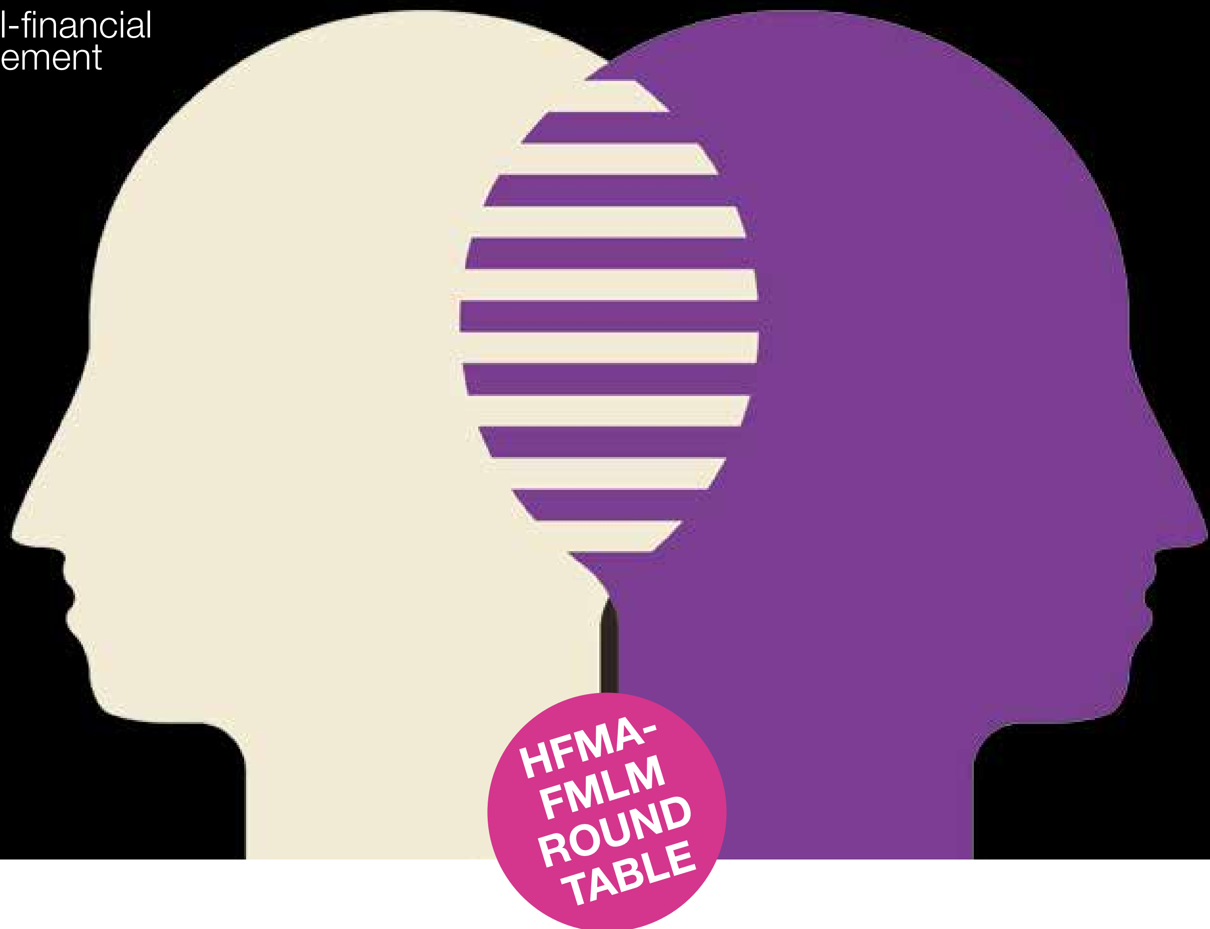


Collective response

Covid-19 has provided challenges for collaboration between clinical and finance staff, but it also led to positive changes. A virtual roundtable in September looked at the importance of continued joint working as the NHS rebuilds post-virus. Steve Brown reports

The NHS is no stranger to calls for closer working between clinicians and finance professionals. However, the Covid-19 pandemic has increased the importance of collaboration as the service looks to capture permanently some of the new ways of working put in place.

