



Department
of Health



Effective Clinical and Financial Engagement

A best practice guide for the NHS

November 2013

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Effective Clinical and Financial Engagement

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Foreword

Effective engagement between NHS clinicians and finance professionals has always been important and never more so than now as the NHS seeks to improve the quality of care for patients while becoming more productive and efficient.

Across England, NHS organisations are facing the challenge of delivering their commitments under the NHS Outcomes Framework within current financial constraints.

Finance managers have a critical role to play in this challenge but they cannot deliver it alone. It is clinicians – doctors, nurses and allied health professionals – who commit NHS resources and who need a greater understanding of the financial consequences of their actions.

In this context, many questions have been raised in the NHS. Not least, what do clinical and financial professionals need to be able to develop more productive partnerships? What are the barriers which the NHS needs to overcome, the key levers for engagement and the best practice steps for a way forward?

This best practice guide has been developed to answer these questions and to help promote and create engagement on a large scale between clinicians and finance professionals. It aims to help NHS organisations to seize the opportunity provided by the current financial challenges to develop new partnerships between their clinical and finance teams which are capable of co-creating added value.

The Department of Health has worked with a number of organisations and individuals to develop this guidance. Now the onus is on all clinical and financial colleagues to use it to make a difference by delivering high quality, value-based healthcare in the NHS.

I am grateful for the support and advice I've received on the journey to lead the development of more effective engagement between clinical and finance professionals in the NHS, in particular from: Richard Douglas (Director General, Strategy and NHS Finance, Department of Health), Professor Sir Bruce Keogh (Medical Director, NHS England), Jim Easton (former National Director for Transformation, NHS England), David Flory (Chief Executive, NHS Trust Development Authority), and senior colleagues from the Healthcare Financial Management Association (HFMA) and Monitor. Special thanks also go to the Department of Health's Payment by Results Team which offered immense help and coordinated the work to make the idea of developing national guidance, a reality.

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Department of Health

1. Introduction

- 1.1 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.
- 1.2 In today's NHS, organisations can only deliver effective patient care within available resources by creating an environment where working relationships between clinicians and finance teams are thriving. Clinicians are responsible ultimately for the way in which services are delivered and for committing resources. They can only do this effectively with input from finance colleagues. For instance, through sharing cost and patient outcomes data for better informed decision making.
- 1.3 It is clear that cost reductions without maintaining or improving outcomes may amount to false savings and have a detrimental effect on the delivery of effective patient care. Therefore it is essential that effective engagement takes place at every level to ensure that all members of the team are focused on delivering high quality and affordable care for patients.

Purpose

- 1.4 The purpose of this guide is to enable individuals and teams to take a systematic and objective approach to improving the levels of engagement between clinical and financial colleagues in provider organisations. It is written with a focus on NHS provider healthcare organisations although the concepts are not exclusive to this sector.
- 1.5 The guide defines the different levels of clinical and financial engagement which are present in the current NHS system, highlighting the characteristics and behaviours of organisations with high engagement, presenting a self-assessment tool to help NHS trusts assess their current level, and provide best practice examples.
- 1.6 The guide is in alignment with many of the lessons identified in the [Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry](#) by Robert Francis QC. The Francis report identified a culture of 'silo working', poor cost control and poor patient care which caused patient safety to be compromised. Its recommendations are designed to change this culture through implementing fundamental standards and measures of compliance which are defined in genuine partnership with patients, the public and healthcare professionals.

- 1.7 The emphasis on working in partnership to deliver improved patient services is one of the key lessons of the Francis report and is reinforced here. More broadly, evidence of high levels of engagement between clinical and finance professionals will help trusts in their reviews by the Chief Inspector of Hospitals.
- 1.8 The Francis report's recommendations which relate to effective engagement between clinical and financial professionals are highlighted in Annex C.

Research

- 1.9 We have used two important strands of research to inform this work:
- The first is the Department of Health's annual reference costs collection and surveys of 2012 and 2013, which provide the current levels of engagement in the NHS. These are covered in Chapter 2 and provide the national position.
 - The HFMA Clinical-Financial Engagement Survey – Finance Leaders (Autumn 2011) and the HFMA Clinical-Financial Engagement Survey – Clinicians (Spring 2012), covered in Chapter 3, provide the views of senior clinicians and finance directors. These have been used to develop the key characteristics of effective engagement.

Guide development

- 1.10 This publication has been developed in consultation with many NHS provider trusts and national organisations whose support, ideas and input have been pivotal to the process. These include: the HFMA; Monitor; Audit Commission; NHS Trust Development Authority; NHS England; Care Quality Commission; Royal College of Nursing; Academy of Medical Royal Colleges; General Medical Council; and Medical Schools Council.
- 1.11 We also wish to acknowledge the work of organisations which have highlighted the importance of engagement between clinicians and finance professionals in their reports and publications over recent years:
- December 2007: [A Prescription for Partnership: Engaging clinicians in financial management](#) – Audit Commission
 - February 2009: [Clinicians and Finance: Improving patient care](#) – Joint statement by the HFMA, Audit Commission, Department of Health, NHS Institute for Innovation and Improvement, Royal College of Nursing and Academy of Medical Royal Colleges
 - July 2009: [A Guide to Finance for Hospital Doctors](#) – Audit Commission and Academy of Medical Royal Colleges
 - November 2010: [Agents for Change: Collaborating for quality](#) – The King's Fund, BMJ, NHS Confederation and Department of Health
 - November 2012: [Clinical-Financial Partnerships in the NHS: Why we need them to deliver the cost and quality challenge](#) – NHS Institute for Innovation and Improvement.

2. Definitions and benchmarking

2.1 To make use of this resource, organisations first need to understand the frames of reference and share them internally. This will ensure there is clarity to guide the process.

2.2 We are using simple but clear definitions for the terms ‘clinicians’ and ‘engagement’:

- **Clinicians** – this covers the full range of clinical staff working with the NHS, including medical, nursing, pharmacy, allied health professional and others.
- **Engagement** – is defined as mutual understanding and cooperation between different professions/cultures leading to joint working.

The four levels of clinical and financial engagement

2.3 A second key frame of reference is to make an assessment of the current position within an organisation through being able to classify its levels of engagement and understand how it is operating. This is done by using the self-assessment tool which we developed for this purpose (see Chapter 4). It is based on four levels of clinical and financial engagement and provides a framework for organisations to assess their position.

2.4 The four levels were originally proposed by the National Advisor for Clinical and Financial Engagement at the Department of Health and colleagues across many NHS trusts were involved in their further development.

