Monitor

Making the health sector work for patients

Reference cost assurance programme: Findings from the 2014/15 audit

www.gov.uk/monitor

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

1. Introduction 4

2. Findings 6

2.1. Accuracy of reference cost submissions 6

2.2. Risk area assessments 8

2.3. Clinical coding audits 10

3. Conclusions 12

Appendices 14

Appendix 1: Background and approach 14

Appendix 2: Results for all trusts audited in 2014/15 17

Appendix 3: Examples of good and poor performance across the areas tested 20

1. Introduction

Good quality cost and activity information should be crucial to day-to-day decision-making by healthcare providers. It is also essential for Monitor to set efficient prices.

The importance of good quality cost and activity information is reflected in Monitor's provider licence, which requires providers to prepare reference cost submissions in accordance with Monitor's costing guidance. This requirement also applies to NHS Trusts under the NHS Trust Development Authority's Accountability Framework. The costing guidance requires trusts to:

- adhere to Monitor's six principles of costing[1]
- comply with the Department of Health's reference costs guidance[2]
- comply with the Healthcare Financial Management Association (HFMA) costing standards, on a 'comply or explain' basis.[3]

In July 2014 Monitor commissioned Capita ("the auditors") to audit the 2013/14 reference cost submissions and clinical coding of 75 acute trusts. The value of the reference costs audited was £23 billion.

The auditors provided an opinion on whether the reference cost submissions were accurate for each of the trusts audited. This opinion was based on separate assessments of the accuracy of costing information for admitted patient care, non-admitted care and other services without mandatory tariffs (eg critical care and community services), as well as an assessment of the accuracy of clinical coding.

The auditors also assessed providers against each of the following risk areas using a red, amber, green (RAG) rating.

- Compliance with reference costs guidance.
- Accuracy of costing.
- Governance in relation to costing.
- Governance in relation to clinical coding.

---

[1] These principles can be found in Section 1.1 of Monitor's approved costing guidance: www.gov.uk/government/uploads/system/uploads/attachment_data/file/404708/Approved_costing_guidance_-_17_Feb_2015.pdf

[2] Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/289224/reference_costs_collection_2013-14_2.pdf

[3] Available at: www.hfma.org.uk/NR/rdonlyres/B0D84D96-0F62-42B4-A655-FBB1DCD869B2/0/AcutestandardsFeb15.pdf

Finally, the auditors assessed the accuracy of clinical coding by recoding a sample of 200 episodes for each trust using the Health and Social Care Information Centre's Clinical Coding Audit Methodology. More information on the background and approach to this methodology is in Appendix 1.

The auditors produced reports with detailed findings for each provider. Providers were asked to develop an action plan to address their respective findings. Monitor expects providers' Audit Committees to oversee the implementation of the action plans. This report summarises the findings of the audits and draws conclusions.

2. Findings

This section summarises the overall findings of the audits including:

- the auditors' opinion on the accuracy of reference cost submissions
- the results of the risk area assessments
- the results of the clinical coding audit.

More detailed findings are in Appendices 2 and 3.

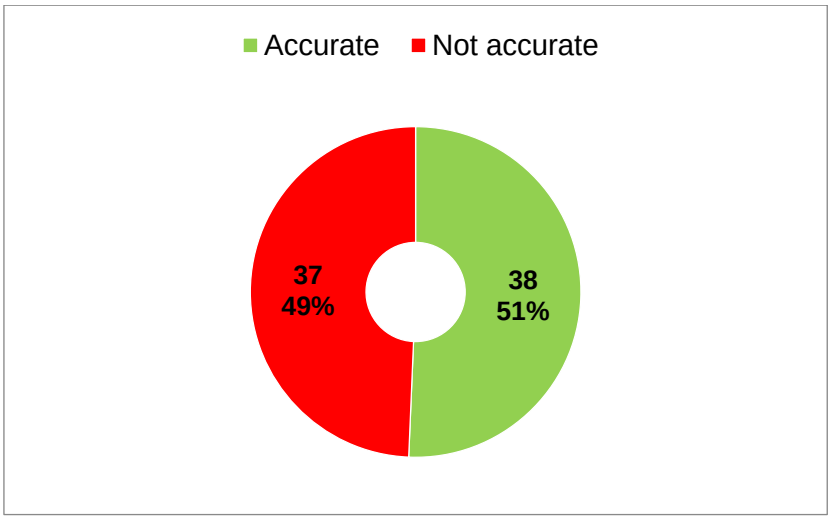
2.1. Accuracy of reference cost submissions

In total, 37 of the 75 trusts audited (49%) had materially inaccurate reference cost submissions, as shown by Figure 1. This figure is made up of:

- 22 of the 49 NHS foundation trusts audited (45%)
- 15 of the 26 NHS trusts audited (58%).

Last year, 17 of the 50 trusts audited (34%) had materially inaccurate reference cost submissions. The increase in the proportion of trusts found to be inaccurate is not statistically significant.

