Monitor

Making the health sector work for patients

Improving the costing of NHS services: proposals for 2015-2021

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About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

Contents

Introduction

NHS care providers' knowledge is continually improving on where and how they spend their income and what impact spending has on patients. Monitor's review of the 2012/13 patient level cost collection[1] noted that costing processes currently employed by providers are generally logical and can be clearly explained.

However, costing processes still vary considerably between care providers. Classifications of human and physical resources and activities, costing allocations and the datasets used for cost and quality management are not consistent. We also know from evidence that not all providers' costing systems can provide detailed information about costs at the level of individual patient care.[2]

These features of NHS costing processes make it difficult for some providers to see exactly where their resources may be better spent. They also make it difficult for providers to benchmark their cost and quality performance against their peers', to see where they stand and how they might improve. In addition, as the regulator that sets NHS prices and pricing rules in the national tariff, Monitor cannot be sure whether differences in costs between providers reported in the national cost collections stem from differences in their clinical or operational practice, or from differences in their costing methods. We also know that cost collection takes up a disproportionate amount of NHS costing professionals' time.

This document sets out a plan to transform NHS costing over the next seven years, and we are seeking to engage with the sector on those proposals – in particular we are inviting your views on the plan and proposals set out in this document. Subject to the necessary funding and resources becoming available, Monitor proposes that:

1. Trusts and licensed independent providers of acute, ambulance, mental health and community services adopt an improved, transparent and intuitive costing method, based on agreed standard definitions and rules. This method should provide consistent and accurate cost information about individual patients across the NHS, leading to better cost management and price and payment regulation.

2. A single national cost collection replaces the three existing cost collections. This improvement would be made possible by all care providers adopting the proposed costing method, since it would accurately capture their costs of education and training, research and development and commercial activities, as well as patient care.

[1] Monitor, '2012/13 Patient level cost collection: review and lessons for the future', available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/345191/201213PLICS_report.pdf

[2] See research by BDO, available at: https://www.gov.uk/government/consultations/improving-the-costing-of-nhs-services-proposals-for-2015-to-2021

These proposals could bring enormous benefits for patients. Standardising how the sector records information about costs in a way that links them to resources, patient activities, and patient outcomes would increase providers' understanding of their performance. This could enable big improvements in quality and efficiency: providers would be able to see better where they can save money with no impact on patients, and reinvest savings to improve quality; wider benchmarking of detailed costs would give lower performing providers a clear idea of where and how to take action to catch up with the leaders; taking action would reduce variations in NHS care quality and improve standards of care overall.

Moving to a single cost collection would lighten the regulatory burden on the sector and release cost professionals at providers to spend more time analysing and managing costs in patients' best interests, a crucially important job. Consistent costing methods would also make data submitted to cost collections a more reliable guide to efficient costs in the sector. The national tariff is built from this data. So, if adopted, these proposals should ultimately make the national tariff a more powerful tool for encouraging good decisions for patients among commissioners and providers. Over the coming years, these will include the decisions they take to shift to the models of care described in the NHS 'Five Year Forward View'.[3]

Monitor believes these potential benefits would mean that if a decision was made to adopt them, rapid implementation of the proposals − amended in light of feedback on this document – would be a priority. However, this won't be easy. Some service areas are more ready than others. There are important costs for providers involved, especially for procuring or upgrading IT. There is a lot of work to be done across the sector to agree standard definitions of resources and activities. Moreover, evidence of the costs and benefits is far from comprehensive.

We therefore recommend testing whether the proposals represent good value for money before adopting and mandating them. That said, the patient benefits to be gained from better cost management make it worth starting the work of transition now and building the evidence base at the same time.

We propose a phased transition, service area by service area, starting from 2015, with each service taking approximately five years to complete their transformation. Acute and ambulances services would start, followed by mental health services, then community health services. These providers would shift to the proposed costing method and be submitting a single national cost collection by 2021. This document sets out provisional timelines for achieving this long-term transformation in each service area.

[3] www.england.nhs.uk/ourwork/futurenhs/

The long-term transformation would entail three types of work:

1. establishing necessary processes and systems, including standard definitions and rules, local patient-level information costing systems (PLICS), a co-ordinated provider costing development programme and the cost collection process

2. establishing an evidence base to test the need for a better national costing method and cost collection. Results will inform the decision whether to mandate both

3. work to support the sector in making the transformation successfully. This will include undertaking assurance processes, developing costing capability and a national costing community, engaging with non-finance healthcare staff and developing mechanisms for making best use of cost information.

Meanwhile, Monitor and our national partners will continue short-term costing projects including work to:

- develop and integrate the reference cost and education and training cost collections into a single cost collection

- expand the group of volunteer providers submitting patient cost collection data to include interested ambulance, mental health and community services.

We are very keen to hear readers' responses to the proposals described in this document and to refine them through both online and in-person discussion and debate. In particular, we would like to know:

- whether providers would like us to develop a central accreditation system for assuring the capability of local PLICS systems

- what you think of the order proposed for service areas over the three four-year phases of the overall implementation programme, ie first acute and ambulance services, then mental health and community services

- what you think of the proposed pace of implementation for each service area.

- what you think of the proposal that independent providers should be subject to the same requirements, and follow the same timelines for implementation, as NHS trusts and foundation trusts.

The engagement period will last until **16 January 2015**, it will include an online response form, a webinar, regional workshops for providers and commissioners, a workshop for PLICS software suppliers, and a closed round table debate.

You can respond to the questions raised within this document by completing our online response form.

To get involved with other engagements activities, please email: **costing@monitor.gov.uk**

The document that follows has four sections:

- Section 1 describes Monitor's proposals for a standard costing approach and single cost collection.
- Section 2 explains why we believe this approach would fulfil all the uses of cost information in a manner that will deliver substantial benefits to patients.
- Section 3 sets out how we propose to transition to the costing method and single cost collection across the sector.
- Section 4 outlines the engagement process for these proposals.

1 Monitor's proposals for a standard costing approach and single cost collection

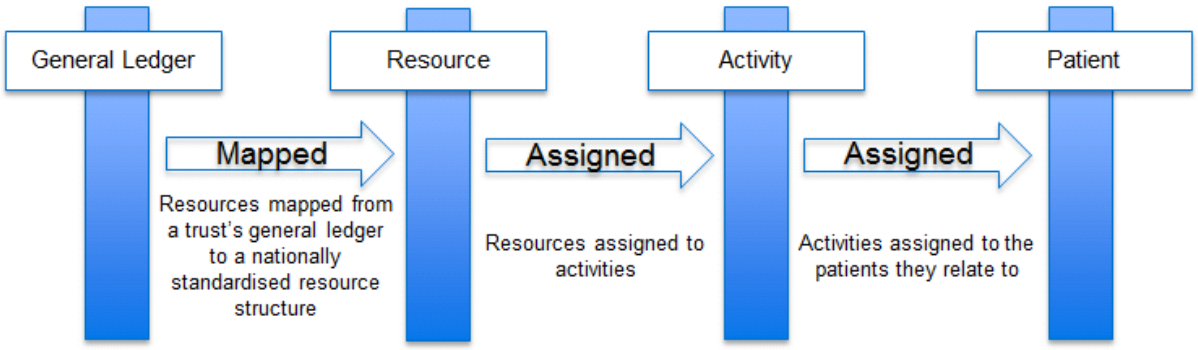
This section sets out the approach to costing and cost collection that Monitor is proposing to the sector. The approach comprises an improved, transparent and intuitive costing method, and standard definitions and rules to ensure that information produced by this method is consistent. Adoption of this approach across the sector would make it possible to undertake a single, national cost collection each year, instead of three separate cost collections.

We believe this approach would benefit the sector greatly by producing comprehensive, consistent and high quality cost information. The final part of this section summarises the expected benefits of the standard costing approach and single cost collection that we propose.

1.1 An improved, transparent and intuitive costing method

The costing method has three stages. Stage 1 maps the expenditure in a provider's general ledger to the provider's human and physical resources. Stage 2 assigns specific resource costs to the activities that use those particular resources. Stage 3 assigns specific activities to the patients they relate to. Figure 1 illustrates the three steps.

Figure 1: The proposed costing method for patient care



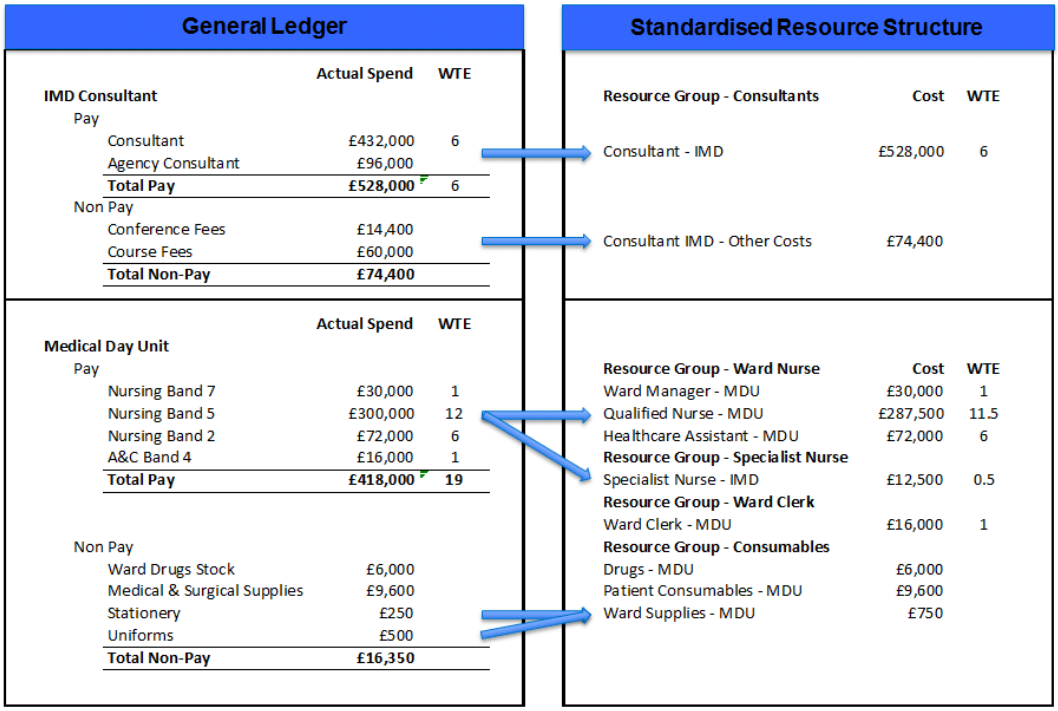
1.1.1 Stage 1: Mapping costs from the general ledger to a provider's resources

For each provider, the first stage is to map costs from the general ledger into nationally standardised resource categories. This ensures a common starting point to the costing process for all providers.

While we expect existing general ledgers to be capable of providing much of the information required for this process, some would need additional detail, requiring preparatory work by providers. Figure 2 provides an example of general ledger costs mapped to the standardised resource categories. The example, which is followed

throughout section 1, focuses on selected elements of care for patients with inherited metabolic disease (IMD) on a medical day unit (MDU).

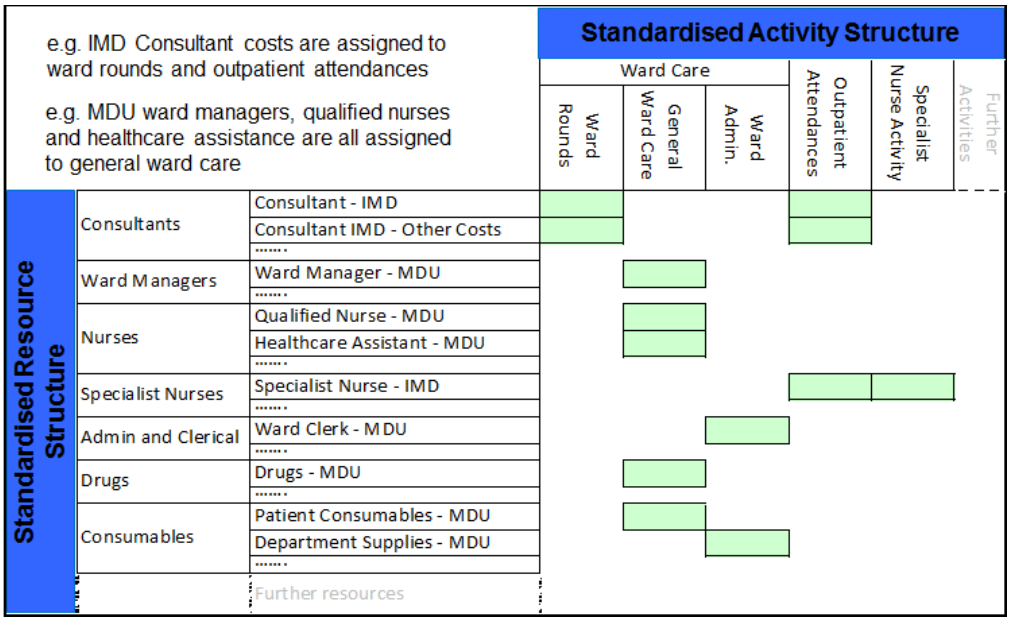
Figure 2: General ledger costs being mapped to the standard resource categories



1.1.2 Stage 2: Assigning the costs of resources to the activities that use them

The second stage is to assign the costs of each resource to the various activities that use that resource. Figure 3 shows an example of treatment and care provided on the MDU. Examples across other services would be pharmacists reviewing medication, or psychologists carrying out gateway assessments.

Figure 3: Resource costs being assigned to activities



1.1.3 Stage 3: Assigning the costs of activities to patients

The final stage is to assign the costs of activities to the patients they relate to, either in groups (for example, groups of patients receiving general ward care from qualified nurses) or as individuals (examples across other services would be a patient receiving radiotherapy or a patient being visited at home by a district nurse).

