Capturing the return on investment of Nurse Consultants within English acute NHS trusts

Alison Leary PhD RN
Independent Healthcare Consultant & Reader In Advanced Practice London South Bank University (LSBU)

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Contents **Page**

1. Introduction

Nurse Consultant posts are relatively new when compared to other specialist nursing roles. Previous work has shown that specialist practitioners represent value - not only in terms of financial benefit but also in terms of quality, particularly in long term conditions (Frontier Economics 2010, National Cancer Action Team, NCAT 2010, RCN 2010, Oliver & Leary 2010). However, most of this research has been based on the specialist nursing role - usually clinical nurse specialists (CNS) and not on Nurse Consultants.

There are two principle ways of identifying a return on investment by specialist practitioners (Leary 2011a). The first is income generation (Figure 1). This includes increased high yield activity. The second is improvements in efficiency (Figure 2)

Figure 1: Generating more income

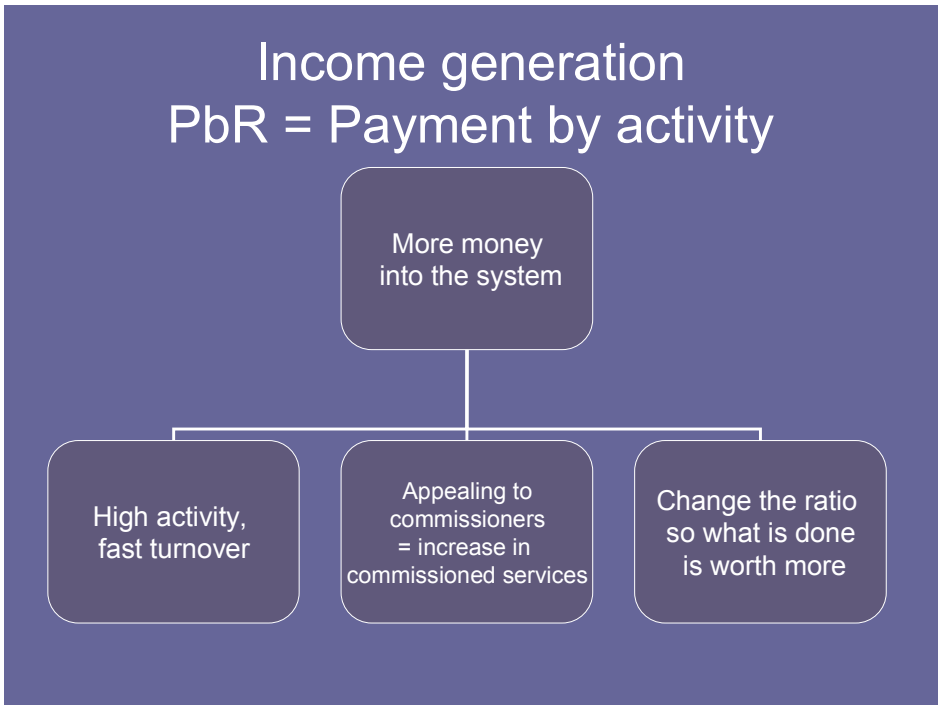
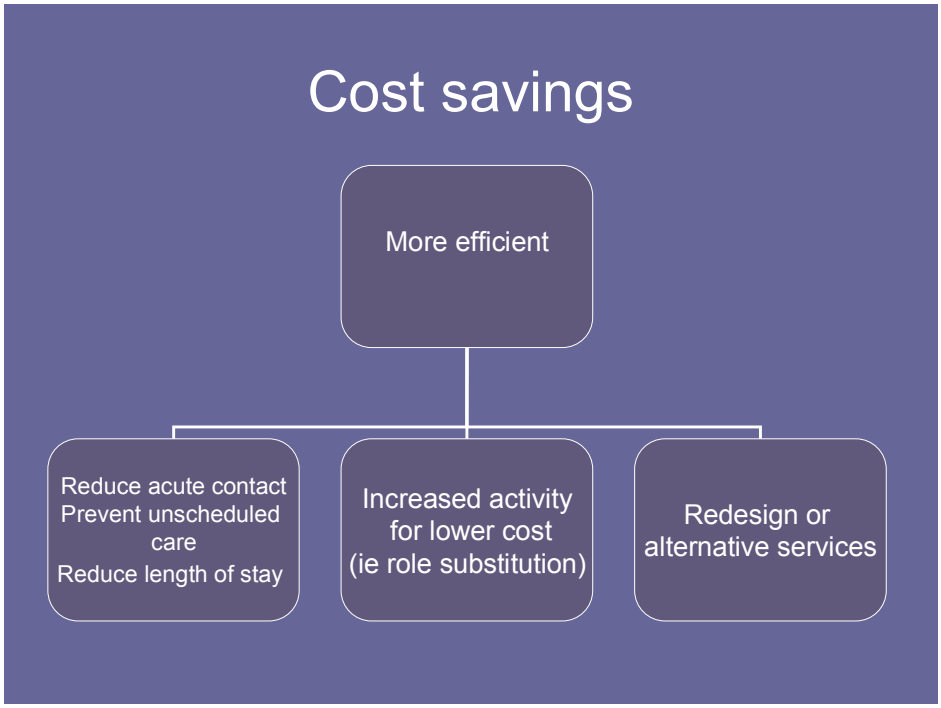