Figure 1: Overall accuracy of reference cost submission



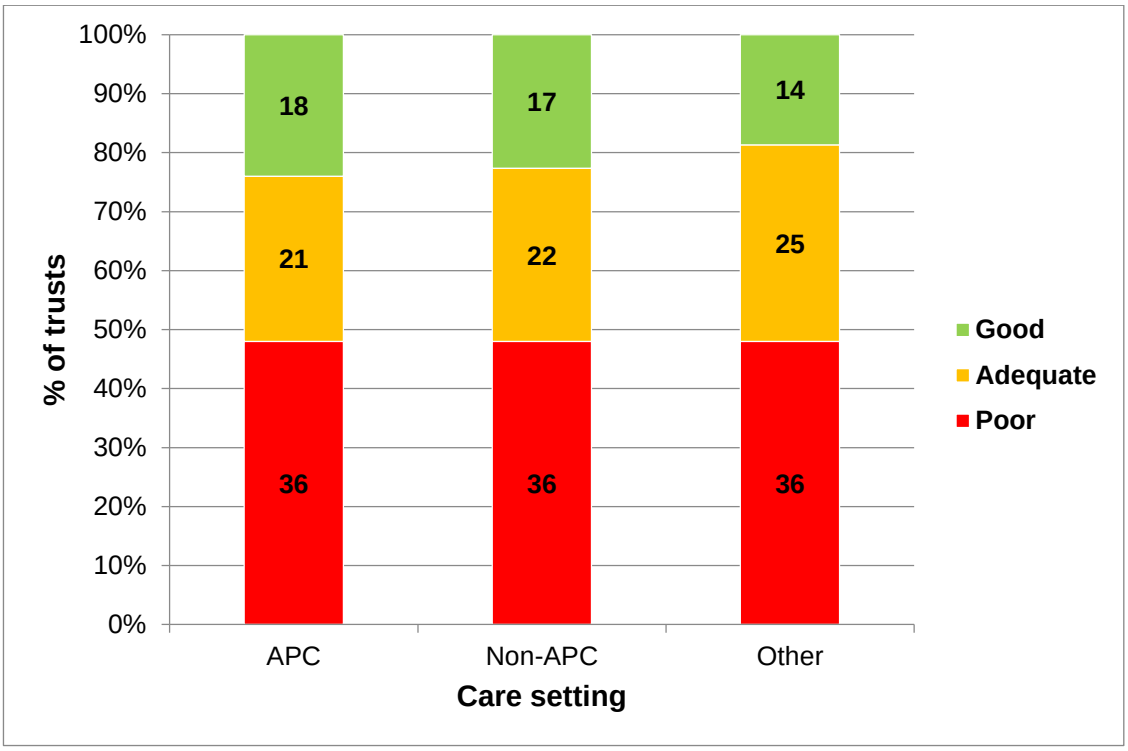
The auditors assessed the accuracy of each provider's reference cost submissions in each of the following care settings:

- admitted patient care
- non-admitted patient care (outpatients, A&E and diagnostic imaging)
- other (all other services without mandatory tariffs eg critical care and community services).

Figure 2 shows that the proportion of providers assessed as good, adequate and poor in each of the care settings was similar. 24 of the 37 (65%) trusts with materially

inaccurate reference costs were found to use poor costing information in all three care settings.

Figure 2: Accuracy of reference costs by care setting



The findings show that many trusts are not undertaking the detailed work necessary to produce accurate costing information. The majority of trusts found to be inaccurate had costing systems and processes in place, but had problems with their design and operation. A small number of trusts made wholly inaccurate reference cost submissions based on national averages or unvalidated weightings. These trusts appear to have made limited effort to produce accurate costing information.

While the causes of error vary between trusts, some themes were identified:

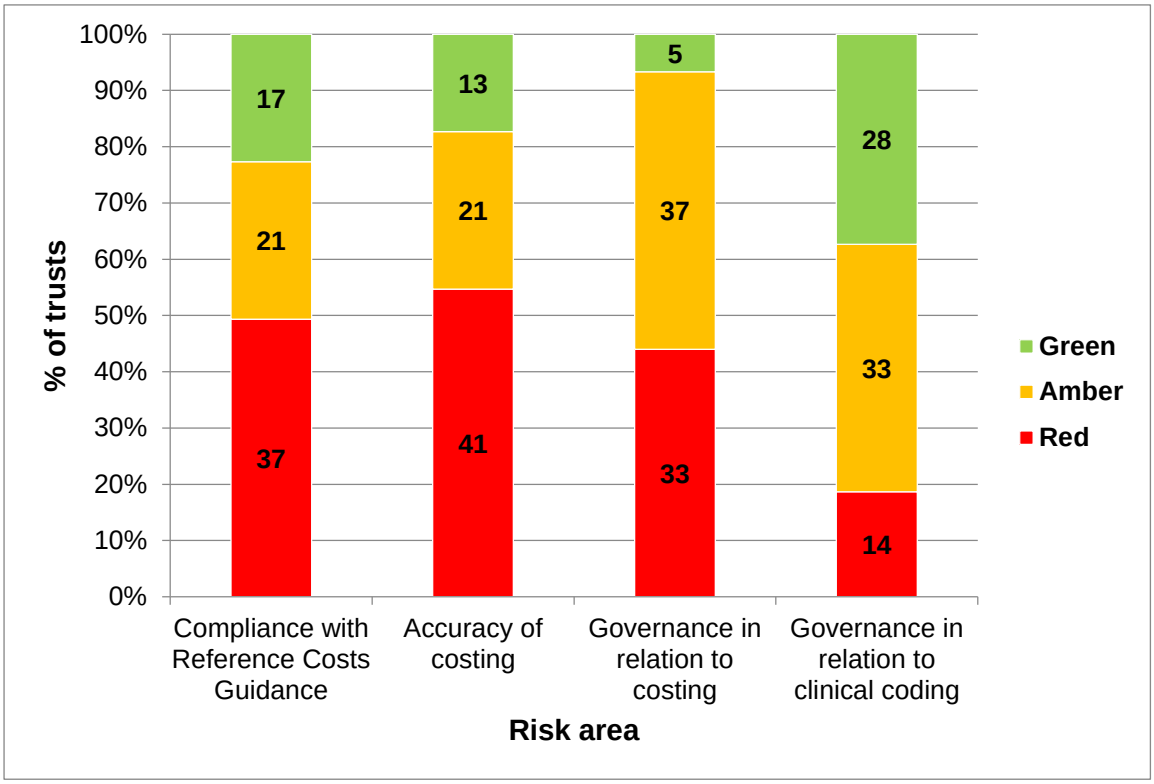
- Weak allocation and apportionment methodologies. For example, the use of standard weightings for outpatient services.
- Poor implementation of costing systems or IT constraints.
- Failure to correctly identify the total costs to include in the submission, particularly around non-NHS patients and excluded services.
- Poor supporting data, such as theatre and pathology systems.
- Poor scrutiny of reference costs by senior management prior to submission.

Only 10 of the providers audited (15%) were found to have accurate costing in each of the settings assessed. Providers with good quality costing were found to use costing information routinely to inform day-to-day decision-making. Costing information was used to hold service lines to account, to improve efficiency and to reduce clinical variation.

2.2. Risk area assessments

A summary of the findings for each risk area is shown in Figure 3.

