



Royal College
of Nursing

Nurses' business

*An introduction to costing
and coding health care*



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Introduction

There can be no doubt that nursing is moving into an increasingly consumer orientated and business focused environment. Some of this change has obvious benefits for the public, especially when there is a welcome focus on patient needs and the quality of care patients receive. For nurses and nursing in general the benefits are sometimes less easy to see, particularly in light of the impact on nursing of substantial financial deficits during much of 2006.

However, within this environment there are opportunities to refresh our understanding of how nursing fits into this world and how nurses can take quite simple steps to make a business case for nursing – to translate the focus on pounds and pence into a focus on high quality patient care – and make the nursing contribution more visible.

This booklet primarily reflects the financial reform agenda in NHS England, although there are some principles which nurses in Scotland, Wales and Northern Ireland may also find useful. While aimed at nurses working at ward manager level and above, this booklet has been designed to be accessible to all levels of nurses including health care assistants and nursing students.

Within each section there are questions and challenges to consider which we hope you will find helpful in developing your understanding of how the reform of NHS England funding flows will impact upon your practice.

Why bother? I'm a nurse, not an accountant

Nursing has been defined as the use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life – whatever their disease or disability – until death.¹

Nursing takes place in a bewildering array of settings and has proved a difficult activity to measure and cost. Almost every NHS organisation around the country is asking why services are organised in the way they are, and asking practitioners to explain how they spend their time. Where there are gaps in nurses awareness of finance issues, gaps in activity data, or a lack of understanding of how nursing impacts on patient outcomes, this can raise questions about the effectiveness of the service, how well resources are being spent or even whether the patient benefits from the service are being delivered at all.

To be clear, this guidance isn't about understanding finance for finance sake, nor is it about getting into lengthy technical debates about how to measure the contribution of nursing. This is an opportunity to begin to understand how funding flows around, in and out of the NHS, and what role nurses can play in explaining what happens in between and – as a consequence – how nurses can influence service redesign.

There is a huge interest in cost effectiveness within health care which can provide some difficult challenges for nursing. However, there is also an opportunity to make sure that what is being measured and costed is based on a clear understanding of what happens, why it happens, what the outcomes are and who is involved.

While this booklet does not exhaustively cover NHS finance or all the work on measuring nursing activity, it does outline some basic steps that can be taken to raise understanding around nursing activity generally. This should create a useful starting point for discussions around improving the quality of care, the efficiency of the service and help to reduce the amount of time and resources wasted – both yours and that of patients.

What this booklet contains

Payment by results in a nutshell

Written by the Healthcare Financial Management Association (HFMA) this section provides a wealth of information about *Payment by results* (PbR), the new system by which money flows around the NHS in England. It gives an overview of the NHS financial environment and deals briefly with the challenges for commissioners and providers under PbR.

Nursing the numbers: coding, costing and data

As a result of the introduction of the PbR process for reimbursement for patient care, clinical coding is an important but often misunderstood part of the commissioning process. In fact it is only one step in a more complicated scheme that is outlined within this section. Alaric Cundy and Anne Casey (RCN adviser on informatics) outline issues in clinical coding, the nurses' role and future developments in this area.

Turning the corner: creating sustainable services

This section from former KPMG executive adviser and nurse, Emily Watling, provides some practical tips for those involved in service redesign or 'turnaround'. It outlines challenges for nurses in acute trusts, gives ideas on how

to improve the business function of ward areas, and provides guidance on how to prepare for and engage with any external financial advisers working within the NHS.

Top ten survival tips from nurses on the front line

Nursing Standard award winners and specialist nurses from across the UK contribute to these 10 pointers for nurses on surviving and thriving in a business orientated environment.

Glossary of terms

This is an abridged version of the RCN's own glossary of terms, which is available on the RCN website at www.rcn.org.uk/policy/briefings/glossary_of_terms.pdf, with easy-to-access definitions and useful links to other organisations and resources for those wanting to know more.

We hope that you will find this publication a useful starting point for discussions, not just with your own health care team but also with business managers and finance teams about how you can all work together to build sustainable, high quality patient-centred services and keep nursing visible and vital in the business of delivering and commissioning patient care.

RCN Policy Unit

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1

Payment by results (PbR) in a nutshell

1.1 The concept of PbR: what is it?

The HFMA definition of PbR is as follows:

“Payment by results (PbR) is based around the use of a prospective, tariff-based system that links a preset price to a defined measure of output or activity.”

1.2 The concept of PbR: general principles

PbR is a radical and fundamental change to the way funds flow between commissioners and providers of health care. It does not in itself affect the way funds flow to commissioners – they still receive allocations from the Department of Health (DH) based on a ‘weighted capitation formula’ (in other words, a formula for distributing government funds which takes account of the size and profile of the population served by each primary care trust). However, it does affect the flow of funds between commissioner and provider. Traditional block/cost and volume contracts are replaced and providers are paid for the actual work they do at a preset rate, on a cost-per-case basis.