Figure 4: Assigning activity costs to patients

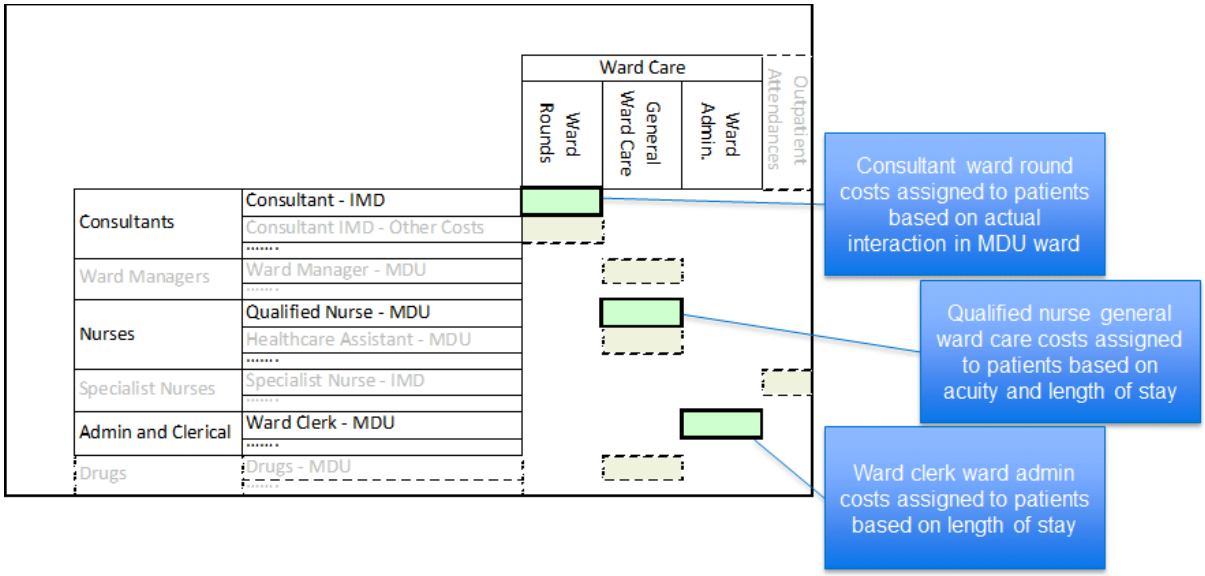
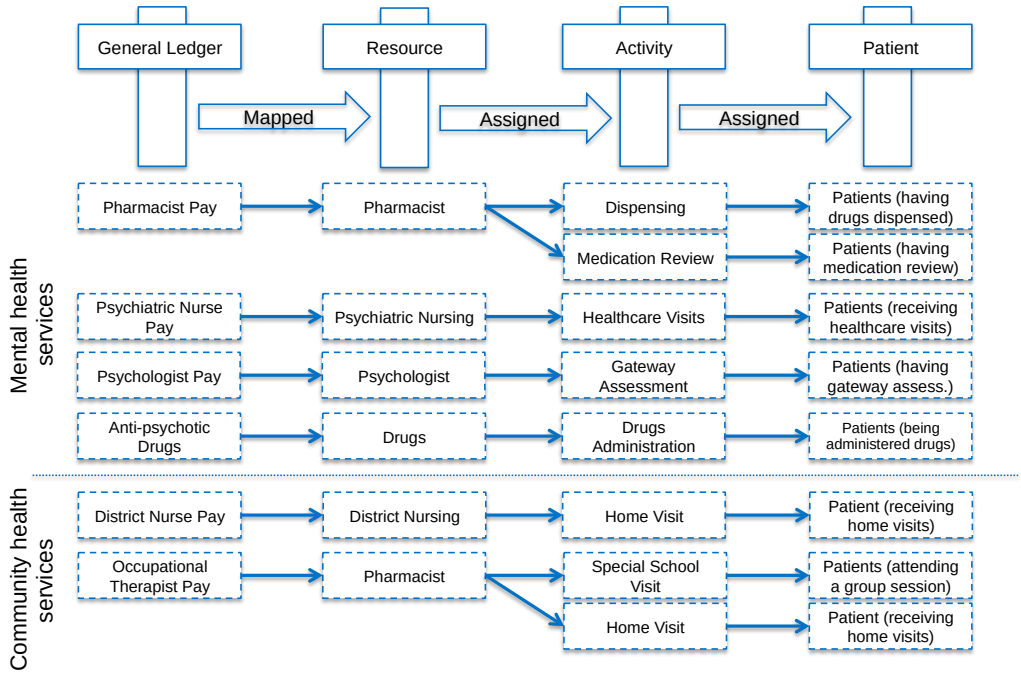


Figure 5 provides examples of ledger costs mapped to standard resources, and assigned to activities, and then to patients, for different services areas.

Figure 5: The proposed costing method – applied to mental health and community services

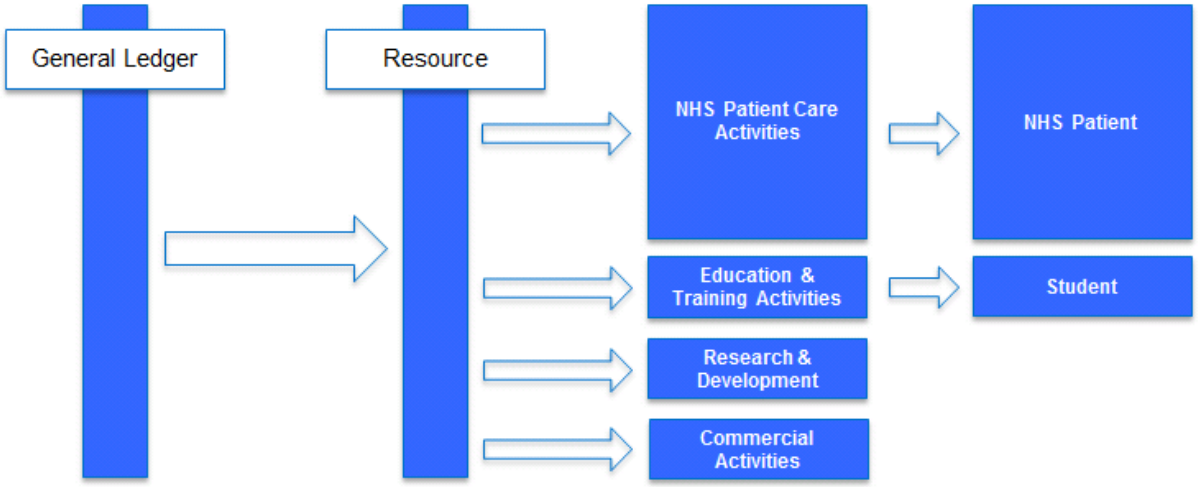


Note, figure 5 simplifies the costing process considerably for illustrative purposes. In practice, the costing method would involve a combination of cost allocation techniques and patient-activity and patient-resource matching, the detail of which would be refined during the design stage.

Non-patient-care activities

In order to have an accurate understanding of the costs of patient care, it is necessary to separate the costs of education and training, research and development, and commercial activities (see Figure 6, below).

Figure 6: The proposed costing method – applied to all provider activities



- Education and training activities: The education and training cost collection carried out in 2014, led by Health Education England and the Department of Health, has begun to explore principles for the consistent and accurate separation of education and training costs from patient care costs. Monitor will work with both organisations to develop these principles so they can be built into the proposed costing method

- Research and development activities: The costs of resources applied to research and development activity similarly need to be identified and separated consistently from patient care activities.

- Commercial activities: The costs of resources required to provide the chosen commercial activities of a provider would be separated from patient care costs, allocating them to the commercial activities in question. This would include private patient care. Income adjustments from commercial activities would not be allowed within the proposed method, and this is covered below.

The expenditure of a provider should not include any adjustments for income received, which can result in the true cost of the provision of services being distorted. It also makes reconciling cost information resulting from the costing approach with provider expenditure extremely difficult. This is at present a common practice across providers, ranging from the 'netting off' of income received from neighbouring providers for the provision of specific services, to the adjustment of costs for commercially profitable income streams.

Figure 7 shows how using the net cost after adjusting for two income streams related to clinical photography leads to the underestimation of the true cost of care to provider patients.

Figure 7: Illustrative example of how income streams can distort costs

Costs for Clinical photography department	Share of Indirect / Overheads	Direct Costs	Income Stream	Net Monthly Cost	Number of patients
Trust's own patients referred from specialities within the trust	£4,000	£12,000	£0	£16,000	500
For other NHS trusts who do not have this facility	£2,000	£4,000	-£6,500	-£500	250
For non-NHS bodies such as the police	£2,000	£4,000	-£7,000	-£1,000	250
Total Clinical Photography Cost	**£8,000**	**£20,000**	**-£13,500**	**£14,500**	

True cost for trust patients	£16,000	Income adjusted "net" cost	£14,500
True cost spread across 500 trust patients	£32	Income adjusted "net" cost spread across 500 trust patients	£29

Summary of the benefits of the costing method

We are proposing this costing method because it should result in a number of important benefits, set out below.

Patient-centred

Because the costing method provides outputs at an individual patient level, it puts the patient at the heart of cost management. This method also allows patient outcomes and patient-centred quality measures to be combined with the cost information. The cost of patient care can be tracked across providers and settings and related to patient outcomes, to provide a fuller picture of the quality and efficiency of patient care (subject to information governance regulations, which need to be dealt with separately). Combining cost and quality information ensures a proper efficiency focus that has a basis in quality care.

Cost-reflective

The costing method accurately reflects how money is spent in a provider. Patients receive services, activities are carried out to deliver these patient services, and resources are used in these activities. We are aware that many providers already use a form of this costing method, but several use simplified versions. These produce cost information that does not reflect how the provider is spending money as accurately as the method proposed here. Using the proposed costing method should lead to better informed decision-making.

Locally relevant and actionable

The costing method begins with a provider's existing general ledger, which is central to cost management processes. It uses the information and decision support structures already in place to manage the operation of a provider. These structures include human resources that are part of the existing organisational structure, physical resources already defined by procurement and stock management, and activities managed by service and operational managers on a daily basis. Finally, linking costs to the care of individual patients means that the cost information yielded

by this method is immediately recognisable to clinicians. This makes it more likely that the information will be used, and makes assessing and improving the accuracy of the information much easier.

Comprehensive

The benefit of a costing method that includes the costs of all provider activities, and does not allow any income to be netted off or cross-subsidised, is that at each stage of the costing method, the total cost can be reconciled with the expenditure in a provider's general ledger, providing a great deal of confidence that it has neither omitted nor duplicated any costs.

1.2 Standard definitions and rules to deliver consistency

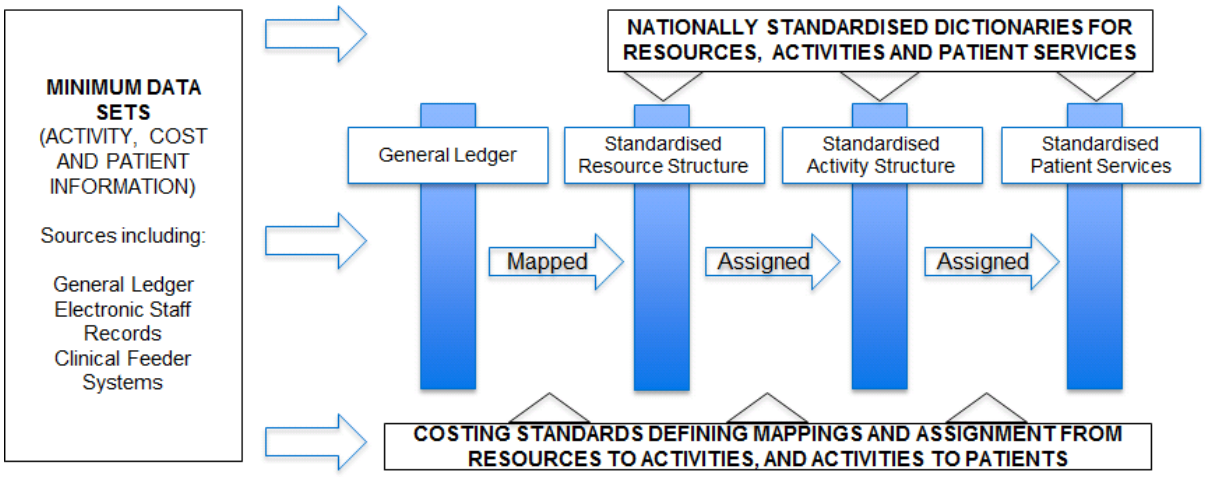
The 2012/13 patient-level cost collection review[4] noted that costing processes currently used in different providers are generally logical and can be clearly explained, but they vary significantly. That is, the resources and activities classifications, costing allocations and datasets they use are not consistent. If we are to be confident that reported differences in costs across providers are due to differences in clinical or operational practice, and not distorted by differences in the costing method itself, we need to ensure that the resource classifications, costing standards and datasets used for costing NHS care are nationally aligned.

We propose the following standard definitions and rules to support the proposed costing method (see Figure 8):

- nationally standardised dictionaries for resources, activities, and patient services
- clear and comprehensive costing standards, defining the rules for mapping general ledger cost centres to the standardised resource classification, and for assigning resources to activities, and activities to the patient receiving care.
- the minimum datasets required by the costing method, defining the activity, cost and patient information.

[4] https://www.gov.uk/government/publications/patient-level-cost-collection-201213-review-and-lessons-for-the-future

Figure 8: Standard definitions and rules in place to deliver consistency



1.2.1 Nationally standardised dictionaries

To provide a common framework for assigning costs, we propose to agree standardised resource types, activity types, and patient services (standardised patient services are discussed in more detail below).

Although there are dictionaries defining resources and activities that can be adopted for the costing method, we know that there are service areas where definitions vary provider by provider. Creating comprehensive standardised dictionaries of definitions suitable for the costing method will be challenging, and will require wide consultation.

The level of detail in the resource dictionary should reflect the association between resources and activities. For example, different groups of nurses that have different day-to-day duties should be recognised as separate groups in the dictionary. For example, nurses who are qualified to administer drugs and other pain management techniques, do diagnostics and monitor and treat tissue viability issues could be grouped together; junior nurses who would be expected to carry out more basic patient care duties would be grouped separately.

The level of detail in the activity dictionary should reflect the association between the activity and the patient. For example, it would be important to distinguish routine MRI scans from more complex scans that take more time and require more support, such as MRI scans with sedation, or scans on multiple body areas.

