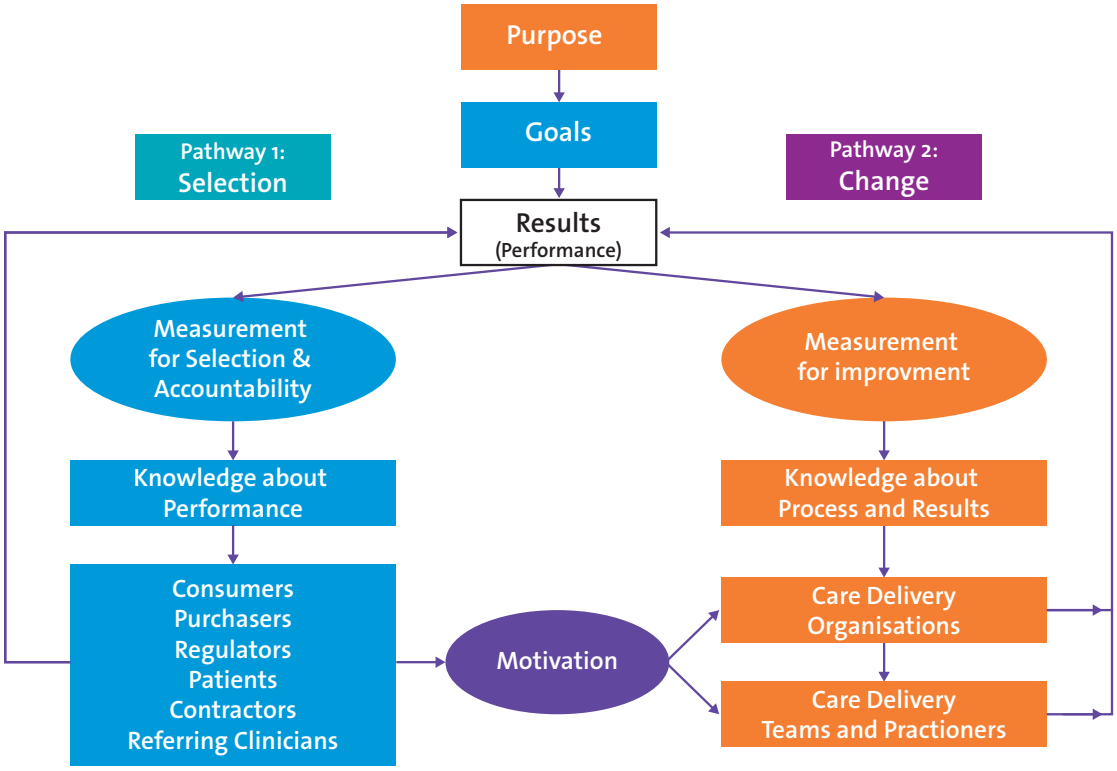
There is tension, however, between the functions of performance management and innovation. The literature from high-performing health systems tells us that the process

of data generation and measurement, and associated knowledge generation is different for performance measurement than it is for innovation. High performing health systems invest in, and give significant attention to, measurement for improvement and innovation (Baker & Denis 2011)[30]. Value is generated through an innovation process more than through a performance management process.

In the UK this becomes translated into the management of risk – the tension between safety / assurance and innovation. In high performing health systems, professionals lead innovation. Improvement, scrutiny, review are all actions of professional practice. A recent Ipsos Mori poll for the Future-Focused Finance Initiative of finance and clinical staff in the UK found that 24% of respondents were able to take time to reflect on how they were doing as a team[31].

Porter & Teisberg (2006)[24] have incorporated healthcare clinical outcomes based on safety and quality into a healthcare-specific measure of value, defining it as the outcome after dealing with "the patient's particular medical condition over the full cycle of care" (p5). Advocating pay for performance, "the results that matter are patient outcomes per unit of cost at the medical condition level" (p6). They combine this measure with the concept of competition, arguing that competition has previously mistakenly concentrated in cost cutting efficiencies. "Competition on value must revolve around results" (p6).

The relationship between measurement and improvement is explored by Berwick et al (2003)[32] who find barriers to change along two pathways (selecting providers and changing services) due to skills, knowledge and motivation (see Figure 1).



