Monitor

# Summary of stakeholder responses to *Costing Patient Care* and *draft Approved Costing Guidance*

21 February 2013

## Contents

## Introduction

The Health and Social Care Act (2012) gives Monitor and the NHS Commissioning Board joint responsibility for setting prices for NHS-funded services in England. Monitor will lead on developing the methodology for price setting, calculating prices, enforcing the pricing regime (through Monitor's provider licence), approving local modifications to national prices and setting rules for local pricing. The NHS Commissioning Board will lead on developing the scope and design of currencies (the services to be priced), and setting rules around local variations to the National Tariff. Monitor and the NHS Commissioning Board will jointly agree the National Tariff before it is published.

Obtaining accurate and comparable cost data is fundamentally important to support our new role in calculating the prices for NHS-funded services in England.

Our approach to obtaining this cost data has been developed following a process of extensive research and engagement with a wide range of sector stakeholders:

- In February 2012, we published the report, *An Evaluation of the Reimbursement System for NHS-funded Care,* which identified that the information underpinning the reimbursement system requires significant improvement.

- We then commissioned further research and, in June 2012, published *Strategic Options for Costing* – an independent report which recommended that Monitor should collect patient-level cost data from providers that can meet a mandated cost allocation methodology and assurance requirements.

- In July 2012, we presented *Strategic Options for Costing* in a joint webinar with PwC and the Healthcare Financial Management Association (HFMA), which was attended by over 500 people from across the health sector. We also received 27 written responses to *Strategic Options for Costing*, which were described in our *Summary of Stakeholder Responses* document, published in September 2012. These responses, and those from live voting conducted during the webinar, were largely supportive of the report's recommendations.

- *Costing Patient Care*, a policy document describing Monitor's proposed approach to improving the quality of the cost data on which prices are based, and which reflected the results of research and stakeholder responses to *Strategic Options for Costing*, was published in November 2012. Between 20 November 2012 and 11 December 2012, we sought the views of stakeholders on it and on drafts of chapters 1 and 4 of the draft *Approved Costing Guidance.* We received 56 written responses which, in general were very supportive of our approach and to the draft chapters of the *Approved Costing Guidance*.

In this document we summarise the stakeholder responses to *Costing Patient Care* and the *Approved Costing Guidance* and give details of the changes we are making to our proposals and guidance as a result of the responses.

## What we asked

We asked stakeholders eleven questions in relation to the policies set out in *Costing Patient Care*, and the guidance in chapter 1 and chapter 4 of the draft *Approved Costing Guidance.* We also provided the Patient-Level Information and Costing Systems (PLICS) collection template to those who requested it.