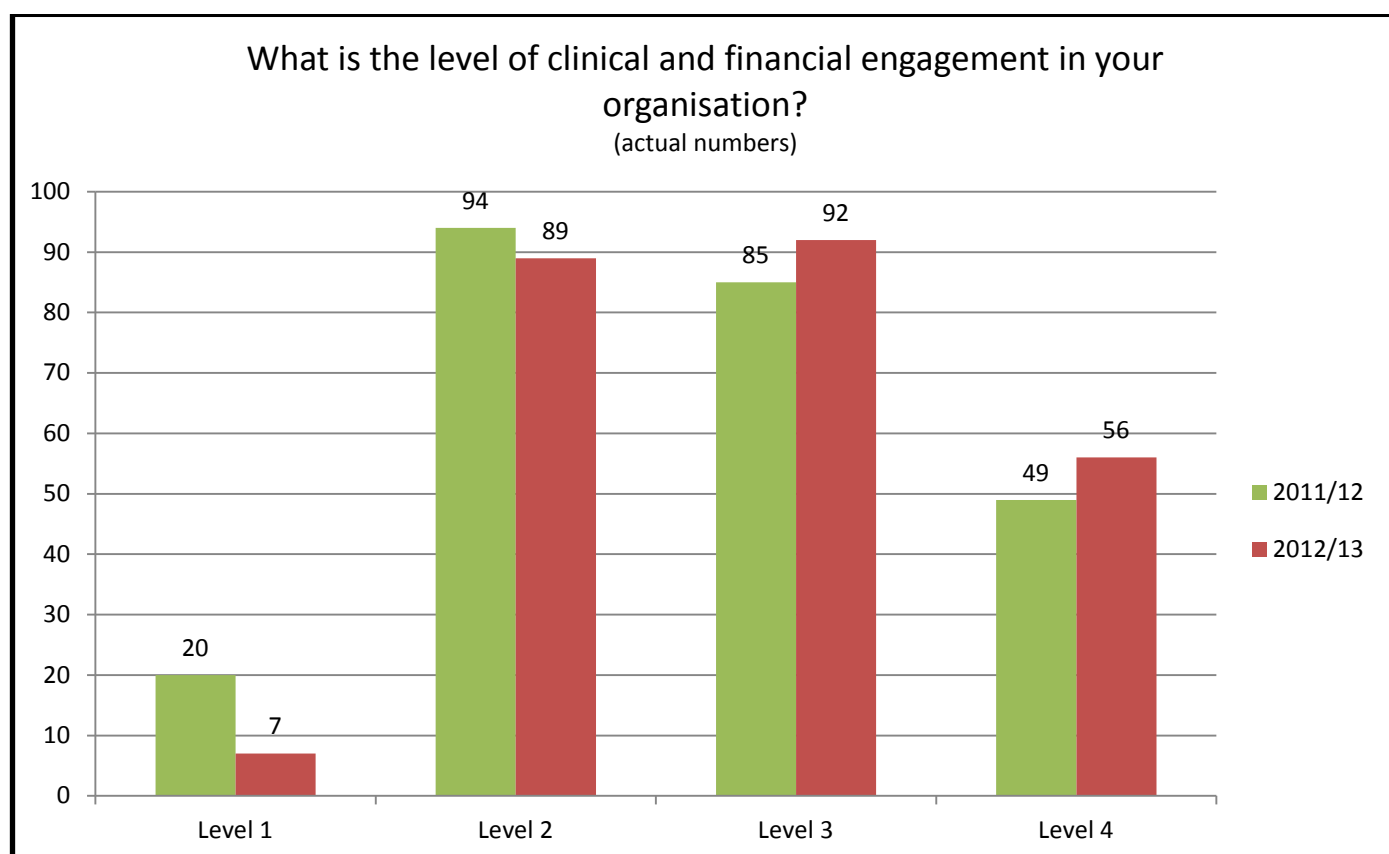
| Level | Characteristics |
|--|---|
| Level 1: Engagement is only at board/strategic level | For example, dialogue takes place between the medical director and finance director, but there is no real joined-up, collaborative work between the wider clinical and finance teams |
| Level 2: There is some joined-up, collaborative working between clinical and finance teams | This happens on an ad hoc basis, when required, e.g. for a specific Commissioning for Quality and Innovation (CQUIN) project |
| Level 3: Joined-up, collaborative working between clinical and finance teams is the norm in at least one clinical specialty/directorate | For example, a finance manager works as an integral part of a clinically-led quality improvement team. There is also a plan to roll this out across other directorates |
| Level 4: Joined-up, collaborative working between clinical and finance teams is the norm across all clinical specialties/directorates | Finance managers routinely work as integral members of clinically-led quality improvement teams and both professional groups share cost and quality data on a regular basis to improve outcomes |

Current national position

2.5 The Department of Health collects data on levels of engagement between clinicians and finance professionals from all NHS trusts via the annual reference costs survey. The results show the current position across the four levels of engagement for the NHS and provide a national benchmark which can be used alongside local benchmarks.

| Level of engagement | July 2012 Number of trusts | July 2013 Number of trusts |
|-------------------------------|-------------------------------|-------------------------------|
| Level 1 | 20 (8%) | 7 (3%) |
| Level 2 | 94 (38%) | 89 (36%) |
| Level 3 | 85 (34%) | 92 (38%) |
| Level 4 | 49 (20%) | 56 (23%) |
| Total number of trusts | 248 | 244 |

NB: The number of trusts is lower in 2013 due to trust mergers.



3. Characteristics of effective engagement

3.1 Organisations have told us they would like a clear picture of ‘what good looks like’ when it comes to effective engagement between clinicians and finance professionals. We have found that those organisations which are succeeding in this challenge generally display a set of key characteristics.

Scoping the characteristics

3.2 These characteristics were initially scoped by conducting national research with clinicians and finance professionals. Two surveys were held by the Department of Health and HFMA: the HFMA Clinical-Financial Engagement Survey – Finance Leaders (Autumn 2011) and the HFMA Clinical-Financial Engagement Survey – Clinicians (Spring 2012). The response rates were 58% and 44% respectively.

3.3 The highlight of the surveys was the clear recognition of the importance of engagement between the two professions: 98% of clinician respondents and 96% of finance director respondents said they believed that high quality services would only be affordable if clinical and finance colleagues are properly engaged to achieve the desired outcomes together.

3.4 Other results which were used to inform the development of the characteristics are:

The top three barriers which need to be overcome, according to clinicians:

- Lack of basic financial awareness/skills among clinicians
- Lack of robust cost data
- Poor presentation of financial and clinical data.

The top three barriers which need to be overcome, according to finance leaders:

- Variability of cost and income data
- Lack of robust cost data
- Lack of basic financial awareness/skills among clinicians.

The top five local measures to improve engagement, according to clinicians:

- Introduction/greater use of patient-level costing
- Wider adoption of service line management (SLM)
- Clear incentives/penalty for achievement or non-delivery of both quality and cost improvement

- Requiring non-finance staff to undertake an introductory course in NHS finance
- Formal programme of job shadowing between finance and clinical leads.

The top five local measures to improve engagement, according to finance leaders:

- Clear incentives/penalty for achievement or non-delivery of both quality and cost improvement
- Introduction/greater use of patient-level costing
- Wider adoption of SLM
- Formal programme of job shadowing between finance and clinical leads
- Regular open access finance surgeries for clinicians, budget holders and other frontline staff.

Finally both groups cited the same reasons for good engagement where it happens:

- Availability of good data
- Clinical champions
- Finance champions
- Shared vision and culture.

3.5 The full survey results can be viewed on the HFMA's website at: [HFMA engagement surveys](#).

Key characteristics of effective engagement

3.6 It was clear there was a great deal of consensus about the issues and what was needed to resolve them. We used the survey data to identify and develop the key characteristics of an effective organisation to provide a clear set of goals for all trusts to help them to undertake their journey towards achieving better engagement. The characteristics have been organised into three categories: organisational behaviours; people; and data.