Figure 2: Saving money already in the system



2. How are hospital providers paid for the services they deliver?

The current system of remuneration for activity is termed Payment by Results. Payment by Results (PbR) is the tariff based hospital payment system that underpins the way funding flows around the NHS in England. Under PbR, commissioners pay providers (for example acute NHS trusts/foundation trusts and the independent sector) a national tariff or price for the number and complexity of patients treated or seen (Department of Health 2010a). Currently these tariffs are based on average costs but there is a move to introduce "best practice tariffs" to improve clinical performance. The Department of Health publishes a tariff each year which sets the "price".

Payment by results is a data driven system requiring three pieces of data function. These are **Classification, Currency and Costing .**

Classification- captures information about patient diagnoses and healthcare interventions in a standard format using systems like ICD 10 (for diagnosis) and OPCS-4 (interventions, operations etc)

Currency – the codes in the primary classification systems above are too numerous to form a practical basis for payment. They are therefore grouped into currencies, the unit of healthcare for which payment is made (Figure 3).

Costing– once a currency has been established, costs are then attached to that currency and assigned a price. Where the price is set nationally, it is called the tariff.

Links between some of the work undertaken by nurse consultants and the Payment by Results system will be explored here. In addition, opportunities for quality indicators will be explored. In line with the move to "best practice" tariffs and patient pathways are likely to have more impact with commissioners. Such "best practice" tariffs are designed to drive up standards but are currently limited to certain areas of care. They focus on areas in which there is currently variation in quality across large areas such as acute care (e.g. acute stroke care, primary total hip and knee replacements). You can read more about best practice tariffs here http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131853.pdf

3. Using Payment by results (PbR) and clinical coding

The remuneration for acute Trusts is recovered using clinical coding.

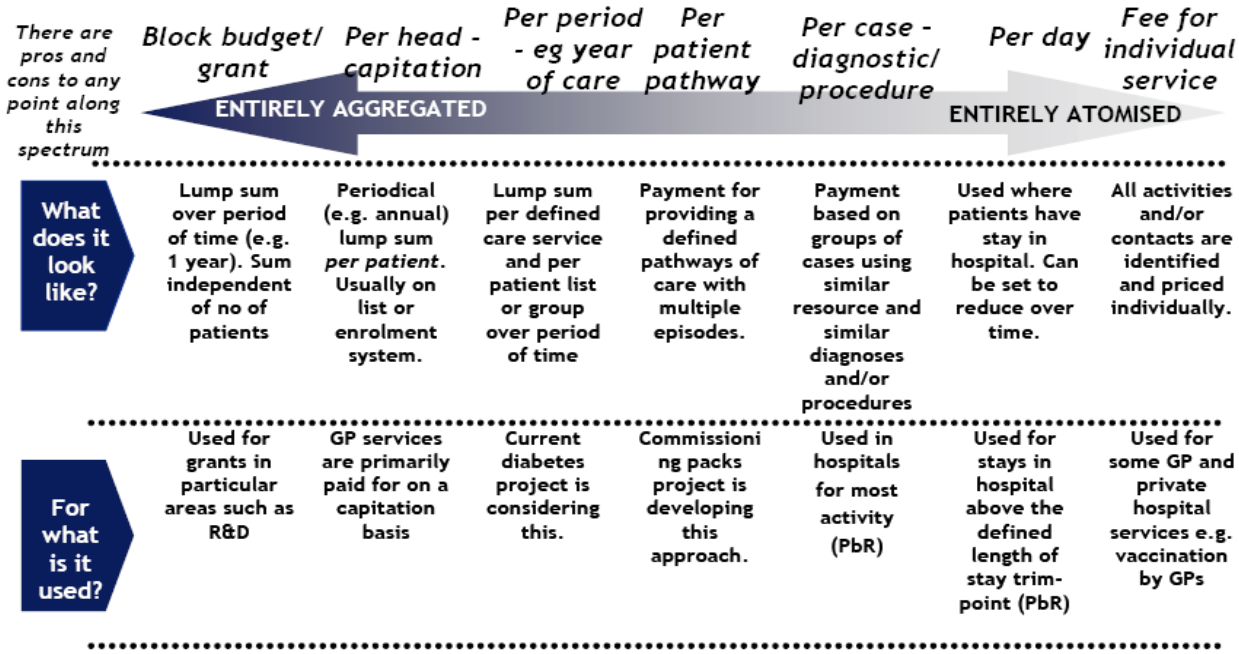
There are approximately 28,000 codes used to describe interventions and diagnoses. Trying to capture payment at this level would be very difficult. A currency is needed to collate these interventions and diagnoses into common