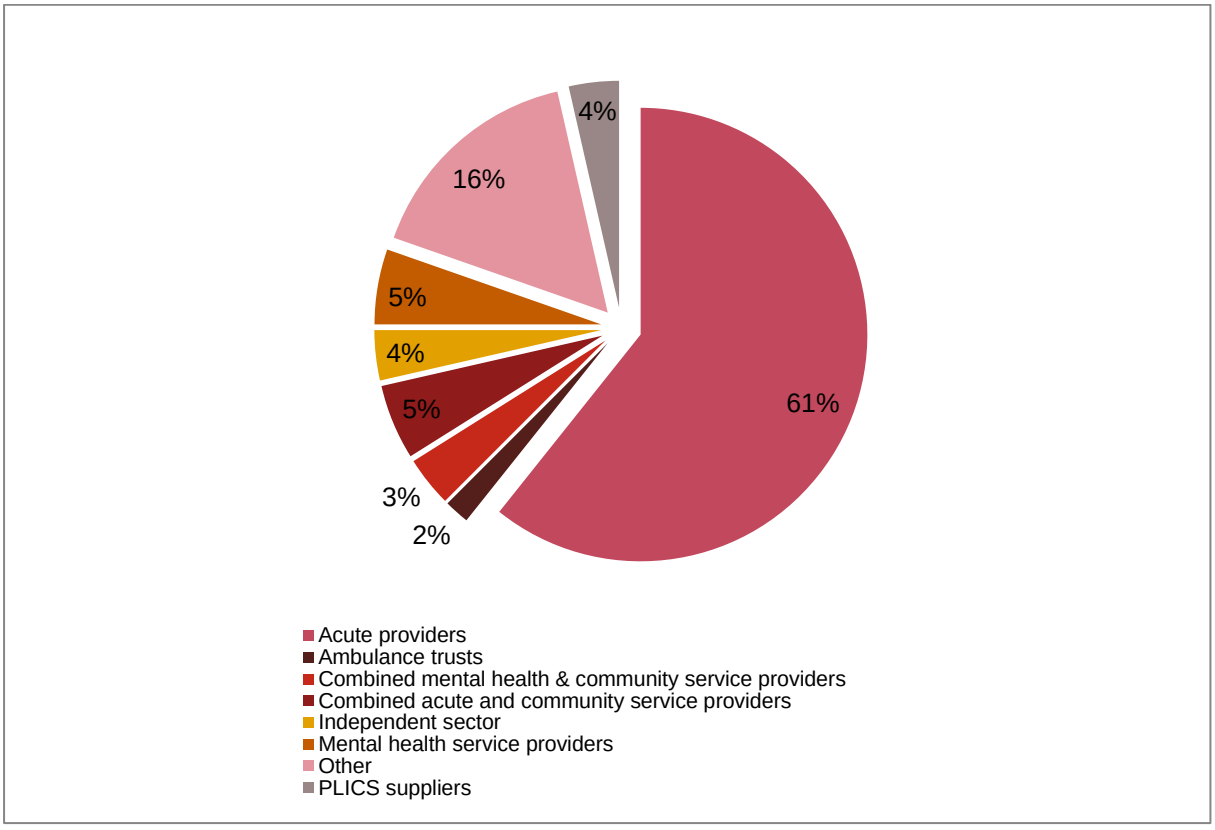
**Table 1: Questions for stakeholders and overview of responses**

| | Questions | Number of responses | | | | |
|---|---|---|---|---|---|---|
| *Costing Patient Care* | 1. Do you agree with our assessment of reference costs? | Agree | Partially Agree | Disagree | No comment/Not applicable | |
| | | 46/53 (87%) | 6 | 1 | 3 | |
| | 2. Do you agree with our objectives for costing and our long-term vision set out in Section 4? | Agree | Partially Agree | Disagree | No comment/Not applicable | |
| | | 48/54 (89%) | 5 | 1 | 2 | |
| | 3. What is the most appropriate timing for the pilot Patient-Level Information and Costing System (PLICS) collection? | After reference costs | Same time as reference costs | Before reference costs | Unsure | No comment/Not applicable |
| | | 35/43 (81%) | 4 | 3 | 1 | 13 |
| | 4. Do you agree with the proposed actions set out in Section 5? | Agree | Partially Agree | Disagree | No comment/Not applicable | |
| | | 44/51 (86%) | 6 | 1 | 5 | |
| *Approved Costing Guidance* | 5. Do you agree with the costing principles outlined in Chapter 1? | Agree | Partially Agree | Disagree | No comment / Not applicable | |
| | | 48/48 (100%) | 0 | 0 | 8 | |
| | 6. Are the costing steps outlined in chapter 1 helpful for providers? | Agree | Partially Agree | Disagree | No comment/Not applicable | |
| | | 47/48 (98%) | 1 | 0 | 8 | |
| | 7. Are there any aspects of costing which require further guidance? | Yes – Work In Progress | Yes – Best practice examples | Yes - Other | No | No comment/Not applicable |
| | | 6 | 5 | 26 | 9 | 10 |
| | 8. Is the collection guidance sufficiently clear and easy to follow? | Agree | Partially Agree | Unsure | Disagree | No comment/Not applicable |
| | | 33/42 (79%) | 4 | 3 | 2 | 14 |
| | 9. Can the proposed fields of data be fairly readily provided by your organisation? | Agree | Partially Agree | Disagree | No comment/Not applicable | |
| | | 25/42 (60%) | 9 | 8 | 14 | |
| | 10. Would your organisation be interested in participating in the pilot data collection? | Yes | Maybe | No | No comment/Not applicable | |
| | | 31/38 (82%) | 2 | 5 | 18 | |
| | 11. Is the template compatible with your costing system? Is it straightforward to use? | See page 13 for details of the responses on the template. | | | | |