Organisational behaviours

Establishing an enabling culture:

3.7 Engagement between clinical and finance colleagues is embedded in the culture at all levels, from board members through to clinical and financial staff/specialists, in high performing organisations. Resources are made available for clinical and financial teams to engage in a meaningful manner.

The importance of whole organisation support:

A clinical lead was given leave to defer clinical practice for a short period of time, and a backfill was provided, so that the person could provide leadership to a service redesign programme. This was a key decision, with associated costs, but ensured the reconfiguration decisions were made with the correct rationale and clinical appropriateness, thus ensuring success and improving patient care.

Prioritising value-based healthcare and clinical quality:

- 3.8 Value in healthcare is defined as outcomes (quality) relative to costs. A high performing organisation is able to demonstrate that clinical and financial teams are working together to deliver value-based, high quality healthcare. There is an understanding that cost reduction without maintaining or improving outcomes may lead to false savings and have a detrimental impact on the delivery of effective care.

Leadership:

- 3.9 Successful engagement between clinicians and finance professionals will only take place if there is recognition at board level. This is essential to ensure the approach is cascaded across the different service lines or directorates within an organisation. The board sets the tone for an organisation and its focus will encourage, support and help to resource systematic activities to develop effective engagement. If medical directors and finance directors are not visibly working together, it is very difficult for specialty leads and finance leads to engage successfully within the organisation.

Whole-system approach:

- 3.10 It is important that the focus of engagement is not just at consultant and cost accountant level, but should include all grades of clinical staff, managers, finance staff, informatics and coding staff, and business managers. Organisations which achieve Level 4 have representatives from all staff groups contributing to decisions to improve performance in the relevant clinical areas. This inclusive approach is seen as the norm, rather than the exception.

Continuous improvement:

- 3.11. Successful organisations seek to continuously review and improve in all aspects of clinical and financial engagement and service delivery. Clinical and financial engagement is not an end in itself, but it is an important part of the journey of continuous improvement in a trust.

People

Training:

- 3.12 The availability of training opportunities across an organisation is an important factor in improving clinical and financial engagement. Clinical staff need the skills to interpret financial data and finance staff need the clinical awareness to understand service delivery and appreciate the impact of financial decisions on the quality of services for patients. Training can be delivered by a formal or informal programme.
- 3.13 In a high performing organisation, informatics, coding and finance staff are working with clinicians to improve the quality of data. A finance induction programme is available for all staff, including budget holders, clinical and non-financial staff. Successful organisations typically have a programme of engagement events where all clinical and finance staff are involved, engaged, informed and empowered.

The importance of accurate clinical records:

A clinical delivery unit lead became aware that junior doctors within her department were inaccurately recording or producing illegible records. This primarily impacted on clinical quality, but also reduced income. Over a period of time, the manager gathered the patient records and coded activity and calculated the income, using the tariff and indicative tariff, which each junior doctor would have brought to the service. The results showed that some staff were recording activity so poorly that no income would be received. The clinical manager set up a training course for new staff which covered clinical coding and which included financial input to ensure they understood the impact and their responsibility for financial as well as clinical areas.

Empowered clinical team:

- 3.14 Good organisations ensure financial and quality improvement goals are built into the annual objectives for all clinical staff so everyone is responsible for delivering efficient services. They also ensure that, organisationally, quality and financial targets are linked with clear ownership and accountability within the clinical team. Using tools such as Patient Level Information and Costing System (PLICS) and service line reviews (SLR) aids the process by encouraging transparency in discussions between the clinical and financial teams and allowing clinical leads to interrogate the data.

Empowered finance team:

- 3.15 Highly engaged finance staff are empowered and informed sufficiently to be able to ask questions of clinical colleagues about improving service delivery and design. Empowered finance teams are able to provide training and guidance for clinical colleagues to enable

them to interpret financial data. They also take proactive steps to deal with any enquiries from their clinical colleagues in an open manner.

Observation time:

- 3.16 Making dedicated time available for finance managers to shadow/observe clinical areas and giving clinicians time to shadow/observe finance colleagues is key to nurturing a sustainable collaborative culture.

Data

Timely and appropriate financial data:

- 3.17 To enable effective engagement, finance teams must generate high quality data on a timely basis. It should be well presented and tailored to suit individual discussions with different clinicians. It should be free of accounting jargon and accessible to the audience. It is helpful to produce high level summaries and notes on issues/factors to consider for review with clinicians, rather than a full costing extract.

The importance of good quality financial reports:

One cost accountant advised that producing just one poor or inaccurate financial report can cause clinicians to switch off and cause reputational damage to the finance team, particularly if this is in the early stages of engagement or rolling out PLICS/SLR systems. However this has to be balanced with producing data in a timely fashion.

Good quality integrated data:

- 3.18 Currently, most data used in clinical and financial discussions is extracted from an individual system/source. The availability of robust integrated data sources is important for developing an effective decision-making tool for discussions with clinical colleagues. This will help to deal with the issues caused when conflicting data, extracted from different local systems, is presented to clinical and financial decision makers.

Evidence-based decision making:

- 3.19 Financial and clinical data is needed to support investment and service design decision making. Using PLICS or SLR data, which is understood by clinicians, helps them to develop evidence-based business cases for quality improvements. Being able to drill into the data while having discussions is extremely useful and adds integrity to the decision-making process.
- 3.20 When setting up sustainable cost improvement programmes, or project teams, successful organisations ensure project teams have a lead clinician supported by finance

staff. This embeds clinical buy-in and the responsibility to consider any impact on quality during the prioritisation and decision-making processes. Organisations report this is not easy, and some resistance may be encountered, but that it is essential for reaching clinically appropriate, evidence-based conclusions.

4. Self-assessment tool

- 4.1 The self-assessment tool has been designed to support NHS trusts in making a robust and objective assessment of engagement levels in order to identify the areas on which they need to focus their efforts. The tool should also be used to inform the self-assessment score provided to the Department of Health in the annual reference costs survey to help to improve standardisation of the data collected.
- 4.2 In February 2013, the Department of Health hosted a national Clinical and Financial Engagement Workshop to define the objective assessment criteria for each of the four levels of clinical and financial engagement. These criteria were used to develop the self-assessment tool to enable organisations to determine their current level of engagement.

Using the self-assessment tool

- 4.3 Self-assessment is not a one-off, annual exercise. It needs to be a continuous process, with organisations using the self-assessment tool to support and drive the development of the key characteristics and progression through the four levels of engagement to reach their overall goals.
- 4.4 The process of self-assessment involves reviewing the organisation against each characteristic within three categories which are: culture and behaviour; process and tools; and benefits and outcomes. Trusts should satisfy themselves that there is good evidence to support the assessment made.
- 4.5 The steps are a guide to the culture and behaviours, processes and tools and benefits and outcomes that are likely at each level. They include many, but by no means all, of the building blocks demonstrated by organisations where clinical and financial engagement is effective and beneficial to the whole organisation.
- 4.6 We have avoided recommending set procedures and processes because we understand that simply having these in place does not always determine the quality of work and commitment of the organisation. Therefore the focus of the assessment is on the holistic culture of an organisation. An organisation that has effective clinical and financial engagement as an integral part of its day-to-day operating processes will be at Level 4.
- 4.7 To have achieved a level, we would expect most, though not necessarily all, of the steps within that level to be consistently demonstrated across the three elements of culture and behaviours, process and tools, and benefits and outcomes. Crucially an organisation that has a culture of engagement at all levels, but does not use PLICS, would still be at Level

4, while an organisation that uses PLICS but only has clinical and financial engagement at board level would still be at Level 1. An organisation which engages all but one or two very small specialties, which would not have a material effect on the outcomes of the organisation, is likely to be at Level 4. Conversely, organisations which do not support their clinicians and other service managers in using financial data to run their departments are unlikely to be at Level 4.