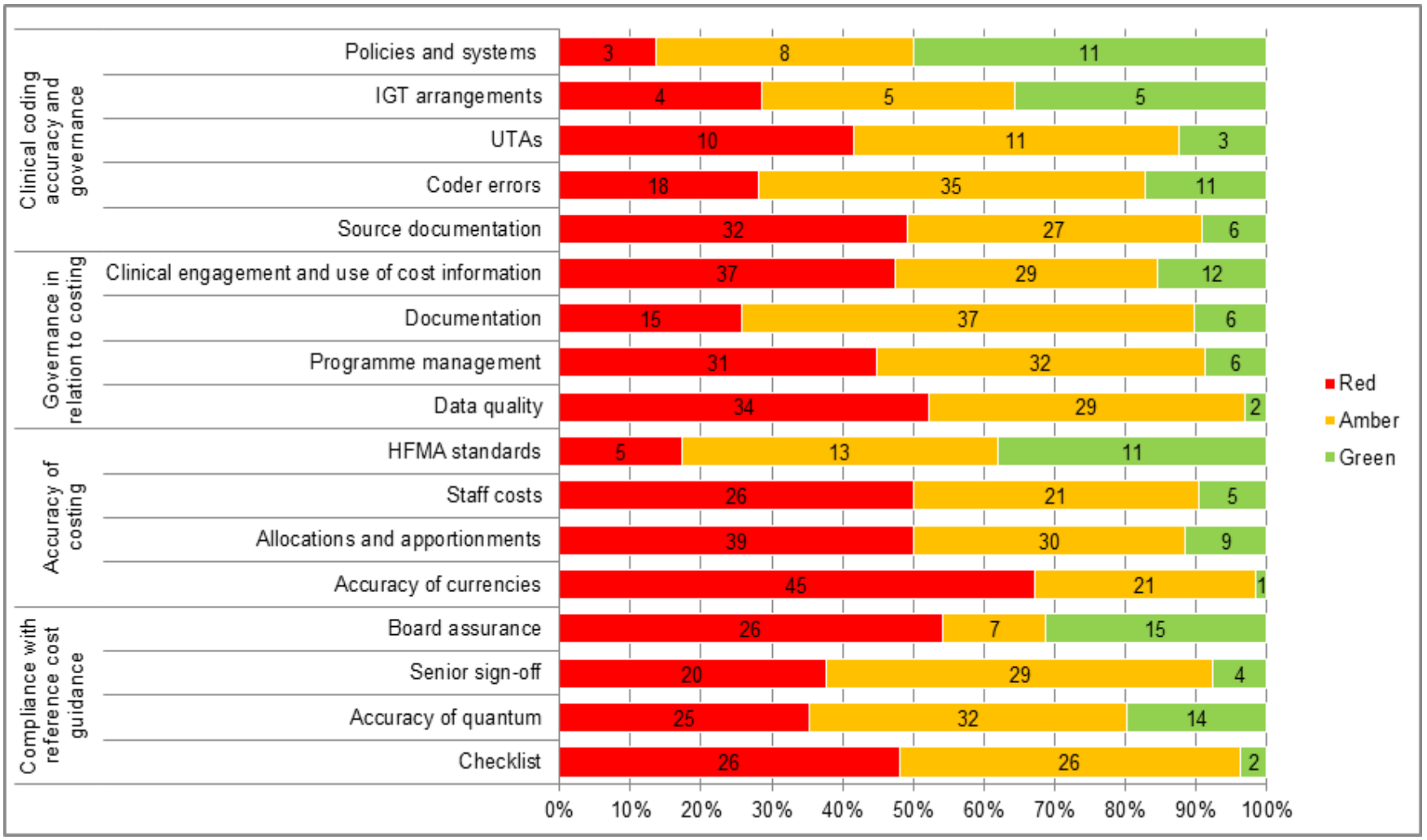
Figure 3: Findings from assessments of risk areas



There was a strong correlation between ratings for the costing risk areas. 28% of trusts were red-rated for all three of the costing risk areas and 4% of trusts were red-rated for all four risk areas.

The auditors determined the rating for each risk area after considering the number and significance of issues identified within certain sub-areas. Figure 4 shows the total number and significance of issues identified within each sub-area.

Figure 4: Total number of issues identified within each sub-area by risk rating



Most trusts did not meet the mandatory requirements in the Department of Health's reference costs guidance relating to data quality, validation and assurance. Many trusts also failed to follow the guidance on the costs that should be included and excluded.

Most trusts met the requirement to comply with HFMA costing standards in areas such as the classification of costs and the use of cost pools. However, as described in Section 2.1, many trusts still made errors in allocating costs or extracting activity data.

The audits identified a number of concerns in relation to governance arrangements for costing. In particular:

- there was limited or poor programme management and documentation for costing
- costing was often done in isolation within the finance department, with little clinical input on allocation methods or validating the unit costs
- data quality arrangements for non-admitted patient care and other data feeds for costing were also consistently poor, with little or no central assurance.

Appendix 3 contains examples of good and bad practice from trusts in each of the specific governance areas.