## Who responded

We received 56 responses from individual NHS organisations, independent providers, PLICS suppliers and others. This includes responses from representative bodies, such as the Healthcare Financial Management Association (HFMA) and the Foundation Trust Network. A full list of the respondents can be found in the Appendix.

***Figure 1 – Stakeholder respondents by type***



## Summary of the responses

Below we summarise the responses from stakeholders and state what actions Monitor will take as a result, where appropriate. For illustrative purposes, we have included a number of quotes from stakeholders. These comments do not necessarily reflect Monitor's views or policies.

***Question 1: Do you agree with our assessment of reference costs? Are there other strengths or weaknesses of the current process that we should be considering?***

46 out of 53 respondents agreed with our assessment of reference costs.

Several organisations noted that some of the weaknesses in reference costs, for example poor underlying data quality (especially coding), also apply to other costing exercises such as PLICS. We recognised this issue in *Costing Patient Care*. One of the benefits of collecting PLICS data is that it is easier to identify providers with data quality issues, and then to exclude their data from analysis if appropriate. This is more difficult to do when using reference costs.

Some respondents identified further strengths and weaknesses of reference costs that should be considered. These are shown in table 2 below.

**Table 2: Additional strengths and weaknesses of reference costs identified by stakeholders**

| Strengths | Weaknesses |
|---|---|
| • Data volumes are manageable | • No feedback on quality of individual submissions |
| • Established process | • Outcome data difficult to map into reference costs |
| • Improving over time as recognised by the Audit Commission | • Pathway costing difficult to achieve using reference costs |
| • Population size covers all providers | • Risk of manipulation greater than with PLICS |
| • Relativity issues may be due to currency design, grouping and coding rather than costing | • Time lag before introduction into prices |
| • Unbundling provides useful granularity | • Unbundling disproportionately resource consuming |

We will continue to assess the strengths and weaknesses of both reference costs and PLICS data to determine the most appropriate source of data for price setting.

***Question 2: Do you agree with our objectives for costing and our long-term vision set out in section 4?***

48 out of 54 respondents agreed with our objectives for costing and our long-term vision.

The six objectives outlined in *Costing Patient Care* are:

1. improve data quality;
2. increase comparability;
3. improve transparency;
4. develop the potential for new pricing mechanisms;
5. proportionate regulatory cost; and
6. improve use by managers and clinicians.

There were some recurring themes in response to this question, including:

- alignment between costing documents is important to achieve comparability;
- engagement of managers, clinicians and other staff is a key aim for providers;
- PLICS data is very valuable information for benchmarking;
- transparency between cost and price is particularly important for providers;
- some providers do not wish to share cost information with commissioners; and
- there is a significant administrative cost to providers from changes to prices or currencies.

We consider that these themes are consistent with our six objectives. Consequently, we intend to pursue our stated objectives and long-term vision, through the actions set out in *Costing Patient Care*. We will also consider whether there are further actions that could be taken in response to the themes identified by respondents.

***Question 3: What is the most appropriate timing for the pilot Patient-Level Information and Costing System (PLICS) collection?***

35 out of 43 respondents suggested that the PLICS collection should take place after the reference costs collection. A minority suggested that the collection should take place at the same time or even before reference costs are collected.

In the pilot year of the collection we wish to give providers as much flexibility as possible to encourage participation. As a result of this feedback, the PLICS collection window is expected to open in June 2013 and to close in mid-September 2013. Participants will be notified of the dates of the collection window, and the process for submitting data, in due course.

***Question 4: Do you agree with the proposed actions set out in section 5? Are there other actions we should be prioritising for 2013?***

44 out of 51 respondents agreed with our proposed actions. A full list of the actions from *Costing Patient Care* is described in table 3 below.