Ref: Berwick, D.M., James, B.C., and Coye, M. The connection between quality measurement and Improvement. Medical Care 2003; 41(1):130-39 (Jan).

Fig 1: This widely cited model from Berwick et al (2003)[32] demonstrates the difference between these two modes of operating.

(c) The finance role in adaptation

It appears that the role of finance in innovation in healthcare is so far described as:

1. Part of the work on new models of care.
2. Structural innovation in funding and payment mechanisms to support innovation.
3. Tackling unwarranted variation.
4. Generating readiness for change through better communication between functions and better relationships.
5. Taking a role in ensuring the NHS delivers value, and that innovation adds value.
6. Ensuring that the process for securing value through innovation is not overshadowed by the different process required for securing value through assurance.

What? – The Innovation Process and Finance

This section looks at specific products/tools and considers strategic resources within the organisation that may be exploited for innovation and growth, the dynamic non-linear process of innovation.

(a) The finance role in measurement and metrics

As seen above, there are different metrics required for performance management (selection) than for improvement. Metrics for performance management relate to contracting and assurance. Metrics for innovation provide data that supports teams and systems in knowing:

a) How are we doing?

b) What is happening here?

c) What needs to improve/change?

A focus on 'what innovation for health?' conducted by structuring a search of Web of Science using the terms "Innovation, Process, Finance, Health" converged on a discussion of balanced scorecards as a means of improving performance. It is not a new idea (Kaplan and Norton, 1992; Garson et al, 1999)[33, 34] but highlights the use of consultation within the organisation to provide meaningful data. A US medical school questionnaire study led to collection of measures that linked to the school's mission of education, patient care, research, service and finance. The project was helpful in setting goals and determining overall performance of the school. Similarly, a burns unit[35] modeled a scorecard against four perspectives: financial, customer service, internal business, growth and learning.

Scorecards are paying greater attention to the domain of Growth and Learning, judging by a recent study that applied Analytic Hierarchy Process to data provided by medical managers (Emami and Doolen, 2015)[36]. The results showed that human capital, or

human resource, metrics have the most significant impact on the performance of the participating hospitals/clinics.

The finance function conventionally has a major role in determining the metrics that are collected and reported through the organisation. The implication of the scorecard papers is that a close connection with other departments, especially with the HR function, is essential.

It is worth noting that improvement and innovation teams have traditionally involved clinicians (see the section on roles) with the finance function being an 'assurance' role for any new ideas. Our review suggests that finance should be embedded in the innovation process to support the development of meaningful metrics for cost and value, alongside quality.

(b) The finance role - resource based view of the firm

A strategic approach to 'what innovation?' might be found by considering which resources should be exploited or developed within the organisation. A scoping review by Ferlie et al (2012)[7] identified the Resource Based View (RBV) of the firm as a strategic management theory that has been researched for 20 years in generic management literature but has not crossed over into health. RBV is concerned with the strategic resources that are found within the organisation, rather than the external competitive environment. The framework encourages managers to identify strategic resources that are valuable, rare, difficult to imitate, and to foster organisational policies that exploit these resources. A detailed literature review[19] found evidence to support:

- "Organisational slack - organisations which are rich in resources will have more headroom to innovate, grow and perform. RBV highlights availability of organisational slack as a strategic objective that is in the interests of the organisation. This poses a challenge to the productivity or 'more for less' efficiency agenda operating in the current fiscal climate" (p11).
- "Quality and finance - organisations that get diverted by resource arguments at the expense of safety and quality will ultimately fail." (p12)
- "Organisation-specific factors outweigh market conditions, accounting for 22% of variation in performance premium according to some studies (Crook et al, 2008)"[37] (p12).
- "Managers matter - leadership, creation of a consistent and psychologically safe culture[38], capitalising on strengths, allied with the internal resource base, allow one organisation to outperform another, even over the same rough terrain" (p12).

The challenge for finance, then, is how to work with the organisation to consider the questions of 'what are our strategic resources?', 'what distinguishes us and gives us potential strength compared to other places?' It may be specific specialties, the culture, relationships, capital assets, and/or community engagement. The question then follows: "can we provide resources, or headroom, to allow those parts of the organisation to innovate and grow?"