Clinical and financial engagement: Self-assessment tool

| | Level 1 Engagement is only at board/strategic level | Level 2 There is some joined-up, collaborative work between clinical and finance teams | Level 3 Joined-up, collaborative working between clinical and finance teams is the norm in at least one clinical specialty/directorate | Level 4 Joined-up, collaborative working between clinical and finance teams is the norm across all clinical specialties/directorates |
|-------------------------------|---|--|--|--|
| Culture and behaviours | | | | Constructively challenging <input type="checkbox"/> |
| | | | | Continuous improvement <input type="checkbox"/> |
| | | | Availability and ownership of data <input type="checkbox"/> | Availability and ownership of data <input type="checkbox"/> |
| | | | Staff are engaged, involved and empowered to make cost and quality decisions together <input type="checkbox"/> | Staff are engaged, involved and empowered to make cost and quality decisions together <input type="checkbox"/> |
| | | Clear joint accountability <input type="checkbox"/> | Clear joint accountability <input type="checkbox"/> | Clear joint accountability <input type="checkbox"/> |
| | | Multi-professional team working <input type="checkbox"/> | Multi-professional team working <input type="checkbox"/> | Multi-professional team working <input type="checkbox"/> |
| | | Cross-departmental boundary working <input type="checkbox"/> | Cross-departmental boundary working <input type="checkbox"/> | Cross-departmental boundary working <input type="checkbox"/> |
| | | Clinical and finance leadership work closely on the board <input type="checkbox"/> | Clinical and finance leadership work closely on the board <input type="checkbox"/> | Clinical and finance leadership work closely on the board <input type="checkbox"/> |

| | | | | |
|------------------------------|--|--|--|--|
| Process and tools | | | | Clinical directors chair SLR meetings <input type="checkbox"/> |
| | | | | Patient feedback <input type="checkbox"/> |
| | | | PLICS implemented <input type="checkbox"/> | PLICS implemented <input type="checkbox"/> |
| | | | Cross-training of clinical and finance staff <input type="checkbox"/> | Cross-training of clinical and finance staff <input type="checkbox"/> |
| | | Benchmark MAQS performance management measure <input type="checkbox"/> | Benchmark MAQS performance management measure <input type="checkbox"/> | Benchmark MAQS performance management measure <input type="checkbox"/> |
| | | Service line review/management <input type="checkbox"/> | Service line review/management <input type="checkbox"/> | Service line review/management <input type="checkbox"/> |
| | Clinical and finance engagement agenda used for performance management only <input type="checkbox"/> | Clinical and finance engagement agenda used for performance management only <input type="checkbox"/> | Clinical and finance engagement agenda used for performance management only <input type="checkbox"/> | Clinical and finance engagement agenda used for performance management only <input type="checkbox"/> |
| Benefits and outcomes | | | | Improved efficiency and productivity <input type="checkbox"/> |
| | | | | Lower cost but higher quality <input type="checkbox"/> |
| | | | Improved patient care <input type="checkbox"/> | Improved patient care <input type="checkbox"/> |
| | | | Improved clinical outcomes <input type="checkbox"/> | Improved clinical outcomes <input type="checkbox"/> |
| | | | Improved planning <input type="checkbox"/> | Improved planning <input type="checkbox"/> |
| | | Increased staff motivation <input type="checkbox"/> | Increased staff motivation <input type="checkbox"/> | Increased staff motivation <input type="checkbox"/> |
| | | Better joined-up, informed decisions based on evidence <input type="checkbox"/> | Better joined-up, informed decisions based on evidence <input type="checkbox"/> | Better joined-up, informed decisions based on evidence <input type="checkbox"/> |
| | Help to conform with local and national requirements <input type="checkbox"/> | Help to conform with local and national requirements <input type="checkbox"/> | Help to conform with local and national requirements <input type="checkbox"/> | Help to conform with local and national requirements <input type="checkbox"/> |

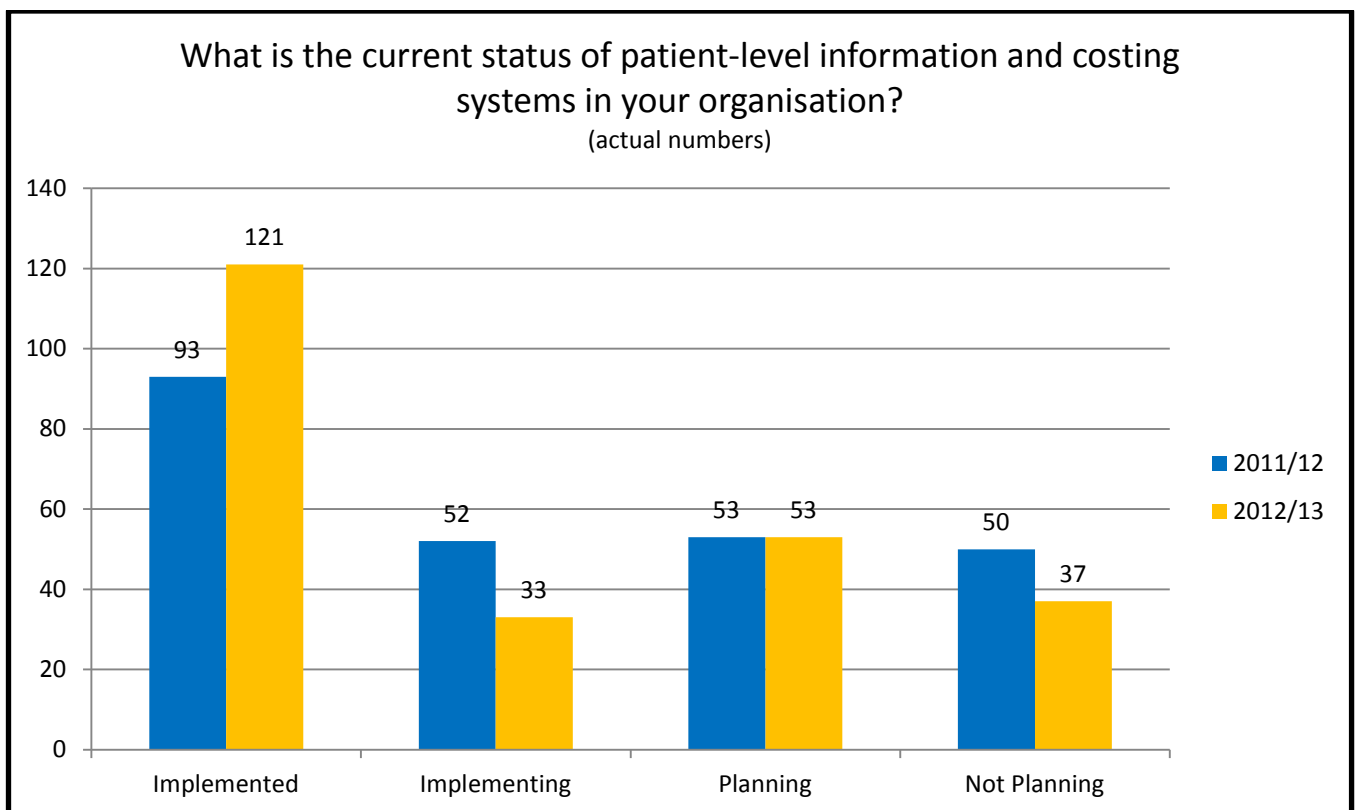
5. Practical suggestions and enabling factors to promote effective engagement

