Clinical Engagement with Finance: Now More than Ever!

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Abstract:
The COVID-19 pandemic has affected all aspects of healthcare. The NHS has had to manoeuvre faster than ever before, which is remarkable for a huge organisation known to advance slowly and steadily. The adaptations have had both positive and negative impacts. There were also funding changes, in the form of temporary contractual arrangements. As the NHS plans for the future, an opportunity has arisen to fundamentally change the NHS funding structure.

This article will describe the effect of COVID-19 on healthcare finance, the challenges in developing a new payment structure, and the role that clinicians can play in helping shape funding arrangements in the future.

Introduction:
The NHS has been under immense financial pressures as, in real terms, the budget has remained virtually static since 2010. Overspend in the revenue budget (day to day running costs) has required money to be diverted from the capital budget (used for buildings, equipment etc.) on several occasions, resulting in a massive maintenance backlog. Lack of capital expenditure will lead to a decline in performance and outcome.

In June 2018, the government set out a funding programme through to 2023-24, to help NHS achieve the goals set out in the Long-Term Plan. This programme aims to provide an average increase of 3.4% a year over the five years to help put the NHS back on a financially sustainable path.¹

Analysis by the Institute of Fiscal Studies in 2018 suggested that healthcare spending needs to increase by 3.4% a year for the next 15 years to maintain the current standard and at least 4% if the services are to be improved.²

To implement the Long-Term Plan and see it through to its full potential, a restructuring of NHS finance was already ongoing. One of the reforms included changes in the payment models. In 2019/20, emergency care and adult mental health services funding moved away from a tariff-based system to a blended...
payment model. It aimed to align with the commitments in the Long-Term Plan.

On the backdrop of pre-existing austere financial climate and amid remodelling of financial architecture for NHS, the pandemic of COVID-19 cast a grim shadow.

THE RESPONSE TO THE COVID-19 CRISIS:

On the 30th January 2020, as part of the NHS England Emergency Preparedness, Resilience and Response Framework, a level 4 national incident was declared, allowing NHSE to control and direct all health service resources in England through its national teams.

NHS organisations were asked to prepare for a surge in coronavirus patients, who had up to that point been treated in specialist infectious disease units. Areas for consideration included reviewing clinical pathways, especially for respiratory illnesses, potential expansion of critical care capacity, and planning for segregated areas.

By mid-March 2020, it was clear that coronavirus would cause a significant burden on NHS resources. NHSE asked organisations to completely change their way of working by postponing non-urgent elective operations, freeing up hospital beds by discharging medically fit patients with responsibility transferring to community providers, and shifting to remote consultations where possible. Organisations had already incurred substantial costs in the procurement of the PPE, preparing for critical care expansion and in building work to create a safer work environment for staff.

These changes would not be catered for in the existing payment structures, so a temporary payment system was introduced. All NHS providers were guaranteed a minimum level of income to cover their costs by introducing a block contract system from 1st April until 31st July 2020.

Clinical Commissioning Groups (CCGs) would provide a monthly payment to NHS providers (Acute, Mental Health, Community and Ambulance Trusts) based on their average expenditure in December (month 9) plus some uplifts to factor in inflation and pay uplifts. Some extra funding would also be added to the payment based on how much a Trust would usually earn for treating patients from outside their area (non-contracted activity). NHSE would also provide a top-up payment if their cost base is higher than the guaranteed income from Commissioners.

Extra funding could also be claimed for additional activity-related costs concerning COVID-19. For example, increased staffing, temporary staffing to cover staff sickness, or increased swab testing and processing.

Primary care also had their income protected, including payments that would have been received for providing enhanced services and the performance-based quality outcomes framework related payments (QOF).

Usually, such a comprehensive funding plan would not be possible within the resources available to the Department of Health and Social Care (DHSC). Fortunately, in the week before this announcement, the Chancellor of the Exchequer committed in Parliament that “Whatever resources our NHS needs to cope with the coronavirus – it will get.”

THE LONGER-TERM IMPACT OF COVID ON NHS FINANCE:

The current block contract-based payment arrangements will likely continue in some form, until the end of the 2020/21 financial year. However, later arrangements are unlikely to be as generous as those made earlier in the year. Despite the fact that the NHS finance appears to be ever-changing, the future regarding these new systems looks more unclear than ever.