(c) The finance role in the innovation process

Dynamic innovation processes require the finance function to:

1. Understand the non-linearity of, and dynamics of, the innovation process

2. Support and enable the development of metrics for innovation

3. Build relationships across disciplines to understand the relationship between cost and quality

And Finance Leaders to:

4. Lead with others (collaboratively) the development of strategic resources (from head-room, to relationships to investment)

How? – The Diffusion of Innovation

This section considers barriers and enablers to the diffusion and adoption of innovation. Relationships have been identified as an important factor. The role of culture is introduced here, linking relationships and environment. Case studies show how organisational features of healthcare can constrain innovation. The role of risk is also considered.

(a) Culture

Hall & Goody (2007)[39] assert that 'culture' is a catch-all category to explain failure to share and implement knowledge and that it would be more instructive to call it a 'power relationship' (p182). McDermott & O'Dell (2001)[40] define culture more generally as the "shared beliefs and practices of the people in the organisation". They link two dimensions by behaviour: a visible dimension (expressed goals) and an invisible dimension (unspoken core values, e.g. risk-aversion), They set out guidelines, advising innovators to harness energy within the organisation: "Human networks are one of the key vehicles for sharing knowledge. To build a sharing culture, enhance the networks that already exist. Enable them with tools, resources and legitimization." (p85)

Dixon-Woods et al (2103)[41] in their study of innovation culture in the NHS cited the following issues that undermined attempts to innovate for quality

- Unclear goals
- Overlapping priorities
- Compliance-orientated bureaucratised management
- Institutional and regulatory environment creating competing demands
- Poor data on quality
- Variable staff support and quality of staff management

In the NHS it is now widely regarded that high performing cultures of quality are related to collaborative leadership (West et al 2014)[42] with The Place-Based Health Commission report (NLGN 2016)[4] citing the need for collaboration on incentives across health and social care and more focus on devising new models of care across organisations. Finance leaders will be playing an active role in both the financial models needed for collaboration, and in achieving collaboration through their active involvement in health innovation.

(b) Risk taking

There is a perception, evident in the literature, that the public sector stifles innovation through a risk-averse culture. Oroyemi (2016)[8] asserts that "the prevalence of bureaucratic governance and risk-averse cultures are held as evidence of innovation stifling cultures and change-attitudes in the public sector" (p37) and this is supported by Dixon-Woods et al (2013)[45].

Bozeman (1998)[43] tested the notion that public sector managers are more averse to risk than managers in the private sector and found that organisations with high involvement with elected officials tend to have a less risk-taking culture. This introduces the notion that the NHS environment, where the Secretary of State is actively involved in policy-making and direction, fosters a conservative attitude to risk. In a cautionary twist, a general search linking Innovation and Finance produced a set of results that highlight the failure, on a global scale, of untrammeled risk.

A search of Web of Science (Web of Knowledge) using terms "Innovation" and "Finance" produced articles mainly dealing with the financial industry at system level and supply of funding via investment vehicles. While the purpose of innovation is to add value, the global financial crash was highlighted as a case of innovation gone wrong, revealing flaws in behaviour, structure and governance. This points to Finance not inherently being a risk adverse culture, but rather the public sector being more inclined to risk aversion.

The following themes emerged from the search of the wider finance landscape:

- Power and fragility of finance (Nesvetailova, 2014)[44] – the financial system has a "seemingly boundless ability ... to adapt, change and evolve" (p542). Financial innovation (by financial agents) is a source of structural power, but the financial ecology is built on complexity and innovation and is fragile.
- Entrepreneurial finance (Chemmanur et al, 2014)[45] – an increasingly large role is played by financial intermediaries, such as venture capitalists and angels, in nurturing entrepreneurial firms and in promoting product market innovation.
- Systemic complexity, interdependence and governance weakness (Pistor K, 2009)[46] – a fundamental weakness in the global financial system was revealed by the global financial crisis that began in 2007. There was a mismatch between the extensive interdependence of financial relations and the reach of governance regimes. The capital base of multinational banks was fortified by Sovereign Wealth Funds (SWFs) and the banks' home governments becoming mutual stakeholders. "From the multitude of individual transactions has emerged a network of equity ties that spans the globe," (p552) bridging institutional practices and governance regimes that were previously independent of each other. As a consequence, the expectation of a converging global governance framework has been displaced by diversity.
- Dangerous innovations (Namaki, 2010)[47] – 'to innovate is to add value', yet structured financial products, i.e. investment vehicles based on asset values, had led to financial melt-down: "asset loss, investment institution collapse, massive government intervention and, last but not least, consumer pain. It is innovation gone berserk!" (p113). Problems include wrong price setting, illiquidity, complexity and lack of regulation. The paper concludes that balancing innovation and risk is essential for innovation to add value.
- Private Finance Initiative (Barlow & Koeberle-Gaiser, 2009[48]; 2005[49]) – the planning,