**Table 3: Summary of actions described in *Costing Patient Care***

| Approach | Action |
|---|---|
| • Collect patient-level costs | • Issue guidance and a template to support a PLICS data collection<br>• Pilot a PLICS data collection from acute providers<br>• Continue to analyse the PLICS data collected from benchmarking groups |
| • Develop costing methodology | • Include the 2013/14 HFMA standards in the costing guidance<br>• Adopt a "comply or explain" approach |
| • Improve assurance over data quality | • Self-assessment checklist<br>• Materiality and Quality Scores |
| • Conduct further research on sampling | • Continue analysing the patient-level data we have already collected, and analyse the data we collect in 2013 |
| • Cost non-NHS patient care activities | • Cost private patients in the PLICS collection |
| • Enhance the quality of reference costs | • Make further updates to the guidance to improve usability<br>• Implement updated assurance measures:<br>  ○ Targeted external assurance programme<br>  ○ Provider Board approval of the process for submitting the reference cost return<br>  ○ Self-assessment against an enhanced quality checklist embedded in the collection return<br>• Collection of HRG costs by cost pools, based on the definitions in the HFMA standards<br>• Collection of Materiality and Quality Scores |

The actions that were of particular concern to stakeholders and Monitor's responses to those concerns are shown in table 4 below.

**Table 4: Stakeholder concerns about *Costing Patient Care* actions**

| Stakeholder concerns | Monitor response |
|---|---|
| • Collection of Materiality and Quality Scores | Monitor has worked with the HFMA to improve significantly the Materiality and Quality Scores methodology and template, for example it is now more user-friendly and scoring has been reviewed fully. As such, we expect the improved methodology to be more robust and the time taken to complete the template to be reduced. |
| • Collection of private patients costs | We have changed this requirement following stakeholder feedback. See page 14 for further details. |
| • Risk of over-burdening providers with multiple collections | We are working with the Department of Health to reduce the burden on providers where possible by:<br>• publishing guidance and templates in a timely fashion;<br>• scheduling collections at different times;<br>• lengthening the collection window, where possible, to give providers more flexibility;<br>• avoiding collecting the same information in multiple collections;<br>• conducting the 2012-13 PLICS collection on a voluntary basis; and<br>• adopting a "comply or explain" approach to costing standards for the PLICS collection. |

Respondents also referred to a need for more action in terms of mental health and community services costing. As highlighted in *Costing Patient Care*, our work has been primarily focused on the acute sector to date. We intend to develop further our approach to mental health and community costing later in 2013.

***Question 5: Do you agree with the costing principles outlined in chapter 1 of the Approved Costing Guidance?***

All (48 out of 48) respondents supported the six costing principles outlined in chapter 1 of the Guidance. Most respondents found the six costing principles to be clear and easy to follow, for example:

> *"The principles are clear and well laid out and provide a good base of knowledge without being too complex."*

One of the key themes that emerged in the responses was the importance of consistency, and some respondents commented that:

- Principle 2 (consistency) is particularly important for national costing exercises. Activity data must be collected in a consistent way to support the implementation of this principle.
- The HFMA Clinical Costing Standards should be mandated to improve consistency of data submissions.

With regard to mandating the HFMA standards, we recognise the value of this guidance and have included it as chapter 2 of the *Approved Costing Guidance*. However, in the first instance, we are adopting the standards on a "comply or explain" basis only – where providers can explain any non-compliance with the standards without the risk of enforcement action. This will assist with the development of the guidance. In the future we may consider mandating the standards.

Other respondents raised the point that implementing these principles will require a culture change and further training, particularly among clinical staff, at all levels of the provider organisation. We will consider how Monitor could support improvements in the level of clinical and other non-finance staff engagement in costing.