The third national dictionary that the proposed costing system needs is one defining standardised patient services. We refer to these in this document as ‘Grouped Patient Activities’, or GPAs (see box in subsection 1.3).

1.2.2 Clear and comprehensive costing standards

The Healthcare Financial Management Association (HFMA) has been working on clinical costing standards for several years, firstly on behalf of the Department of

Health, and now on behalf of Monitor. Significant progress has been made for acute services in particular, and more recently mental health services. While there are many commonalities between the current clinical costing standards and the propose costing method, it would be necessary to build on the existing clinical costing standards to align them fully. Specifically, additions would need to be made to define rules for mapping general ledger cost centres to the standardised resources, and adjustments would be necessary in some areas to align the costing standards to the assignment of costs of resources to activities, and of activities to patients. The costing standards would represent Monitor's published cost allocation methodology, required for licenced providers.

1.2.3 Minimum datasets

The application of the proposed costing method would depend on several patient, activity and cost information sources, including the patient administration system, the general ledger, clinical feeder systems (examples being pathology, radiology and theatre systems), and electronic staff records. The information feeds would be defined and communicated to providers as minimum datasets. We will work with the Health and Social Care Information Centre (HSCIC) to ensure that where possible the costing method is based around existing national datasets.

1.3 A single, national cost collection

We propose moving to a single annual cost collection covering all provider activities that will be possible if all providers follow the costing method described above. This single cost collection would provide access to much more detailed information than any current cost information held centrally in the sector. We therefore propose that all providers adopt the single costing method over time.

1.3.1 Moving from three collections to one collection

NHS trusts and foundation trusts are required to collect reference cost and education and training cost data annually, and can voluntarily submit an additional patient level cost collection. A common concern from costing professionals in trusts is that they spend too much time on cost collection, with typical estimates being 50% of a costing team's time.

We propose moving from three collections to one annual cost collection for all provider activities. This would reduce the collection burden on trusts and allow their costing teams to spend time more productively, developing high standard costing processes, and using the information produced to improve the quality and efficiency of patient care. It would also ensure that costs are counted and reported on only once, with built-in safeguards against duplication and omission.

1.3.2 Cost collection underpinned by high quality costing

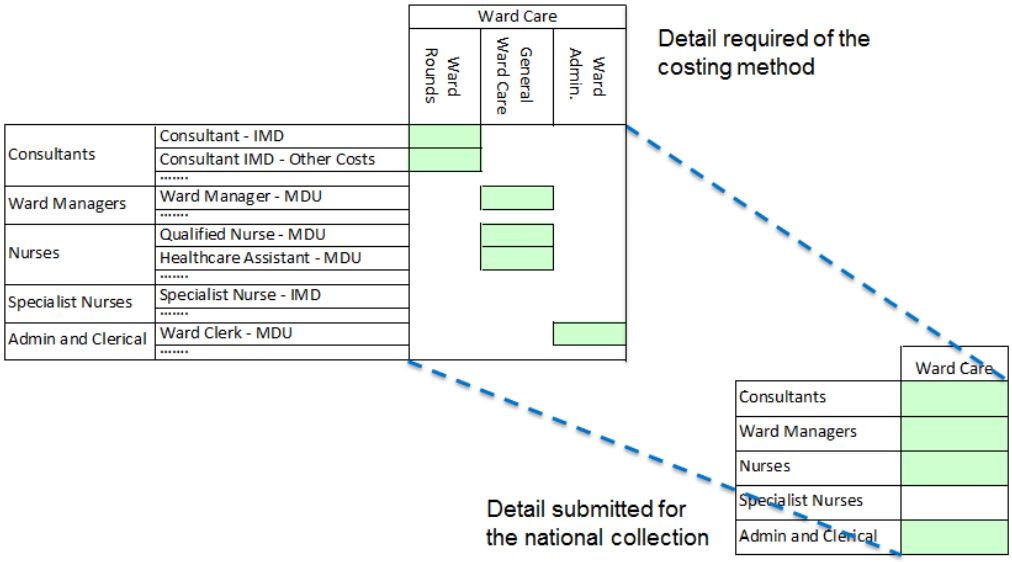
If we are to be confident in the quality of the cost information that we collect, we need to ensure that it has been constructed using a high quality costing method, applied consistently across every provider. We therefore propose that providers should be required to apply the proposed costing method when submitting costs, guided by the standard definitions and rules to ensure national consistency.

1.3.3 Cost collection for patient care

Using the costing method that identifies every resource and every activity that contributes to the care of a patient, local provider costing systems would provide more detailed information than would be necessary for the purpose of national cost collection.

The example in figure 9 outlines the likely level of detail required by the costing method. It then shows how categories of resource and activity might be collapsed to produce the level of detail required for the national collection.

Figure 9: Costing level detail simplified for the national cost collection



For the cost collection, we would ask providers to submit information in two components. Firstly we would collect the information related to the characteristics of each patient, including their diagnoses and the procedures that they received; demographic information and other qualitative information related to their care, such as length of stay and time in a critical care unit. This information is available through existing provider systems, and is illustrated below.

Figure 10: Collected patient details

Identifiers		Procedures			Diagnoses			Demographics			Qualitative Information		
Patient ID	Grouped Patient Activity ID	Primary Procedure	Procedure 2	...	Diagnosis 1	Diagnosis 2	...	Age	Gender	Etc.	Length of Stay (Days)	Operating Theatre Time (Minutes)	Critical Care Time (Hours)
L12345	**50456.2**	X913	U072		I431	H544		18	M		0	0	0

Secondly, we would ask providers to submit a two-dimensional grid of costs (the resource activity matrix), which would be linked to the above patient details through unique identifiers. An example of the resource/activity matrix is provided below, again based on the example of a patient receiving treatment through a medical day unit for inherited metabolic disease.

Figure 11: Example patient resource/activity cost matrix

Patient ID: **L12345**
GPA ID: **50456.2**

Collection Resource Groups	Collection Activity Groups: Theatre care	Ward Care	Critical Care Unit Care	Pathology	Radiology	Outpatient Care	Pharmacy	Radiotherapy	Chemotherapy	Endoscopy	Therapies	Other Diagnostic Testing	Total Activity Cost
Consultants		£500		£30									£530.00
Junior Medical Staff													£0.00
Ward Managers		£10											£10.00
Nurses		£50											£50.00
Specialist Nurses													£0.00
Allied Health Prof.													£0.00
Professional & Technical				£60			£5						£65.00
Portering Staff													£0.00
Admin and Clerical		£30		£5			£0.27						£35.00
Specialty management		£8		£1			£0.07						£9.00
Directorate management		£5		£0.82			£0.05						£6.00
Trust management		£3		£0.41			£0.02						£3.00
Drugs		£5											£5.00
Consumables		£10											£10.00
Blood													£0.00
Implants													£0.00
CNST		£9		£1			£0.08						£10.00
Utilities		£5		£1			£0.05						£6.00
Equipment		£21		£3			£0.19						£25.00
Buildings		£17		£3			£0.15						£20.00
Total Resource Cost	**£0.00**	**£672.47**	**£0.00**	**£105.66**	**£0.00**	**£0.00**	**£5.87**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£784.00**

Although this collection information is considerably simpler than the information that would be generated locally at a provider, it would still provide very useful detail. We can see, for example, that the majority of costs result from care provided by a consultant on the ward; that the patient care activity included aspects of ward care, pathology and pharmacy, and that the total cost of the patient is £784. Linking this to

the patient information in figure 10 allows a great deal of useful analysis and comparison.

How we propose to standardise the collection of groupings of patient activities into the above resource/activity cost matrix is discussed in the box below.

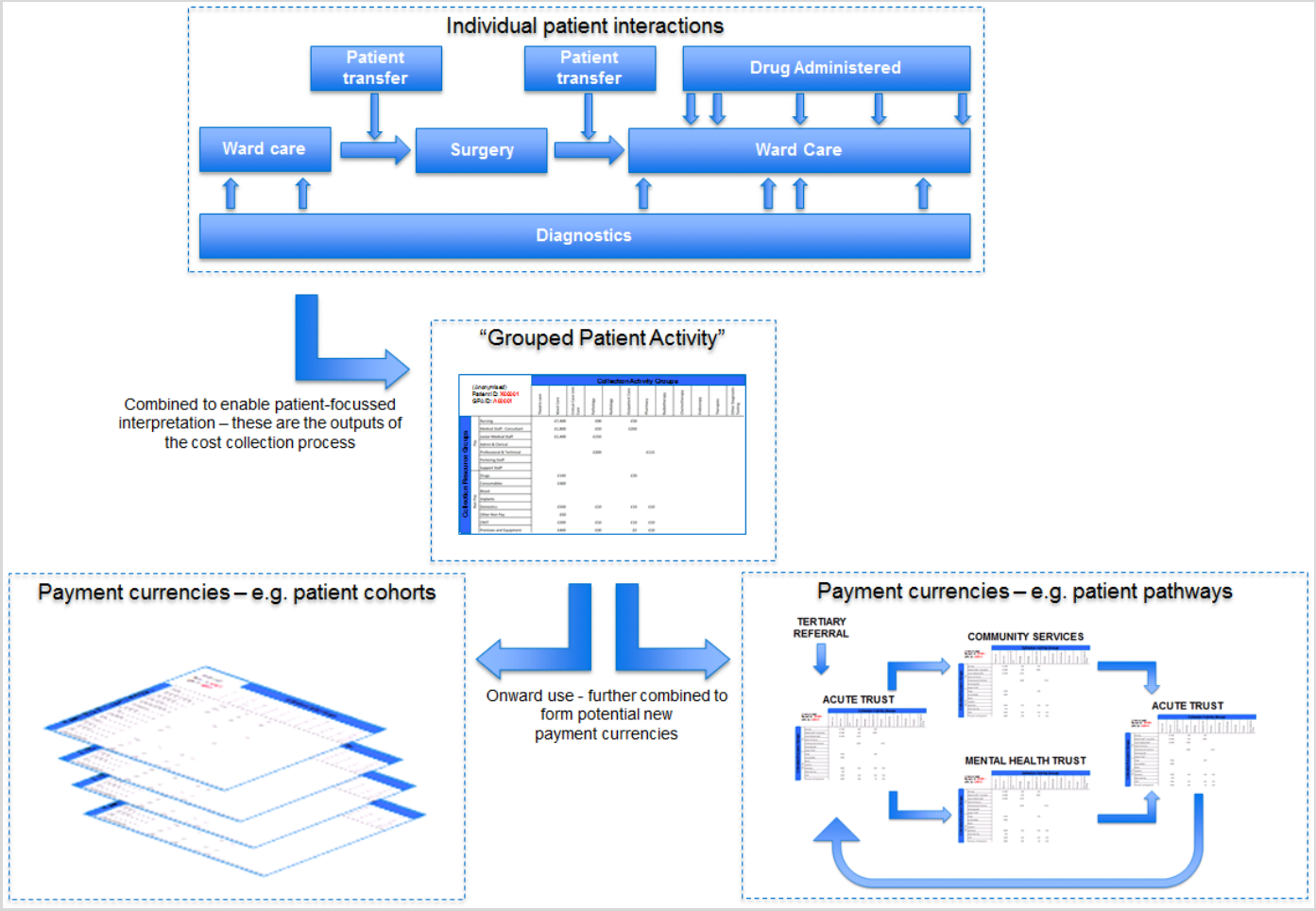
Standardised patient services: 'grouped patient activities'

The objective of the costing process should be to provide cost information that satisfies the needs of its many users. The proposed costing method generates patient level cost information, but an important question is how this information should be grouped together in the collection exercise to make best use of it.
It could be argued that each patient interaction should be identified and costed separately for the cost collection – individual diagnostic tests, drug doses, etc. However, such an approach is likely to lead to too much focus on the cost efficiency of individual interactions at the risk of losing sight of whether the overall package of care is suitable for the patient. On the other hand, grouping together all patient interactions over a long duration, spanning care related to multiple medical conditions, will forfeit understanding.

The challenge is to define the groups of patient care for which costs can be collected at the right level of detail, that is, at a level that aids understanding of the nature, quality and efficiency of patient care and allows action to be taken to improve all three if need be. Defining the right groups is particularly challenging given the widely varying nature of healthcare. Lifelong conditions have to be managed over many years; planned care can take place in episodes over days or months, whilst a single home visit in a community setting can take minutes. These groups of care, referred to in this document as **grouped patient activities (GPAs)**, represent the level of aggregation at which we would collect costs on an annual basis. Where appropriate we would use existing aggregations of activity. For example, in admitted patient care, 'finished consultant episodes' – the package of care received by a patient under the lead care of an individual consultant – would be used. It is less clear what the same grouping of patient activities should be for services in the community or in mental health, and this would need to be determined during the detailed design process.
Importantly, the GPAs would be defined at a sufficiently detailed level that they could be used in the payment currency design process to develop and assess potential payment currencies.

The Grouped Patient Activities would represent the Approved Costing Currencies (ie categories of costs published by Monitor) required for licenced providers.

Illustration of the role of grouped patient activities



1.3.4 Cost collection for non-patient care

The previous section explained that the costs of resources for patient care and non-patient care would be separated through agreed principles. The detail required for information collected for non-patient-care activities would be developed, with the Department of Health and Health Education England in particular being interested in developing costs to a student level.

2 Why this approach fulfils the uses of cost information

We believe that with careful design, the costing method and single cost collection should serve much broader purposes than regulating the payment system alone.

By ensuring that all activities in providers are included, and that the information produced is at a patient level, the proposed costing method creates comprehensive cost information that can be aggregated for any defined cohort of patients, group of services, and collection of resources or activities. Additionally, subject to information governance concerns being addressed, the costing method allows users to follow the costs of a patient's care across healthcare providers and settings. For example, from ambulance 'convey and treat' services, through acute A&E services, to admitted care, and onward to community services, including any mental health services.

The scope of the proposed costing method and cost collection encompasses existing reference cost and education and training cost collections, so would not result in information gaps.