financing, constructing and operating of new hospitals is considered in relation to design and construction innovation. "The PFI was partly introduced to inject increased innovation into the delivery of healthcare infrastructure" (2009, p126). Case studies found that the PFI model has not generated the anticipated innovation benefits. Risk allocation and lack of integration between PFI consortium and hospital have produced facilities that might not be able to cope with future changes in demand. The authors conclude that adoption of "new public procurement models do not automatically provide efficiency and innovation benefits" (2005, p1392).

(c) The role of finance in diffusion and adoption

Finance in the wider literature is associated with innovation, diffusion and adoption. Reference to innovation and finance in the healthcare sector is, however, primarily restricted to the supply of capital, either through the private finance initiative or for innovation projects that have difficulty in securing funding. The finance role is seen as (and potentially colludes with) providing infrastructure or using money to innovate, rather than being collaborative partners in value generation for quality.

In summary:

1. Aversion to risk is a likely phenomenon of a politicised public sector
2. Finance leaders (wider community) are innovative and not necessarily risk adverse
3. Health finance leaders are associated with specific types of innovation and spread, primarily through the release of resources, rather than leading social value
4. Innovation in the NHS to adapt to current and future challenges is seen to require collaborative leadership
5. There is a role for finance in creating the cultural conditions for innovation and enabling collaborative innovation

Who? – Professionals and the Finance/Information Function

Innovation effectiveness at organisational and systems level is contingent on the relationship between managers and healthcare professionals. Finance staff, although professionals with expertise, are identified as 'managers' in the context of healthcare as distinct from 'healthcare professionals'.

(a) Finance function in the NHS

A census at the end of June, undertaken by HFMA and NHS Finance Skills Development, found that out of 16,211 finance staff working in the NHS, 53% work in financial management roles (a three-point increase from 2013). Financial management duties include strategy, financial planning, management accounting, performance measurement, commissioning and contracting. 27% of staff work in financial accounting roles, across accounts payable and receivable, and treasury functions. 18% work in financial services, including audit and payroll. Overall, the number of finance staff has increased by 3% from 2013.

(Identity is considered further in Annex B drawn from the Journal of Critical Accounting).

(b) Professionals

Styhre (2011)[50] conceives of "professionalism as a form of systematic and institutionalized knowledge sharing". "Today professional life is messier and characterised by relationality" (p10). He uses Leicht and Fennell (2008)'s[51] definition of professionals which emphasises the public nature of professionals, legitimated by society, with expertise based on knowledge that is 'generally acknowledged' (p20):

> *"We define professional work as incumbents: (a) whose work is defined by the application of theoretical and scientific knowledge to tasks tied to core societal values (health, justice, financial status, etc.), (b) where the terms and conditions of work traditionally command considerable autonomy and freedom from oversight, except by peer representatives of the professional occupation, and (c) where claims to exclusive or nearly exclusive control over a task domain are linked to the application of the knowledge imparted to professionals as part of their training (Leicht and Fennell, 2008, p421)"* (quoted in Styhre, 2011, p16)

Professions set up entry barriers, which may be formal (credentials) and informal boundaries, based on complex routines and confidence based on knowledge. Mitton et al's (2007)[52] review of healthcare literature identified 'authority to implement changes' as an enabler to knowledge transfer. Generic management literature assumes that managers have authority because the lines of accountability in private industry may be determined by the organisation. In the NHS there are multiple (and often non-negotiable) lines of accountability due to professional groupings, the dominant one of which is the medical profession[53].

Autonomy and authority of professionals within their sphere can challenge the ability of finance staff to introduce innovation. Relationality offers a way through this.