2.3. Clinical coding audits

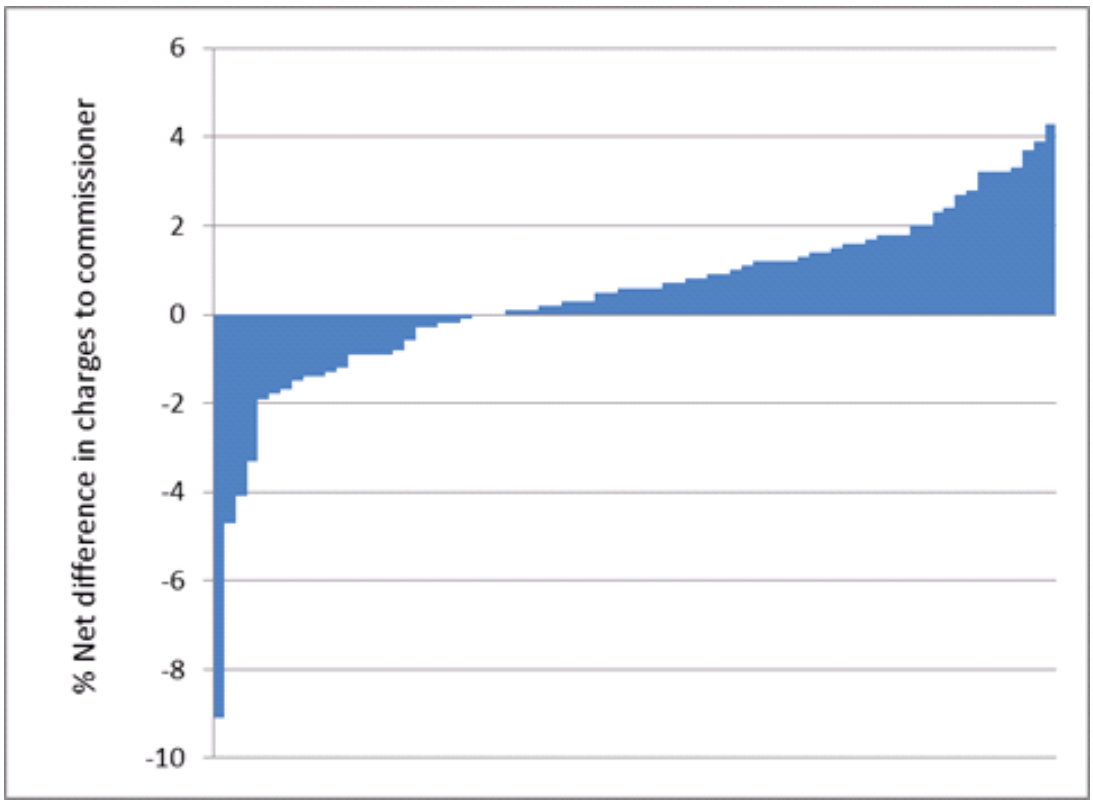
The clinical coding audit looked at 15,000 episodes of care with a total value of £21 million. Trusts' coding produced an incorrect spell price in 6.2% of episodes. The gross financial effect (summing both upward and downward adjustments) of these pricing errors was £682,000 (3.3%) and the net effect (allowing positive and negative values to set-off and partially or entirely cancel each other out) was £62,000 (0.3%).These results are summarised in Table 1.

Table 1: Gross and net financial error from 15,000 audited episodes

Gross financial error	Net financial error
£682,165	£62,177
3.3%	0.3%

The error rate identified varied significantly between providers. Figure 5 shows how the net financial effect of coding errors varies between providers.

Figure 5: Net difference in financial value of the audit samples by trusts audited



However, the sample size and selection method makes it difficult to draw statistically significant conclusions about the results of individual trusts or to make comparisons with the results from previous audits.

3. Conclusions

We are concerned that almost half of the trusts audited submitted materially inaccurate reference costs in 2013/14. Providers should be using accurate costing information to make day-to-day management and operational decisions. Accurate costing information is also a pre-requisite for Monitor to be able to set efficient and cost-reflective prices.

The requirements in Monitor's costing guidance have not changed significantly in recent years. The lack of compliance suggests that most acute trusts use budgetary rather than costing information for day-to-day management and do not see the benefit of devoting resources to producing accurate costing information. A few trusts have taken this position to the extreme by submitting reference costs based on national averages or standard weightings instead of costing information.

Monitor's costing standards should not be difficult to meet. Yet 69% of trusts were red-rated in at least one of the costing risk areas assessed.

Some trusts were found to be costing well. Those that are not could benefit by learning from these trusts. Monitor is keen to share good practice to help trusts improve the overall quality of cost information in the sector.

The findings on clinical coding were more positive than those for costing. The average error rate of 6.2% suggests that coding errors are likely to have had a smaller effect on the accuracy of reference costs than errors in costing. The governance risk area assessments for clinical coding produced much better results than for the costing risk areas, although half of trusts were still rated red or amber.

In response to these findings, we will:

- Ask all trusts to review their costing processes to ensure they are compliant with Monitor's costing guidance.
- Improve the clarity of Monitor's costing guidance, working with other organisations (such as the Department of Health's reference cost team) where necessary.
- Work with trusts to facilitate benchmarking and other activity to validate the accuracy of costing information.
- Write to the chairs of trust audit committees to ask them to ensure that action plans to address the recommendations of individual provider audit reports are implemented.
- Improve the design and operation of the audit programme to focus on the areas of highest risk.

- Consider excluding providers found to have submitted materially inaccurate reference cost submissions from the methodology for determining national prices.
- Consider whether to take enforcement action against trusts found to be non-compliant with the costing guidance.

Appendices

Appendix 1: Background and approach

The payment and tariff assurance framework (formerly the PbR data assurance framework)

- provides assurance on the quality of data underpinning payment
- promotes improvements in data quality
- supports the accuracy of payment within the NHS.

The Health and Social Care Act 2012 outlined Monitor's responsibilites for setting tariff and enforcing the payment system. To support these duties, Monitor took over responsibility for the payment and tariff assurance framework and began to provide overall managerial direction for the work programme in 2014/15. Prior to this the Department of Health oversaw the framework. This was delivered by the Audit Commission until 2012/13, when the delivery of the framework moved to Capita.

The focus of the assurance framework is to improve the quality of data underpinning payments, but the data is also of wider importance to the NHS as it is used to plan and oversee healthcare provision.

As part of the work programme to deliver the assurance framework in 2014/15, Capita:

- reviewed trusts' arrangements for producing accurate cost and payment information
- assessed the accuracy of trusts' national cost submissions (reference costs)
- completed an audit of clinical coding.

The coding and costing reviews were done to provide a view on trust performance across both areas. All audited trusts received one report covering both elements.

Approach

Between October 2014 and May 2015 Capita was commissioned to audit the 2013/14 reference cost submissions and clinical coding of 75 acute trusts. The findings from the clinical coding audit informed the findings of the reference cost audit as part of a single integrated audit.

This was the first year of a combined costing and coding audit programme since taking over the contract from the Department of Health in July 2014. A risk assessment approach established for the 2013/14 audit programme was used to inform trust selection. This year the trusts audited consisted of:

- 22 trusts deemed ‘at-risk’ of poor data quality to support local improvement (this figure included all other ‘at-risk’ trusts that had not been selected for audit last year, as well as some poor-performing trusts that were audited last year).
- 14 trusts deemed ‘low risk’ to ensure the capture of good practice.
- 39 trusts selected at random (this figure included seven ‘low-risk’ trusts).

The risk assessment[4] used to inform trust selection covered:

- previous costing audit results
- other data quality audit results from the assurance framework
- benchmarking of reference costs, based on the analysis available in the Monitor Benchmarker[5]
- local factors.