A recent virtual roundtable organised jointly by the HFMA and the Faculty of Medical Leadership and Management (FMLM), in association with Future-Focused Finance (FFF), set out to explore how clinicians and finance can work together to build a new, stronger NHS post-Covid.

Roundtable chair Su Rollason, chief finance officer at University Hospitals Coventry and Warwickshire NHS Trust, asked the clinicians and finance managers taking part to describe how well clinicians and finance professionals were working together before Covid.

There were plenty of examples of good practice, but also a concern that engagement differed from team to team and from organisation to organisation. And engagement across whole systems could be improved.

GP and West Hampshire Clinical Commissioning Group chair Sarah Schofield said the creation of clinically led CCGs had catapulted GPs into the position of taking decisions about major budgets. 'We were thrown into a financial environment very quickly where we had to address financial decisions that had huge impacts on our population,' she said. 'It was fundamental to the set-up of CCGs that clinicians had to work very closely with finance. I have learnt a lot from them, but it requires a clinical mindset that values that experience as much as clinical experience. There is a lot to be gained from both parties.'

Madi Parmar, director of contracting at University Hospitals Birmingham NHS Foundation Trust, said the historic perception by clinicians of finance staff being preoccupied with money and not appreciating quality still prevailed in some areas. But she also suggested that clinicians can have a fear of finance.

'Some clinicians have suggested they don't like to be ill-informed and this can lead to them not getting involved in the finance business arena,' she said. 'So there is an important role for finance colleagues to remove this fear and ensure we are sharing finance information in a very accessible way. Engaging and using a common language is really important – it might be something as simple as pictures not pivot tables.'

Tools and approaches such as service line management have helped to foster joint working around service improvement in some organisations.

Tim Yates, neurology registrar and chief medical information officer at the Royal Free London NHS Foundation Trust, said his trust's system had seen some success. 'Where this works, it works tremendously well. For example, the management and costs around our therapy services were hugely improved by a clinician getting to grips with the service's finances,' he said. 'But that only works where the clinician takes the time to understand how to read the financial reports and then engages with that. Where that hasn't happened, the service line management process is unsuccessful.'

Dr Yates suggested there is still a tendency for clinicians to see finance as a function to restrict their opportunities for innovation. And he said

Top (l-r): Sarah Schofield, AK Maheswaran, Ros Preen
Centre: Madi Parmar, John Devapriam, Jenny Ehrhardt
Bottom: Su Rollason, Kate Langford, John Graham

HFMA-FMLM ROUND TABLE

Participants

- Paul Buss, Powys Teaching Health Board
- John Devapriam, Worcestershire Health and Care NHS Trust
- Jenny Ehrhardt, Manchester University NHS FT
- John Graham, Stockport NHS FT
- Kate Langford, NHS England
- AK Maheswaran, University Hospitals of Leicester NHS Trust
- Madi Parmar, University Hospitals Birmingham NHS FT
- Ros Preen, Shropshire Community Health NHS Trust
- Chair: Su Rollason, University Hospitals Coventry and Warwickshire NHS Trust
- Sarah Schofield, West Hampshire CCG
- Tim Yates, Royal Free London NHS FT

this was reinforced if improvements or innovations by service lines didn't lead to opportunities to invest in that service.

Paul Buss, director of clinical strategy and interim medical director at Powys Teaching Health Board, said he had seen a sea-change in clinical-financial engagement in the past five years. 'Twenty years ago, clinicians saw finance managers as knowing the cost of everything and the value of nothing, but now I see really good relationships developing,' he said.

'Finance is an incredible reflector of behaviours in our system. So when you look at the money, you see the clinical behaviours and comparative differences between organisations. For me, it is finance data that raises all the really interesting questions and I think the dialogue has changed. There is less fear now in conversations between finance and clinicians and there should be more expectation of these conversations happening. It should just be the norm in a modern healthcare system.'