(c) Relationships and business partnering

Relationships within the organisation are emphasised by professional body CiMA in its report on business partnering (CGMA, 2015)[54]. The focus on business partnering also marks a trend to bring finance staff closer to the heart of the organisation:

> *"Finance business partnering begins after standard reports and analysis have been produced. At this point the focus then shifts from accounting to management. This is when the disciplines of management accounting are applied in the business and insights developed to inform decisions and improve performance. Providing effective finance business partnering is still proving to be a challenge for many businesses. There are capacity constraints and accountants may not be recognised as having the business acumen or soft skills required. It is important that businesses and accountants address this challenge"* (p2)

An NHS corollary is 'Close Partnering', an action area in the FFF initiative, which is multi-disciplinary and being led by a consultant intensivist at the University Hospitals of Leicester NHS Trust. It focuses on three areas: (i) helping clinical staff to understand finance, and vice versa; (ii) understanding stakeholders' views, including those of patients,

the public and clinical staff; (iii) identifying best practice, particularly in the reduction of waste in the NHS. It is a national work stream involving accountants, patient champions, nurses, doctors and allied health professionals throughout the country, as well as specialists in patient safety.

A national inquiry into the productive relationship between Management and Medicine (Kirkpatrick et al, 2012)[55] found these characteristics of effective relationships that are delivering capacity for service innovation:

- Working for the Whole: A negotiated sense of shared identity and collective responsibility for the 'management of outcomes.'
- Working Together: Open, participative and inclusive modes of communication.
- Collaborative leadership styles, both of clinicians and managers.
- Shared Decisions: Greater clinical input into management decision-making at all levels.
- Our Business is Health: A shared focus on the centrality of managing the means of production.

(d) The finance role in collaborative innovation

1. The finance function is varied

2. Professionals innovate within their discipline and find collaborative innovation more difficult

3. Innovation requires better working relationships between clinical professionals and managers

Conclusions

Innovation in the NHS is the translation of ideas and practices into local context (new to here). Whilst the NHS is familiar with technical innovation, much of the challenge of the current and future context requires social innovation – creative solutions generated through relational approaches to generate social value.

This brief review found that 'risk aversion' is a dynamic of a politicised public sector, and not notably attributed to finance in the wider community. Any attribution in the NHS could be a product of the political context.

The literature suggests that finance innovation in the NHS has been perceived to be related to catalysing innovation through allocation of financial resources. However, the finance function and finance leaders have a significant role to play in:

1. The generation of metrics to shed light on and create frustration with the status quo; and to supporting inquiry and change.

2. Securing ambidexterity (focusing on the long term and the short term) to ensure organisational adaptation.

3. Generating a culture of readiness for innovation through more productive relationships with clinical professions and bringing all disciplines' effort to bear on the challenges facing the NHS together.

4. Creating a focus on value, and a balance in the attention given to performance management versus improvement and innovation.

5. Lead with others (collaboratively) the development of strategic resources (from head-room, to relationships to investment).

In terms of the aims of the study, the literature review provided the following insights and leads us to pose the following questions:

Aim 1: Generate clarity within the finance community of what constitutes innovation, and determine a language that the function can comfortably engage with.

The review demonstrated the role of social innovation

> **Question:** *How widely understood is social innovation in the finance community? Are there examples of finance leaders playing a role in social innovation?*

> **Question:** *How do finance leaders see their role in generating social value?*

Aim 2: Understand the nature of innovation in finance and how/ if that differs from other professional groups.

It became clear that the finance role in innovation (in terms of the literature) in the NHS is related to the allocation of financial resources. The perception is that finance is an enabler of other professionals' innovations. This clearly is not the case and has to change. Finance has a significant role in generating metrics for innovation, generating processes that secure value, being collaborators in leading innovation for public good.

> **Question:** *Where there are examples of finance leaders participating in collaborative social innovation, what was it that made that possible?*

> **Question:** *How is the finance function shifting from resource allocation to enabling a culture of innovation with finance as a partner?*

Aim 3: Identify what it takes for finance leaders to innovate individually as well as organisationally. Particularly, what cultural issues feature across the whole of the NHS and what issues are specific to finance in terms of generation and spread of innovation.

The risk aversion of the NHS is predicated on its political context. Anecdotally the finance function is seen to be risk adverse, but given that outside the public sector this is not the case, then it seems that this is a specific dynamic in the NHS.