Every aspect of the healthcare “business” has changed. Some of these changes are discussed below:

Models of Care

• One of the positives to emerge out of the pandemic was the rapid implementation and use of remote consultations, whether by phone or video. Occurring in both primary
care and outpatient environments, this has completely changed how these areas work. Face to face consultations are still necessary, but work will be done to determine the proportion of each consultation mode that will be required in future. This will directly affect the available capacity and cost base for running these services, and will also indirectly affect the logistical and infrastructure requirements (dictation, records management, IT availability, waiting room requirements).

- Models for COVID-19 aftercare in community and GP support for the ‘shielding’ cohort will need development. This will put additional financial and staffing pressure on primary care, mental health, and community health services.

- There is a need for a systems-based approach to service, which may require changes regarding where money is invested. For example: if blood tests are required after a remote consultation, is there a unified phlebotomy service across the system or does the patient have to visit the hospital/GP practice dependant on who orders the test?

**Changes in Demand**

- The challenge now facing the NHS is to maintain the capacity to provide high-quality services for patients with COVID-19, whilst also increasing other urgent clinical services and diagnostics and planned surgery. Also, in due course, routine non-urgent elective work will need to be resumed to pre-COVID levels in order to work through the backlog that is derived from suspended services during the initial part of the COVID-19 crises.

- During the initial COVID surge, there was a marked reduction in emergency activity and non-COVID emergency hospital admissions. However, these will return to normal levels, but with the added possibility of future increases in COVID-related admissions. Organisations will need to ensure that their bed capacity is flexible enough to cope with changes in demand.

- There will be increased pre-admission testing of all elective and non-elective patients, as well as increased vaccination programmes, increased mental health referrals, and enhanced social care and community care are other areas expected to need special consideration. As always high standards of personalised care and patient experience will be expected, regardless of the extreme demand of the situation.

**Forecasting and Budgets**

- The baseline for contracting arrangements between commissioners and providers and departmental budgets is usually calculated using the activity data from previous years and predicting future changes in activity. This will be challenging due to uncertainty over this and future pandemics, and the different ways of working that have developed.

**Costs**

- The cost base for all care will have markedly changed. At patient-level, there will be increased staffing requirements, increased use of PPE, testing, and segregation pathways will lead to increased inpatient costs.

- The pandemic is likely to have highlighted more infrastructure deficiencies which will need to be addressed on top of the existing maintenance backlog.

**Income**

- The current financial regime is unsustainable, particularly with the grim national economic outlook.

- There was already a move away from activity-based payments, with the introduction of blended payments for emergency care. Unfortunately, block contracts are reliant on accurate cost and activity information, which is difficult to predict.

- There are fears that without some tariff-based component to drive elective activity, waiting lists will rise.

- Any future payment system/contracting arrangement will need to be flexible to appreciate local differences in activity levels and underlying cost base, whilst incentivising activity to deal with demand.

THE QUESTION IS, HOW DO WE ENGAGE THIS AS YET UNTAPPED CLINICAL WORK FORCE?
IMPORTANCE OF CLINICAL INVOLVEMENT:

It has been well established that engagement between clinicians and finance professionals is vital for providing the best care to patients with the finite resources available. A Department of Health report in 2013 stated,

“Effective engagement between clinicians and finance professionals is the key to improving value in the current financial environment. It must be embedded within each healthcare organisation’s culture and practices and considered an important element of any high performing, patient-centred organisation.”

Despite this, a survey carried out in 2016 by the Department of Health as part of the annual cost collection showed that collaboration was far from embedded into provider organisations.

The figure above suggests that whilst there is some collaboration, it is patchy and probably still only involves clinicians in senior management roles (directorates). It is important to state that these are self-assessments by finance teams and, due to the nature of the survey, are skewed towards clinical involvement in costing.