Although the other countries within the UK are considering a move to tariff based systems, at present PbR applies in England only. In March 2007 the DH issued a consultation paper on the future of PbR which sets out a flexible and pragmatic approach to its development. In particular, the consultation document emphasises the importance of strengthening the underlying building blocks of the PbR system and acknowledges that a national tariff approach for all services is not the best way forward.

The most important aspect of PbR is that cost no longer equals price. Local costs will be different to the published national tariff price for each individual procedure, depending on whether the local provider cost is higher or lower than the national average. Theoretically, commissioner purchasing power is not affected under PbR, as allocations have been adjusted so commissioners can afford to pay tariff prices (enabling them to afford to buy the level of activity they could before PbR was introduced).

As cost no longer equals price it is unlikely that providers will break even and will instead make a surplus (if they

are a low cost provider) or a deficit (if they are high cost). Under PbR these surpluses can be retained by the provider but deficits also need to be managed.

1.3 PbR context and objectives: the financial context

There has been an annual average increase in funding for the NHS in England of 7.4% in real terms (after excluding the effects of inflation) over five years from 2003/4, as illustrated in the table below.

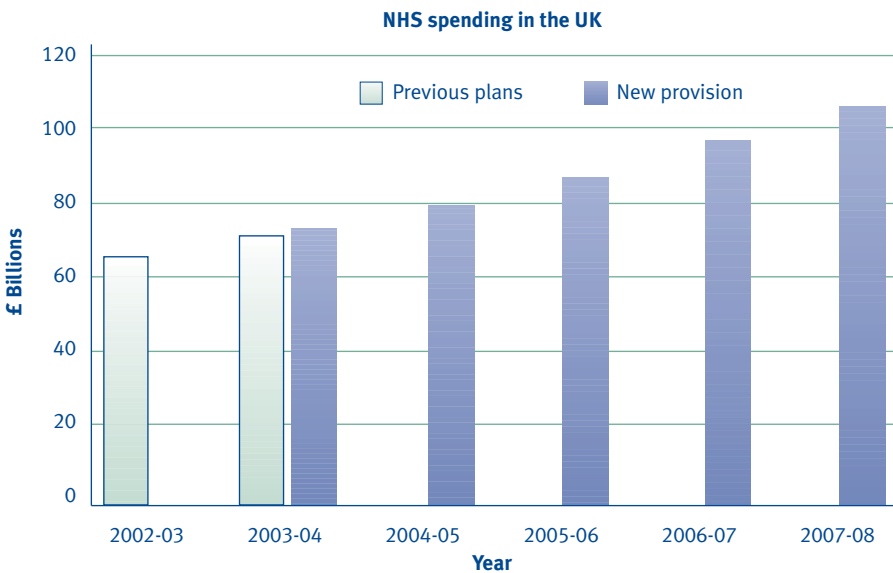
This significant increase in funding has given the NHS the opportunity to grow

and to deliver improved services, but also brings with it the responsibility to demonstrate clear improvements for patients and the public. There are greater expectations of accountability and transparency for how the money is being used. In order to reduce the risk of this sustained increase in funding being poorly used, significant reforms to NHS finances were required.

1.4 PbR context and objectives: the system's reform programme

The Department of Health publications *The NHS plan* and *Delivering the NHS*

HM Treasury planned spend (from the 2002 Budget)



plan set out a significant programme of investment, expansion and reform for the NHS over a decade. The vision outlined in *The NHS plan* was to offer a prompt, convenient, high quality service that treated patients as partners in their own care, and for the NHS to catch up with the wide-scale social changes that have resulted in our current consumer society.

In *Delivering the NHS plan*, the DH set out the government's objective of allowing patients to select which hospital they receive treatment in. The potential for movements in historic patterns in patient referrals, as patients become consumers and exercise choice over treatment options, also means traditional funding streams had to change. If funding fails to follow the patient after they exercise their choice, there is a danger of placing financial burdens on centres that are more successful in attracting referrals. Conversely, financial benefits will accrue to those providers with declining activity. Money must follow the patient.

As well as introducing patient choice, the government has sought to increase significantly the overall capacity within the NHS, encourage greater diversity in service provision, and provide more information for patients.

Because of these changes, a financial

system is needed that:

- ◆ ensures providers are funded based upon where patients choose to be treated
- ◆ supports *Patient choice* and helps match the capacity for delivery of services to the demand for those services
- ◆ provides incentives for good performance
- ◆ rewards efficiency in providing increased patient services
- ◆ supports effective planning and delivery
- ◆ works for a diversity of providers.

The PbR system was developed to help meet these objectives.

1.5 PbR context and objectives: the international context

Internationally, many health systems use 'casemix adjusted' payment methods to fund hospital activity. This approach measures and classifies health care activity in terms of the mix and complexity of patient treatments, based on the diagnosis, the procedures carried out and the care and resources involved. For example, diagnostic resource groups (DRGs) are a casemix measure that was

first developed in the USA to measure activity. DRGs form the basis for paying for acute care in the Medicare programme (a private health care system) in the States.