- 5.1 The following suggestions, tools and enabling factors represent a range of options which an organisation should consider to help it develop and embed the key characteristics of engagement. It is not necessary to have all of these processes and tools in place although these have been found by high performing organisations to promote effective engagement.
- 5.2 It is useful to highlight that to be able to participate fully, clinicians need knowledge and understanding of finance and costing processes, while finance professionals need to understand the clinical work of the different specialties, the fundamentals about quality, and how to measure the financial impact of improvement initiatives.

Patient-Level Information and Costing System

- 5.3 PLICS is an activity-based costing methodology which records all the significant activities – including clinical interactions, processes and procedures – which happen to individual patients from the time of admission until discharge. It can be used to calculate the resources consumed because it uses the actual costs incurred by the organisation in providing the services and activities related to a patient's care.
- 5.4 PLICS produced costing information at a patient level, giving finance and clinical teams access to detailed patient cost data. They can use this to jointly understand patient costs, and use the data to make more efficient use of resources when making clinical decisions. For example, ensuring the number of tests performed or the costs of drugs prescribed for each individual patient is as efficient as possible while maintaining a high quality outcome.
- 5.5 PLICS data provided to managers and clinicians supports better business and clinical decision making because it enables them to consider how resources should be allocated to achieve the best outcome for the patient. It allows key questions to be answered, such as: does allocating additional resource to a particular classification of patient shorten their length of stay or deliver specific improvements to the patient?
- 5.6 Patient-level costing is essentially the resource consequences of clinical activity and is primarily informed by the measurement of each clinical activity. This necessitates the involvement of clinical staff in the definition, documentation and authentication of data inputs into PLICS.

- 5.7 One trust uses PLICS data to carry out peer comparisons of clinicians. When examining data it found one clinician was an outlier compared to their peers which was explained by the clinician being newly qualified. The clinician’s data was regularly reviewed over the following six months to ensure that, as they became more experienced, their costs of treating patients reduced and became comparable to those of their peers, without compromising quality.
- 5.8 The number of NHS providers which have implemented PLICS or are planning to implement it is increasing as these figures from July 2013 demonstrate:



Best practice at Wrightington, Wigan and Leigh NHS Foundation Trust

The trust's SLM pathfinder project involved finance managers and clinicians working collaboratively using PLICS and SLM to understand clinical practices and move a service line from loss to profit.

The motivation for the project was that primary total prosthetic replacement of hip joint, the most common procedure in their specialist elective orthopaedic centre at Wrightington Hospital, involving over 1,000 patients each year, was delivering excellent clinical outcomes but showing an annual loss of £1 million.

The Musculo-Skeletal Division reviewed the patient-level costs, identifying specific areas of practice that were adversely affecting income. As a result, while ensuring quality outcomes would be maintained, they identified efficiency opportunities amounting to £1.5 million through the redesign of clinical practices and pathways. These included productivity savings in which reductions to patient lengths of stay freed capacity for an additional 600 episodes of new activity in 2011-12, without an increase in associated resources. At the same time, the procedure pathways were standardised to ensure that patients received the best quality care and experience, e.g. no unnecessary radiology or pathology tests, and only being discharged when medically fit.

Clinical costing standards

- 5.9 When finance professionals regularly engage with clinical professionals to ensure costing models and allocations reflect how care is delivered in the trust, the quality of costing improves.
- 5.10 The HFMA's Acute Health Clinical Costing Standards and Mental Health Clinical Costing Standards set out best practice guidance for deriving cost data in the NHS. These can be viewed on the HFMA's website at: [Clinical costing standards](#). In particular, the quality assessment and measurement standard is aimed at supporting the assessment and improvement of the quality of costing data.
- 5.11 Robust and transparent cost information is essential for the engagement of clinicians and managers, and for improving the management of resources and clinical care. The HFMA's Materiality and Quality Score (MAQS) assessment tool provides organisations with a means of assessing their current costing processes and identifying opportunities for improving the costing process. The MAQS tool also provides greater transparency about costing processes, which provides assurance to clinicians and boards on the costing methodologies which are being used. It can also be used to demonstrate improvement as scores improve, which helps to generate greater confidence in the process over time.

Service line review

- 5.12 SLR was developed by Monitor for NHS foundation trusts, although its principles apply equally to other NHS settings. Service lines are the units from which the trust's services are delivered. Each has a focus on particular medical conditions or procedures and is run by specialist clinicians. By understanding how the service works, teams can see where there are potential efficiencies, and how services can be improved.
- 5.13 Trusts with high levels of engagement have developed and embedded a culture of challenging reviews. The reviews need to take place frequently to help instil a culture of continuous improvement. The best way to test this approach is to set up a pilot with two or three services initially.

Tips for a service line review meeting

Tip 1. Use this best practice format for an effective SLR:

Prepare

- Gather the necessary information and data

Diagnose

- Establish the current state and where you want to be
- Identify priority areas with room for improvement and establish a baseline in each
- Size the possible improvement

Design

- Define what success looks like
- Identify actions to make improvements
- Size, prioritise and plan the actions
- Present the action plan

Deliver

- Put the actions into practice
- Keep track of progress
- Prepare for the next SLR
- Present the successes achieved.

Tip 2. Pay particular attention to reviewing which of the costs can be more effectively controlled through safe changes to clinical and operational practices and behaviours.

Tip 3. Focus on specific themes such as:

- The use of temporary staff
- Reviewing the staffing model and role of the clinical nurse specialist team
- Reviewing drugs prescribing policies, and the timing, quantity and duration of prescriptions
- Streamlining the discharge process.

Tip 4: Ensure the following people participate:

- Clinical service lead
- General manager
- Business/Financial analyst
- Performance manager
- Service manager.

Additional participants who will add value are:

- Clinical nurse specialist
- Quality improvement specialist
- Administrator
- Nurse
- Consultant
- Pharmacist.

Best practice at Chelsea and Westminster Hospital NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust put in place the four step SLR process and invited the core and optional participants to their review meetings. They also used independent facilitators at their SLR meetings.

Examples of services covered by their reviews are:

- A review of the use of temporary staff which resulted in the trust saving £60,000 a year in one specialty where permanent vacancies were not being filled.
- A review of staffing models and the role of the clinical nurse specialist teams resulted in reduced waiting times during annual leave periods when it was identified that one patient pathway was dependent on one clinical nurse specialist.
- Following a review of discharge procedures, a saving of £35,000 was identified through streamlining the discharge of intensive therapy unit (ITU) patients to other wards. This allowed the ITU to use staff more efficiently and treat more patients.