Most uses of cost information in the sector, both current and future, can be categorised into:

- local uses – provider cost benchmarking and cost management
- national uses – payment regulation and sector development.

This section reviews some of these uses, providing case studies to illustrate how we believe the proposed costing method and cost collection meets its requirements. It also illustrates that continuity of existing cost information can be provided.

2.1 Cost benchmarking by providers

Being able to draw comparisons both within and between organisations is extremely useful in helping providers to identify opportunities for efficiency savings and improvements to patient care. It can help to identify areas of best practice, within or across departments, or across organisations, so that lessons can be learned and shared. The following case study illustrates how the information resulting from the proposed costing method could be applied to a cost benchmarking exercise, leading to clinically led efficiency improvements in patient care.

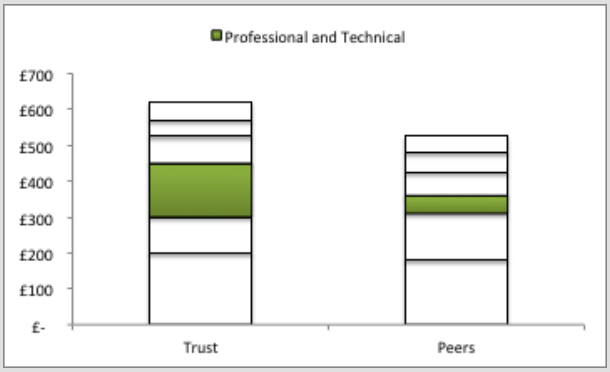
Case study 1: Medical oncology benchmarking

A trust reviews a service line and identifies medical oncology as loss-making.

They select specific peer trusts with similar operating models to make comparison as relevant as possible.

They decide to exclude overheads and clinical negligence scheme costs to concentrate on immediately actionable areas.

Resource type comparison to peers



They review a benchmark report comparing average patient unit costs across peer trusts, broken down into patient cohorts of similar complexity, further split by resource type.

They identify that their professional and technical costs are much higher than the average for each patient cohort.

Resource/activity matrix for chosen patients

	Theatre Care	Ward Care	Critical Care Unit Care	Pathology	Radiology	Outpatient Care	Pharmacy	Other Diagnostic Testing
Consultants		xx		xx	xx		xx	
Ward Managers		xx						
Nurses		xx						
Allied Health Professionals								
Professional & Technical				xx	xx		xx	
Portering Staff								
Admin and Clerical		xx		xx	xx		xx	
Drugs		xx						
Consumables		xx		xx			xx	

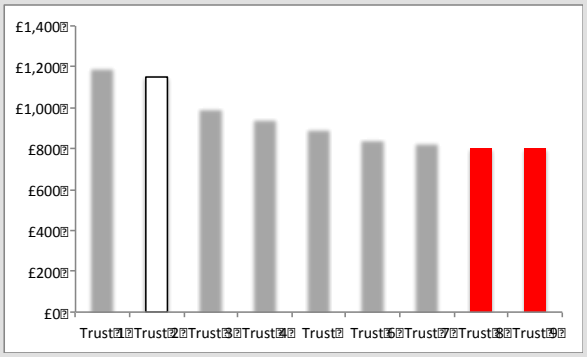
The trust's technical and professional costs are reviewed against the averages of a group of peer trusts by activity, again by patient cohort.

Pharmacy and radiology are discounted as the cause. Pathology is identified as a high cost area relative to the peer group.

Reverting to comparing individual trusts for the identified patient cohorts, best practice peer trusts are identified, based on medical oncology patient unit costs, pathology costs and patient outcome information.

Two trusts are identified, contacted, and a collaborative operational and clinical review of pathology services for medical oncology is started.

Comparison to identify best practice trusts



Test counts by type by consultant

		Avg Count			Peer Trust
Test Type	Unit Cost	Consultant 1	Consultant 2	Consultant 3	Avg Count
Glucose	£4.94	12.1	8.4	7.4	9.3
Sodium	£4.43	2.3	2.6	7.4	4.1
Urine Microscopy	£13.47	3.6	3.1	2.5	3.1
Urea and Electrolytes	£3.69	8.6	5.6	4.2	6.1
C reactive Protein	£4.43	12.1	11	7.1	10.1

To investigate this further, information from the costing system is put together into a report on the count and cost of tests on patients by type, highlighting the most frequent tests.

This information is presented to a cross-trust peer group of consultant medical oncologists.

The consultant medical oncologists request example records for patients receiving the highest frequency tests, and analyse them in detail with their peer group. A patient's need for certain tests depends on the results of others.

Patient bill - medical oncology

HRG	PM43A - Paediatric Other Neoplasms....
Point of Delivery	Elective
Service Line	Medical Oncology
Consultant	CXXXXXXX
Episode Start Date	18/04/2011
Episode End Date	21/04/2011
Length of Stay	4
Cost	£13,964

Activity Type	Date	Activity Code	Quantity	Amount
PATH	19/04/2011	C reactive Protein	1	£ 4.43
PATH	19/04/2011	Urine Microscopy	1	£ 13.47
PATH	19/04/2011	Urine Culture	1	£ 9.79
PATH	19/04/2011	Urea and Electrolytes	1	£ 3.69
PATH	20/04/2011	C reactive Protein	1	£ 4.43
PATH	20/04/2011	Sodium	1	£ 4.43
PATH	20/04/2011	MRSA Screen	1	£ 11.87
PATH	20/04/2011	Urea and Electrolytes	1	£ 3.69

The review identifies that the benchmark trust sequences its tests to avoid any that are unnecessary, but the higher cost trust does not. By adjusting its requesting process, this trust can reduce the number of tests requested. This process change will have no impact on patient care and will release capacity in pathology, and reduce expenditure.

An adjusted requesting process is agreed by the peer group, communicated and accepted by all medical oncologists in the trust.

The resource/activity matrix for each patient provides the required level of detail for the areas of interest. Nationally aligned definitions and costing standards give confidence that any identified cost differences at peer providers are due to real differences in clinical or operational practice, not distorted by differences in the

costing method itself. Finally, considering costs in parallel with the outcome for the patient is enabled by the cost information being available at patient level.

2.2 Cost management

Cost management covers a wide spectrum of organisational processes, including service development and design, cost improvement programmes, business case development, procurement, etc. Accurate and detailed cost information is key to all of these areas, but summarised national collection information would often not be suitable for this purpose. Instead, more granular information would need to be sourced directly from the provider's local costing system. The following case study illustrates how the information resulting from the proposed costing method could be applied to assess the impact of a required service redesign.

Case study 2: Gynaecology service change impact assessment

An acute trust is notified by a local CCG of a plan to develop community clinics that will act as an intermediate stage of care between primary care and secondary care, designed to ensure non-complex patients are less frequently referred into acute settings as they may more appropriately be seen in premises nearer to patient homes. The CCG will be procuring providers for the new community clinics, which would provide a range of gynaecological services.

The executive team meet to understand the proposals. A project team is set up, including the finance team and operational and clinical staff, to assess the implications and generate options, and assemble a business case for presentation to the board. Some of the key finance questions related to the impact of the services change include:

- What is the current expenditure and income of the gynaecology service as a whole?
- What type and quantity of existing patients at the trust would be directly affected by the intended service changes? Similarly, what would the affect be on onward referrals within the trust?
- What would the impact on income and expenditure be resulting from the service changes?

Current expenditure and income

The trust has previously implemented the proposed costing method according to the prescribed standards, and is using the cost information for service line reporting. This means that they have an understanding of the costs of providing services in gynaecology, and would not need to carry out additional ad-hoc costing processes to establish a baseline.

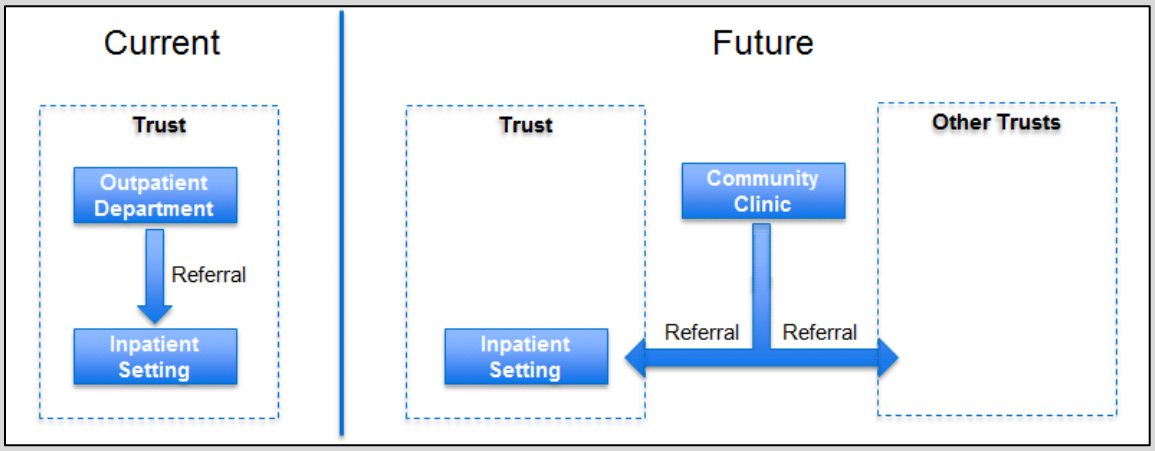
Estimating the type and quantity of patients impacted

Using historical data held within the patient level costing system, the project team

could identify specific cohorts of patients that would previously have been impacted by the intended service change. These patients would provide a basis for estimating the impact on the trust's services in the future. They would break down into:

- those treated in the trust's outpatient clinic who in the future would receive care through the community clinic;
- more complex patients referred to an inpatient setting for more complex procedures, who in the future might similarly be referred to the trust from the community clinic.

Flow of patients affected by the service change – current and future



Estimating the reduction in expenditure due to the service changes

The costs of each patient identified in each of the two cohorts would be available in the trust's costing system, allowing identification of the specific activities carried out in the care of these patients, and the human and physical resources used in the activities. This would form the information that the project team could interrogate to understand the impact on the required level of resources that would result from patients of this type and quantity no longer being treated in the trust's gynaecology service.

This granularity would be essential in understanding the nature of the resources affected. For example, the patient consumables used in the care of these patients would no longer be required, leading to reduced expenditure. But nursing staff and consultants involved in the patient's care would need to be very carefully assessed by the project team to understand what level of clinical and nursing input was required to continue to provide high quality care for patients still using the gynaecology service.

Through careful analysis and interpretation of the resources used in the care of the patients, it would be possible to build a picture of what service model would be appropriate to continue to provide high quality and safe patient care for the reduced number of patients, and a realistic estimate of the likely reduction in expenditure as a result.

Finally, having identified the number of potential complex patient referrals, an unknown number of which would be directed to the trust, this could inform the appropriate level of flexibility to build into the service model for the service.

Combined with the income data related to the patients affected by the service changes, this would be a strong starting point from which to assess options for the trust board, which would include exploring bidding for the provision of the new community clinics.

Detailed cost management of the type illustrated in the above case study requires highly granular information at the patient level to identify the resources likely to be relevant to the service changes, and enable decisions to be made about whether reduced numbers of patients would realistically lead to reduced expenditure.

Traditional financial reporting would require data to be gathered from a number of sources and subjective estimates of cost, revenue and hospital wide input into the treatment would need to be made. Access to comprehensive cost data that has been constructed according to the proposed costing method would ensure that the decision-makers have readily available information that they can rely on.

2.3 Payment regulation and currency development

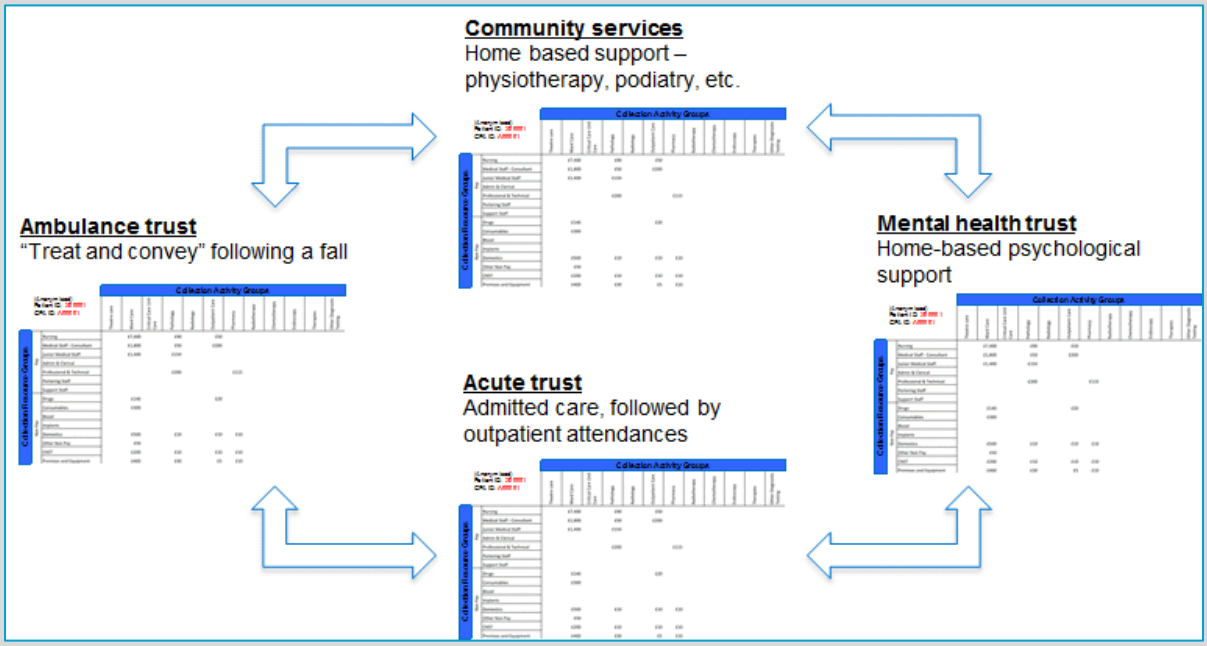
Cost information collected centrally must be able to serve the many demands of payment regulation and currency development; the determination and impact assessment of national tariffs, and the design of local price setting, local variations or modifications. The following case study shows how information from the proposed costing method could be applied to the development of a capitation payment approach, requiring costs to be traced across multiple providers and settings.