Consultant anaesthetist at University Hospitals of Leicester NHS Trust and FFF clinical engagement lead AK Maheswaran agreed that the perception of finance had changed in recent years. 'When I first got involved with FFF about five years ago, there was definitely a perception among clinicians that finance colleagues were barriers to what they were trying to achieve. But as I engaged with finance professionals, I found they were very keen to engage but often didn't know how to.'

And 'finance for clinician' sessions over the past few years have shown there is a real appetite for finance knowledge among clinicians – particularly at the new consultant and senior registrar level. Again, the issue is with knowing how to engage and finding a common language.

Dr Maheswaran also believes there is an 'obsession with business cases and income generation', with clinicians feeling they have to know how they are going to make more money rather than focusing on quality or the broader system impact of new ways of working.

Ros Preen, director of strategy and finance at Shropshire Community Health NHS Trust, said it was great to hear about the positive examples of good engagement that were supported by tools such as service line reporting or patient-level costing. 'But it is not a level playing field,' she said. 'Some of these tools make these conversations easier – but we should remember there are parts of the NHS where service line management information doesn't exist. And those conversations have to be formed in a different way in order to support change – you have to be creative and use what you've got at your disposal.'

Covid impact

The Covid-19 pandemic has provided major challenges for the NHS, with a significant burden put on frontline staff. Many clinicians were redeployed as the service put a huge amount of focus on treating patients with the virus, while running other core services in a Covid-secure way.

Support functions, including finance, have also faced major upheaval. Again, staff have often been redeployed to support the supply of personal protective equipment or to help the frontline effort in other ways. And many finance departments have moved wholesale to homeworking.

This has had both negative and positive impacts on ongoing joint working. Regular interaction between finance, clinicians and operational managers on budget management has reduced as financial considerations became less of a priority. Ongoing and year-end engagement over costing data was also put on hold as normal summer costing deadlines were pushed back until the end of the year. But in other ways, the pandemic has enhanced collaboration.

Ms Parmar said that, in the early stages, some sections of the wider finance team became much more visible to the rest of the organisation than normal. Procurement staff, for example, were working seven-day shifts to ensure PPE was procured and moved around healthcare sites to where it was needed.

'It was the same with payroll,' she said. 'Setting up the Nightingale hospital in Birmingham, we had to get thousands of payroll changes implemented in a few weeks, such as medical rota changes and putting temporary bank staff and student nurses onto the payroll very quickly. This shone a light on back-office areas of finance and we became a bit more visible to the organisation in terms of what we contribute, including finance staff repurposed from other teams.'

The contracting function was also able to use project management, analysis and diplomacy skills to broker new pathways – for example, for direct access imaging and to support the rapid adoption of a confer-before-refer model in outpatients. Finance staff were able to facilitate

> **"There is an important role for finance colleagues to ensure we are sharing finance information in a very accessible way, engaging and using a common language"**
> **Madi Parmar, University Hospitals Birmingham NHS FT**

discussions, manage queries and set up reporting mechanisms to ensure new pathways were working as intended, Ms Parmar said.

'We managed and supported the clinical primary and secondary care interface, talking to clinical teams and GPs, ensuring good communications, troubleshooting and providing information. Working as a close team from the start has helped to break down a lot of barriers.'

John Graham, finance director at Stockport NHS Foundation Trust, agreed that some of the redeployment of finance and procurement staff had really helped to mix people in together. 'It gave people a chance to appreciate each other's roles, whereas before there was perhaps a tendency to just go about doing your job and we didn't get the interaction with clinical colleagues.'

Changing the governance arrangements also helped, he added. 'We stood down a lot of our formal board committees and set up clinical, workforce and financial advisory groups. In the early days, these were meeting daily. We were presented with some great ideas and were able to turn these around really quickly. That positive outcome helped, as a I think clinicians started to see us as enablers and facilitators. The challenge is how we keep some of that going on.'

John Devapriam, medical director at Worcestershire Health and Care NHS Trust, said he had found Covid to be a good experience in terms of collaborative working, building on the trust's focus on quality and sustainability in recent years. 'We had to act quickly and clinicians got together to look at the best things to do in terms of clinical pathways and services. And finance colleagues corralled around us to support us. Trust was a key issue.'