The audit methodology, agreed with Monitor, covered trusts’ processes to support accurate costing and coding, from board level down to the individual cost allocations used to determine each unit cost. Each audit comprised a:

- Review of the accuracy of the total costs included within the reference cost submission.
- Clinical coding audit of 200 patient episodes, selected using the analysis available in the Monitor Benchmarker:
    - 100 finished consultant episodes (FCEs) from an area scoring poorly against clinical coding indicators
    - 100 FCEs from an area with wide variation from national costs in the latest reference cost submission.
- Review of the trust’s approach to costing, with a targeted review of the accuracy of costing in specific specialities and services, informed by benchmarking of reference costs.
- Review of governance and arrangements for:
    - the production of costing information
    - checks on the reference cost submission
    - clinical engagement in coding and costing
    - board review and submission sign-off
    - data quality.

[4] The risk assessment identified the worst scoring 25% of trusts as ‘at risk’ based on the risk criteria. The best scoring 25% were deemed ‘low risk’. The random trusts were selected from all acute trusts irrespective of risk rating.

[5] The Monitor Benchmarker is available at www.nationalbenchmarker.co.uk.

Where trusts had implemented service line reporting or patient level costing, Capita looked at the arrangements in place to support this, and how this related to the production of the reference cost submission.

Each clinical coding audit used the Clinical Coding Audit Methodology 2013/14 v8.0, compiled by the Health and Social Care Information Centre (HSCIC). The audits also tested the accuracy of other data items that affect the price commissioners pay for a spell under PbR: age on admission, admission method, sex, and length of stay. For each of these data items the information submitted to the HSCIC's Secondary Uses Service (SUS) was verified against information in source documentation.

Audit Judgement

Capita adopted rules around materiality to guide judgements on the accuracy of the overall submission, and for the individual areas of detailed testing.

The submission was found not to be accurate if trusts failed to meet any one of the following criteria.

- If one or more of the errors identified changed the total cost quantum by 0.5%. This was identified through failure in at least one of the following areas:
    - Detailed testing of the reconciliation of trust's reference costs quantum to the audited annual accounts.
    - Issues identified through the review of costing in individual services.

- If one or more of the errors identified in the trust's costing within a service:
    - resulted in an impact greater than 5% on some or all the unit costs in the service **and**
    - the service tested reflects more than 3% of the total quantum of costs.

- If a failure of governance arrangements meant we were unable to provide assurance that the submission was correct.

The outcomes of the clinical coding audits also informed judgements around the accuracy of cost information. A detailed quality assurance process ensured consistency across audits and enabled fair and comparable judgements to be made for organisations with varying approaches to costing. The judgements made this year are consistent with those made last year.

Appendix 2: Results for all trusts audited in 2014/15

Trust name	Compliance with Reference Costs Guidance	Accuracy of costing	Governance in relation to costing	Governance in relation to clinical coding	Overall judgement	APC	Non-APC	Other	Coding judgement
Aintree University Hospital NHS Foundation Trust	Green	Green	Amber	Amber	Accurate	Good	Good	Good	Adequate
Alder Hey Children's NHS Foundation Trust	Green	Green	Green	Amber	Accurate	Good	Good	Good	Good
Ashford and St Peter's Hospitals NHS Foundation Trust	Amber	Amber	Amber	Green	Accurate	Good	Good	Adequate	Good
Barts Health NHS Trust	Red	Red	Red	Red	Not accurate	Poor	Adequate	Poor	Poor
Birmingham Children's Hospital NHS Foundation Trust	Red	Red	Red	Green	Not accurate	Poor	Poor	Poor	Good
Brighton and Sussex University Hospitals NHS Trust	Red	Red	Red	Amber	Not accurate	Poor	Poor	Poor	Adequate
Buckinghamshire Healthcare NHS Trust	Green	Amber	Amber	Green	Accurate	Good	Good	Good	Good
Calderdale and Huddersfield NHS Foundation Trust	Red	Amber	Red	Green	Accurate	Good	Poor	Poor	Good
Central Manchester University Hospitals NHS Foundation Trust	Amber	Red	Red	Amber	Accurate	Adequate	Poor	Adequate	Good
Chelsea and Westminster Hospital NHS Foundation Trust	Amber	Amber	Amber	Green	Accurate	Adequate	Good	Poor	Good
City Hospitals Sunderland NHS Foundation Trust	Amber	Amber	Amber	Amber	Not accurate	Good	Poor	Adequate	Good
County Durham and Darlington NHS Foundation Trust	Amber	Red	Amber	Green	Accurate	Poor	Poor	Adequate	Good
Dartford and Gravesham NHS Trust	Red	Red	Red	Amber	Not accurate	Poor	Poor	Poor	Adequate
Derby Hospitals NHS Foundation Trust	Green	Amber	Red	Amber	Accurate	Adequate	Adequate	Adequate	Poor
East and North Hertfordshire NHS Trust	Red	Red	Red	Red	Not accurate	Poor	Poor	Poor	Poor
East Kent Hospitals University NHS Foundation Trust	Red	Amber	Amber	Red	Accurate	Poor	Adequate	Adequate	Poor
East Lancashire Hospitals NHS Trust	Amber	Red	Amber	Green	Accurate	Adequate	Adequate	Adequate	Good
George Eliot Hospital NHS Trust	Green	Red	Red	Amber	Not accurate	Poor	Poor	Poor	Adequate
Gloucestershire Hospitals NHS Foundation Trust	Amber	Amber	Amber	Red	Accurate	Poor	Adequate	Poor	Poor
Harrogate and District NHS Foundation Trust	Red	Red	Amber	Green	Not accurate	Adequate	Poor	Adequate	Good
Heart of England NHS Foundation Trust	Red	Red	Red	Amber	Not accurate	Poor	Poor	Poor	Adequate
Imperial College Healthcare NHS Trust	Green	Green	Green	Red	Accurate	Adequate	Good	Adequate	Poor