Other health systems, similar to the NHS in that they are financed by taxation and social insurance and have publicly run hospitals, have also introduced similar casemix systems. These include countries such as Austria, Norway, Sweden, and Australia. The past decade has seen a growing international trend towards the use of casemix adjusted payment for health care. Due to their experience of using casemix for inpatients, day cases and outpatients, some countries have now extended these payment systems to cover ambulatory care, rehabilitation and some community health services. Evidence shows that casemix adjusted payment has supported increased use of day surgery and aided the reduction in lengths of stay in hospital in some countries. In England casemix is measured using 'Healthcare Resource Groups' (HRGs) – see section 2.2 for more details.

The PbR system being introduced in England is based on this international experience. However, it is more ambitious in terms of its scope and implementation timetable. The government hopes to have the majority of hospital services within a

tariff based system by April 2008.

In 2005 the HFMA published its research *Home thoughts from abroad – international comparisons project*, which provides a comparison of the international experiences of prospective payment systems.

1.6 The benefits and risks of PbR: the impact on commissioners

A key feature of PbR is that primary care trusts (PCTs) are expected to commission further activity from alternative providers where agreed targets are not met. The advantages and disadvantages to PCTs of PbR are:

Advantages	Disadvantages
Easier to shift funds between providers	Increased financial risk
Financial incentive to reduce referrals into secondary care	Possible inability to manage demand effectively
Pay once per 'spell' (from admission to discharge) regardless of the number of Finished Consultant Episodes (FCEs) within that spell	Uncertainty over impact of patient choice
Payment is on a fixed price tariff	Some of the financial risk associated with variations in the level of activity is met by commissioners (for example if there is greater than expected demand for a particular procedure)
Casemix taken into account	Scale and speed of change
Focus on quality and quantity rather than price	

1.7 The benefits and risks of PbR: the impact on providers

The advantages and disadvantages of the PbR system for providers are:

Advantages	Disadvantages
Paid for what you do – incentive to increase activity	Lack of certainty in referrals
Planning becomes more sensible and certain	Difficult for high cost providers to get 'back on track'
Casemix is taken into account	Need to manage smaller units of activity
Discussions focus on quality and quantity rather price	Paid once per spell regardless of the number of FCEs within that spell – this will be a particular problem for providers with high levels of sub specialisation
Ability to retain surpluses	Tariff does not take account of clinical outcomes/best clinical practice

PbR is a rules-based approach to the commissioning of services across all providers and all commissioners. Providers therefore have a clearer picture of the volume of activity that is required and the income that flows from it. There are direct financial incentives for increasing activity which did not exist under fixed block agreements or traditional central funding initiatives.

1.8 Minimising the risks: key actions for commissioners

There are a number of risks inherent for commissioners under PbR. In order to minimise these risks, commissioners should (as a minimum):

- ◆ engage clinicians – practice based commissioning will help here
- ◆ actively seek to learn from others and to fully explore opportunities for collaboration in order to build organisational capacity
- ◆ ensure PCT planning assumptions (particularly relating to forecast activity levels) tie in with those made by key providers in their capacity plans and activity forecasting
- ◆ ensure that they continue to work with providers to maintain positive partnerships – for example, developing joint clinical pathways, data sharing, open communication and so on
- ◆ plan and develop demand management and service redesign initiatives, particularly for high cost/high volume services, using incentives, engaging clinicians and trusts in the process and learning from other initiatives that have been put in place elsewhere

- ◆ establish robust local monitoring arrangements to provide assurance on data quality and appropriateness of payments, while understanding the reasons behind activity changes for planning purposes.

1.9 Minimising the risks: key actions for providers

There are also a number of risks inherent for providers. To minimise these risks, providers should (as a minimum):

- ◆ engage clinicians through reporting on income and expenditure or devolving budgets to departmental level and through regular dialogue with hospital clinicians
- ◆ ensure provider capacity plans and activity forecasts tie in with the planning assumptions made by relevant commissioners
- ◆ use the richer information generated under PbR to strengthen performance management, engaging service managers and clinicians through activity and financial reports and devolving budgets to departmental level to drive operational change

- ◆ strengthen coding arrangements where necessary, monitor coding backlog and benchmark the quality and timeliness of coding with other trusts within the health economy
- ◆ review and strengthen internal costing systems – using data not only to inform reference costs but to inform decision making
- ◆ ensure that they continue to work with commissioners to maintain positive partnerships – for example, developing joint clinical pathways, data sharing, open communication and so on
- ◆ establish robust local monitoring arrangements – provide assurance to commissioners on the data by establishing a zero-tolerance policy on ‘gaming’, sharing audit findings on data quality with commissioners and being open and responsive to queries.

2

Nursing the numbers: coding, costing and data

2.1 Understanding clinical coding

As a result of the introduction of the PbR process for reimbursement for patient care, clinical coding has become mission-critical in support of the commissioning process, but in fact it is only one step in a more complicated scheme that is outlined within this section.