> *"Employing the stated costing principles will bring about an improvement in the costing process. However, applying the costing principles will require a change in culture not only from within organisations' costing teams but also from other finance and non-finance stakeholders."*

***Question 6: Are the costing steps outlined in chapter 1 of the Approved Costing Guidance helpful for providers?***

47 out of 48 respondents considered the six costing steps outlined in chapter 1 of the *Approved Costing Guidance* to be helpful. Some found these steps easy to follow and beneficial to people new to costing, for example:

> *"These steps are helpful for non-cost accountants and/or newly appointed NHS finance staff."*

> *"The guidance would be helpful to a trust building PLICS from 'scratch'."*

A number of respondents provided detailed suggestions on how the description of these steps could be further strengthened to avoid misinterpretation. Where appropriate, we have incorporated these comments into our updated guidance, for example the worked example in step 5 has been separated from the text of the guidance to improve clarity.

Monitor's intention to link these steps to the HFMA Clinical Costing Standards was welcomed by a number of respondents. Respondents agreed that clear and consistent costing guidance and standards will lead to improved costing.

The costing steps are built on the concept of Activity Based Costing (ABC). Some respondents observed that not all organisations are currently conducting their costing exercises based on this approach. It will take time to embed these costing principles and steps and to achieve the consistency desired.

***Question 7: Are there any aspects of costing which require further guidance?***

37 out of 46 respondents thought that some aspects of costing still require further guidance.

The areas suggested for further guidance included:

- work in progress (WIP);
- examples of best practice;
- matching;
- cost classifications;
- cost pools;
- cost driver selection;
- acuity;
- treatment of non-patient care costs and income, such as education and training;
- treatment of private patient costs and income; and
- costing of in-hour and out-of-hour work.

Monitor has been working closely with the HFMA on the development of the costing standards. Existing clinical costing standards for cost classification (standards 1 and 4) and cost pools (standard 2) have been reviewed and updated, and new standards have been developed for WIP and matching. In addition, the HFMA is planning to release a new version of the Materiality and Quality Scores (MAQS) template which incorporates a new set of standards on cost driver selection. These changes are reflected in the 2013-14 Acute Clinical Costing Standards which form chapter 2 of the *Approved Costing Guidance*.

Acuity is a concept discussed under our costing examples in chapter 1. Using acuity scores in costing is considered a "Gold" standard by the HFMA for cost allocation of medical staff and nursing staff costs. A number of respondents have asked for further guidance on this. Detailed guidance on how to implement acuity scores can be found on the website of the Association of UK University Hospitals.

Monitor will continue to work with the HFMA, the Department of Health and costing professionals to address the other issues identified, and will consider introducing further guidance into the *Approved Costing Guidance* at a later date.

***Question 8: Is the pilot PLICS collection guidance sufficiently clear and easy to follow?***

33 out of 42 respondents thought the PLICS collection guidance was sufficiently clear and easy to follow.

> "*The collection guidance appears to be clear and easy to follow*."
>
> *"The prescriptive nature of the guidance and details of cost pools should help reduce some of the ambiguities in current published costs."*

Some respondents observed that there were differences between the PLICS data collection and the reference costs collection, and were concerned that, without further alignment, there would be additional burden on providers. We have sought to align the collections wherever possible, but there are some fundamental differences which prevent full alignment. In particular, we would like to analyse the variation in the full cost of patient care at the episode-level for the PLICS collection, without the exclusions and unbundling in reference

costs, as a means to developing pricing methodology  For many providers, the absence of a requirement to unbundle or exclude costs will result in a lower burden.

At the time of publishing our draft publication, *Approved Costing Guidance*, some of the cost pool groups and sub cost pool groups included in the collection guidance were different to those published in the HFMA's 2012-13 Acute Clinical Costing Standards. Since then, we have worked closely with the HFMA costing group to align our cost pools. The final collection guidance is fully aligned with standard 2 of the HFMA's 2013-14 Acute Clinical Costing Standards.

Several respondents were concerned about information governance issues relating to sensitive data fields (patient ID, episode ID and spell ID). In response, we have changed the guidance and are now requiring that providers anonymise patient ID before submitting it to Monitor. Episode ID and spell ID are not currently considered to be sensitive fields; therefore we do not expect to require providers to anonymise these fields.