Case study 3: Developing a capitation payment approach for services across multiple settings

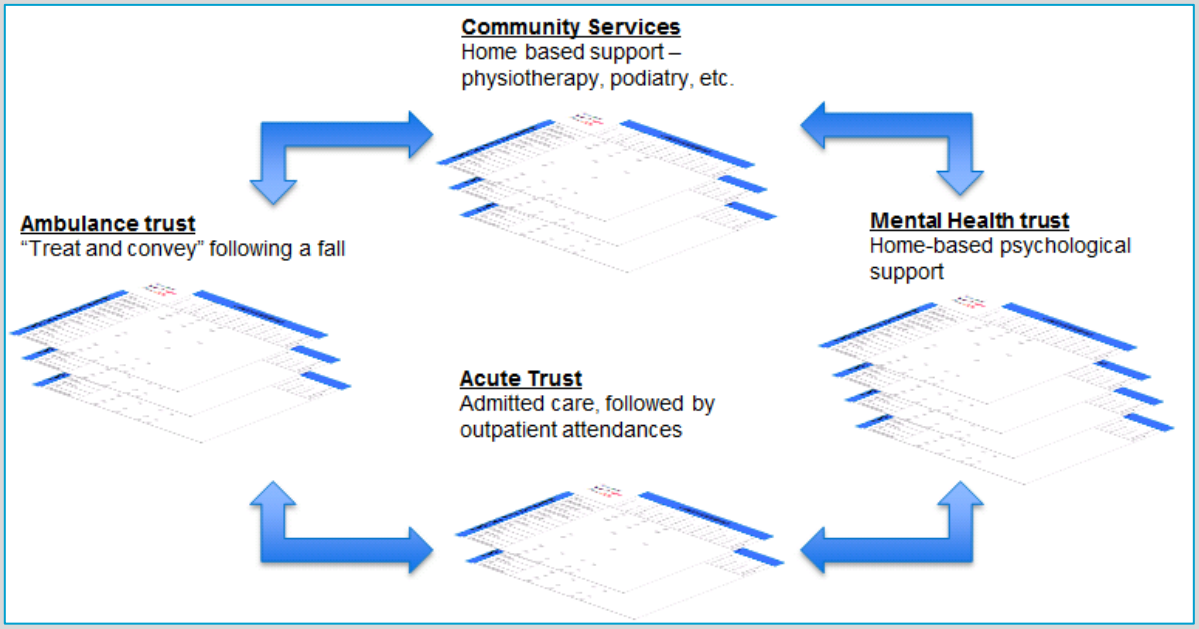
Capitation payment structures are designed to cover a fixed payment for the costs of all (or most) of the services received by a defined cohort of patients across multiple providers and settings. Calculating the capitation payment per patient in the cohort requires an understanding of the cost of each individual 'package' of care that patients in the cohort might receive, and how frequently patients are likely to need each package. To provide that understanding, subject to information governance concerns being addressed properly, all of the care provided to individual patients over a given time could be identified and aggregated into care profiles for the cohort of patients whose care is to be paid for by capitation. This information could then be used to develop capitation-based payment structures. Ideally, the capitation payment per patient would include payment for their primary and social care.

Example: Using patient-level cost data to construct capitated payments for the care of a cohort of patients with multiple long-term conditions

A patient would be identified as a member of the cohort by checking their records for long-term diagnoses such as diabetes or chronic obstructive pulmonary disease. All of the care received by a patient in the cohort could then be identified, across acute, mental health, community and ambulance services, together with the detailed costs of the care at patient level. The care provided over one year would be collected into a care profile for each patient of the cohort.



The care for all patients in the cohort could then be collected and analysed.



Using the activity information, with the cost at patient level for each activity, it would be possible to build up an average total cost for patients with multiple long-term conditions. This could be analysed across different regions and different demographics to help understand variations seen in different areas of the country. Over time it would be possible to analyse year-on-year variation to begin to understand uncertainty and therefore the financial risk associated with giving a fixed capitation payment for the care of such a group of patients. Finally, data related to quality of care and individual patient outcomes could be collected alongside the costs provided.

The cost information created by the costing method and single collection becomes the foundation for any collection of patient service costs across any defined cohort of patients, and enables the design of payment approaches based on both cost and quality of patient outcome.

2.4 Providing continuity for other uses of cost information

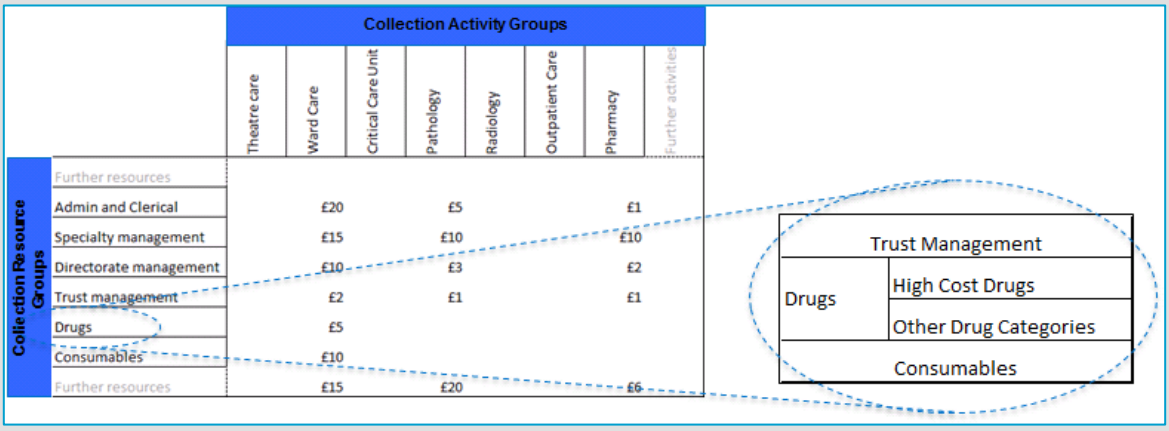
The proposed costing method and cost collection would not lead to any omission of cost information that is currently collected. The reference cost collection is the most developed cost collection in the sector, and has developed many uses over time, set out in the annual reference cost publication. All of these current uses would continue to be served at the point at which we transition to the new method, with reference costs themselves being calculable from the proposed cost collection. Similarly, it would be possible to calculate the cost pools currently used for reporting areas of cost for each patient episode in the current patient-level cost collection. This ability to provide continuity is shown below.

Reference cost calculation from the resource/activity matrix

The proposed costing method and cost collection would naturally provide the information necessary to calculate reference costs for most patient services. However, because reference costs often require certain cost types to be unbundled from the other aspects of patient care, the capability to identify such costs would be included in the detailed design work.

Reporting of unbundled high drug costs

Unbundled high drug costs, as required by reference cost collection, would be catered for by identifying high cost drugs throughout the costing process, and communicating them separately for each patient episode, and aggregating them into the HRG groupings of patients.



Cost pool calculation from the resource/activity matrix

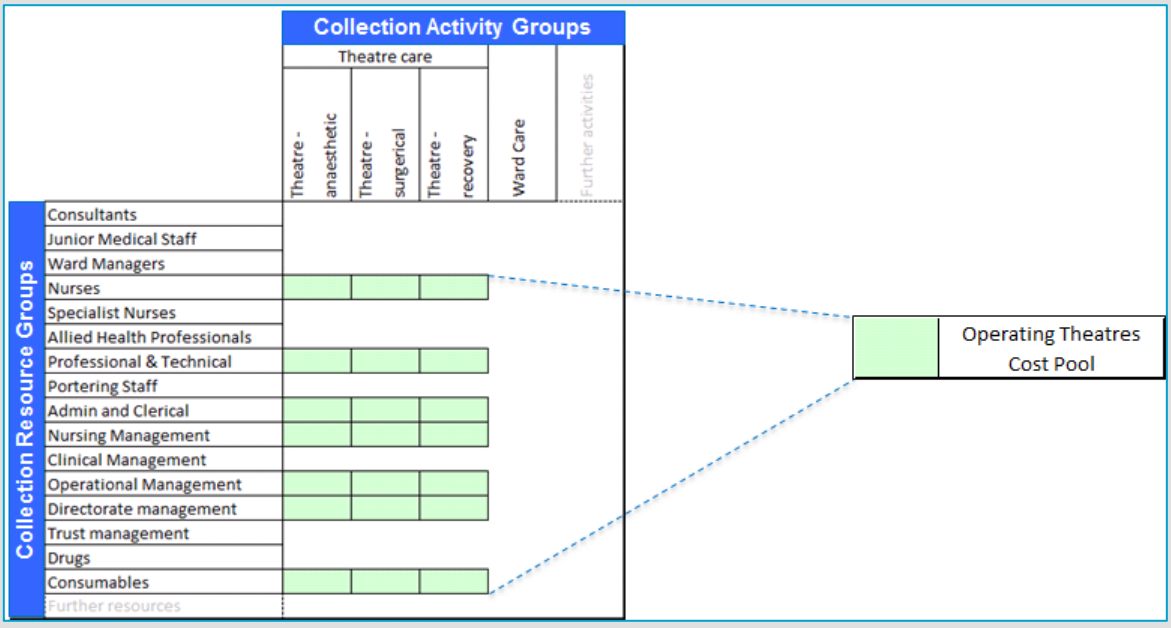
The cost pools identified in the HFMA clinical costing standards are now well established across a large number of providers for reporting. Again, if this information is of value to providers then the capability to identify such groupings of costs would be included in the detailed design work.

Reporting of the operating theatre cost pool

According to the HFMA clinical costing standards, the operating theatre cost pool should be populated as follows:

Include	Exclude
• nursing salaries and wages, including recovery and anaesthetics • other staff salaries and wages • medical and surgical supplies • anaesthetics costs • other goods and services	• medical staffing • pathology • imaging • pharmacy/drugs • prostheses • blood and blood products

The costs for the operating theatre cost pool would be reportable by ensuring that each of the classifications above are identifiable in the cost collection resource/activity matrix for each patient episode, as demonstrated below.



3 How we propose to transition to the costing method and single cost collection across the sector

We strongly believe that the improved costing method and single cost collection outlined in Section 1 would provide great benefits across the sector – to national bodies using the collected data, to providers, to commissioners, and ultimately to patients.

Over time, as outlined in 3.1.3 below, we propose to mandate the improved costing method and single cost collection for NHS services, using Monitor's licence conditions and the NHS Trust Development Authority (TDA) accountability framework that currently applies elements of the Monitor licence related to costing and cost collection. Under the existing standard licence conditions,[5] Monitor may in particular require licence holders:

(a) to record costs of providing NHS care and allocate those costs to specified categories, in accordance with costing methodology published by Monitor; and

(b) provide information about costs for the purposes of its pricing functions.

Monitor proposes to use these powers (which would in effect also apply to NHS trusts by virtue of the TDA's accountability framework) to impose the necessary requirements to implement the new costing method and cost collection process. This requirement would apply to all foundation trusts, NHS trusts, and independent providers subject to Monitor's provider licence. It would include those providing acute, mental health, community and ambulance services.

We recognise that a case needs to be made to demonstrate the value for money of the proposed approach for providers, and for the sector as a whole, and to demonstrate the need for applying the proposed costing method and cost collection in all trusts and licensed independent providers. We will develop this case in the coming year, and will seek feedback throughout.

This section outlines the proposed transition programme, which follows many of the principles and details recommended by the expert review earlier this year,[6] and is designed to be ambitious yet achievable. The programme uses parallel work streams to deliver long-term change, while ensuring continued development in the short term. The long-term development programme aims for all trusts and licensed independent providers to be able to contribute to a single national cost collection using the improved costing method, following a planned timeline for the type of services they

[5] See Section 2 (Pricing), condition P1 (recording of information) and P2 (provision of information). The standard licence conditions are available at: https://www.gov.uk/government/publications/the-nhs-provider-licence

[6] See research by BDO, available at: https://www.gov.uk/government/consultations/improving-the-costing-of-nhs-services-proposals-for-2015-to-2021

provide. Separate timelines have been developed for acute, mental health, community and ambulance services and are given at the end of this section. But many of the work streams are common to all service areas.

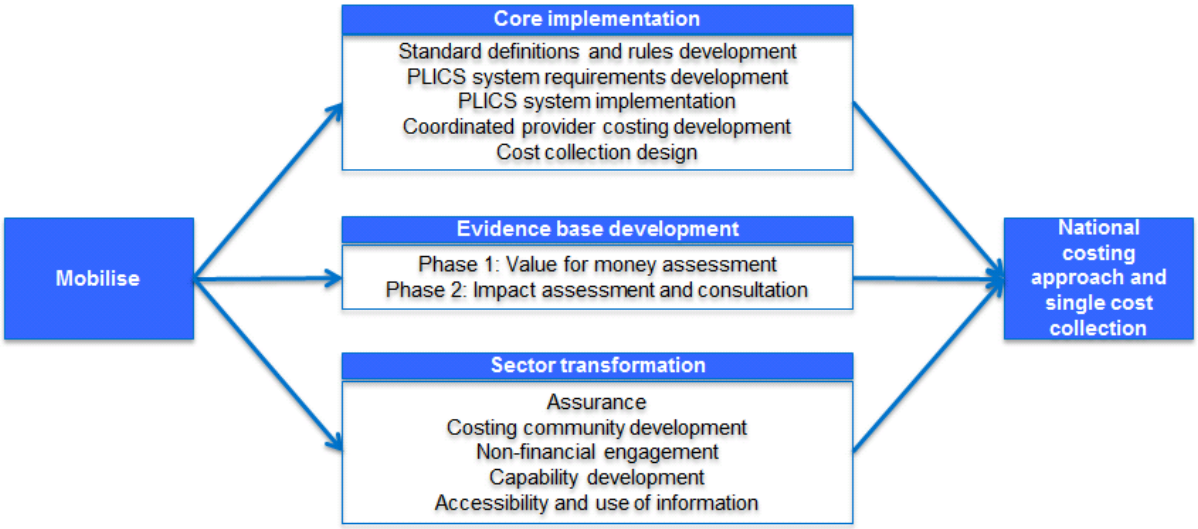
3.1 The long-term development programme

The programme would begin with a phase of mobilisation, after which several work streams run in parallel. These can be categorised as:

- Core implementation work streams to establish necessary processes and systems, including standard definitions and rules, local patient level information costing systems (PLICS), a coordinated provider costing development programme and the cost collection process.
- Work streams to establish an evidence base to show the need for a national costing method and cost collection.
- Transformation work streams to support the sector in ensuring process quality, including assurance processes, costing capability and community development, engagement with the non-finance community, and mechanisms for making best use of the cost information produced.

