

Summary of stakeholder responses to the *Strategic Options for Costing* report

3 September 2012

Alongside the publication of the report [Strategic options for costing](#) we asked stakeholders to comment in particular on the recommendations made by PwC, the suggested implementation timescales, and the applicability of the recommendations to non-acute care settings.

This document is a summary of responses and includes the main themes and key findings we have taken from the feedback.

Summary of stakeholder responses to the *Strategic Options for Costing* report

Introduction

Under the Health and Social Care Act (2012), Monitor and the NHS Commissioning Board will have joint responsibility for pricing NHS services in England. One of the key findings of the report [An evaluation of reimbursement systems for NHS funded care](#) was that the information underpinning the current reimbursement system requires significant improvement. To help us understand how this might be achieved in respect of cost data, we commissioned PwC to consider possible options. The report, [Strategic options for costing](#) made recommendations to Monitor on how to improve the methodology, collection and assurance of the costing data required for pricing.

We asked stakeholders to comment in particular on the recommendations made by PwC, the suggested implementation timescales, and the applicability of the recommendations to non-acute care settings. We received twenty-seven responses from a range of stakeholders. We have reviewed these responses carefully and this document highlights the key issues identified (see Appendix A for a summary chart of responses). The quotes from stakeholders included in this document do not necessarily reflect Monitor's policy, which continues to be under development.

Monitor has also been engaging with stakeholders through other means, such as a joint [webinar](#) with the Healthcare Financial Management Association (HFMA) and PwC. The webinar was attended by over 500 people from across the health sector. In the webinar we conducted live voting, the results of which are shown in Appendix B. We will continue our stakeholder engagement with a particular focus on mental health and community service providers through other forums, such as workshops.

In the coming months we intend to publish further details of our approach to costing in the future, which will contain further details of plans for improving the cost data that will be used to inform pricing in our new role. In particular, we will be developing with the NHS Commissioning Board an overall approach to pricing, which our future programme of work on costing will support. As a result we have not included Monitor responses to the feedback in this document, but we will be taking the feedback into account as both pricing and costing are developed. As part of developing our strategy, we will be conducting further research to address some of the issues identified by stakeholders.

What we asked

We asked stakeholders five questions based on the recommendations of the *Strategic Options for Costing* report. These are shown in Table 1 below.

Table 1: Consultation questions

1. *Do you have any comments on the need for further development of a standardised costing methodology?*
2. *Do you agree that Monitor should move towards collecting a representative sample of more granular patient-level data to inform its price setting?*
3. *Do you agree that assurance processes should be focused on self-assessment and peer review, with a targeted approach to external assurance?*
4. *Do you have any comments on the practicality of implementing the recommendations in the time scales indicated in the report?*
5. *Do you agree that the recommendations in this report are also applicable to mental health and community services and do you have any views on how they could be implemented in these settings?*

Who responded

We received responses from individual providers, healthcare public bodies, and others. A full list of the respondents is included in Appendix C. Since most provider responses came from the acute sector, our intention now is to encourage further stakeholder engagement on costing from mental health and community service providers. We also received responses from representative bodies, such as the Foundation Trust Network and the HFMA.

Summary of the responses

Several responses referred to issues such as currency design and pricing methodology. Whilst we recognise the importance of these issues, and their relationship with costing, in this document we have focused on the responses that relate more directly to costing.

Question 1: Do you have any comments on the need for further development of a standardised costing methodology?

There was strong agreement in the responses that the methodology of costing should be developed further. The majority of votes received through the webinar also agreed with this recommendation. Most respondents believed a standardised methodology would bring consistency benefits for Monitor, providers and the sector more generally.

“Mandating standards for costing should ensure consistency across providers as for too long the costing methodologies used were too varied and not accurate.”

Most respondents also agreed that the standardised methodology should draw from the HFMA Clinical Costing Standards.

“The work of the HFMA in developing and disseminating the costing standards has been beneficial to all sectors of NHS, and not just in terms of setting prices and [we] support using these in developing the methodology.”