groupings to enable tariffs to be set at a workable level. The currency for admitted patient care is Health Care Resource Groups (HRGs), the latest version of which is HRG4. HRGs are "clinically meaningful groups of diagnoses and interventions that consume similar levels of NHS resources" (DH 2010a).

For nurse consultants who admit patients or directly avoid admission, HRGs may represent a logical way to capture activity leading to remuneration - particularly in light of the Trusts integration with the community. HRG v4 does allow for non-admission but still revolves around procedure (for example chemotherapy).

Admission avoidance leading to bed days saved can be relatively easy to map but is time consuming to perform. See Baxter & Leary (2011) for further information on this process.

The currency structure of PbR is shown below in Figure 3 (DH 2010a)



As can be seen in Figure 3 HRGs are only one currency. In terms of the work of the nurse consultants, another currency such as a **year of care** or **per patient pathway** might be a more pragmatic way of capturing and remunerating their work. This has been achieved in some pathways such a Cystic fibrosis which are testing the "Year of Care" in long term conditions.

In acute Trusts most of the activity is captured by the patient administration system (PAS) and it is important that clinical activity of consultants whatever the currency is captured by this and other secondary systems. Conversations with some nurse consultants revealed that this may not be occurring either fully or at all. Here are

some suggestions regarding how nurse consultant activity might be captured within hospital systems:

Outpatient work
Treatment function codes (TFCs) are used in PbR to describe types of outpatient attendances. TFC is based on the main specialty code which is the specialty within which the consultant is recognized or contracted to the organization (DH 2010a). In 2010-11 there are 49 TFCs which have a mandatory outpatient attendance tariff. Here is the link to the NHS Data dictionary:
http://www.datadictionary.nhs.uk/web_site_content/supporting_information/main_specialty_and_treatment_function_codes.asp

The outpatient attendance tariff is payable for a pre-booked appointment at a consultant-led clinic (the consultant may not be physically present but they remain clinically responsible) (DH 2010a). Although here consultant refers to a consultant activity recoded via a GMC number (i.e. a medical consultant), there are opportunities for coding within consultant as a nurse or midwife (code N9999998) As with the admitted patient care tariff, the DH have aimed to provide the right incentives by publishing separate tariffs for:

First attendances that include some of the costs of follow up attendances to disincentivise unnecessary follow ups. Making better use of appointment time to better utilize the ratio of new:follow up patients.

Single-professional and multi-professional or multi-disciplinary attendances that recognise the benefit to the patient in seeing two or more healthcare professionals at the same time.

Information on how to code activity to a consultant who is a nurse or midwife with no GMC number can be found in the NHS data dictionary:
http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/c/cons/consultant_code_de.asp?query=nurse%20consultant&rank=1&shownav=1

Non face to face activity
Many Nurse Consultants engage in non face to face activity such as telephone follow up clinics. Non face to face work is part of the non mandatory tariff. This can be used as a starting point for local negotiation. As this is non-mandatory there is no obligation for trusts to use this tariff, however community trusts who care for patients with long term conditions are anecdotally expressing more of an interest in using this tariff to capture telephone follow-up. For Nurse Consultants this maybe a realistic option to capture their activity and monetary terms.

Best Practice Tariffs
Best practice Tariffs were introduced for several high volume areas with the intent of pushing up quality of services (e.g. stroke, cholecystectomy, cataracts, hip fracture) where there is a consensus on what constitutes best practice and how to

incentivise its use. This tariff was introduced in 2010-11and it is predicted to expand to other areas. This makes quality indicators and best practice pathways increasingly important. Nurse consultants working in any of the four initial areas covered by the best practice tariff may well find that their activities are captured within this tariff. For further information on the best practice tariff see the DH website at: http://www.dh.gov.uk/health/2011/12/bpt-update

4. Quality indicators/measures

As best practice and other areas of performance become linked to remuneration or commissioning there may be more opportunities for nurse consultants to demonstrate their economic impact.