Knowledge and training

- 5.14 Finance teams must properly understand the business which they support. Taking the time to shadow frontline clinical staff helps develop understanding of how services operate, increasing awareness of and empathy for clinical staff and their work. The HFMA's 'Medicine for Managers' series of briefings provide an overview of some clinical specialties, outlining the key clinical activities, the staff involved and the specific challenges faced by each specialty. These can be viewed on the HFMA's website at: HFMA: [Medicine for managers](#).
- 5.15 Clinicians may not have appropriate knowledge or understanding of the cost implications of their clinical decisions due to a gap in their undergraduate and postgraduate training curriculum. They may therefore miss opportunities to improve quality and decrease cost simultaneously. By providing relevant financial training to clinical staff, in particular medical professionals, a cost-conscious culture can be embedded which makes the best use of resources to deliver the best outcomes for patients.
- 5.16 Junior clinical staff and accountancy/management trainees should be encouraged to engage with their trainee counterparts. This will build relationships and lay down strong foundations for the engagement process at the beginning of their financial and medical careers.

- 5.17 Early positive discussions aimed at finding ways to include a finance module in undergraduate and postgraduate medical training programmes have taken place with the Medical Schools Council, Health Education England and General Medical Council. The goal is to develop a medical workforce which can effectively manage the cost and quality challenges in the NHS.

Best practice from the national workshop

One of the trusts which participated in the Department of Health's national workshop has nominated clinical and business leads in each speciality area who are responsible for understanding and influencing both coding and costing within the organisation. They are given an overview of the costing process and shown how to access information for review. This is being undertaken on a rolling basis with areas being prioritised according to their relevance to trust-wide and divisional strategies.

Communication and shared language

- 5.18 The trusts which attended the Department of Health's national workshop emphasised the need for a shared language that is clear, consistent and understood by clinical and financial teams. Both professions need to find out more about the others' services so they improve relationships and communication, and achieve a shared frame of reference.
- 5.19 Professions have their own technical language with terms and acronyms that may not be readily understood. Explaining terms and avoiding acronyms helps build the relationship between professions.
- 5.20 It is essential to identify clinical and cost champions at specialty level who will promote clinical and financial communication on a regular basis and help to encourage the flow of information, dialogue and constructive challenge between professions.
- 5.21 Presentation of easily understood and timely costing information should be the starting point to truly comprehending how and which cost decisions can deliver clinical quality. Costing departments cannot do this in isolation. One trust has finance staff embedded within each clinical specialty to develop relevant information through collaborative working with clinicians.

Robust and timely data

- 5.22 Clinical ownership of data is a critical factor in increasing engagement. In trusts with high levels of engagement, finance managers work closely with clinicians to develop an agreed set of patient-centric performance data and to make the costing process as transparent as possible. Finance staff and clinicians analyse the data together to bring credibility and transparency to the data.

- 5.23 Good data quality is crucial, but striving for perfect data should not hold back progress. Trusts with high engagement work at continuously improving data quality, e.g. through a rolling programme of coding reviews.
- 5.24 Using current data is essential. One trust reported that the data they use at SLR meetings is a maximum of one month old. Automated collection and presentation of data supports the production of timely data..

Best practice at Alder Hey Children's NHS Foundation Trust

The Endocrinology Service had been developing rapidly due to new treatments and services, updated NICE guidelines and increasing awareness of available services. The challenge was to determine the optimum strategy that matched service demand while delivering a financially robust service. Additionally, there was a need to introduce greater levels of multi-disciplinary working to meet the aspirations of clinicians in terms of research, and to provide assurance that investment in the service was in line with trust objectives and financial targets.

A cost accountant worked with the consultant team to ensure that the SLR data was robust, moving to reporting and analysis on a monthly basis. Following a review of the SLR reports by the consultant and management teams, refinements to the costing process were made to ensure it provided an excellent basis for reviews of service performance and capacity. The outcomes from increased confidence in the data have been additional investment in the service, improved outcomes for patients, greater adherence to NICE guidelines and increased sub-specialisation of services.

Benchmarking

- 5.25 Seeking to understand the reason for performance which is above or below a range of appropriate indicators, for example the mean average or the top quartile, requires clinicians and finance professionals to work collaboratively to interrogate data and understand the results. Those trusts in which high levels of engagement are reported interrogate their benchmarking data.
- 5.26 Comparing individual performance against the mean, either internally or as part of local or national benchmarking groups, can generate the helpful questions:
- Are our results different?
 - Why is this?
 - What can we do about it?

- 5.27 In one trust with high levels of engagement, the medical director monitors the cost of carrying out specified procedures by individual clinician. Those who are outliers report to the trust's board to explain why the cost of procedures is significantly higher than the mean.
- 5.28 One trust hosted a joint finance and information workshop, inviting colleagues from peer organisations to join the debate, share best practice and learn from each other. This set the foundations to enable them to better benchmark their costing data across cancer services.

Best practice at Liverpool Heart and Chest Hospital NHS Foundation Trust

The trust purchased a PLICS system four years ago and is recognised as a national leader. Benchmarking data is used extensively within the trust; for example, to carry out clinical peer comparisons in respect of costs of surgery, incidences of complications with associated costs and the cost of individuals' practice against income. Consultants are encouraged to sit with finance experts to explore the PLICS system and the benchmarking data it generates.

Feedback from staff and patients

- 5.29 Reviewing feedback jointly is an effective way to identify where quality can be improved, and where costs can be saved. Two sources of patient feedback are:
- From April 2013, patients have been asked whether they would recommend hospital wards and accident and emergency departments to their friends and family if they needed similar care or treatment. This means every patient in these wards and departments will be able to give feedback on the quality of the care they receive. From October 2013, an NHS friends and family test has also been available to women who use maternity services, and other services are likely to follow.
 - All NHS patients having hip or knee replacements, varicose vein surgery, or groin hernia surgery are invited to fill in patient reported outcome measures (PROMs) questionnaires. Patients are asked about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards.
- 5.30 SLRs are an effective way to obtain feedback and ideas from colleagues about where improvements should be made. Many staff will have already identified areas which could be improved and, subject to being confirmed by SLR data, these ideas should form part of a review.

Best practice at Birmingham Children's Hospital NHS Foundation Trust

The trust collects feedback on patients' experiences from a wide range of sources, including friends and family questionnaires, 'thank you' cards, verbal complaints and an app for real-time feedback.

Feedback is considered at monthly and quarterly performance reviews attended by the associate service director, the head of nursing and the clinical director, where the key challenge is 'what will we do differently next time?'

In one example, after the trust received a complaint regarding an injury caused by a cannula, which extended a patient's stay, a specific set of procedures to follow when using a cannula were implemented.

Improvements made in response to patient feedback are presented at corporate level to the associate director of nursing, the deputy director of performance and the deputy director of finance. There is a shared understanding that if the care is right first time it will deliver a better patient experience and a positive financial impact.