The NHS Connecting for Health's *Clinical coding instruction manual* defines clinical coding as:

"...the translation of medical terminology, as written by the clinician, to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format that is nationally and internationally recognised."

Clinical coding can be applied to the records for any form of patient care, including outpatients and A&E attendances, but normally reference to clinical coding is restricted in scope to records for inpatients and day cases.

Clinical coding is a skilled task that requires extensive knowledge of anatomy, physiology, the classification schemes, and national and international coding rules. In most trusts the activity is undertaken by trained clinical coding officers. There is a nationally recognised qualification, that expects very high standards, and the long-term pass rate is only around 50%. It takes between four to five years for a new recruit to attain the standards required by the examination, though recruits with a prior clinical background often progress more rapidly.

The detailed clinical coding process varies from trust to trust, but there are elements that are universal:

- ◆ location of source clinical records
- ◆ review of the records, and abstraction of the appropriate relevant details
- ◆ code those details in accordance with the coding rules and conventions
- ◆ enter the codes onto the computer system.

In many trusts the third and fourth elements are amalgamated and supported through use of commercially available clinical encoding software.

2.2 Healthcare resource groups (HRGs) and tariffs

Any reimbursement scheme based on the full list of 14,000 diagnostic and 8,500 intervention codes would be completely unwieldy; hence the PbR scheme is based on a much smaller set of just over 600 different healthcare resource groups (HRGs). HRGs have been developed over a period of nearly 20 years through a set of clinically led specialty-specific expert working groups, comprising clinicians and analysts.

Each individual HRG groups together a number of clinically-led similar procedures or diagnoses that are also similar in terms of expected resource requirement. HRGs were originally developed to support the *Resource management initiative* of the late 1980s, and their use in financial re-imburement schemes is still relatively immature.

HRGs are calculated from the diagnosis and procedure codes, using a national standard algorithm that is executed through nationally developed software used by all trusts and commissioners. Once the HRG has been deduced, the appropriate tariff – that is, the level of the payment – is also calculated in accordance with rules that are supplied by the DH. There are different values of

the tariff for elective and non-elective patients, and some adjustments are incorporated, for example for specialist services, for children, for long or short length of stay, and for London.

Many HRGs have been developed as ‘matched pairs’ depending on the presence or absence of complications, though usually elderly patients are assumed to be ‘complicated’ whatever the detailed clinical records include.

An example of a ‘matched pair’ from the neurosciences HRG chapter is shown below:

A14 Brain Tumours or Cerebral Cysts
>69 or with complications

A15 Brain Tumours or Cerebral Cysts
<70 and without complications

There are long lists of potential complications, the presence of any one or more of which would result in the patient being ‘grouped’ to A14 rather than to A15, including diarrhoea, constipation, gout, obesity, arthritis, dementia, diabetes, and pneumonia.

2.3 Why does clinical coding matter?

Though it is undoubtedly the case that the financial agenda is now the main driver for clinical coding, coding in some

form or other has been undertaken since the inception of the NHS, to support functions such as:

- ❖ national funding levels for the NHS
- ❖ clinical governance
- ❖ clinical research, audit, effectiveness
- ❖ benchmarking/comparative performance
- ❖ clinical indicators/league tables/star ratings
- ❖ medium and long-term planning, such as new hospital developments
- ❖ national and international health care statistics
- ❖ public health.

However, from a financial perspective the situation is:

- ❖ no coding or late coding results in no payment
- ❖ incorrect or incomplete coding results in incorrect payment
- ❖ complete and timely coding results in optimum payment.

To illustrate: for the A14/A15 example given previously, for a trust in central London, the standard 'tariff' in 2006/7 for HRG A14 was £3,745, and for A15 it was £2,195, so the accidental omission of an appropriate complication from the patient's record would potentially result in over £1,500 of lost income.

2.4 The nurse's role

Whatever the details of the coding process employed within any specific trust, there will inevitably be substantial interaction between the coding team members and staff on individual wards. It is important that the ward nursing team are on hand to help and support coding staff. Any requested action that helps to fill gaps in available data is likely to contribute directly to improved trust income.

Records need not only to be available, but they must also be full, clear, and legible, and include full details of the operations carried out, details of any 'out of theatre' procedures, co-morbidities and underlying chronic conditions. It is particularly important to ensure that the most invasive procedure is highlighted. Additionally, it should be ensured that entry of data through electronic data recording systems such as electronic patient records or local departmental computer systems should be timely – and permit clinical coders to access them. Improved and more complete data will also provide the basis for more appropriate service planning.

The coders are crucially reliant on complete, legible and timely source data. Any action that the ward staff can take to help to achieve that ideal will

undoubtedly result in financial benefits. Regular review meetings between coders and clinicians are a key part of the quality assurance process, and on a sample basis, clinicians should review coding and ‘feedback’ comments to the coding team.