However, he said, while he experienced clinicians getting together across systems to think through how pathways worked across organisational boundaries, it would be good to see clinicians and finance all collaborating at the system level.

Fundamental questions

Dr Buss believed Covid was asking fundamental questions about finance and the model for delivering services. 'We threw a lot of money at what was an old hospital model out of necessity,' he said. 'But now we are reflecting about the potential of digital working and how we can look after patients very differently.

'If you follow the money at the moment, it is invested in the hospital, but the really big challenges in the next 10 to 15 years post-Covid are going to be diabetes and dementia. And the model is going to be a social, primary care and mental health one.' He said clinicians and finance would need to work together to make this transition.

Ms Parmar said one of the key roles of finance leaders was to navigate some of the tricky issues. 'One of the issues thrown up for us has been around phlebotomy, where we have separate primary care and secondary care phlebotomy services,' she said. 'What we are reflecting on now is whether we can have a system phlebotomy service that is primary and secondary care agnostic.

'The challenge, as system finance leaders, is to find a way to pool our resources for phlebotomy and thereby help to design a service where it doesn't matter who the patient is referred by – removing the obstacle to further effective clinical pathway change. Sometimes it is these small issues that can derail some of the bigger things we want to do around transformation.'

Kate Langford, medical director for systems improvement and professional standards for NHS England's South East region, said a big difference she observed during Covid was the way it gave people courage to do things without waiting for formal permission. 'The move to virtual outpatients was a good example of that,' she said. 'We've been trying to make the move for a really long time, but everyone could always think of one more thing that might go wrong. Suddenly it became a necessity and we did it. And we got through the teething problems and it worked. That shift has brought together colleagues from clinical areas and finance.'

Dr Langford acknowledged that the temporary financial regime – with money not allowed to be an obstacle to the frontline response – facilitated this. 'But it is those relationships that we now need to build on and nurture because we finally got people in the same room talking in a "let's do this and then sort out the problems"-type of way,' she said. 'That was really very healthy.'

Ms Preen said the command and control approach taken to support the response to Covid at system level had helped with rapid decision-making. Lessons should be learnt for the way sustainability and transformation partnerships go about business in future. But she said the service has also benefited from having a real clarity of purpose. Systems and solutions were put in place because the funding was secure.

Also solutions such as digital systems had national backing, due diligence had been done once and organisations could just deploy. She said there was a real danger that processes would slow down again as finances re-tighten and the service returns to local decision-making.

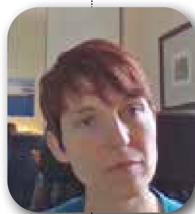
Dr Maheswaran said that in Leicester, a lot of clinical engagement around costing had been disrupted by Covid and effort was needed to get this going again. But virtual meetings had enhanced engagement in other areas, enabling clinicians to take part in meetings they previously wouldn't have attended. 'Often, to attend meetings, I lose at least half a day of clinical time to factor in travelling,' he said. 'Now I can arrange cover for 30 minutes or an hour and attend from within the operating theatre complex, where I can easily be reached if any problems arise.'

Jenny Ehrhardt, group chief finance officer at Manchester University NHS Foundation Trust and FMLM treasurer, underlined concerns about the impact that uncertainty – over what comes after the temporary finance regime – might have on engagement. 'As we think about recovery, there is a frustration that we don't yet know what the money will look like in the next half of the financial year,' she said, 'and that's been a hindrance in terms of decision-making, which then has a negative impact on engagement.'

Participants expressed concerns about falling back into old habits or previous ways of working, both in terms of frontline services and governance arrangements.

There is an understandable focus on the waiting list backlog and the resources that might be needed to address this. But Dr Buss said the service should avoid traditional responses. 'We need to resist going back to the same old. We've got to resist moves to just having more people – particularly doctors – and be talking about how we can have more differently. I think that is one of the things we've learnt from Covid. We want more different things. And the challenge from clinicians back to finance should be that we don't want a blanket approach.'

But Mr Graham was concerned about existing staff. Frontline and support staff had worked hard and in stressful circumstances. 'How do we keep that resilience going and how do we support people?' he asked.