Performance management

- 5.31 Organisations where clinical and finance teams engage jointly in business planning, objective setting, and reviewing and challenging performance, report a sense of shared purpose about improving patient services and reducing costs safely.
- 5.32 Trusts with high levels of engagement between clinicians and finance professionals report using a range of performance management tools to improve performance. Common to both professions was the use of performance data as an integral part of the evidence-based performance management of teams. For example, one medical director assesses the performance of clinicians against 16 different performance criteria.
- 5.33 One trust recently implemented the 'balanced scorecard' approach which uses a broad range of key performance indicators that reflect longer term prospects as well as immediate performance across four different perspectives: customer; internal business process; innovation and learning; and finance. This produces a joined-up picture of performance across the trust.
- 5.34 To specifically increase engagement, one trust advised that they had set clinical engagement objectives for finance staff and were intending to do the same for clinical staff.

Best practice at Nottingham University Hospitals NHS Trust

The trust runs a leadership programme which encourages managers from all departments to work together to achieve the trust's objectives and service line goals. The programme is run by an organisation which specialises in leadership and organisational alignment and has been well attended by consultants, matrons, general managers, finance teams and the Education Department. It is continuing to roll out across the trust.

The trust recently held an HFMA/Institute of Healthcare Management conference which was attended by over 100 delegates. The costing and SLR manager and other trust managers shared their experiences of the programme and fed back that it had helped them to realise they needed to help other departments to achieve their goals as well as achieving their own. They now have weekly meetings where scorecards are reviewed and progress is discussed and they encourage engagement from all levels of staff.

6. Best practice inspiration

6.1 These inspiring examples demonstrate the ways in which effective engagement between clinicians and finance professionals can have a positive impact on an organisation, its patients and other stakeholders.

6.2 They represent a selection of the many excellent examples of good working practice which are taking place across the NHS and many more can be found at: [NICE website](#).

6.3 These examples have been obtained from a range of sources, including the Department of Health's Clinical and Financial Engagement Workshop, discussions with NHS provider trusts, and the Audit Commission's A Prescription for Partnership report.

6.4 The examples chosen are not an endorsement of particular trusts over others. Rather, each of these examples has been identified to highlight a specific element of the engagement criteria and to demonstrate the positive outcomes when engagement occurs.

West Middlesex University Hospital NHS Trust

6.5 In West Middlesex, a partnership between clinicians and finance staff to review the flow of patients through hospital wards led to a smarter and more efficient system of bed management. Clinical and finance staff worked together to find ways to reduce the inefficient use of hospital beds while ensuring that quality standards were maintained and, where possible, improved.

6.6 A root cause analysis was led by the finance team to evaluate the efficiency of the existing bed system. This information enabled frontline clinical staff to explore how their processes for patient flow management affected patient costs and outcomes. Throughout the review, finance and clinical professionals supported each other to understand the implications from each of their perspectives. This led to a solution on which both professional groups agreed. Due to the success of the new bed management system, West Middlesex University Hospital has been able to close two wards without any adverse impact on patient care.

Salford Royal NHS Foundation Trust

6.7 A partnership between the trust and its commissioners was set up to redesign the patient pathway for emergency care services. Joint work between trust clinicians and finance staff has facilitated a new patient pathway. This is supported by a far deeper understanding of the costs associated with what happens before and after a patient enters the emergency care pathway and of variation.

- 6.8 The initiative has resulted in a reduction in the costs of emergency care within Salford of approximately £4 million. This is supported by a revised contractual methodology based upon locally-agreed groupings of activity, known as 'stripes', which use SLM and a PLICS to develop a deeper understanding of variation in cost.

The Christie NHS Foundation Trust

- 6.9 The trust has dedicated informatics time to the PLICS process which is essential for the production of good quality and timely information. This arrangement also allows the finance and information teams to understand the whole costing process from the initial data feeds through to the final costed results. The trust has initiated internal and external audits of the PLICS system to provide assurance over the data which has helped to highlight areas for improvement. This was linked with the self-assessment checklist within the reference costs survey and enabled the trust to create a PLICS-specific quality checklist.
- 6.10 The trust now requires PLICS data to be used within business case development. This has been a successful way of promoting clinical engagement; for example in the development of the Haematology and Transplant Unit which had been a loss-making area. Here a team of clinicians, business managers and finance staff used patient-level data to forecast costs and savings and improve efficiency.

Chelsea and Westminster Hospital NHS Foundation Trust

- 6.11 A facilitated workshop and an exercise that mapped and costed a patient's journey through the bariatric service resulted in an increased use of telephone clinics that freed face-to-face clinic capacity and benefited patients through earlier identification of those requiring more in-depth support. The creation of a 'one-stop-shop' service with seminar clinics also reduced the number of visits needed. Improved performance outcomes were achieved, with annual savings of: £55,000 through anaesthetising the first patient in theatre; £140,000 through increasing the number of operations per day from two to three; and £20,000 by standardising the use of staff, approach and equipment.
- 6.12 In the Dermatology Department demand and waiting times did not correlate which prompted a capacity review. Reinforcing the 'did not attend' (DNA) policy cut the DNA rate to 12%. The result was the elimination of unused outpatient slots saving £80,000 per year and a reduction in excess follow-ups by the earlier discharge of patients to GPs saving £33,000 per year. The benefit to patients was a reduction in waiting times.

Harrogate and District NHS Foundation Trust

- 6.13 The trust has finance staff based within clinical directorates, and this is seen as essential to enable staff to understand the clinical process. The trust holds a three-day training programme twice a year for all staff who have budget responsibility or who manage

resources and anyone else who wants to understand more about finance. The course covers a wide range of finance topics including payment by results, accounting concepts, coding, and the importance of financial management. As a result managers in Harrogate are asking for more information from the finance team.

Somerset Partnership NHS Foundation Trust

6.14 Due to the shortage of placements for mental health service users the trust was outsourcing care. This was not good for service users and the trust was breaching its budget. The trust developed alternative local facilities using a placement panel consisting of a senior nurse; a variety of clinicians, including occupational therapists; social workers; and finance staff. A consultant psychiatrist led the change, which ensured it was driven by care values. The trust was able to make considerable financial savings and accommodate service users closer to home.

Liverpool Women's NHS Foundation Trust

6.15 The trust's In Vitro Fertilisation (IVF) Centre was incurring a loss, which was contrary to what was happening in other IVF centres. The trust followed four approaches:

- Bottom-up costing – led by finance but involving a wide range of clinical staff
- Trading account preparation – matching clinical activity to cost
- Service redesign – following process mapping and feedback from all staff
- A new business model – to allow expansion.

6.16 The use of bottom-up costing allowed financial and clinical directors to understand staff resourcing better and to better use consultants' time. Using trading accounts gave the centre greater focus on financial targets. Productivity improved by 30% and the centre moved from a deficit of £0.2 million to a surplus of £1.2 million. This improved performance has generated plans to build a new centre with better facilities.

Epsom and St Helier University Hospitals NHS Trust

6.17 Prosthetics is a significant cost for the South West London Elective Orthopaedic Centre. As a centre for excellence and clinical choice, the traditional method of keeping costs down by restricting products was not available. The centre achieved reduced costs through consultant surgeons working with the finance team to negotiate with suppliers to agree prices for prosthetics which were set by the centre. If the supplier could not meet the price, their components were not stocked. The resulting impact was significant financial savings and improved stock management systems from the suppliers.