However, some had specific concerns about the HFMA Standards and other guidance documents, such as the absence of a standard on matching¹ or work in progress², the costing of non-NHS patient care income³, and issues relating to cost pool⁴ design. Respondents noted that changing their costing methodology would be costly and time consuming. Another common theme was that the existing guidance needs to be streamlined, as there is some confusion about the different documents. For example:

“There are far too many guides/guidance notes for Costing professionals to adequately use at costing collection time. It would be desirable to consolidate.”

Others raised the point that a mandatory methodology alone is not sufficient to improve costing. Good costing also relies on the quality of underlying activity and other information, the capability and integration of costing systems, and the engagement of clinicians. Several respondents believed that systems certification, an option presented in the costing report, should be considered further because standardisation of patient-level information and costing systems (PLICS) might benefit the sector.

¹ Algorithms used to link patient events from fragmented activity recording systems onto a single patient record.

² Treatment of costs incurred for incomplete Finished Consultant Episodes at the time of reporting.

³ “Non contractual” or “Category C” income. See [Attributing the costs of health & social care Research & Development](#), Department of Health (2012) for further explanation.

⁴ Grouped types of costs such as wards or theatres. See Standard 2 of the HFMA [Acute Health Clinical Costing Standard 2012/13](#) for further explanation.

Question 2: Do you agree that Monitor should move towards collecting a representative sample of more granular patient-level data to inform its price setting?

This question concerns the cost data Monitor should collect and from whom it should collect. The Department of Health currently collects average cost by Healthcare Resource Group. The collection applies to all NHS and Foundation Trusts. The PwC report recommended that Monitor should collect more granular data for validation and benchmarking purposes. PwC also recommended that in the short run this could be achieved by collecting costs from a representative sample of providers who are able to cost to a certain standard. Over time the collection could be broadened to include more providers.

Should Monitor collect more granular data?

Most respondents agreed that collecting patient-level costs and/or cost pool-level data would give Monitor a richer database for validation and pricing. One respondent noted that linking this to outcome data would make more sophisticated pricing possible. Some respondents recognised that this data would also be valuable for other purposes, such as benchmarking:

“[We] agree with splitting costs in to cost pools . . . there is also an additional opportunity for benchmarking for providers from this level of data that can support internal operational improvement. Historically it has only been possible to compare costs to an overall national average, and if there is a variance, trusts may not be able to see whether it's due to [length of stay], theatre minutes, therapies, diagnostics etc.”

However, the collection of more granular data did raise some concerns about Monitor's ability to process large volumes of data. Others expressed concern that the costs of moving to a patient-level collection, for the sector and Monitor, may outweigh the benefits.

“The chief concern we would have is the ability of [Department of Health]/Monitor to procure systems capable of much larger and more granular data collections, and the associated development of the guidance, specifications and data protection rules in this regard.”

Should Monitor collect from a representative sample of providers?

The respondents had mixed views on sampling. Many provider respondents expressed a willingness to be included in a sample group. Others recognised that sampling was a necessary stepping stone to allow Monitor to develop its collection capacity and costing guidance, and the sector to develop its costing systems and capabilities. In the webinar voting, approximately half of respondents supported a representative sample. The other half supported a two tier collection, where all NHS providers submit costs, but only a subset of high quality data is used for pricing.

“We definitely believe that price setting should exclude outlier submissions and an accredited sample is clearly the best solution so long as it is truly representative.”

Several concerns were expressed about sampling including:

- Risk of deterioration of costing at providers not in the sample group
- Difficult to obtain a truly representative sample
- Importance of transparency in sample selection
- Risk of under-representation of specialist services
- Incentives/reimbursement required for participation in the sample.

Question 3: Do you agree that assurance processes should be focused on self-assessment and peer review, with a targeted approach to external assurance?

There was general agreement that some combination of self assessment, peer review and external assurance would be appropriate. However, there was disagreement about the right balance between these three approaches.

Many responses supported peer review in principle, as a way of sharing best practice; this was also reflected in the webinar voting. One respondent suggested this could take place in small regional groups. But there were concerns about the practicalities of peer review, such as training and resource implications. Some respondents noted that there may be commercial issues with sharing cost information with competitors:

“It would be useful and beneficial to promote and create costing groups to discuss the standards; how well they are implemented and practical issues, this would create greater harmonisation and allow some level of peer review and comparison.”