This section details the work streams in these three categories and the implementation considerations that we have taken into account in developing the proposed transition timelines.

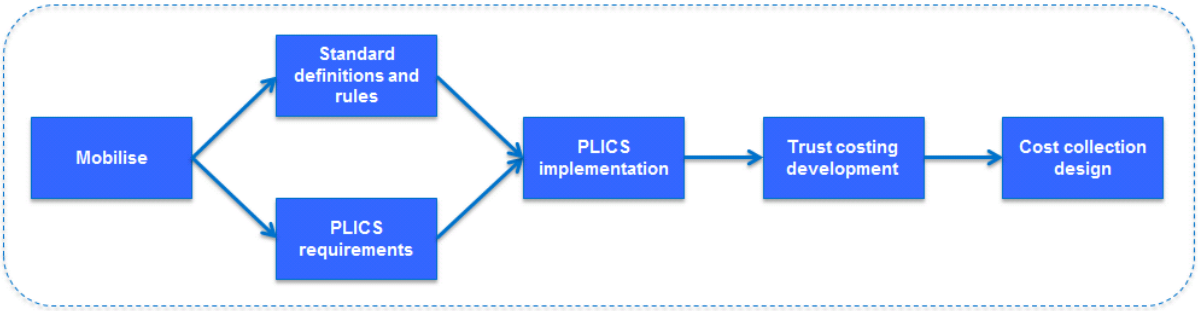
Figure 12: The long-term development programme



3.1.1 Core implementation work streams

The core implementation work streams establish the costing method, standard definitions and rules, patient level costing systems, provider costing processes, and the cost collection process. They drive the pace of change possible.

Figure 13: Core implementation work streams



Programme mobilisation

Crucial to the success of the programme is support from the sector and from national stakeholders. Therefore, the focus of the programme will be to support and encourage an environment of strong partnerships to ensure that it delivers the transformative benefits to the sector. It will be led by the programme board with strong working relations with both advisory and steering groups. Sector advisory input will be provided through the Costing Policy Advisory Group, which was set-up in mid-2014 to provide advice on key developments to costing for the payment system. The steering group will include membership from organisations such as NHS England, the Department of Health, Health Education England and the HSCIC.

Standard definitions and rules, and collection guidance

Agreeing and putting in place the definitions and rules of the costing method and cost collection is a large work stream and critical to robust and consistent cost information. As detailed in section 1, it entails agreeing definitions for the dictionaries for resources, activities and patient services; developing clear and comprehensive costing standards; defining the minimum activity, cost and patient data sets required by the costing process, and developing guidance on the content of the cost collection.

For the standards to reflect strong and implementable costing practice, their development requires both detailed development work with selected providers, and wide sector input to refine, finalise and test the standards.

PLICS requirements and assurance

Local PLICS systems, of which there are many variations implemented in the NHS in England, are a key enabler to effective costing processes in providers. It is essential

that these systems are functionally capable of implementing the detail of the proposed costing method. We propose working with healthcare and software providers to develop a specification of the minimum requirements of PLICS systems. This specification would provide clarity to software providers, and would help healthcare providers to procure adequate systems.

> We would like your views and comments on whether providers would appreciate assistance in the assurance of local PLICS systems through the development of a central accreditation system.

PLICS implementation programme

166 NHS trusts and foundation trusts have now either implemented or are implementing PLICS systems and 78 have yet to start. Table 1 summarises the level of PLICS system implementations across the sector, based on the 2013/14 reference cost survey. A national costing method across all providers would require not only a significant implementation programme for provider without PLICS systems, but reconfiguration work for many of the providers that have PLICS systems in place. It would also require integrated providers that have not yet implemented their PLICS system across their non-acute services to expand the scope of their system.

Given that there is a finite number of PLICS software providers and personnel capable of implementing PLICS software systems, it is important to allow sufficient time in the transition programme for a large number of providers to prepare the necessary infrastructure in a controlled manner.

Table 1: PLICS implementations in NHS trusts and foundation trusts

	Acute	Ambulance	Community	Mental health	All trusts
Implemented	118	1	2	9	**130**
Implementing	21	0	2	13	**36**
Planning	10	0	4	27	**41**
Not planning	9	9	9	7	**34**
Not answered	2	0	1	0	**3**
Total	**160**	**10**	**18**	**56**	**244**

Provider costing development

Following the development of the costing method, definitions and rules, and collection guidance, providers would need to decide their development path to compliance with the proposed costing method and single cost collection. We expect that most providers would require some level of investment, both in implementing systems and in enlarging and developing costing teams.

We propose providing a phased national programme to support providers in their transformation of the new costing method, definitions and rules into fully implemented costing systems and approaches. There would be many streams to this support, which are outlined in the sector transformation work streams in subsection 3.1.4. In principle, the support programme would apply a phased approach, separating the transformation into several phases, considering the data feeder systems, the application of the standard dictionaries, and development of the costing standards.

A co-ordinated programme would enable an active system of feedback throughout, meaning that collaborative support, advice and support materials for the application of dictionaries and costing standards could be provided in parallel with provider developments.

Cost collection development

The move to one cost collection would significantly reduce the burden of cost collections as long as there is a low burden interface between local PLICS systems and the central collection mechanism. This would enable costing practitioners to focus their efforts on costing system development, and using the cost information that their systems produce.

It will be important to develop intelligent submission validations, capable of cross-referencing patient procedure and diagnosis information with the types of costs reported for each patient. We also aim to develop and encourage a more iterative, communicative submission process to support the assurance processes, where clear errors can be rectified, and potential costing developments for future years can be identified.

3.1.2 Implementation considerations

In building the timelines for the programme towards the proposed costing method and cost collection, our key implementation considerations were:

- the overall pace of change
- the development sequence for acute, mental health, community and ambulance services

- the four-year collection development process
- the discontinuation of reference cost submissions.

1. Pace of change

While many factors influence the pace of change proposed, including available resources centrally and in the sector as a whole, the most significant work streams are:

- **The development of new costing standards**. It is estimated that this will take 12 months for acute and ambulance services, and 18 months for mental health and community services. This stage has to be complete before any local provider implementation of the proposed costing method can take place. However, we would encourage providers to take preparatory actions where possible.
- **The PLICS implementation programme**. As explained earlier, this requires a significant phased implementation to cover a large number of providers, which may need to reconfigure existing systems or implement new ones. The timeline for each service area allows a minimum of 22 months between a confirmed mandate decision to the beginning of the first mandated collection year, to give providers enough time to develop PLICS systems of the required standard.

2. Sequencing of service areas

It is expected that acute, mental health, community and ambulance services can all benefit from the proposed costing method and cost collection, but that the benefits would differ in scale and nature. We also believe that the challenges of implementation in different service areas are quite different.

We therefore propose that development is sequenced by service area, working towards parallel national collections for acute and ambulance services, followed by national collection for mental health services a year later, and community services two years later (see detailed development paths for providers by service area in subsection 3.3).

The proposed sequence takes account of an assessment of the relative benefits of applying the new approach to the payment system and for local cost management. However, the dominant consideration was the specific challenges of implementation for each service area. We believe that the reasonably developed state of nationally agreed resource, activity and patient care dictionaries, data feeder systems and provider costing capability within the acute sector significantly reduces the risk of programme failure for acute services. Similarly, we believe that the lack of similar development in most mental health and community service providers requires that additional preparation time would be given to these providers.

We recognise that the development work for integrated service providers would necessarily be more complex. Having explored the issue, we have concluded that to achieve a controlled transition, providers spanning service areas need to develop each service area following the service-specific timeline.

> Monitor would like your views and comments on the proposed sequencing of implementation across service areas.

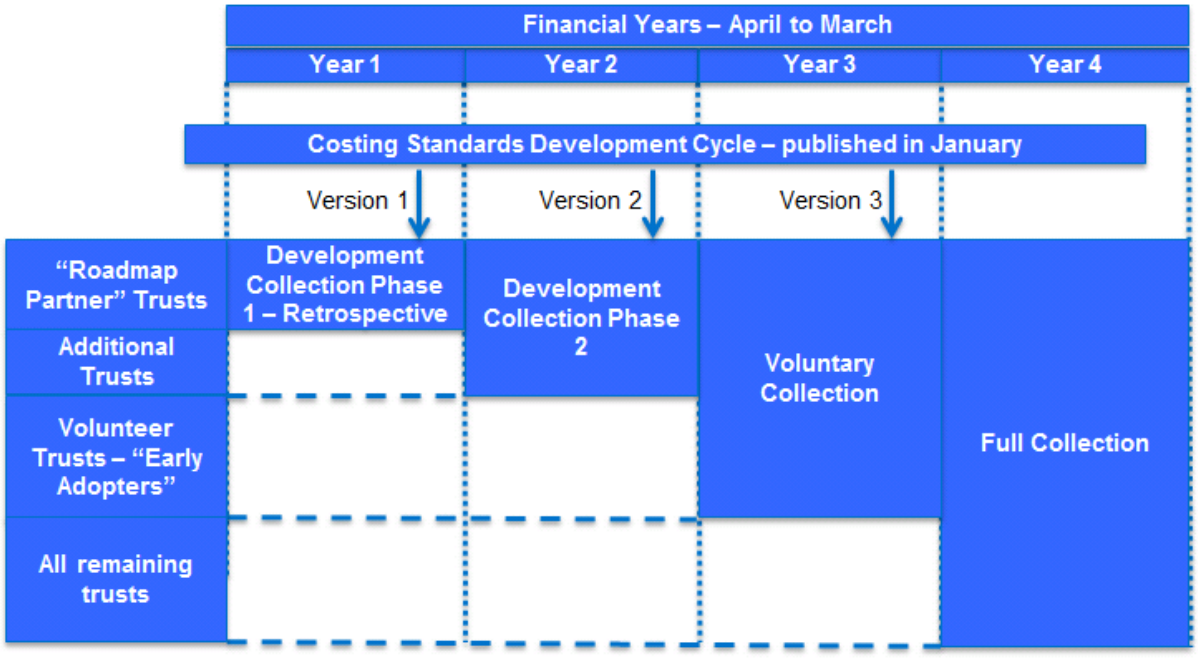
We propose that independent providers subject to Monitor's provider licence should be subject to the same requirements relating to costs as NHS trusts and foundation trusts and should follow the same service-specific timelines for implementation .

> Monitor would like your views and comments on the proposal that independent providers be subject to the same requirements, and should follow the same timelines, as NHS trusts and foundation trusts.

3. Four-year collection development process

The proposed route to a mandated collection would take four financial years for each service area, phased to burden providers as little as possible. 'Development' collections would take place in the first two years and would be restricted to a small number of volunteer 'roadmap partner' providers. These providers would work closely with Monitor to establish and test the new costing standards, focusing on lessons to be taken into future collection years. The third year would include a full voluntary collection, and the fourth a mandated national collection. Figure 14 illustrates this four-year process, and each year is explained further below.

Figure 14: Four-year collection phasing



Year 1 – **development collection phase 1**, carried out with roadmap partner providers. Version 1 of the definitions and new costing standards would be complete in January of the year of this collection, meaning that some collection data would need to be generated retrospectively. The collection would therefore primarily aim to yield information about the process rather than generate fully compliant cost information that could be used for payment regulation or cost management.

Year 2 – **development collection phase 2**, opened up to a small number of additional volunteer providers by agreement with Monitor. This collection would be restricted to small numbers. The limited two month preparation time between version one of the standards and the beginning of the collection year means it would not be worth collecting data from a large number of providers. Again, the main aim of this collection would be to gain process learning, not usable cost information.

Year 3 – **voluntary collection**, open to all providers for the first time. All providers would be welcome to take part because the standards would by this point be in their second year of publication. Additionally, we would explore at an early stage whether it would be possible to work with providers to form a strong representative sample in this year, with the aim of using the cost information for payment regulation.

Year 4 – **full collection**, including all providers. At this stage, the standards would be in their third year, published 26 months before the beginning of the financial year.

The four-year development process, coupled with the sequencing by service area, leads to proposed national collections in the following years:

- acute and ambulance service providers – 2018/19
- mental health providers – 2019/20
- community service providers – 2020/21

Monitor would like your views and comments on the proposed pace of the programme of implementation for each service area.

4. Discontinuation of reference cost submissions

Providers submitting a patient level cost collection using the proposed costing method for the first time would also need to submit reference costs that year. The patient level submission would then be used to construct the same reference costs centrally. For providers where the two versions are reconcilable to an acceptable threshold, there would be no need to submit reference costs in future years. Given views on the burden of cost collection, we are hopeful that this would encourage providers to implement the proposed process in the voluntary collection year.

3.1.3 Evidence base development work stream

The proposed process for developing an evidence base for moving to a mandated costing method and cost collection has two stages.

Stage 1: Value for money and need assessment, leading to a provisional mandate

The cost of implementing a PLICS system and the investment of time and resource both within and outside the finance function required to make best use of a system are considerable. While a growing majority believe that the benefits of possessing robust patient level cost information far outweigh these costs, a clear case needs to be brought together to show that the proposed approach offers value for money.

As well as value for money considerations, the application of the proposed costing method in all providers is necessary to provide robust and comprehensive cost information for the payment system and to inform sector development.

The first stage of the decisions to require costing and collection on the basis of the proposed new method would be considered for all service areas, on an individual basis. It would assess whether a patient level costing approach is value for money, and would set out the case for the national application of the costing method and single cost collection. It would involve gathering evidence from which to estimate the value for money of the proposed approach, bringing together expected costs and benefits delivered to date across the sector through patient level costing approaches.