***Question 9: Can the proposed fields of data be fairly readily provided by your organisation? If not, what changes would make that more feasible?***

25 out of 42 respondents indicated that they could readily provide the data fields required for the PLICS collection.

Some noted that the collection of certain data fields would be a challenge for their organisations such as:

- different cost pool structure;
- fixed, semi-fixed and variable costs;
- identifying costs of private patients;
- specialist service codes; and
- reporting of overhead costs.

For the 2012-13 pilot PLICS data collection, we have included the collection of cost pool groups. The creation of these cost pools is based on the costing standards developed by the HFMA. Although not all acute providers currently construct their cost pools in the same way, we believe that a standardised set of cost pools will allow us to undertake meaningful comparisons.

We understand that the majority of patient-level costing systems are capable of reporting overhead costs separately. However, some systems may find this challenging and it will require a change to their current configuration. The rationale for collecting overhead costs separately is to facilitate analysis, for example, to benchmark providers' costs excluding overheads.

Based on the comments received, we have removed fixed, semi-fixed and variable costs fields from the pilot collection. We have also made the submission and identification of non-NHS patients optional. Further amendments to the PLICS data fields are described on page 14.

***Question 10: Would your organisation be interested in participating in the pilot data collection?***

31 out of 38 respondents indicated that they would be interested in participating in the pilot collection. This figure includes responses from a number of PLICS suppliers, private providers and representative bodies.

Some respondents commented that they would need to consult with their PLICS supplier or conduct further testing before committing to participating in the pilot collection.

Monitor will write to all NHS acute providers to invite them to participate in the pilot collection. Further details on the collection will be provided to the pilot group in preparation for the collection.

***Question 11: Is the PLICS template compatible with your costing system? Is it straightforward to use?***

A total of 22 providers and PLICS suppliers had received and tested the PLICS collection template. All PLICS suppliers that we are aware of had also been given the opportunity to comment on the template. The feedback on usability has been generally positive, although some providers and PLICS suppliers have raised specific concerns. In particular, some stakeholders were concerned about proposed data fields and others experienced issues with performance. As a result of this feedback, we have made several changes to the template, described below. These changes are also reflected in chapter 4 of the *Approved Costing Guidance*.

**Data fields**

We have reviewed the list of data fields and made some changes to address concerns raised by stakeholders. See table 5 for a full list of changes.

Some stakeholders have suggested collecting additional data fields, such as activity measures for pathology or radiology. For the pilot collection we want to limit the number of fields to encourage as many providers as possible to participate. However, we recognise the value of this data and will consider collecting it in future collections.

**Table 5: Changes to data fields**

| Data field | Stakeholder comments | Monitor actions |
|---|---|---|
| Private patients flag | Providers were concerned about sharing commercially sensitive information and the amount of work required to modify their systems to enable such data to be reported. | Providers will now have two options:<br>• to exclude the costs of private patients from the submission; or<br>• to submit costs of private patients as part of this collection. Where such costs are included, providers should use the "private patient flag" to allow clear identification of such activities and costs. |
| Fixed, semi-fixed and variable costs | Currently there is insufficient guidance on the classification of fixed, semi-fixed and variable costs to collect meaningful data in these fields. | These data fields have been removed. We will review existing guidance on these classifications and consider re-introducing the fields in a later collection. |
| Acuity | Most stakeholders indicated that they were unable to provide this data. | This data field has been removed. |
| Critical care start and end date | Some stakeholders indicated that there may be multiple incidents of critical care within the same core episode. This would make these data fields difficult to populate. | This data field has been replaced with critical care length of stay. |
| Primary procedure and primary diagnosis | Stakeholders were concerned that these fields were an unnecessary duplication of the other procedure and diagnosis fields. | These data fields have been removed. |

### Validation process

Providers have indicated that the existing validation process was too slow. We have taken several steps to improve the validation as described in table 6 below.