Indicators such as the Commissioning for Quality and Innovation (CQUIN) payment framework may offer opportunities for nurse consultants. CQUINs is a national framework with locally agreed schemes-one of the current national indicators being patient experience. CQUINs are evolving and there may be some considerable scope for the nurse consultants to be involved in locally agreed indicators. For the latest on CQUINs see:
http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

Other areas of performance and quality indicators include Chlamydia screening uptake which is a core part of the Transforming Community Services (Community Indicators for Quality Improvement) as is rehabilitation (which can be assessed using a validated assessment tool such as that used by many nurse consultants). More details can be found at:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_126111.pdf

Performance against such indicators offers the opportunity to show value even if not direct economic benefit.

For nurse consultants who work in cancer services, there are numerous quality indicators which can be found at: http://www.cquins.nhs.uk/?menu=resources

Last year the National Cancer Action Team (NCAT) announced plans to link cancer peer review performance to CQC registration and possible payment frameworks. This provides an excellent starting point for nurse consultants to discuss issues around services with local managers as the cancer peer review and associated CQUINs are likely to have considerable impact.

Setting other KPIs
Setting key performance indicators or other quality measures locally can also be a useful approach. This can be done by deciding with colleagues and patients what particular national standards or local issues act as an indicator of good care.

5. Return on investment

Role substitution
In specialist practice where role substitution features (i.e. a nurse now doing the work of a more expensive doctor) cost savings are very much easier to show. Substitution for junior medical staff is the premise of the "Hospital at Night" and other initiatives. Complex nurse role substitutions can be seen in long term conditions such as rheumatology (Oliver & Leary 2012).

Where the work of a nurse consultant is part of an integrated care organisation with a community focus, this may mean that the role has an opportunity for expansion into new areas of coded business as an independent practice.

Admission Avoidance
Many clinical nurse specialists exhibit patterns of admission avoidance (Baxter & Leary 2011, Quinn 2011, Oliver & Leary 2012), for example using unscheduled care services such as Emergency Departments. Use of emergency services for unscheduled care for a long term condition for example is very inefficient and expensive.

Non clinical income
Many nurse consultants generate income from research, teaching and consultancy. This consultancy work offers a substantial opportunity for a trust to gain return on investment (both financial and reputational) which may not be routinely captured within the organisation.

Re-design of services is a further area to explore in terms of cost benefit**.**

6. Using opportunities to highlight your activity

It may be useful for nurse consultants who haven't already explored these issues to enter into open dialogue with their trusts around coding and with commissioners around currency. Useful questions to consider include 'would a "year of care" or "per patient pathway" be a more productive method of remuneration than using HRGs in an ICO?' 'If using HRGs are the services provided by the nurse consultants bundled or unbundled?' 'How are they being captured?'

A useful strategy may be to consider quality indicators for specific services against national guidance and audit against them, for example Transforming Community Services:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_126111.pdf

The proposed NHS Outcomes framework (domain 2 long term conditions) may provide a useful indicator for some nurse consultants: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122956.pdf. Alternatively, more specific tools are available on the NHS Information Centre website - see http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/nhs-outcomes-framework-indicators

Undertaking recorded assessments (DH 2010b) in all the consultant areas of practice and others that are specific such as Holistic Needs Assessment (NCAT 2011) and auditing that these have been done could be form part of annual reports and dialogue with both managers and commissioners: http://www.ncat.nhs.uk/our-work/living-with-beyond-cancer/holistic-needs-assessment

It may be useful to consider using patient experience as an indicator not just as a way of capturing satisfaction and linking this in with the Outcomes Framework (DH 2010b) e.g. Capturing responses to the question "Did you feel supported to manage your illness?" would be a tangible piece of data in some long term conditions.

It may also be worth discussing the development of nursing specific Key Performance Indicators (KPIs) according to the speciality if a measure or target doesn't already exist.

It's always worth remembering the importance of being clear about the service and what it provides - summing this up in a couple of sentences helps considerably in the negotiation process/meeting with managers.

See Leary (2011b) for further practical guidance and tips on how to 'prove your worth' and demonstrate that your role represents a good return on investment to your organisation. The latest tariff information can be found at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131826

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