Trust name	Compliance with Reference Costs Guidance	Accuracy of costing	Governance in relation to costing	Governance in relation to clinical coding	Overall judgement	APC	Non-APC	Other	Coding judgement
Ipswich Hospital NHS Trust	Red	Red	Amber	Amber	Accurate	Adequate	Adequate	Adequate	Adequate
Isle of Wight NHS Trust	Amber	Amber	Amber	Red	Accurate	Poor	Adequate	Adequate	Poor
Kingston Hospital NHS Foundation Trust	Red	Red	Red	Green	Not accurate	Poor	Poor	Poor	Good
Lancashire Teaching Hospitals NHS Foundation Trust	Red	Red	Red	Amber	Not accurate	Poor	Adequate	Poor	Adequate
Liverpool Heart and Chest Hospital NHS Foundation Trust	Red	Red	Red	Green	Not accurate	Poor	Poor	Poor	Good
Liverpool Women's NHS Foundation Trust	Red	Red	Amber	Green	Not accurate	Poor	Poor	Poor	Good
Luton and Dunstable University Hospital NHS Foundation Trust	Red	Red	Red	Amber	Not accurate	Poor	Poor	Poor	Adequate
Mid Cheshire Hospitals NHS Foundation Trust	Red	Red	Amber	Amber	Not accurate	Poor	Poor	Poor	Good
Mid Yorkshire Hospitals NHS Trust	Red	Red	Red	Amber	Not accurate	Poor	Poor	Poor	Good
Moorfields Eye Hospital NHS Foundation Trust	Amber	Red	Red	Green	Not accurate	Poor	Poor	Poor	Good
Norfolk and Norwich University Hospitals NHS Foundation Trust	Red	Amber	Red	Green	Accurate	Adequate	Adequate	Adequate	Good
North Middlesex University Hospital NHS Foundation Trust	Red	Green	Amber	Amber	Not accurate	Good	Good	Good	Adequate
North Tees and Hartlepool NHS Foundation Trust	Green	Green	Green	Amber	Accurate	Good	Good	Adequate	Good
Northern Devon Healthcare NHS Trust	Red	Red	Red	Amber	Not accurate	Poor	Poor	Poor	Adequate
Northern Lincolnshire and Goole NHS Foundation Trust	Red	Red	Red	Green	Not accurate	Poor	Poor	Poor	Good
Northumbria Healthcare NHS Foundation Trust	Red	Red	Amber	Green	Not accurate	Poor	Poor	Poor	Good
Nottingham University Hospitals NHS Trust	Amber	Green	Red	Amber	Accurate	Good	Adequate	Good	Adequate
Oxford University Hospitals NHS Trust	Amber	Amber	Green	Green	Accurate	Adequate	Adequate	Adequate	Good
Portsmouth Hospitals NHS Trust	Red	Red	Red	Amber	Not accurate	Poor	Poor	Poor	Adequate
Royal Berkshire NHS Foundation Trust	Green	Red	Red	Red	Accurate	Adequate	Poor	Poor	Adequate
Royal Devon and Exeter NHS Foundation Trust	Green	Green	Amber	Amber	Accurate	Good	Good	Good	Adequate
Royal Liverpool and Broadgreen University Hospitals NHS Trust	Red	Red	Red	Amber	Not accurate	Poor	Poor	Adequate	Good
Royal National Orthopaedic Hospital NHS Trust	Red	Red	Amber	Green	Not accurate	Poor	Poor	Poor	Good
Royal Surrey County Hospital NHS Foundation Trust	Amber	Red	Red	Red	Not accurate	Poor	Poor	Poor	Adequate
Royal United Hospital Bath NHS Trust*	Red	Green	Amber	Amber	Accurate	Good	Good	Good	Adequate

Trust name	Compliance with Reference Costs Guidance	Accuracy of costing	Governance in relation to costing	Governance in relation to clinical coding	Overall judgement	APC	Non-APC	Other	Coding judgement
Salford Royal NHS Foundation Trust	Green	Amber	Amber	Green	Accurate	Good	Good	Good	Good
Salisbury NHS Foundation Trust	Amber	Amber	Red	Green	Accurate	Adequate	Adequate	Adequate	Good
Sheffield Teaching Hospitals NHS Foundation Trust	Amber	Amber	Amber	Red	Accurate	Good	Good	Good	Poor
Sherwood Forest Hospitals NHS Foundation Trust	Red	Red	Red	Green	Not accurate	Poor	Poor	Poor	Good
South Devon Healthcare NHS Foundation Trust	Green	Amber	Green	Green	Accurate	Good	Adequate	Adequate	Adequate
Southend University Hospital NHS Foundation Trust	Red	Red	Red	Amber	Not accurate	Poor	Poor	Poor	Adequate
St George's Healthcare NHS Trust	Amber	Red	Amber	Amber	Accurate	Poor	Poor	Good	Good
St Helens and Knowsley Hospitals NHS Trust	Red	Green	Amber	Green	Not accurate	Poor	Good	Poor	Good
The Christie NHS Foundation Trust	Green	Green	Amber	Amber	Accurate	Good	Good	Good	Good
The Clatterbridge Cancer Centre NHS Foundation Trust	Amber	Green	Amber	Green	Accurate	Adequate	Good	Good	Good
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Amber	Amber	Amber	Green	Accurate	Adequate	Adequate	Adequate	Good
The Princess Alexandra Hospital NHS Trust	Green	Red	Red	Amber	Accurate	Adequate	Adequate	Poor	Adequate
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	Red	Red	Amber	Green	Not accurate	Poor	Poor	Poor	Good
The Rotherham NHS Foundation Trust	Red	Red	Red	Amber	Not accurate	Poor	Poor	Adequate	Adequate
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Red	Red	Amber	Red	Not accurate	Poor	Poor	Poor	Adequate
The Royal Orthopaedic Hospital NHS Foundation Trust	Green	Green	Amber	Green	Accurate	Good	Good	Good	Good
The Walton Centre NHS Foundation Trust	Green	Amber	Amber	Amber	Accurate	Good	Good	Adequate	Good
United Lincolnshire Hospitals NHS Trust	Red	Red	Amber	Red	Not accurate	Poor	Poor	Poor	Adequate
University College London Hospitals NHS Foundation Trust	Amber	Amber	Amber	Amber	Accurate	Adequate	Adequate	Adequate	Adequate
University Hospitals Birmingham NHS Foundation Trust	Red	Amber	Amber	Green	Accurate	Adequate	Adequate	Adequate	Good
University Hospitals of Leicester NHS Trust	Red	Red	Red	Red	Not accurate	Adequate	Poor	Poor	Poor
University Hospitals of Morecambe Bay Foundation Trust	Green	Green	Amber	Red	Accurate	Good	Adequate	Good	Adequate
West Hertfordshire Hospitals NHS Trust	Red	Amber	Red	Amber	Not accurate	Adequate	Adequate	Poor	Adequate
West Suffolk NHS Foundation Trust	Red	Red	Red	Green	Not accurate	Adequate	Poor	Poor	Good
Western Sussex Hospitals NHS Foundation Trust	Amber	Amber	Amber	Red	Accurate	Poor	Adequate	Poor	Poor
Weston Area Health Trust	Green	Red	Amber	Amber	Accurate	Adequate	Adequate	Adequate	Adequate
Wye Valley NHS Trust	Amber	Red	Amber	Amber	Not accurate	Poor	Adequate	Adequate	Adequate
Yeovil District Hospital NHS Foundation Trust	Amber	Red	Red	Amber	Not accurate	Adequate	Poor	Adequate	Adequate