If the value and need is clearly shown, Monitor and NHS England would then adopt a specific proposal to mandate the proposed process, with this decision timetabled for late 2015. We would communicate this proposal to the sector, along with a provisional timetable to the date when the requirement would come into effect, if the proposed process passes the second stage of the mandate decision process.

Stage 2: Impact assessment and consultation, leading to a confirmed mandate

Completing the national dictionaries, costing standards and required minimum datasets would make it possible to understand in more detail the costs to the sector of the proposed method, taking into account its information requirements. Given that the expected change in the costs of improved costing processes would represent a material change to the Approved Costing Guidance and have a significant impact on providers[7] we would carry out an assessment of the likely impact of implementing the proposal and consult. Depending on the results of this impact assessment and subsequent consultation process, Monitor and NHS England would make a final decision on whether to implement the new requirements for the service area in

[7] Monitor has a duty to carry out an impact assessment of a proposal which has a significant impact on providers, patients or the general public, before implementing that proposal, and a duty to consult on any such proposal (see section 69 of the Health and Social Care Act 2012).

question. A final decision to implement would also confirm the timetable. Our current proposal is that the final decision in each area would be as follows:

- June 2016 for acute and ambulance services
- June 2017 for mental health services
- June 2018 for community services.

For each service area, this would give a minimum period of 22 months from the mandate decision to the beginning of the first mandated collection year.

Reaching a mandate decision in parallel with the implementation programme

A key assumption of the transition programme is that to deliver change as quickly as possible, work should begin immediately on programme mobilisation, then costing standards and PLICS requirements development. This means that a significant amount of work would have been completed by the time the value-for-money exercise is complete. This may not sound ideal, but we are confident that these early work streams will provide a great deal of benefit to the sector as well as being necessary for the development of the proposed costing process, and should therefore not be delayed. Figure 15 illustrates this parallel approach.

Figure 15: Parallel evidence base development and implementation

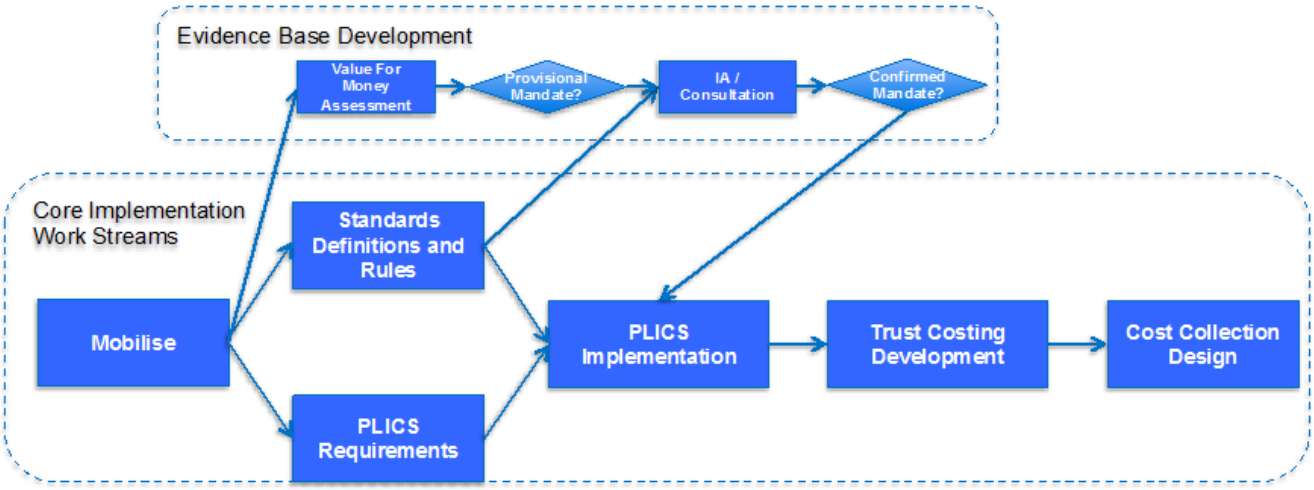
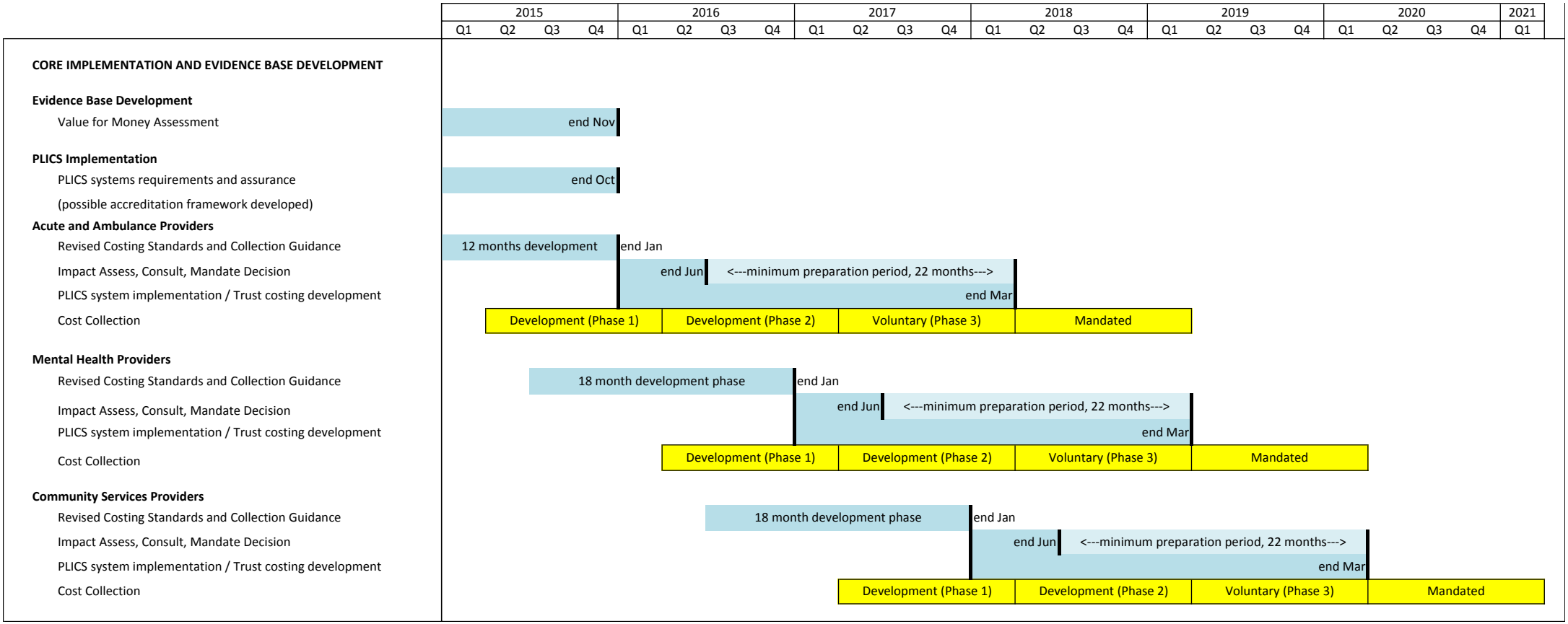


Figure 16 below brings together the core implementation and evidence base development work streams, providing a high level illustration of the timelines for each service area.

Figure 16: Core implementation work streams – timelines



3.1.4 Transformation work streams

While the core delivery work streams would establish the necessary processes and systems for all providers to use the proposed costing method and cost collection, the transformation work streams would ensure the quality of both processes, and thus the quality of their output. The support work streams would require a significant amount of support from providers, and championing of the goals of the programme from national bodies and representative organisations.

The support work streams comprise:

- developing a framework for quality assurance and continuous improvement
- developing a national costing community
- developing costing capability across the sector
- designing and conducting a programme of engagement with clinicians, and operational and senior managers
- creating structures and guidance to make best use of the information produced.

Quality assurance and continuous improvement

In the short term, we will continue to focus audit processes on the national cost collection exercises that input directly to the payment system. But it would be necessary to develop future audit and assurance processes that are able to ensure both quality of output of the proposed costing approach for the many uses of cost information, and a cycle of review and improvement for the approach.

In the longer term, quality of output would be assured through mandated minimum standard costing approaches set out in the costing standards, aimed at ensuring a high quality of input into both the payment system and cross-provider benchmarking. Continuous improvement would be encouraged by identifying and sharing existing best practice costing approaches, gradually adopting them in the costing standards.

The assurance process would be underpinned by the costing method being reconcilable to provider accounts at each stage of the process. Additionally, costing quality metrics such as the HFMA's materiality and quality score (MAQS) would be developed not only to assure quality, but also to direct and prioritise costing development at a national level.

National costing community development

There are many useful local costing forums such as regional costing practitioner groups and PLICS software user groups. However, there is as yet no national costing community. We therefore propose to work with the sector to create national

forums for costing professionals to communicate with each other, allowing them to share costing practices and developments, and use of cost information locally.

With wide and active involvement, such forums could be used to give costing practitioners direct input into costing development nationally, enabling a much broader and frequent input from the frontline of healthcare costing into costing standards and collection guidance.

Costing capability development

Developments in costing in the sector over recent years have been enormously encouraging, but they have also varied greatly from provider to provider, as have the resources committed to costing.

We believe that the profile of costing needs to be raised, and that it will be necessary to increase both the number and the capabilities of costing professionals across the sector. We also believe that it is important to increase the engagement of financial management teams in both the costing process and in using cost information to manage providers.

As part of this better use of cost information, Monitor will be providing support through its change agents programme that will be promoting clinical management of budgets, and clinical leadership in decision-making on best use of resources for patient outcomes. The change agent programme will help to promote good governance arrangements in delivering high quality patient services and meeting key performance targets.

The development of the capability of the sector in costing must ultimately be a sector-wide effort.

Engagement with clinicians, operational managers and senior management

As the Department of Health's guide to 'Effective clinical and financial engagement'[8] states finance managers are critical to delivering high quality cost information, but they cannot deliver it alone. It is clinicians – doctors, nurses and allied health professionals – who commit NHS resources. Giving them a clearer understanding of the financial consequences of their actions could accelerate improvements in the allocation of resources from a patient perspective that we anticipate as a result of the proposed costing approach.

Setting out a clear evidence base for the changes that we propose will ensure that trust boards, clinicians and operational managers can monitor the benefits of the improvement process and gain their support. The proposed value-for-money exercise would bring together the many examples of benefits already created through accurate, highly detailed costing and resultant service development.

[8] https://www.gov.uk/government/publications/nhs-clinical-and-financial-engagement-best-practice

Additionally, the change agents programme will promote integrated working within all functions, with finance acting as an enabler to assist clinicians, nurses and healthcare professionals to measure the financial consequences of their decisions.

We believe that with the support of providers, our partners and representative organisations such as the Foundation Trust Network, NHS Confederation and Royal Colleges, we can increase greatly the extent to which cost information is used to deliver efficient and effective patient care.

Case study 4: Nottingham University Hospital patient level costing – sharing the knowledge

Nottingham University Hospital (NUH) believes it is lucky to be in an industry with such a high degree of expertise, education and experience – but that these things aren't used enough to run their business. They have a vision of rolling out their patient level cost information to all 630 consultant staff by mid 2015.

To achieve this, the costing team have engaged fully with their financial management colleagues, as in practice they will hold the day-to-day discussions and receive most of the feedback with clinicians.

The programme started by holding weekly meetings with financial management staff, building their confidence and detailed understanding of the patient level cost information. They now have all of financial management confident of the figures in their service line and PLICS system reporting.

Their next move is to roll out the process to all of their clinicians. They have set up meetings with 60 service line leaders and over an eight-week period are holding weekly half-hour meetings with the clinician, the finance manager and a costing lead.

At the beginning of the meeting they ask for a confidence score - 'Would you recommend the patient level cost information to your peer consultants?' (1-10). At the end of the meeting they ask 'What is the one thing we can do to improve your score this week?'. This gives them continuous feedback of the system whilst unearthing ideas for development.

At the end of the 8 week process (or when confidence scores reach 9 or 10) they ask the clinician to present the patient level cost information to their peers with the finance manager. The costing team hands the programme of embedding patient level costing over to financial management and moves onto the next service line.

They now report patient level costs monthly, have dashboards that have been built by their own consultants with the help of their PLICS supplier, and are tracking the number of users on a weekly basis.

They feel they are starting to move to a point where they have the data experts focussing on the inputs and the clinical experts and senior managers focussing on

the outputs. This should lead to a high quality service for their patients whilst delivering the necessary service developments needed to ensure they do so as efficiently and effectively as possible.

Structures and guidance to make best use of the information produced

As noted above, the information to be gained from an extensive and granular cost database would have many uses beyond its applications to payment and pricing regulation. Although the volume of information available would grow rapidly over the next five years, patient level information is already in its second year of collection. We should consider how to best use the information at our disposal as a result of improvement in costing, both now and in the future.

Beyond the intended national uses of the data, for example, as the input into the payment system, careful consideration needs to be given to the wider accessibility and use of granular and aggregated cost information. Patient level information is of course very sensitive, meaning that IT infrastructure will require appropriate security, and data will need to be anonymised and aggregated according to the intended use.

Monitor will work with the HSC Information Centre to set out proposals for access to and use of the information created through the cost collections proposed in this document that protect and promote patients' interests.

3.2 Short term development

A clear focus on long-term objectives is important but progress in the short term also has to be achieved. We believe that short-term developments to current practices can be used as a building block to the proposed costing method and cost collection, making the transition for providers easier.

We plan to work with our partners to improve the quality and scope of existing cost collections in the following areas:

- Reference cost collection
- Education and training cost collection
- The current voluntary patient level cost collection

3.2.1 Reference cost development

Monitor will continue to work with the Department of Health to develop the reference cost collection, in order to meet the needs of the payment system and the other uses of reference costs. In the long term, this collection would be generated from the single patient level cost collection, reducing administrative burden on the centre.