2.5 Current issues

Data accuracy is frequently noted as an issue. There are two aspects to this issue:

- 1 One of the rules to which coders operate is that they can only code information made available to them by doctors. Contrary to the views held by some doctors, coders are not allowed to ‘make it up’. That comment specifically encompasses the situation where the coder notices that the clinical record ‘does not add up’. In that situation, the coder should raise queries with the appropriate doctor, but in practice, doctors are busy individuals and coders have demanding targets to achieve. The concept ‘get it right first time’ very much applies in this context.
- 2 Clearly, good quality coding also depends on the availability of good quality and well-trained staff. As with other staff groups, the *Agenda for change* pay review has created many anomalies within clinical coding,

which in turn can then sometimes lead to high turnover and vacancy rates. Training for clinical coders can take a long time and hence can be expensive and budgets are not always adequate. Work is underway within the NHS Health and Social Care Information Centre to address the issues of grading, training, and qualifications for clinical coders, but inevitably this work is long-term.

Clinical coding has been a virtually ignored back-office function for many years, but with the advent of the PBR scheme it has suddenly become mission-critical. Not surprisingly, significant investments have been made in clinical coding in the recent past and as a consequence data quality has substantially improved – even if it is still open to further improvement. Generally, improved quality of coding has led to higher tariffs. Whereas trusts see improved data quality, commissioners perceive evidence of ‘up-coding’ or malpractice, and tensions have arisen between commissioners and trusts.

As noted earlier, HRGs were not originally conceived as the basis of a reimbursement scheme, and there is published evidence that currently neither the HRGs nor the associated tariffs are fully fit to support such a scheme.

The new draft tariffs for 2007/8 seek to overcome many of the identified issues. In the meantime, undue pressure is put on both doctors and clinical coders to ignore coding rules in order to achieve a more appropriate tariff for the care actually delivered.

2.6 The future

When the implementation of the NHS Connecting for Health's National Programme for IT (NPfIT) has been progressed, there will be a significant effect on the clinical coding process. There will be greater reliance on real-time 'noting' by doctors and other clinicians, based on the SNOMED CT² terming scheme, and there will be some element of automated encoding from these terms.

² SNOMED CT (Systematized Nomenclature of Medicine – Clinical Terms) is a joint project between the NHS and the College of American Pathologists (CAP) to develop an international clinical terminology. It is a vocabulary which aims to represent the words and phrases used in health care in a consistent way in association with unique codes that are recognisable by machines. See Connecting for Health (2007) *SNOMED CT – the language of the NHS care records service: a guide for NHS staff in England*.

3 Turning the corner: creating sustainable services

Over the past few years there has been significant change across the NHS, with a particular focus on cost effectiveness and the management of clinical areas. It is recognised that nurses make a strong contribution to the patient pathway and the emphasis is often solely on the clinical input. However, the ward manager and senior nursing management team have additional significant contributions to make in the effectiveness of running a ward.

It is not unusual for trusts to turn to 'turnaround teams' or external consultants to review ways of working or the effectiveness of patient pathways. We would expect that the rationale and the overall objectives for the review should have been clearly communicated to all staff in advance. Whilst those objectives might be different in every trust, we hope the following guidance will give you some practical tools to help prepare for such a review and carry forward those practices into the everyday management of a ward and your staff.

3.1 Preparing for review

It is essential to understand your baseline nursing establishment in terms of both headcount and working time equivalent (WTE) under the following categories:

- ◆ skill mix
- ◆ clinical nurse specialist review
- ◆ rostering demands.

Skill mix

Turnaround teams will often review the nursing establishment; it is after all, the largest part of the workforce and therefore a significant cost to the trust. However, a skilled review team will also recognise the importance of getting this skill mix right with the focus on improving the patient's experience through the delivery of safe and good quality care throughout the whole pathway.

There are several methods to carrying out a skill mix review for nursing and all have their weaknesses and strengths³, but the most important point is to adapt the review to fit your needs. Adapting the nursing skill mix review model is not intended to 'cheat' the results, rather to

³ See Keith Hurst (2003) *Selecting and applying methods for estimating the size and mix of nursing teams*, Nuffield Institute of Health, Leeds.

be realistic about what is achievable for your trust. There are factors to consider, such as:

- ◆ can we recruit to the vacancies that are showing as a gap in our ward or department?
- ◆ if an investment is needed, how can this be counter-balanced with savings elsewhere in the department or will it require additional funds?
- ◆ what are safe levels of nursing? Is there a national benchmark you can identify to support your decision?
- ◆ is there an opportunity to develop and train health care assistants in-house to take on extended roles, rather than increase the 'trained nurse' establishment?

- ◆ how can we reduce the usage of temporary staffing and invest in substantive staff?
- ◆ are qualified nurses carrying out duties 'historically' or because these need a trained nurse?
- ◆ are you recruiting what you need in terms of skill and contractual hours, or replacing like for like?
- ◆ are we prepared to redeploy nurses where the skill mix is rich and numbers high?
- ◆ are we truly flexing nursing staff across directorates?