“Peer review could become ‘political’ between organisations as providers do compete for market share so this would need to be handled carefully; and with data protection and data sharing protocols developed.”

Some respondents strongly supported a greater role for external assurance. Recognising that external assurance is costly, and that there is a shortage of expertise, one respondent still argued that it is the only way to build greater confidence in cost data:

“We understand the expense of carrying out external reviews but feel strongly that reference costs should have been audited ... Finance functions within the NHS are not good at peer reviews and self-assessment and would need to learn from the clinical disciplines such as cancer but this will take time. If we are going to have tariffs that are not going to be challenged every time they are published, external assurance is the only [way] for this to be minimised.”

Many respondents mentioned Materiality and Quality Scores (MAQS) – a tool developed by the HFMA for measuring the quality of costing. Respondents recognised the potential of the tool for comparing costing across providers and for identifying where costing could be improved. Some respondents were concerned that, without rules on matching, MAQS were open to manipulation (e.g. a provider could increase its MAQS artificially by using a looser matching rule).

“It is also worth noting that the MAQs is a tool with great potential, which should definitely be developed.”

“Self-assessment via MAQs is one route but they need to be robust. At present there are no ‘rules’ as to matching parameters. If the parameters are wide enough, everything will match and a perfect score will result. Rules must be set in order for MAQs to be meaningful.”

Several respondents expressed a view that elevating Reference Cost sign-off to Board level may reduce the time available for costing. One respondent suggested focusing Board sign-off on the costing process, rather than on the costs themselves, to address this timing issue.

“The timing of this sign off may need to be considered. Organisations may be required to convene a specific board meeting in order to obtain sign off or the board may require evidence before signing off that may not be available until June / July when cost calculations and reviews are complete. We would suggest that boards would be able to sign off on the processes undertaken to calculate costs rather than the actual costs calculated within current reporting timescales.”

Question 4: Do you have any comments on the practicality of implementing the recommendations in the time scales indicated in the report?

Many respondents thought that the time scales were ambitious but achievable. Some respondents thought that this ambition was necessary given the scale of the problems. Others suggested delaying the timetable to give more time for the sector to adjust.

“The time scales are very challenging but this is long overdue and we have to try and get our costings more accurate as quickly as possible. We should try and deal with the issues as they come up. Lengthening the time scales will not make this transition problem free.”

The following issues were suggested as risks to the time scales:

- Monitor’s ability to collect and process large volumes of patient-level data
- Scarcity of PLICS expertise, both in terms of cost accountants and software developers
- Pressure on resources from other commitments and from cost saving programmes.

Some respondents noted that, although PLICS is not yet universal, there are relatively large existing PLICS datasets that Monitor could collect immediately to begin analysis, such as from the benchmarking user groups.

Question 5: Do you agree that the recommendations in this report are also applicable to mental health and community services and do you have any views on how they could be implemented in these settings?

Most respondents agreed that the recommendations were applicable to mental health and community services in principle. However, many also recognised that weaker activity data will delay the implementation of PLICS in other care settings, especially community services.

“Having just taken on our local community services, I can confirm that it will take time before the activity data is available to allow any kind of patient level costing for community services”

“Costing systems, particularly within community services are not sophisticated enough to calculate patient level costs”

Several respondents highlighted the need for transitional arrangements to enable the spread of Payment by Results into mental health and community services whilst patient-level costing is developed.

“Acute sector reference costs (and activity data) is – by and large – sufficient for the purposes of setting the existing tariff. The main data problems lie in expanding the tariff to the rest of acute sector activity and into mental health and community services.”

“These recommendations are primarily for acute, though in theory they could apply to mental health and community once tariff extends; however, patient level costing is less well developed in these sectors. Therefore there will need to be a separate way of setting tariffs in those sectors in the medium term. This is a significant challenge as a greater pace is needed to move forward the development of payment systems that encourage/support integrated care pathways.”

Appendix A

Heat map of the 27 responses received

Methodology note

We did not directly ask respondents to state “agree” or “disagree”. We have interpreted this from the written responses. There is an element of judgement in this interpretation so the results shown here are for indicative purposes only.