* NHS trust at the time of submission (2013/14), now Royal United Hospitals Bath NHS Foundation Trust

Appendix 3: Examples of good and poor performance across the areas tested

Compliance with reference costs guidance

Area	Assessment criteria	Examples of good performance	Examples of poor performance leading to error
Checklist	Trusts are required to complete a self-assessment checklist to say how they checked the national submission.	- All mandatory and non-mandatory validations in the reference costs workbook investigated - Use of benchmarking information embedded, using different sources and available to services - Draft reference costs submission circulated to services for clinical review - All activity reconciled against national and local data - Outcomes of all checks documented, with an audit trail of changes made	- No checks undertaken on reference costs submission – reliance placed on PLICS or SLR - Checks only undertaken at specialty level - Checks undertaken but no time to follow up outliers - No benchmarking undertaken as trust did not see the benefit - Non-mandatory validations not investigated - Draft submission not shared outside costing team - Checklist completed inaccurately - Information reported in the checklist or survey not accurate which undermines the board assurance process.
Accuracy of quantum	The total costs (the quantum) included in the reference costs submission should reconcile back to the audited accounts and should be completed in line with guidance.	- Quantum completed or approved by chief accountant - Review of quantum part of senior sign-off process - Exclusions and amendments reviewed annually with services - Clear working papers linking quantum worksheet to final accounts and costing system outputs - Non-NHS patients identified, costed and removed from the quantum - All changes in guidance discussed with services	- Quantum completed by reference costs lead and no senior scrutiny of quantum calculations - No reconciliation made back to audited accounts or to costing system outputs, and no audit trail maintained - Changes in guidance not discussed with services - Income used as a proxy for non-NHS patients - Additional adjustments made without seeking prior approval from the Department of Health
Senior sign-off	National guidance stipulates that the reference costs submission should be subject to the same senior scrutiny as other financial returns submitted by the trust.	- Senior scrutiny part of the ongoing costing process - Frequent detailed review by deputy director of finance, linked to sign-off by director of finance - Documented senior sign-off by director of finance - Sign-off process included review of all validations, checks and benchmarking	- Costing accountant responsible for whole costing process, with no senior over-sight or support - Reference cost submission submitted by cost accountant using director of finance log-in - No review of submission by director of finance or - Senior review of costs at high-level, with no review of information that would highlight incorrect data

Board assurance	National guidance requires boards to provide visible leadership to the process costing within trusts. Each year boards must confirm that the approach to costing at the trust is satisfactory.	- Senior clinical support to costing across the services, and costing viewed as a clinical tool - Quarterly PLICS report and draft reference costs submission presented to board or delegated committee, including unit costs level information - Use of internal audit to measure compliance with national standards as part of board assurance process - A non-exec is nominated to lead on costing issues	- No board assurance process in place - No or limited costing information reported at board level - No costing strategy, and no lead clinician for costing - The reported resources for costing also undertaking income or cost improvement work - Paper presented to the board did not provide adequate supporting information

Accuracy of costing

Area	Assessment criteria	Examples of good performance	Examples of poor performance leading to error
Accuracy of currencies	Currencies are the units that activity is measured by. This ranges from episodes and spells in admitted patient to the number of high costs drugs or the repair of wheelchairs.	- All data provided centrally - Data signed off by services as part of validation of costs - Activity validated by clinicians alongside cost information - Changes in counting guidance discussed with service	- Poor quality clinical coding across all specialties - Ungrouped activity included in the submission - Poor data capture leading to inaccurate information - Data captured in line with local agreements not national definitions - Point of delivery of activity incorrectly identified - Community data incomplete and incorrect - Activity for individual services based on previous years without validation with service
Allocations and apportionments	The costing principles in Monitor's approved guidance describe how costs should be accurately identified and then allocated to currencies in the way that best describes the costs of the care being delivered.	- Bases of allocations reviewed and signed off by all services in-year - Theatre time split between used and unused time - downtime is allocated separately - Costing team has access to floor area system - Each theatre and each ward has its own cost pool - where more than one specialty uses a theatre, there are allocation keys used to split those costs - Patient level information available for all material cost drivers, including prosthesis and devices	- No costing system in place – submission completed using spreadsheets - National prices used as a proxy for real information - Standard weightings used that have not been agreed with services - Allocations and cost drivers not reviewed annually or verified with services - Income used as a basis for apportioning costs - PFI and CNST not allocated correctly - Use of very small number of cost pools

Area	Assessment criteria	Examples of good performance	Examples of poor performance leading to error
Staff costs	Staffing is the main cost driver at any healthcare organisation, and often accounts for the majority of costs allocated to a service.	- Access to electronic job planning or staff rota system - Measuring nursing acuity - All job plans are reviewed and signed off on a quarterly basis as part of the performance management process - Individual staff grades identified separately and junior doctors' time is allocated from their rotas - In year changes are included in calculations - Job plans accurately identify clinical and teaching activity - Individual costs codes for staff type, or for specific consultants.	- Out of date job plan used after major reorganisation of hospital - No differentiation in staff grades, including junior doctors allocated using senior consultant job plans - Standard weightings used instead of job plans, with no input from service - Staff costs based on subjective codes that were not accurate - No process for differentiating emergency costs such as on-call activities.
HFMA standards	HFMA standards describe how costs should be classified, how cost pools should be organised, and how income and other non-patient activities should be handled.	- Clear classification of costs in line with national standards - Cost pools in line with national standards - Income and non-patient activity handled in line with national standards	- No use of HFMA standards - Cost pools not in line with national standards

