Richmond House
79 Whitehall
London
SW1A 2NS

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Dear Colleague

Have you ever wondered how the Department of Health arrived at a price for a particular orthopaedic procedure?

More than 300 frontline clinicians are involved, across different specialties, either through membership of the Expert Working Groups advising on HRG design or through the Payment by Results Clinical Advisory Panel, in work that helps to create the structure of the national tariff. The prices in England however, (which are also used for benchmarking purposes in other parts of the UK), are largely based on the annual collection of costs from NHS trusts known as the Reference Costs. The accuracy of the tariff is therefore only as good as the accuracy of the reference costs: as seen in the example below:

> HRG HB21C – Major knee procedures for non trauma category 2 without cc has a national average unit cost of £6,033 for NHS trust and PCT elective inpatient data.
>
> One trust submitted an average unit cost of £14.82 per procedure
>
> The same trust submitted £28, 640.10 for the one day case they carried out in this HRG

We are writing to bring your attention to a programme of work aimed at encouraging greater involvement from orthopaedic surgeons into the annual reference costs collection process and to highlight the associated benefits for your organisation.

We would also like to let you know how to get involved in this work and how your involvement can help drive up the quality of data submitted to the Department of Health..

Why is clinical engagement important?

Reference costs are usually generated by Finance Departments but they depend on some key data other than costs. For example:

- Length of stay
- Time spent in theatre
- Time spent in critical care/rehabilitation

- Implant/drug/device costs
- Complications and co-morbidities
- Costing methodology

Clinical information therefore needs to be of the best possible quality to ensure that the reference costs return is an accurate reflection of the activity undertaken by your organisation. Your reference costs team will be expected to take such data into consideration when undertaking costing – this is set out in guidelines known as the Clinical Costing Standards and NHS Costing Manual.

As well as reference costs, the Department has been encouraging NHS organisations to implement patient level costing and information systems (PLICS).

PLICS can also be used to provide service line reporting information and gives an understanding of where resources are utilised and where there are variations in cost and their causes. Reporting costs at this level gives you, the clinician, greater ownership of the data and a better understanding of resource decisions.

What can you do?

To help improve the quality of reference costs the Department's PbR team want to work with organisations to:

- review the data collection process,
- refine the guidance and advice,
- look further into the relationship between reference costs and PLICS and the relationship between reference costs and tariff.

An **orthopaedic specific working group** has been established and will be reporting in 2011. For this group the main focus will be reviewing orthopaedic activity and cost data with a particular focus on the relationship between reference costs and PLICS. The group will also review the current methodology of reference cost collection, with special focus on data validation , the aim being to decrease the variation that currently exists between trusts.

If this work can improve the quality of the submitted costs it will reduce the amount of adjustment the PbR team currently has to undertake to draft prices. More accurate prices should lead to more confidence in the tariff and a greater willingness to use the data for other purposes such as business management.

In the meantime, we strongly recommend that you make contact with your finance colleagues so that you can be fully engaged in the process of improving the quality of reference costs within your organisation. Things you could ask to discuss are:

- How your trust records and reports data from your work area
- How your trust produces its costs
- How your trust validates the data which is produced – would you have spotted the £14 knee procedure?
- How year on year activity and costs compare
- How your data compare to nationally published reference costs
- How your data within the trust varies and why
- What plans your trust has for implementing Patient Level data
- How you can improve communication between clinical, IT and finance staff

By engaging in this process you will improve your own data and, through the link between the reference costs and the national tariff, the price all organisations receive for their orthopaedic activity. Please take the time to make this happen.

If you have any queries regarding reference costs centrally, please contact the reference costs team via: pbrdatacollection@dh.gsi.gov.uk.

Martin Campbell
Deputy Director NHS Finance
Head PbR Development
Department of Health

Rohit Kulkarni
Consultant Shoulder and Elbow Surgeon
Deputy Chair
Orthopaedic Expert Working Group

Joseph Dias
Professor of Hand and Orthopaedic Surgery
Vice President
British Orthopaedic Association

The Department of Health in partnership with the British Orthopaedic Association

Annex A - Background – what are reference costs?

Reference costs have been collected annually from 1998 as a result of the 1997 White Paper *The New NHS*. They are the richest source of financial data available about the NHS held by the Department. The Department collects cost and activity data from all NHS providers. Costs are collected at an aggregate level. In 2009-10 reference costs were collected from over 400 organisations, this data details over £51 billion of NHS expenditure. In order to support organisations identifying what activity should be reported and how this should be costed, Each year the Department issues the Reference Costs Collection Guidance which is supported by the NHS Costing Manual, the two documents can be found at the costing pages of the Department's website:

http://www.dh.gov.uk/en/Managingyourorganisation/NHScostingmanual/index.htm

The key concepts and principles for costing in the NHS are outlined in the NHS Costing Manual, these include:

- Reference costs are retrospective, the resultant quantum of costs should be reconciled to final accounts;
- The mandatory submission is composed of activity and unit cost data reported on an episode basis;
- Reference costs are based on full absorption costing;
- In preparing reference costs, the emphasis is on the cost of delivering a service, and not the funding streams that are used to recover these costs.

The fundamental premise is that reference costs should be produced using full absorption costing. Each reported unit cost should include the **direct, indirect and overhead costs** associated with providing that treatment/care. The costing process should also be transparent with a clear audit trail. The costs should be directly allocated to specialty level and where this is not possible, appropriate apportionment methodology should be used.

Reference costs are the responsibility and signed off by each organsation's Director of Finance.

Data quality and the Review of Reference Costs

Over the last few years, a number of questions have been raised about the quality of reference costs. In response the Department recently carried out an exercise in partnership with the Audit Commission to examine quality, uses and fitness for purpose of the collection. Outcomes of the Review of Reference Costs can be found at:
http://www.dh.gov.uk/en/Managingyourorganisation/NHScostingmanual/DH_104762

There is no doubt that year on year the quality of costing data appears to be improving, but more work needs to be done in order to ensure good quality data is submitted by all organisations. In order to support this PbR has formulated an action plan for reference costs introducing several workstreams. The commitments include supporting the Audit Commission in audits of reference costs within provider organisations and the assembly of the Reference Costs Advisory Group (RCAG).

The RCAG is comprised of representatives from the Department, the NHS Information Centre and colleagues from NHS provider organisations and SHAs. The group is contributing to several current workstreams including the production of reference costs guidance; a guide to best practice for producing the reference costs return, and; supporting work on data validation, to help organisations ensure the accuracy of their data prior to submission.