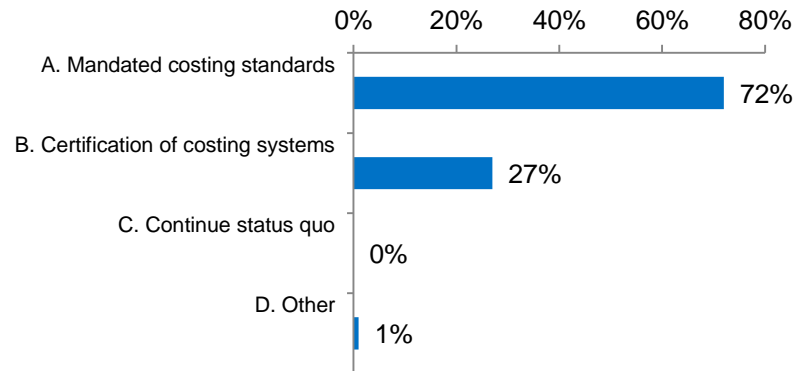
Key	
Strongly agree	Agree without caveats
Agree	Agree with caveats
Disagree	Disagree due to practical objections
Strongly disagree	Disagree due to principled objections
n/a	No clear view

Respondent Type	1. Do you agree with methodology recommendations?	2. Do you agree with collection recommendations?		3. Do you agree with assurance recommendations?	4. Do you agree with recommended implementation timeline?	5. Do you agree that the recommendations are applicable to other care settings?
		More granular data	Sampling			
Acute providers	Strongly agree	Strongly agree	Strongly agree	Strongly disagree	Strongly agree	Strongly agree
	Strongly agree	Strongly agree	Strongly agree	Strongly disagree	Strongly agree	Strongly agree
	Strongly agree	Strongly agree	Disagree	Strongly disagree	Disagree	Strongly agree
	Strongly agree	Strongly agree	Disagree	Strongly disagree	Strongly disagree	Strongly agree
	Strongly agree	Strongly agree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly agree
	Strongly agree	Strongly agree	Strongly disagree	Disagree	Disagree	Strongly agree
	Strongly agree	Strongly agree	Strongly disagree	Disagree	Disagree	Strongly agree
	Strongly agree	Strongly agree	Strongly disagree	Disagree	Disagree	Strongly agree
	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly agree
	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly agree
Mental health and community providers	Strongly agree	Strongly agree	Strongly agree	Disagree	Strongly agree	Strongly agree
	Strongly agree	Strongly agree	Strongly agree	Strongly disagree	Strongly disagree	Strongly agree
	Strongly agree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly agree
	Strongly agree	Strongly disagree	Strongly disagree	Strongly disagree	Disagree	Strongly agree
Other responses	Strongly agree	Strongly agree	Strongly agree	Strongly disagree	Strongly disagree	Strongly agree
	Strongly agree	Strongly agree	Strongly agree	Strongly disagree	Strongly disagree	Strongly agree
	Strongly agree	Strongly agree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly agree
	Strongly agree	Strongly agree	Strongly disagree	Strongly disagree	Strongly disagree	Disagree
	Strongly agree	Strongly agree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly agree
	Strongly agree	Strongly agree	Disagree	Strongly disagree	Strongly disagree	Strongly agree
	Strongly agree	Strongly agree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly agree
	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly agree
	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly agree
	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly agree