"We don't yet know what the money will look like in the next half of the year – and that's been a hindrance in terms of decision-making, which has an impact on engagement"

Jenny Ehrhardt, Manchester University NHS FT

Top: Ros Preen and Sarah Schofield
Bottom: Su Rollason and Tim Yates

Ms Parmar also warned that the 'pendulum was swinging back on reporting' as the service moved into phase three of the response. 'There is a danger that we will get swamped with multiple rapid turnaround template returns resulting in a disconnect between "back-office" finance and the real redesign work that is going on at the coalface, which does not lead to accurate modelling and is not a good outcome for anyone.'

Dr Langford stressed the importance of finance staff helping clinicians to understand the financial changes accompanying the move to phase 3.

'I would love to see people capitalising on the new-found personal relationships formed through Covid to explain to clinicians about the reporting requirements and the new rules around financial flows.'

Participants were asked what they wanted to happen to improve joint working in future. Several participants said the tariff system should not be reintroduced, with the old payment by results approach creating perverse incentives. For example, moving to new ways of delivering outpatient appointments could lead to a loss of income for the provider.

However, Dr Schofield said payment systems could be used to good effect to improve population outcomes. In the US, for example, she said reducing payments for Caesarean section had incentivised a health system to invest earlier in the pathway to improve the health of young women and new-born birth weights across the system.

Dr Langford said the clinical and financial focus must to be on pathways. Ms Preen agreed and called for an emphasis on system-based costs along the pathway – to support a better understanding of resources consumed in providing care – rather than income. NHS England and NHS Improvement had already started to move away from the tariff system before introducing the temporary block contract approach during Covid. But there are increasing calls for faster adoption of aligned incentive-type contracts or moves to population health budgets.

Dr Buss would like to see a chief value officer appointed by all providers overseeing a move to integrated reporting – a medical director or assistant director who would work closely with finance to educate all staff on the importance of value-based healthcare.

Dr Maheswaran said it would be important to be able to explain the system simply to clinicians and avoid unintended consequences. It would be a backwards step if the move away from payment by results led to a reduced focus on clinical coding. He said there were big opportunities to improve value by moving investment earlier in the pathway, but clinicians needed support from finance teams to make this happen.

Summing up, chair Su Rollason said the challenges and changes forced by Covid presented an opportunity to change the way clinical and financial professions work together.

'We need to capitalise on this,' she said. The improved visibility of finance should be maintained. And the two disciplines should continue to implement change at pace, building on some of the successes achieved during the initial Covid response.

"The burden on finance staff in terms of reporting seems enormous... It was great that we were able to throw those shackles off briefly"
Tim Yates, Royal Free London NHS FT

In general, there were calls for finance to get more involved with workforce issues and to create better links between workforce and financial planning – with finance staff working with clinicians to understand the costs and benefits of new roles.

Ms Ehrhardt called for a pragmatic approach to prioritising service change. 'Every service is looking to build back better and there is an issue with the sheer scale,' she said. 'Will finance and operational teams have the capacity to respond to all the change that is important to individual clinicians? There is a risk that we don't do anything because we can't get our heads around all of it. It would be better to do some things really well than to do everything thinly.'

Governance changes

Some reporting requirements were also relaxed during Covid – while new daily sitreps were introduced to provide a national view of the infection's spread and impact. But overall there was a feeling the focus was on acting and doing rather than reporting. Dr Devapriam said direct virtual conversations between clinicians and finance enabled agreements to be made outside of the usual bureaucratic arrangements. 'We need to look at how we can continue some of this,' he said. 'So if there was a clinical idea on how to implement something, you could have a conversation with finance and implement and test it without going through all the approval and business case processes. It needs to be about rapid implementation and real-time learning.'

Dr Yates echoed this. 'The burden on finance staff in terms of reporting seems enormous and that gets in the way of dialogue with clinicians and the ability to focus on other things,' he said. 'It was great that we were able to throw those shackles off briefly.'

Having access to finance staff at the Royal Free had worked well, he said, and organisations that had chosen to offsite their back-office functions might want to think about the implications for future engagement with clinicians.