To prepare for nursing establishment reviews you may wish to gather the information outlined in the following table.

Information required	Readily available?	Owner of information
Numbers of nurses in WTE, band and headcount overall and each area	YES / NO	For example: HR Director
Numbers of clinical nurse specialists in WTE, band, specialty and headcount	YES / NO	
Number of matrons in WTE, band and headcount	YES / NO	
Number of nurse consultants in WTE, specialty and headcount	YES / NO	
Completed job plans for clinical nurse specialists	YES / NO	
A copy of the last completed review of nursing establishment	YES / NO	
A copy of the ward managers development training programme	YES / NO	
Temporary staffing usage overall, by area, WTE, band and cost	YES / NO	
Vacancies per area by band and WTE	YES / NO	

Clinical nurse specialist review

This is always a sensitive area to address and the emphasis should be placed on contributing to the direct delivery of care to the patients; a job plan review will help identify where this is already happening, where there are gaps, and help define roles and responsibilities more clearly for this highly skilled group of nurses.

A few simple steps will avoid unnecessary concern throughout this review process:

- ◆ plan out the whole process in partnership with the HR director, nursing director and communications team before commencing the review
- ◆ always include a contingency plan for those who may be absent during the announcement of the review, during it, or when the results are to be shared
- ◆ ensure the list of clinical nurse specialists is accurate
- ◆ put in place a robust communications plan and make sure the key stakeholders are familiar with it
- ◆ involve and work with staff side representatives
- ◆ consider posts that are linked with services that the PCT may be taking on and look for opportunities to redeploy where appropriate
- ◆ identify roles that could be developed to generate income through more

direct patient care, for example nurse led clinics

- ◆ always communicate honestly and directly with the clinical nurse specialists
- ◆ always ensure there is a consultation period once the review has been completed
- ◆ consider establishing a panel to hold the review that may include an external professional
- ◆ ensure other members of the multi disciplinary team are kept informed of the process.

Rostering demands

It is easy to forget just how challenging it can be to manage a ward nurse roster but the pressure can be reduced by a few key steps:

- ◆ calculate the annual leave needed to be taken each week of the year and invite the staff to spread their leave across the whole year
- ◆ encourage staff to take their leave entitlements in year; excessive 'carry over' of annual leave will add pressure to the following year
- ◆ train all ward managers and Band 6 staff in Excel so they can use a template for staff rostering to save time, and prevent unauthorised changes, with the added benefit of being legible

- ◆ remove the 'request book' and replace with a written request form that must be submitted well in advance of the requested holiday dates; this helps to reduce those weekly requests for an 'early shift on a Friday'
- ◆ fill night shifts and weekends with substantive staff first, this will avoid costly temporary staffing
- ◆ review the controls and levels of authorisation for requesting temporary staffing and where necessary provide clarification on how to request temporary staffing (see Appendix 1)
- ◆ calculate training and development days across the whole year and plan ahead, identifying those who need to attend mandatory training as a priority
- ◆ share the load and train at least two other senior nurses to manage the roster; this will also help others to appreciate the challenge
- ◆ manage sickness/absence proactively, ensuring back-to-work interviews are carried out
- ◆ keep staff informed of the budget statements and encourage ideas for saving money whilst improving patient care; for example, ensuring everything is ready on time to allow the patient home and minimising the

length of stay to that needed and not beyond.

The above may appear to be basic steps in managing a roster but processes do not have to be complex to be effective and save time. The review should provide an opportunity to clarify expectations for managing a ward roster and identify any additional support that is required.

3.2 Getting the best from the review

Turnaround teams and external consultants are renowned for demanding information at a fast pace. If you are not prepared for this pressure it might feel like the review is being done to you, rather than with you. Here are some simple steps you can take to prepare in advance:

- ◆ find out who the local lead from the review team is and identify how you can engage with them regularly, maybe even once a week to start with
- ◆ prepare a list of concerns or questions you would like the team to address – it's possible that they don't know all the issues that are affecting your area
- ◆ ask the review team for contacts at other hospitals where changes have been made – for example, clinical nurse specialist reviews – so you can learn from each other

- ◆ identify how other members of the senior nursing team are engaging with the process and ensure you are aware of each other's role and responsibility throughout the process
- ◆ be clear on how you would like to be kept updated (daily meetings, email, or telephone conference)
- ◆ be clear on your expectations of the review team in terms of its dealings with staff and working in clinical areas
- ◆ make sure you know and understand your budgets by cost centre; if there are anomalies, start addressing them with your finance department now
- ◆ know the stock levels needed for the wards/areas, for example when were these last reviewed?
- ◆ have all the patient pathways been mapped out ready for review and discussion?
- ◆ identify any blocks in your patient pathways such as delays in arranging major diagnostic tests, for example, X-ray, CT scan, MRI
- ◆ have the latest hospital acquired infection rates for your hospital and ward/department available
- ◆ have a copy of the nursing structure clearly illustrated, showing the WTE at each level
- ◆ ensure that where annual leave has been booked during the review period, adequate cross cover is arranged to avoid delays in the work progressing.