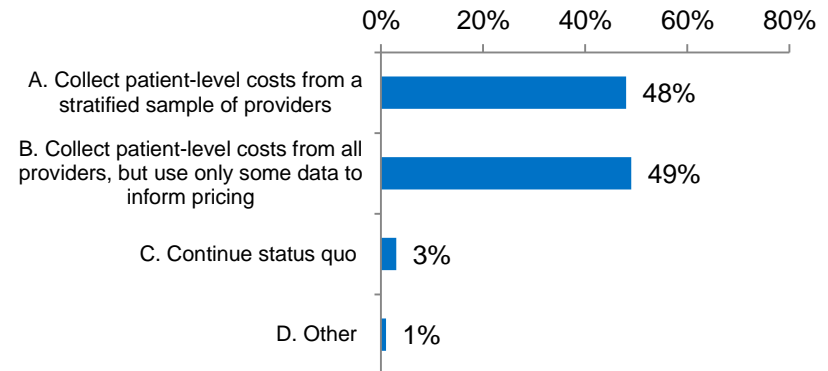
Appendix B

Webinar voting question responses¹

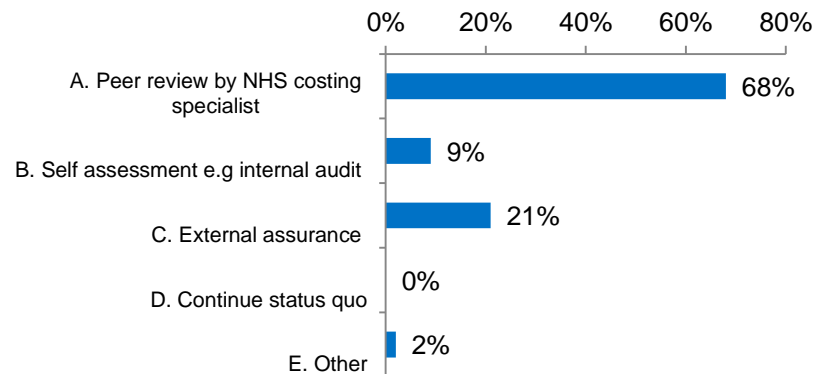
Q1. What is your preferred option for improving the methodology of costing? 129 respondents



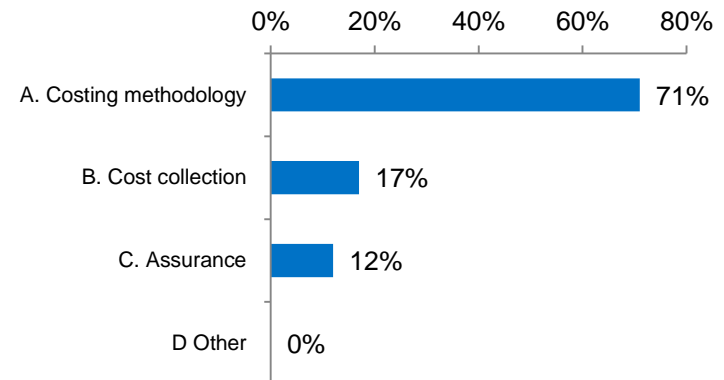
Q2. What is your preferred option for improving cost collection? 113 respondents



Q3. What is your preferred option for improving assurance of costing? 129 respondents



Q4. In your view, what is the most important area for Monitor to focus on to improve costing? 104 respondents



¹The webinar took place on 24 July 2012 and can be accessed [here](#). The voting results are indicative only and voting was optional. The majority of webinar attendees were NHS costing professionals.

Appendix C

List of stakeholder respondents

Alder Hey Children's NHS Foundation Trust
Audit Commission
Chelsea and Westminster Hospital NHS Foundation Trust
Chesterfield Royal Hospital NHS Foundation Trust
Colchester Hospital University NHS Foundation Trust
Derbyshire Community Health Services NHS Trust
Dorset HealthCare University NHS Foundation Trust
Foundation Trust Network
Great Ormond Street Hospital for Children NHS Foundation Trust
Healthcost User Group
Healthcare Financial Management Association
Imperial College Healthcare NHS Trust
Member of the public
NHS Partners Network
NHS Sustainable Development Unit
Oxford University Hospitals Trust
RSR Consultants Ltd
Sheffield Teaching Hospitals NHS Foundation Trust
Shelford Group
Somerset Partnership NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust
Specialist Orthopaedic Alliance
The Royal College of Radiologists
University College London Hospitals NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
University Hospitals Southampton NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust

Monitor, 4 Matthew Parker Street, London SW1H 9NP

Telephone: 020 7340 2400

Email: enquiries@monitor-nhsft.gov.uk

Website: www.monitor-nhsft.gov.uk

© Monitor (September 2012)

Publication code: IRCP(R) 14/12

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-nhsft.gov.uk or to the address above.