Governance in relation to costing

Area	Assessment criteria	Examples of good performance	Examples of poor performance leading to error
Data quality	National guidance mandates that the activity information submitted by trusts be an accurate reflection of the care delivered.	- Clear and recognised senior accountability for data quality - All data quality issues monitored through a data quality group with a robust risk log - Issues identified through data quality audits followed through and addressed - Data audit programme with formal reviews of the accuracy and completeness of data for service line reporting - informatics team has ownership of all data, not just admitted patient care, and provide all information for costing - Formal and ad hoc checks on all areas of activity	- No centralised assurance of data - presumption that services check data quality when no processes in place - No checks to ensure data provided by informatics is in line with reference costs guidance - No audit programme for outpatient, A&E or any other non-admitted patient care service - Costing team responsible for sourcing data from services - Data estimated or collected manually - No clear strategy to address issues caused by new PAS implementations

Area	Assessment criteria	Examples of good performance	Examples of poor performance leading to error
Programme management	Trust should establish formal programme management arrangements for the production of cost information that enforce accountability at the different stages of cost production.	- Costing groups chaired by senior clinician - Clear lines of accountability for the review and validation of cost information - Programme plan covers clinical engagement and the process for checking the reference costs submission - Process for senior sign-off and board assurance linked to costing programme management - Data quality and informatics support monitored by costing groups	- Costing undertaken in isolation with no support from divisional accountants - No formal governance in place for costing and no senior scrutiny of cost accountants work - Costing plan unrealistic and does not include time to validate and review outputs - Reference costs not viewed as within remit of costing group - Poor IT support resulting in system failure - Reference costs viewed as low priority by informatics - Reliance placed on contractors to complete submissions
Documentation	All aspects of cost production should be transparent and repeatable.	- Costing calculations are transparent and described on the trust dashboard for clinicians - Operational notes maintained for all aspects of the process - Data sources are recorded for all services - Known issues log is maintained and shared throughout finance, and audit trail of all changes made maintained	- No documentation of costing process - System instructions viewed as satisfactory documentation - Single hardcopy sheet of allocation methods with no audit trail when changes made - No explanation of calculations when engaging with clinicians - Known issues and risk not captured or managed.
Clinical engagement and use of cost information	Clinical ownership of financial information is a key requirement of national guidance to ensure care accurately reflects the costs of care delivered.	- Cost information is routinely used by services for analysis and decision-making - Business cases and savings plans based on same information submitted in reference costs - All allocation bases and resultant costs are validated and signed-off by clinicians on an annual basis - Clinicians validate both PLICS/SLR costing and reference costs - Clear programme of roll-out and engagement to ensure all services use and trust PLICS data - Costing outputs are refined with clinical input to catered outputs for different clinical groups	- No costing information shared with services - Reference costs completed by cost accountant with no clinical engagement - Assumption that clinicians will not be interested in costing - Fear of sharing information until completely accurate - Granular unit costs not shared with clinicians - presumption that service line reporting represents clinical engagement in reference costs - Cost information shared without follow up or support from divisional accountants - Lack of resources within finance and clinical teams to engage

Clinical coding accuracy and governance

Area	Assessment criteria	Examples of good performance	Examples of poor performance
Source documentation	Case notes and other source documentation are a medico-legal document, and as such must accurately, completely and clearly describe treatments and illnesses.	- Well-structured and ordered case notes - Use of discharge summaries for day case activity that are complete and consistent with case notes - Typed operation notes - Integrated electronic systems that contain complete information - Clear definitive diagnoses for emergency and complex patients - Case note audit to identify issues with documentation	- Information not in chronological order or by specialty, loose pages in notes, large volumes of notes held together by bands - Illegible hand writing, abbreviations and diagrams used instead of clear clinical notation - Discharge summaries and coding pro-forma used as the basis for coding which are incomplete or inconsistent - Use of electronic systems that do not store information in the correct order - No or poor information in the notes on cancelled operations - Pro-forma for routine attendances not filed on time - No clear definitive diagnoses
Coder errors	National coding standards mandate that clinical information should be coded in line with latest national guidance.	- Adherence to national standards - Accurate extraction of information from case notes - Correct indexing of information to identify the most appropriate codes (Indexing is the process a coder follows to identify the most appropriate code for the diagnosis or treatment).	- Failure to use latest coding standards - Poor data extraction when information is clear in case notes - Use of unspecific codes when more specific ones are available - Failure to code secondary information, such as comorbidities, when the information is clear in documentation - Incorrect sequencing of codes (will impact on payment)
IGT arrangements	The trust must complete the HSCIC's information governance toolkit (IGT) on an annual basis, which includes information on how trusts ensure coding is accurate.	- Detailed audit programme for clinical coding - All coding staff are ACC qualified - Accuracy of information provided for coding linked to clinical revalidation - Good system of career progression in the department - Routine engagement with clinicians to raise understanding of how activity is and can be coded - Monthly validation of coding, including sharing main procedures and diagnosis coded - Use of analysis to validate coded data prior to submission - A robust programme of training in place including regular external training and mentoring for trainee coders	- No auditor or trainer in post - No programme of audit in place to check the accuracy of coded data - High proportion of trainee coders - Limited to no use of external training - No validation of coders work by senior coders - No validation of coded data by clinicians - Clinical engagement only in limited specialties - No accountability with clinicians for the accuracy of their data - Coding done in isolation with no input from informatics or finance

Policies and systems	Any local policies, processes and systems must conform to national standards.	- Local coding policies are reviewed and updated on a quarterly basis - All local policies are in line with national guidance - IT systems support accurate coding	- Clinician specifications contravened national coding standards - Local policies out of date and not in line with national guidance - IT systems pre-code patients without coders validating against case notes

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

This publication can be made available in a number of other formats on request. Application for reproduction of any material in this publication should be made in writing to enquiries@monitor.gov.uk or to the address above.

© Monitor (September 2015) Publication code: IRRES 14/15