> **Question:** *What is the proper role of risk in innovation? How is that best collaboratively enacted?*

Question: *Is the finance function perceived as risk adverse, and if so how is that demonstrated? Is that inherent in NHS finance or inherent in the NHS?*

Aim 4: Identify what is needed in order for NHS finance teams to become more innovative, and whether the need varies depending on the nature of the organisation (commissioner/ provider; large/ small).

We have uncovered some critical characteristics of innovation in teams – frustration with the status quo, the need for collective interdisciplinary effort based on effective relationships, the need for metrics that shed light on the problem/issue and that generate intelligence as new ideas are tested, the need to demonstrate value, the need for creative space and openness to ideas, the ability to translate ideas into a local context, the authority to change. Whilst uni-disciplinary innovation is easier, the future is in interdisciplinary place-based innovation.

Question: *How ready is the finance function to take its place in innovation teams?*

Question: *What types of organisations are ready for innovation that incorporates finance as full collaborative partners?*

These questions, stimulated by the literature view, have been addressed through the Inquiry fieldwork that was summarised and presented in Section 1 of this report.

Annex A: Summary of Ilinca et al (2012) All you need to know about innovation in healthcare: The 10 best reads

Why? – The Purpose

Two papers cover: innovation for survival through competitive advantage (Senge, 1990)[56]; and innovation to improve population health through technology (Webster, 2007)[57]. Senge's 'fifth discipline' describes the learning organisation that must be adaptable and, to survive in the market place, must develop a set of core capabilities: clarify goals and be energetic; update mental models and assumptions; crystalise a shared vision of the future; and engage in team learning. It requires systems thinking and an understanding of interrelationships between people and organisations.

Webster provides a sociological critique of the influence of corporations and the profit motive, leading the pharmaceutical industry to innovate and produce technologies that may over-medicalise society. Webster proposes the need the for sociological critique health policy. The two papers are polarized in that Senge's underlying premise is that competition and the search for competitive advantage sets a constructive and creative environment, while Webster views society in terms of power and conflict that will not be resolved through a market mechanism.

What? – The Innovation Process

Three papers cover: innovation as a dynamic adaptation process that is twisted rather than linear (Akrich et al, 2002)[58]; innovation that is path-dependent, relying on limited existing knowledge (Consoli and Mina, 2009)[59]; innovation that is disruptive, starting with small applications that go on to dominate the market and the field (Christensen et al, 2009)[60].

Akrich et al adopt an evolutionary perspective (consistent with Plamping et al, 2009), distinguishing between invention and innovation. There are no guarantees that good innovation will succeed in a linear and rational process. Technology will not be propagated unless key allies support it. (The non-linear nature of knowledge mobilisation in healthcare was also described by Gabbay and Le May (2004)[61] in their influential paper describing 'mindlines' as the route through which general practitioners process evidence and apply it in their patient consultations.)

Consoli and Mina also use an evolutionary perspective at a systems level, where the main conduits are: gateways, through agents interacting within the boundaries of an institution; pathways or trajectories of change, shaped by accumulation of knowledge and the happenstance of time and place.

Christensen et al apply systems thinking to institutional theory. Small, disruptive innovations can take the world by storm, because they are open to being refined by experience, whereas big ideas can get left on the shelf. Three important factors are

identified as: technological enablers, business model innovation, and the value network. Healthcare offers opportunities for innovative technologies that allow complex tasks to be performed by less skilled workers.

How? – The diffusion of innovation

Three papers have been selected by Illinca et al: adoption of innovation (Berwick, 2003)[62]; patterns of diffusion based on actor-network theory concepts (Denis et al, 2002)[63]; a synthesis of literature on diffusion (Greenhalgh et al, 2004)[64].

Diffusion of innovation is the area that has traditionally received most attention. Innovation spreads in healthcare when it relates strongly to its environment. Berwick reviews the field and identifies three main clusters of factors that determine whether knowledge will be disseminated into practice: perception of the innovation; characteristics of the adopters; and a set of contextual factors such as managerial competences of leadership and their capacity to adapt to social and technical circumstances.