The introduction of Patient-Level Costing Information Systems (PLICS) has undoubtedly been a driver for a better clinical understanding of financial matters. The HFMA Costing for Value Institute and the pilot EVO (Engagement, Value, Outcome) scheme that it ran with Future-Focused Finance have highlighted the benefits of clinical engagement. The limitation of these projects is that they attract clinicians who are already interested or involved with finance. They are often from organisations that already have good collaboration between their clinical and finance teams and wish to gain even more benefits.

Primary Care is almost forgotten when discussing healthcare finance- it is often thought that GPs, as business owners, are used to managing their finances. However, with ever-increasing numbers of multi-practice partnerships, companies or even provider trusts running GP surgeries, it is becoming increasingly important that GPs also understand how finance in the wider NHS works. Not to mention, all of the GP-based non-medical clinical staff such as the nursing, pharmacy, and allied healthcare professionals whose roles are increasing in scope.

COVID-19 AND FUTURE OPPORTUNITIES:

We have already touched upon some of the challenges the NHS faces in the short to medium term. Clinicians will play an important role to help organisations navigate the various changes described above. The main motivation, quite rightly, will be providing good patient care. However, these decisions must be informed by an understanding of how services are funded and how much services cost to run.

There are probably three key areas where clinical engagement is paramount to ensure value is achieved: clinical pathways, staffing and, equipment.

**Clinical Pathways:**

- The shift to virtual consultations, both in primary and secondary care, is likely to continue as part of a hybrid model. This will likely mean greater use of community-based teams, with the aim of limiting attendance at secondary care facilities. Clinicians (particularly nursing and allied health professionals) need to be involved in
How can finance engage with clinicians?

Finance professionals are often keen to engage with clinicians, whilst clinicians are keen to develop, improve and expand their services which often requires financial investment.

Relationships between finance and clinicians are required at Board and directorate level, although they may not always be the most productive. How do we engage the rest of the clinical workforce?

Arming clinicians with some understanding of the financial structures that underpin their services will help. This needs to be done in a way where finance can appreciate how changes in funding can affect the services provided, and vice versa: clinicians must be aware of how service changes and quality improvement will affect funding.

Communication is key; although ensuring lines of communication are kept open is a major component, there are additional elements. These include, but are not limited to, the language that is used, and how the data is presented. Efficiency, CIP (cost improvement plan), and targets all have negative connotations, with clinicians feeling that money is being prioritised over patient care.

Similarly, spreadsheets and tables are hard to decipher, whereas graphs and infographics of key points and messages entice clinicians to interrogate the underlying data.

A starting point for finance professionals attempting to engage clinicians would be to show the clinicians activity data and associated coding/costing data, which could be at the ward, speciality or individual level. The next step is crucial, as a common initial reaction will be criticisms of the data quality. By showing where the data comes from, clinicians will often get involved in improving data quality both for income and cost data. Once there is confidence in the quality of data, it can be used to make service improvement or changes to clinical pathways.
How can clinicians engage with finance?

In some ways, it is more straightforward for clinicians to engage with finance. For all the reasons described earlier, clinicians must be involved in how resources are utilised.

It will be easier for clinicians to gain knowledge of the pressing financial issues if they gain some understanding of how their service is funded. No-one is expecting clinicians to be accountants, however there are numerous free resources on offer from both Future-Focused Finance and the HFMA, or one can simply ask a local finance professional.

The requirement for clinicians is not to see the finance teams as barriers to development but as useful allies to help navigate the complexities of the healthcare system. Utilise the value equation to frame service improvement ideas so that everyone understands the benefits.

Looking on the bright side:

The first surge brought out the best of the NHS, with everyone in all parts of the healthcare system coming together with a common purpose.

This extraordinary response has also brought out some excellent leadership, which has allowed us to maximise the beneficial changes achieved. Some of these include local partnerships, rapid scaling of new technology-enabled services and remote working. Harnessing the lessons learnt may allow us to reconfigure and improve our services, and to be more prepared for any future waves.

There is some time for a new payment system to be developed and evolve. This is likely to involve whole system budgets, and perhaps a link between funding and outcomes. The extra funding given to the NHS will be time-limited and, with a struggling economy, large funding increases are unlikely to be sustainable. High level of engagement between clinical and finance teams will enable the difficult cost and quality decisions to be made together.

References:


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