7. Resources

Audit Commission: [A Prescription for Partnership: Engaging clinicians in financial management](#)

Audit Commission and Academy of Medical Royal Colleges: [A Guide to Finance for Hospital Doctors](#)

Audit Commission, Academy of Medical Royal Colleges, Department of Health, HFMA, NHS Institute for Innovation and Improvement and Royal College of Nursing: [Clinicians and Finance: Improving patient care](#)

BMJ, The King's Fund, Department of Health and NHS Confederation: [Agents for Change: Collaborating for quality](#)

HFMA: [Clinical costing standards](#)

HFMA: [HFMA engagement surveys](#)

HFMA: [Introduction to NHS Finance \(England\)](#)

HFMA: [Medicine for Managers \(Mental Health\)](#)

HFMA: [Medicine for Managers \(Paediatrics\)](#)

HFMA: [Patient-level costing case studies](#)

HFMA: [Responding to the Francis Report](#)

Monitor: [Approved Costing Guidance](#)

Monitor: [Service-Line Management](#)

NHS Institute for Innovation and Improvement: [Clinical-Financial Partnerships in the NHS: Why we need them to deliver the cost and quality challenge](#)

National Institute for Health and Care Excellence (NICE): [Good practice examples](#)

Robert Francis QC: [Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry](#)

Royal College of Nursing: [Patient-Level Costing and Nursing](#)

Shape of Training: Securing the future of excellent patient care (Final [report](#) of the independent review Led by Professor David Greenaway)

Annex A: Achievements – Development of clinical and financial engagement in the NHS

In the last three years, steps have been taken to strengthen the engagement between clinical and finance professionals in the NHS. These achievements and milestones are summarised as follows:

| Focus | Achievements |
|--|--|
| Scoping | <p>National surveys of clinicians and finance managers</p> <p>Four levels of engagement devised to identify current practices in NHS provider trusts</p> |
| Building capability | <p>Discussions with the Medical Schools Council, Health Education England and the General Medical Council to find ways to incorporate a finance module in undergraduate and postgraduate medical training programmes</p> <p>HFMA published ‘Medicine for managers’ guides covering paediatrics and mental health services</p> |
| National policy and drivers | <p>National system to collect levels of engagement data from all trusts annually</p> <p>National policies (Department of Health’s Reference Costs Guidance 2012-13 and Monitor’s Approved Costing Guidance) highlighted the importance of actively engaging clinicians in the costing process</p> |
| Service and academic research | <p>National Institute for Health Research awarded a £467,685 grant for a three year research project to evaluate the current and potential uses of PLICS in the NHS, led by the University of Manchester Business School</p> <p>Unique international collaborative project with USA organisations (Kaiser Permanente and Intermountain Healthcare) to develop and share a business case for the quality model</p> <p>Increased number of NHS trusts exploring the potential use of PLICS data to improve engagement between their clinical and finance teams, evident from various awards applications</p> |
| Identifying and spreading best practice | <p>Health Service Journal, HFMA and other national and local organisations established awards to acknowledge outcomes achieved through effective clinical and financial engagement</p> <p>NICE has created a web portal of quality and efficiency improvements, many of them are underpinned by joined-up working between clinical and finance teams.</p> |

Annex B: Acknowledgements

We acknowledge the contribution and support of the following organisations in improving clinical and finance engagement in the NHS and help us to achieving many of the milestones:

- Healthcare Financial Management Association (HFMA)
- The Medical Schools Council
- General Medical Council
- Health Education England
- Academy of Medical Royal Colleges
- Audit Commission
- Royal College of Nursing
- Care Quality Commission
- NHS England
- National Institute for Health and Care Excellence (NICE)
- Monitor
- NHS Trust Development Authority
- Manchester Business School
- Health Service Journal
- Institute of Healthcare Improvement (Boston, USA)
- Kaiser Permanente (California, USA)
- Intermountain Healthcare (Utah, USA)
- Participants in the national Clinical and Financial Engagement Workshop hosted by the Department of Health in February 2013: Wrightington, Wigan and Leigh NHS Foundation Trust; Liverpool Heart and Chest Hospital NHS Foundation Trust; Chelsea and Westminster Hospital NHS Foundation Trust; The Christie NHS Foundation Trust.

Annex C: Recommendations of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry which are pertinent to effective clinical and financial engagement

| Number | Recommendation | Accountability |
|--------|--|---|
| 2 | <p>The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done. This requires:</p> <ul style="list-style-type: none"> • A common set of core values and standards shared throughout the system • Leadership at all levels from ward to the top of the Department of Health, committed to and capable of involving all staff with those values and standards • A system which recognises and applies the values of transparency, honesty and candour • Freely available, useful, reliable and full information on attainment of the values and standards • A tool or methodology, such as a cultural barometer, to measure the cultural health of all parts of the system. | Every single person serving patients to contribute to a safer, committed and compassionate and caring service |
| 35 | Sharing of intelligence between regulators needs to go further than sharing of existing concerns identified as risks. It should extend to all intelligence which when pieced together with that possessed by partner organisations may raise the level of concern. Work should be done on a template of the sort of information each organisation would find helpful. | The Healthcare Commission |
| 65 | The NHS Trust Development Authority should develop a clear policy requiring proof of fitness for purpose in delivering the appropriate quality of care as a pre-condition to consideration for support for a foundation trust application. | NHS Trust Development Authority |
| 69 | The assessment criteria for authorisation should include a requirement that applicants demonstrate their ability to consistently meet fundamental patient safety and quality standards at the same time as complying with the financial and corporate governance requirements of a foundation trust. | Monitor |

| | | |
|-----|--|--|
| 132 | <p>Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period:</p> <ul style="list-style-type: none"> • Such monitoring may include requiring quality information generated by the provider. • Commissioners must also have the capacity to undertake their own (or independent) audits, inspections, and investigations. These should, where appropriate, include investigation of individual cases and reviews of groups of cases. • The possession of accurate, relevant, and useable information from which the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulation. • Monitoring needs to embrace both compliance with the fundamental standards and with any enhanced standards adopted. In the case of the latter, they will be the only source of monitoring, leaving the healthcare regulator to focus on fundamental standards. | NHS England, Clinical commissioning groups |
| 198 | <p>Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the cultural health of front-line nursing workplaces and teams, which build on the experience and feedback of nursing staff using a robust methodology, such as the cultural barometer.</p> | Individual trusts and regulators |
| 214 | <p>A leadership staff college or training system, whether centralised or regional, should be created to: provide common professional training in management and leadership to potential senior staff; promote healthcare leadership and management as a profession; administer an accreditation scheme to enhance eligibility for consideration of such roles; promote and research best leadership practice in healthcare.</p> | NHS Leadership Academy |
| 287 | <p>The Department of Health should together with healthcare systems regulators take the lead in developing, through obtaining consensus between the public and healthcare professionals, a coherent and easily accessible structure for the development and implementation of values, and fundamental, enhanced and developmental standards as recommended in this report.</p> | Department of Health |
| 288 | <p>The Department of Health should ensure that there is senior clinical involvement in all policy decisions which may impact on patient safety and well-being.</p> | Department of Health |