3.2.2 Support to education and training cost collection development

The existing reference cost collection currently estimates patient care costs by collecting costs including those related to education and training, and then requiring trusts to subtract their education and training income, as a surrogate for education and training costs. The education and training cost collection recently introduced by the Department of Health and Health Education England aims to quantify the actual costs of education and training, with the objective of enabling a move to an integrated collection of patient care costs and education and training costs in coming years. Monitor and NHS England will work with both organisations to explore the transition plan to an integrated cost collection, with consideration given to how this integrates with the proposed transition plan in this document.

3.2.3 Development to the current voluntary patient level cost collection

Monitor plans to work with a small number of volunteer providers in 2015 and 2016 to expand the patient level collection to:

- mental health services, and outpatient procedures and accident and emergency services in acute settings for 2014/15 costs;
- community health services for 2015/16 costs.

Similarly to the long-term development of cost collection, the first year would be a ‘development’ collection, restricted to a small number of volunteer providers, and focussing on improving the process, rather than generating fully compliant cost information. However, this would form the basis for voluntary collections in the years immediately following the development collections.

3.3 Detailed development paths for providers by service area

We believe that we need to balance the delivery of long term, step-change improvements with the continuation of improvements to existing cost collections in the short term. This section brings together a view of what alternative progression paths might look like for providers by service area. We recognise that the path of integrated service providers will be more complex, and propose that each service area will be required to meet each service area timeline.

Figure 17: Collection Participation Scenarios for Acute and Ambulance Services

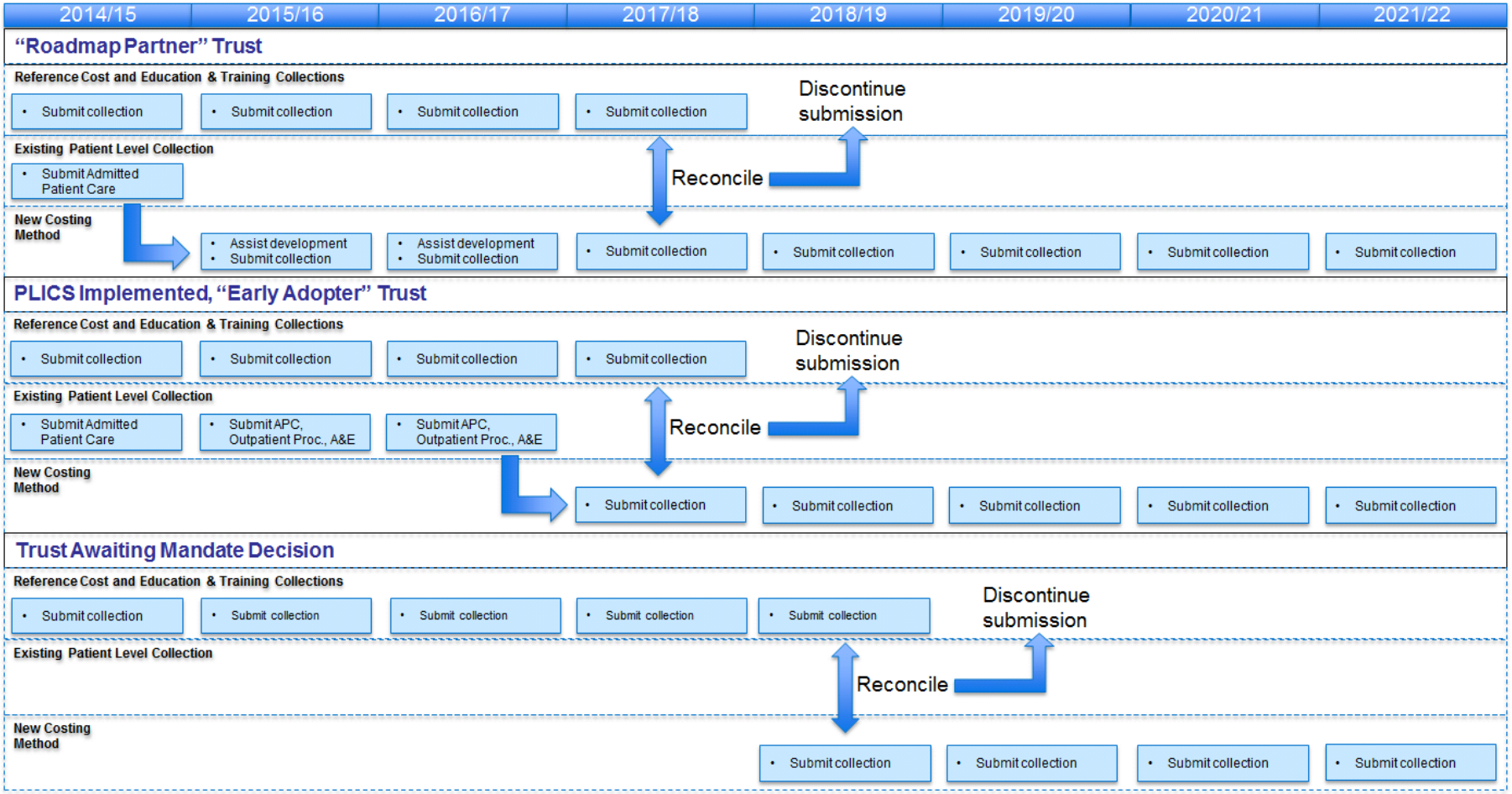


Figure 18: Collection Participation Scenarios for Mental Health Services

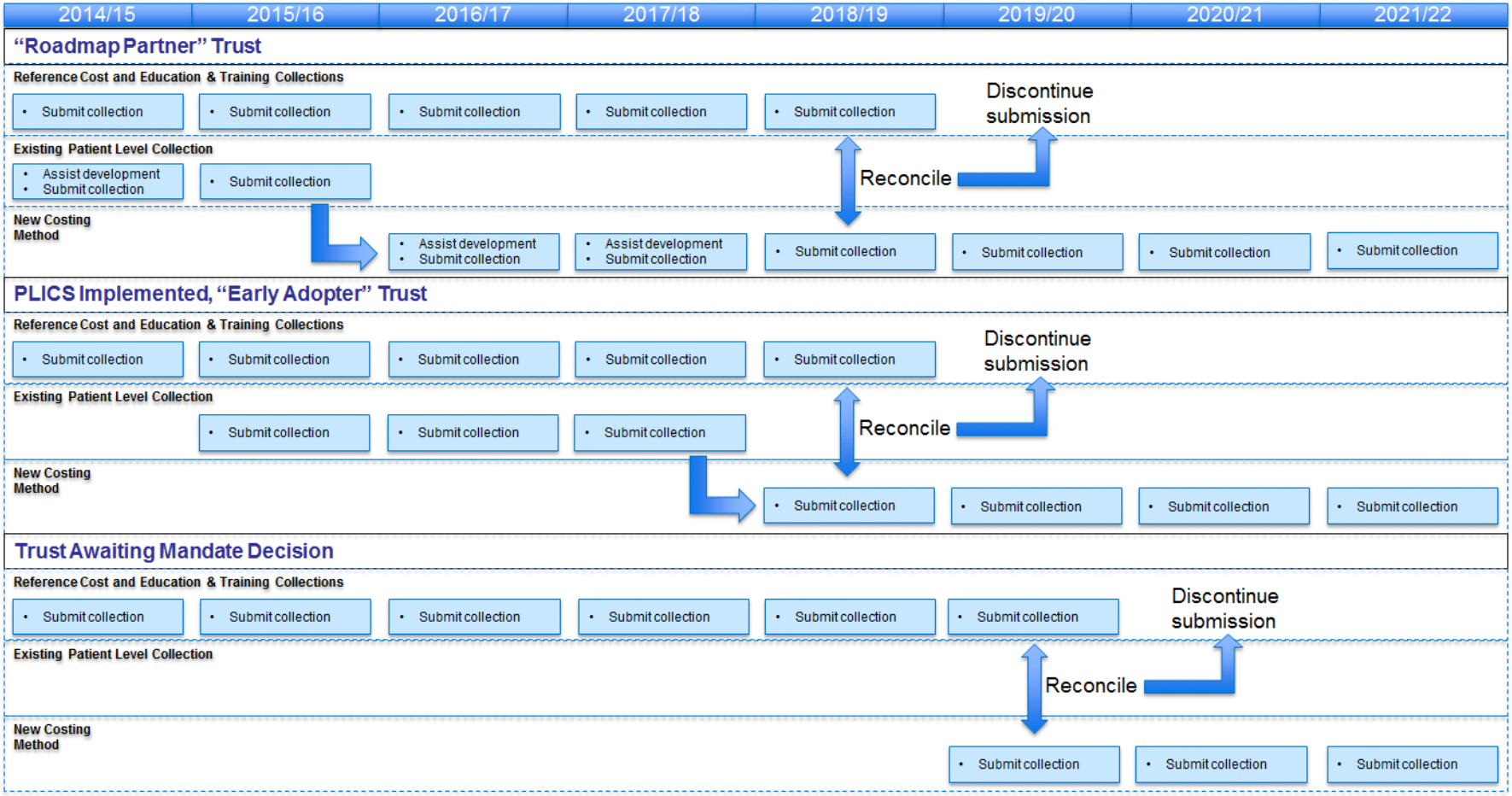
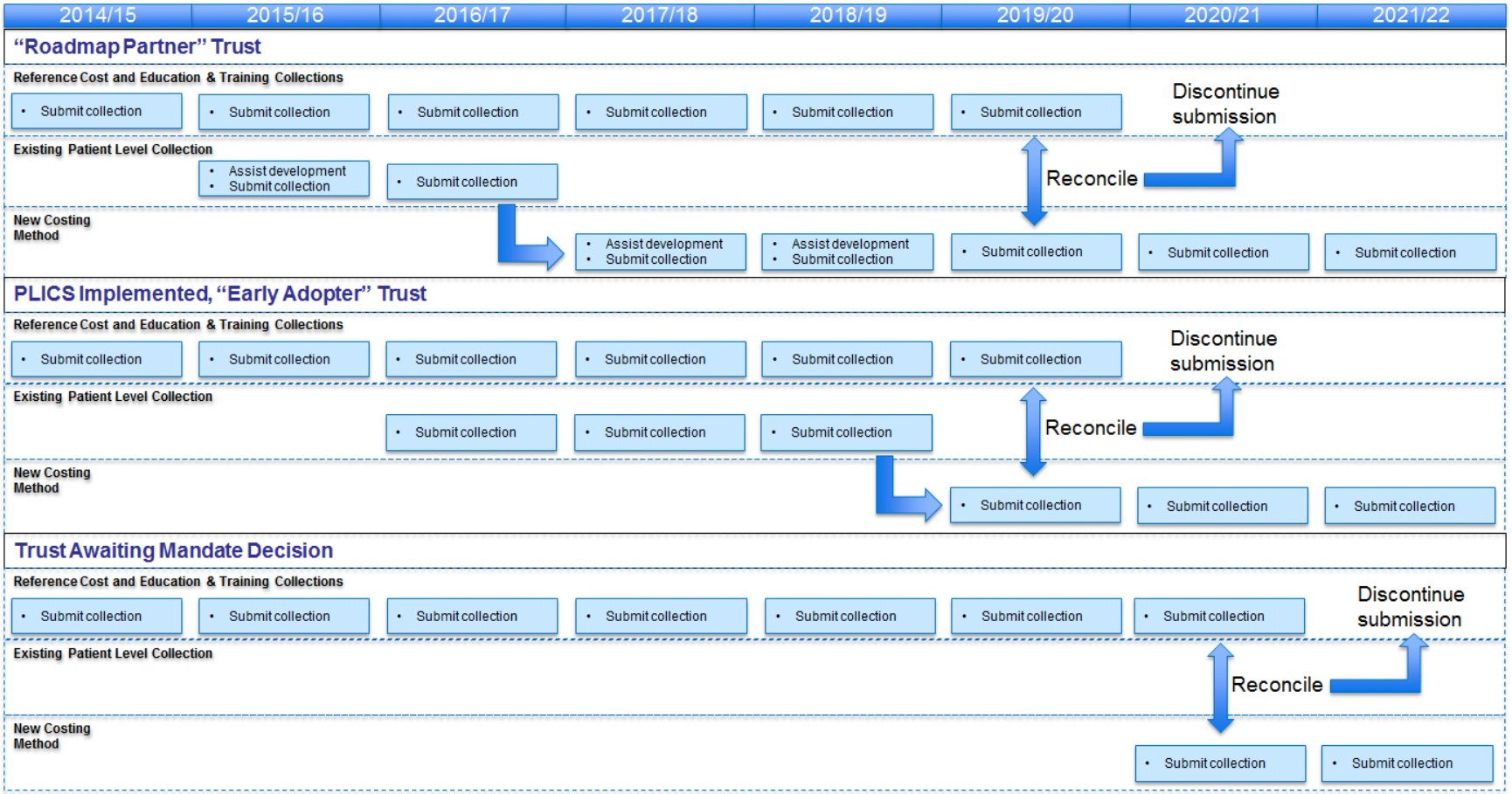


Figure 19: Collection Participation Scenarios for Community Services



4 How you can provide your views on the proposals

We are very keen to hear readers' responses to the proposals described in this document and to refine them through both online and in person discussion and debate.

The engagement period will last until **16 January 2015**. It will include:

- a webinar to launch the engagement process
- regional workshops for providers and commissioners
- a workshop for PLICS software suppliers
- a roundtable workshop for representative organisations
- an online response form.

In particular, we would like to know:

- whether providers would like us to develop a central accreditation system for assuring the capability of local PLICS systems
- what you think of the order of service areas proposed for the three four-year phases of the overall implementation programme, ie first acute and ambulance services, then mental health and then community services
- what you think of the proposed pace of implementation for each service area
- what you think of the proposal that independent providers should be subject to the same requirements and follow the same timelines as NHS trusts and foundation trusts.

There will also be opportunity for you to provide your feedback on any aspect of the proposals, and to give your view on what you think the largest challenges to deliver the proposed programme will be.

Please respond to the questions raised and provide and more general comments by completing our **online response form**.

To get involved with other engagements activities, please email: **costing@monitor.gov.uk**

Monitor

Making the health sector work for patients

Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.gov.uk/monitor

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