Denis et al analyse the characteristics of the innovation, describing a well-defined and relatively fixed hard core that is fundamental to the innovation, surrounded by a flexible periphery that can be manipulated and adapted along the way. The diffusion process is represented by an adopting system involving clinicians and managers who have different and often conflicting interests, and multiple adoption pathways. One diffusion pattern is driven by clinicians who are mainly interested in providing state of the art care. Another pattern is driven by managers who are focused on procedural and structural efficiency.

Greenhalgh et al synthesise literature from a wide range of disciplines to build a comprehensive framework to consider the drivers of diffusion, dissemination, and implementation of innovations. Innovation diffusion depends on: characteristics of the innovation itself; characteristics of the adopters; system antecedents; and inter-organisational networks. Within this, innovations that have been introduced to potential adopters at an early stage are likely to reflect values and expectation of the adopters, and therefore have a better chance of being implemented.

Who? – The Actors

Two papers have been selected, each of which focus on the role of healthcare professionals and sit within 'sociology of professions' literature: the impact of professionalization on diffusion of innovation (Adler and Kwon, 2009)[65]; and the uni-disciplinary nature of professional groups which may isolate them from each other (Ferlie et al, 2005)[66].

Adler and Kwon consider the idea that a high level of professionalism leads to higher levels of diffusion (speed, scope and depth of the innovation adoption process). They argue that, while the autonomy and control associated with professionals gives them a high level of control over diffusion, it may lead to sub-optimal adoption. They are likely to under-adopt new practices that are recommended by managers and over-adopt practices that are championed by professionals and boundary spanners. Innovations supported by

professional associations will diffuse more readily than those initiated at administrative or policy level. Adler and Kwon suggest that organisations can harness the support of professionals by putting in place formal communication channels and strategic controls.

Ferlie et al (2005) find that barriers to diffusion are not only located in professional-manager or professional-government relations, but also between different professional groups. They form tightly knit communities of practice separated from each other by social, cognitive and identity barriers. Strong professional groups have a tendency to block external sources of change and learning. Uni-professional diffusion will therefore be faster than multi-professional initiatives.

Annex B – Search Journal "Critical Perspectives on Accounting"

- Hand search of 2 year history of the journal available on Web of Science
- Selected abstracts and titles relating to healthcare and public sector

1. Management accounting versus medical profession discourse: Hegemony in a public health care debate - A case from Denmark

   By: Malmmose, Margit

   CRITICAL PERSPECTIVES ON ACCOUNTING
   Volume: 27, Pages: 144-159, Published: MAR 2015

   This study uses discourse, ideology and hegemony as a theoretical foundation to investigate the development of the polarised discourses of management accounting and the medical profession during the introduction of a NPM reform in the public health care debate, using Denmark as a case study. 194 newspaper articles and 73 medical profession articles from 2002 to 2008 are analysed, using critical discourse analysis. The analysis shows that the management accounting discourse becomes the dominating ideology which is embedded in the public rhetorical debate. There are three peculiar outcomes of this domination; the absence of physicians in the general public debate, the creation of a phantom phenomenon meaning that the negative consequences of the reform are blamed on a third person, typically the system, and finally a changing meaning of the health care service quality provided from a medical perspective of a patient oriented focus to a quantitative focus through strong rationalised arguments. This puts the medical profession in a dilemma concerning their ideological Hippocratic Oath versus the NPM efficiency focus. However, they choose to gradually adopt management accounting terms in their own medical professional debate. (C) 2014 Elsevier Ltd. All rights reserved.

2. A selective critical review of financial accounting research

   By: Callen, Jeffrey

   CRITICAL PERSPECTIVES ON ACCOUNTING
   Volume: 26, Pages: 157-167, Published: FEB 2015

   This essay provides a selective critical review of the financial accounting literature focusing primarily on accounting valuation including implied costs of equity capital, empirical accounting proxies, and frictions in accounting theory. In the opinion of this author, accounting research in these areas is often too complacent, suffering from a lack of critical reasoning. Complacency distorts research innovation and hinders the long-run sustainability of accounting academe in the area of financial accounting. The examples discussed in this essay include (but are not limited to) the issue of structural modeling and model falsifiability; determining whether a firm is over or underpriced based on valuation models that do not allow for such phenomena;

arbitrarily "merging" two disparate models one for valuation and one for the discount rate; failing to appreciate the empirical limitations induced by risk-neutral valuation models in estimating costs of capital; employing the same proxies over and over again that ostensibly have no underlying theoretical bases; estimating regressions that necessarily yield biased coefficients when the econometrics literature provides ready solutions; and generating complex models absent the frictions that are essential to the issue being researched. (C) 2013 Published by Elsevier Ltd.