External consultants are often employed by a trust to help identify causes of deficit, ways to improve efficiency and prevent waste. The added value of such teams is that they have carried out this type of work in numerous hospitals and will have a catalogue of ideas, experiences and successes to share with you.

However, you are the expert in your hospital and your local knowledge of the processes, policies and issues will be invaluable to these teams; a partnership approach to the review work is central to its success. We hope that this section has added to your understanding of how to demonstrate a 'business case' for nursing during a review.

4 Ten top tips for thriving (not just surviving!)

Day-to-day working

1. Make an effort to understand, at least in principle, the financial environment of your employer and its impact upon your department. Part of this will involve learning some new terms or doing a bit of reading, but it will be worth it. In time, you may want to consider formal training in business skills or finance.
2. Get to know other members of the health care team and what they do – clinical coding teams, finance manager, business manager, IT support, library staff, and medical records. All these people are essential parts of the care path way and it might just make your life a little easier if you understood more about how they work.
3. Make sure that you tell people about what you are doing, and let them know about your successes. Don't wait to be asked for a report – seize the moment. Consider using the staff newsletter or, after consultation with your employer, why not use local media?

Bidding for extra money or a new project

4. If it is your first bid for extra resources or funds, don't get carried away with the size and scope of your project. It is better to do a small thing well than a big thing badly. In addition, if it does go wrong, the chances of any real damage are lessened with a smaller scale project.
5. Do your homework on all aspects of cost pressures on your project or proposal. Remember that almost everything will cost someone, something. Even pulling patient notes for activity data from your own employer's archives will cost money-per-file, if they are more than a few months old.
6. Partnership is essential. Who are your supporters? Who will champion your cause in other circles (for example, medics, AHPs, the coding team)? You should put in as much work into these relationships with other team members as you do into constructing your bid. A broadly supported bid will have much more chance of success than one that comes from you alone.

7. Having said that, don't be afraid to go it alone! Just because something has always been done 'that way' doesn't mean it has to stay that way! But don't forget to have a robust circle of trusted peers and friends who can offer moral support for the highs and lows of your project.
8. If you are asking for additional resources or for go-ahead on a new service remember the decision to grant your request for resources may be based as much on your reputation as a manager and whether you handle existing resources well, as it is on the figures.
9. When making a bid for new services, staffing or resources, because the financial climate is based on very little – if any – funding growth you will need to demonstrate that your request includes an element of:
 - ◆ financial return (cost savings which can be ploughed back into self-funding your bid)
 - ◆ efficiency improvements (how your new service will improve patient experience, reduce inputs like length of stay or other resource uses)
 - ◆ commitment to feedback results in a comprehensive and useful manner.
10. Finally don't forget, it's all about the patients! They can be your greatest critic or your best friend. Make an effort to listen to the patient view, and build that into your project plan, delivery and evaluation. If what you do doesn't improve the service to the patient, why are you doing it?

Glossary of terms

Casemix adjusted payments

Payments to providers, which are varied according to the severity of illness or patient need. *Payment by results* (PbR) is based on a casemix adjusted tariff of prices.

Commissioning

Commissioning relates to the purchasing and contracting of health care services. It is a broad term that can cover a range of activities but in principle, a distinction can be drawn between two levels of commissioning. At one level, commissioning can involve service planning and design through identifying population need, assessing the local priorities, understanding the market, and determining where and how services should be provided and by whom. Secondly, commissioning can involve the daily purchasing of services, through managing contracts and spending budgets.

Healthcare resource groups (HRG)

Healthcare resource groups (HRGs) simply allow the classification of patients into a manageable number of groups of cases that are clinically similar and that

require similar levels of health care resources for diagnosis, treatment and care. HRGs form a major part of *Payment by results* (see Chapter 1).

Market forces

Market forces may be characterised as any system of incentives which rely on market-type mechanisms such as contracts, price or cost, to create a desired behaviour from the various participants in that market. For example, competition, fixed or decreasing budget limits, bidding for contracts, and so on may all be seen as market forces.

Market forces factor (MFF)

An index used in resource allocation under *Payment by results* to adjust for unavoidable variations in costs. It is designed to take account of the differing costs of staff, regional allowances or weightings, land, buildings and equipment.

Tariff

Essentially this refers to the list of prices for any given activity. In the case of *Payment by results* the tariffs will effectively fix the prices that organisations can charge NHS

commissioners in relation to services for NHS patients. Simply put, prices are based on a national average cost with variations allowed for geographical differences in costs called a market forces factor.

Weighted capitation formula

Funding for primary care trusts (PCTs) is informed by a weighted capitation formula, which determines their target shares of available resources to enable them to commission similar levels of health care for populations with similar health care need.

There are separate components in the formula for different services: hospital and community health services (HCHS), primary medical services, prescribing, and HIV/AIDS. Within each component, each adjustment for age, additional need and unavoidable costs is expressed as an index, comparing the PCT score on the adjustment to the national average.