**Table 6: Changes to validation process**

| Issue | Stakeholder comments | Monitor actions |
|---|---|---|
| Performance speed | Some providers experienced performance speed issues when running the validation checks. | We have re-designed the validation so performance should be quicker on most systems. We expect the complete validation to run on 200,000 episodes within 5 minutes on most systems. |
| Number of validation steps | Validation process contains too many separate steps. | We have condensed the validation process into a single step. |
| Validation of episode IDs | It was suggested that we should validate whether episode IDs are unique. | Validation introduced to test the presence of duplicate episode IDs. All episode IDs must be unique for this collection. |

### Other issues and clarifications

Stakeholders raised several other issues which have been clarified further below:

- **Exclusions**
  Reference cost exclusions do not apply to the PLICS collection.

- **Frequency**
  The collection is intended to be done on an annual basis, subject to the success of the pilot.

- **Point of delivery definitions**
  Some providers were confused by the definitions we used for point of delivery. We have introduced more detail in the guidance on how reference costs definitions align with the PLICS definitions.

- **Reconciliation sheet**
  Providers indicated that there was insufficient guidance for the reconciliation sheet. We have updated this section to reconcile the quantum of costs submitted to the reference costs quantum of admitted patient care, taking into consideration costing differences such as service unbundling.

- **Treatment of non-clinical income**
  Some providers requested that we collect the cost, rather than the income, of non-clinical activities. Our preference is to collect the cost, but recognise that many providers cannot yet cost at this level. For the pilot collection we will collect income,

not cost, at the episode level but may change this requirement in future years.

- **Trim points**
  Trim points do not apply to the PLICS collection. The full inlier and excess bed-day cost should be included in each episode.

- **Unbundling**
  We have asked for unbundled costs, such as critical care, to be re-bundled for this collection. Some providers have raised concerns that this will reduce the granularity of the data. However, for our pricing research, we require all costs to be included in the core episode. We can still use the cost pool breakdown to analyse some of the costs that could have been unbundled.

- **Work in progress**
  The HFMA clinical costing standards give providers options for how to treat work in progress. Some providers who tested the template indicated that we should record in the template which method has been used, to improve comparability. This has been introduced to the template.

# Appendix – List of respondents[1]

Alder Hey Children's NHS Foundation Trust
Assista Consulting UK Ltd
Basildon & Thurrock University Hospitals NHS Foundation Trust
Birmingham Community Healthcare NHS Trust
British Dental Association
Buckinghamshire Healthcare NHS Trust
Chelsea & Westminster Hospital NHS Foundation Trust
Chesterfield Royal Hospital NHS Foundation Trust
Colchester Hospital University NHS Foundation Trust
Cystic Fibrosis Trust
East Sussex Healthcare NHS Trust
Foundation Trust Network
Gateshead Health NHS Foundation Trust
Great Ormond Street for Children NHS Foundation Trust
Guy's & St Thomas Hospitals NHS Foundation Trust
HealthCost Ltd
HFMA
InHealth Limited
Kings College Hospital NHS Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Liverpool Heart and Chest Hospital NHS Foundation Trust
Newcastle upon Tyne Hospitals NHS Foundation Trust
NHS London - Project Diamond
Norfolk and Norwich University Hospitals NHS Foundation Trust
Norfolk and Suffolk NHS Foundation Trust
North East Ambulance Service NHS Foundation Trust
Northampton General Hospital NHS Trust
Optical Confederation
Oxford University Hospitals NHS Trust
Papworth Hospital NHS Foundation Trust
Pennine Acute Hospitals NHS Trust
Royal Devon & Exeter NHS Foundation Trust
Royal Free London NHS Foundation Trust
Salford Royal NHS Foundation Trust
Shelford Group
Somerset Partnership NHS Foundation Trust
South Essex Partnership NHS Foundation Trust
South Tees NHS Trust
St Helens & Knowsley Teaching Hospitals NHS Trust
Tameside NHS Foundation Trust
The Christie NHS Foundation Trust
The NHS Partners Network
The Royal Bournemouth and Christchurch NHS Foundation Trust
The Royal Marsden NHS Foundation Trust
UCLH NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust

[1] 9 organisations who responded requested that their names be kept confidential. They have been excluded from the list above.

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