3. Relationships between national economic culture, institutions, and accounting: Implications for IFRS

   By: Cieslewicz, Joshua K.

   CRITICAL PERSPECTIVES ON ACCOUNTING
   Volume: 25, Issue: 6, Pages: 511-528, Published: SEP 2014

   National economic culture has an indirect influence on accounting at the national level through the mediating variable of institutions. The relationships are evaluated using measures of national economic culture from Culture, Leadership, and Organizations: The GLOBE Study of 62 Societies (House et al., 2004); measures of institutions from the World Bank (Kaufmann et al., 2007); and measures of national accounting from the Financial Standards Foundation (2008). At the national level, institutions are found to mediate the relationship between economic culture variables and accounting. The empirical findings indicate that accounting in a given nation is linked to the nation's supporting institutions, which institutions in turn are influenced by the national economic culture of those who maintain them. This suggests that altering aspects of accounting within a nation can be expected to entail much more than formal adoption of standards, principles, or innovations. Institutional adjustments must be made and the impact of national economic culture must be understood and appropriately addressed. (C) 2013 Elsevier Ltd. All rights reserved.

4. A 'panoptical' or 'synoptical' approach to monitoring performance? Local public services in England and the widening accountability gap

   By: Eckersley, Peter; Ferry, Laurence; Zakaria, Zamzulaila

   CRITICAL PERSPECTIVES ON ACCOUNTING
   Volume: 25, Issue: 6, Pages: 529-538, Published: SEP 2014

   This article highlights how recent reforms to the auditing and assessment of local public services in England suggest there will be a shift from panoptical to 'synoptical' monitoring approaches. This is because the UK Government has abolished its centralised monitoring regime and instead required local authorities to publish a range of financial and performance datasets online, ostensibly so that citizens can hold organisations to account directly. However, the complexity and raw nature of these data, along with the sidelining of professional auditors, will result in most citizens being either unable or unwilling to undertake this task. As such, the proposed

'synoptical' approach will not materialise. Indeed, other legislative changes will mean that outsourcing firms effectively become the new, unaccountable observers of local public sector bodies within an enduring panoptical system. In many cases these companies will then assume responsibility for delivering the same services that they have assessed. (C) 2013 Elsevier Ltd. All rights reserved.

5. Accounting, innovation and public-sector change. Translating reforms into change?

By: Liguori, Mariannunziata; Steccolini, Ileana

CRITICAL PERSPECTIVES ON ACCOUNTING
Volume: 25, Issue: 4-5, Pages: 319-323, Published: JUL 2014

No abstract

6. Accounting change and value creation in public services - Do relational archetypes make a difference in improving public service performance?

By: Bruns, Hans-Juergen

CRITICAL PERSPECTIVES ON ACCOUNTING
Volume: 25, Issue: 4-5, Pages: 339-367, Published: JUL 2014

Evidence points out that the outcome of accounting change in local governments is not simply a matter of `corporate' resource investments and change management activities to accounting system replacement. This paper examines the link between such corporate level interventions and the patterns of value creation at street-level. It emphasizes a resource-and capability-driven approach to explore processes and consequences of an 'embedded agency'-effect assigned to the street-level rationale of public service improvement. Considering a logic chain of cause-and-effect sequences, the data analysis provides evidence that corporate and street-level interventions are unique dimensions to signify the multiple patterns of accounting change in local governments. The supplementary effect of cross-functional relationships is also distinguished, considering the relational archetype as a mechanism to explain the emerging outcome state. Recognizing the distinction and the sequential effects of relational archetypes induces a refined typology of accounting change according to its processes and outcomes in local governments. The analysis is based on a comparative case study design to explore accrual accounting introduction in six German municipalities. (C) 2013 Elsevier Ltd. All rights reserved.

7. Public sector governance and accountability

By: Almquist, Roland; Grossi, Giuseppe; van Heiden, G. Jan; et al.

CRITICAL PERSPECTIVES ON ACCOUNTING
Volume: 24, Issue: 7-8, Pages: 479-487, Published: NOV 2013

No abstract

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