The demands of a rural economy are reflected in both the additional need and unavoidable cost adjustments. The additional need adjustment recognises that access to services is more difficult in rural areas by including measures of distance in the statistical modelling.

Resources

Royal College of Nursing

The RCN Policy Unit briefings, which can be found on the RCN website, contain a wealth of additional information relating to this topic.

www.rcn.org.uk/policy

Healthcare Financial Management Association (HFMA)

The HFMA is the professional financial voice of the NHS. As well as enabling personal and professional development by providing access to tailored education and training, it also offers a professional network for members and provides a route to making a contribution to national policy.

www.hfma.org.uk

The King's Fund

The King's Fund is an independent charitable foundation working for better health, especially in London. It also undertakes research, policy analysis and development activities.

www.kingsfund.org.uk

For further information about the *Payment by results* initiative visit the Department of Health's website www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSFinancialReforms/fs/en

For further information about *Healthcare resource groups* visit

www.ic.nhs.uk/our-services/classification-and-standards/casemix/healthcare-resource-groups

For further information about the *Clinical coding classifications* visit

www.connectingforhealth.nhs.uk/clinical-coding

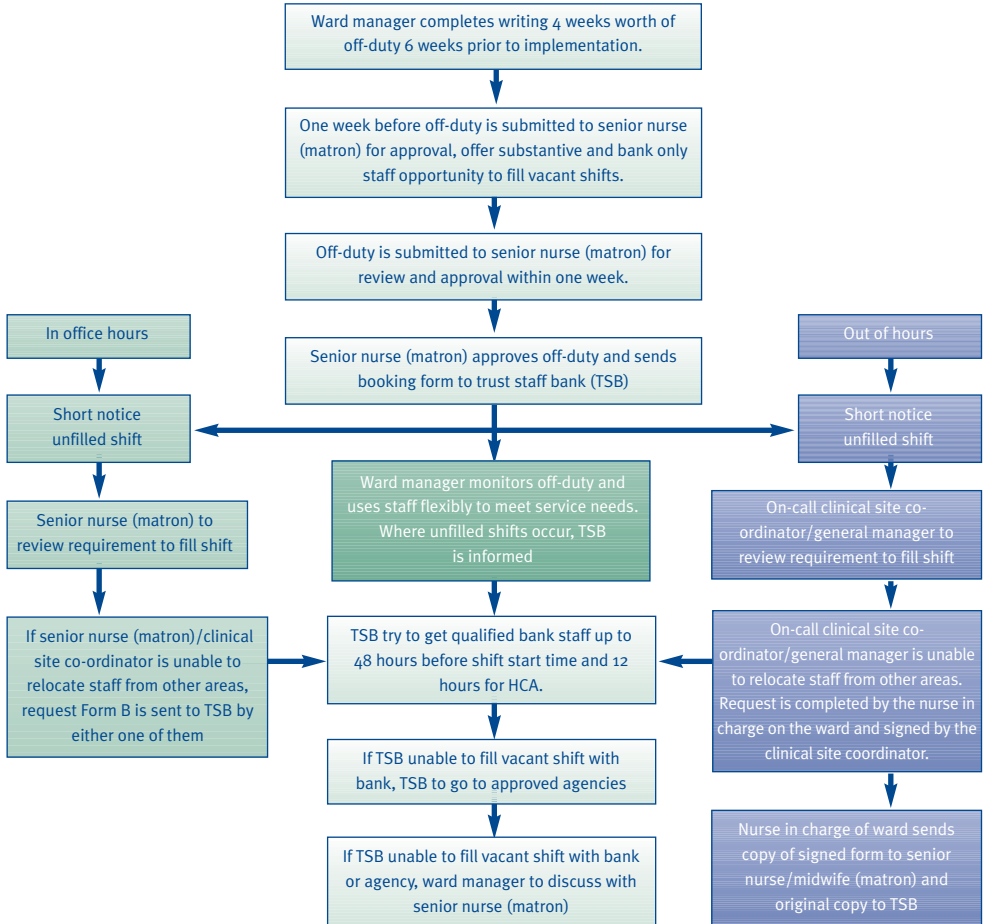
For more general comments about *Clinical coding* visit

www.codeinfo.org/paccuk/index.html

Note: some aspects of this website are available only to members of the *Professional Association of Clinical Coders – UK*

Appendix 1

Process for requesting and approving bank and agency nurses



Things to consider and explore before going out to agency:

- ◆ can non-ward based nursing colleagues support/assist the area?
- ◆ ready reckoner and reasons for using temporary staff must be recorded; incomplete forms will be returned
- ◆ site co-ordinator with matron to review skill mix elsewhere and look to re-locate staff if appropriate and possible
- ◆ assessment of risk to the staff and patients if the shift is not covered must be undertaken
- ◆ the cost of using agency must be retrieved within the calendar month to keep within budget.

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