Monitor

Making the health sector work for patients

2012/13 Patient level cost collection: review and lessons for the future

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

Foreword

The 2012/13 patient level cost collection for admitted patient care was the first of its type for Monitor and its partners. Given that it was a voluntary exercise we were delighted with the response, with 66 trusts participating in total.

Following the close of the collection window in September 2013, we provided some initial feedback on the collection through a webinar in November, and just before the Christmas holidays distributed an analysis tool which allows trusts to compare their cost data to other participant trusts.

With over 7 million patient episodes, representing over £13 billion in costs, this is an outstandingly rich information source. We have since been assessing the dataset to understand as much as we can about the quality and consistency of the data.

The information we received in all the discussions we had on costing practices is enormously encouraging. It reflects what we found to be systematically reasonable approaches to connecting the resources used to the patient receiving care.

Of course there are improvements to be made. There is a clear need to continue to work on the quality of data on which the costing processes are based. Additionally, if we are to consider patient level costs for price setting, and providing increasingly meaningful benchmarking information, then we need to work hard on the consistency of the approaches taken by trusts.

The current PLICS collection guidance and the Clinical Costing Standards developed by the Healthcare Financial Management Association are a good starting point and looking forward we need to concentrate our efforts to further align costing processes, balancing the need to reach a pragmatic approach that all trusts can adopt with the desire to develop and pursue best practice.

The findings in this document have been presented with two main goals: firstly, to highlight aspects of last year's collection where issues were evident, with practical guidance on how to resolve these issues; secondly, to indicate the likely areas of development for next year's collection so that trusts can begin to consider how they might adapt to the changes.

We hope that this document will be helpful to trusts participating in the 2013/14 patient level cost collection, and trusts in the process of implementing PLICS solutions or considering such a development in the near future.

Ric Marshall
Director of Pricing

1. Introduction

Patient level cost data is extremely valuable in support of price setting, trust financial and operational management and for the NHS as a whole in understanding the cost drivers that underpin the treatment of patients across a range of settings.

The Health and Social Care Act 2012 gives Monitor and NHS England joint responsibility for the pricing of NHS services in England. Obtaining accurate and comparable cost data is fundamental to this role. We first collected patient level costs on a voluntary basis in 2013 with 66 trusts contributing to the collection which covered admitted patient care in acute trusts

This document reviews the 2012/13 admitted patient care Patient Level Information and Costing Systems (PLICS) pilot collection, identifying key areas where improvements can be made so the NHS as a whole can continue to improve the quality of costing as we move towards a heavier reliance on the outputs.

It covers the collection process, the data collected and the documents and tools that inform and guide the overall process.

How to use this document

This document is intended for all NHS staff who are responsible for, or contribute to, the production of cost information. It includes information that is relevant to the overall process of patient level costing and indicates where we would encourage trusts to focus in the short (2013/14 collection) to medium term (2014/15 collection). It has been released in time to be used for the 2013/14 PLICS collection.

We recommend you review this document in time to ensure that you can consider the recommendations relating to the 2013/14 collection and act on them where possible before the submission window closes on 3 October 2014.

2. Background

The NHS is a complex organisation with a large range of services being provided to varying populations in different settings. Underpinning this is an ever-changing environment with corresponding cost pattern changes fuelled by medical and technological advances.

The funding of patient services needs to reflect the care given while ensuring that resources are used in the most efficient way.

Patient level costing gives the NHS an opportunity to more directly reflect the care provided to patients in the price setting process. Having access to the resources and activities that make up a cost will give us a greater understanding of how money is spent and allow us to make meaningful comparisons, which in turn will equip providers with the tools necessary to effectively manage their organisations, identify and act upon inefficiencies and make other appropriate improvements.

Costing services accurately can help to deliver higher quality care to patients within existing budgets, through more appropriate prices and improved information for clinicians and other decision makers. Getting to this point requires a considered process of quality improvement and overall alignment of the costing process.

As sector regulator for health services in England part of our role is to lead on developing the methodology for price setting, calculating prices, enforcing the pricing regime (through our provider licence), approving local modifications to national prices and setting rules for local pricing. NHS England leads on developing the scope and design of currencies (the services to be priced), and setting rules around local variations to the national tariff. Monitor and NHS England jointly agree the national tariff before it is published.

PLICS collection background

On the 20 November 2012, we published 'Costing patient care: Monitor's approach to costing and cost collection for price setting' which set out our intentions on costing and cost collection for 2013 and the direction of travel for future years. We requested stakeholder comments on all aspects of our proposals and published the full stakeholder outcomes on 21 February 2013.

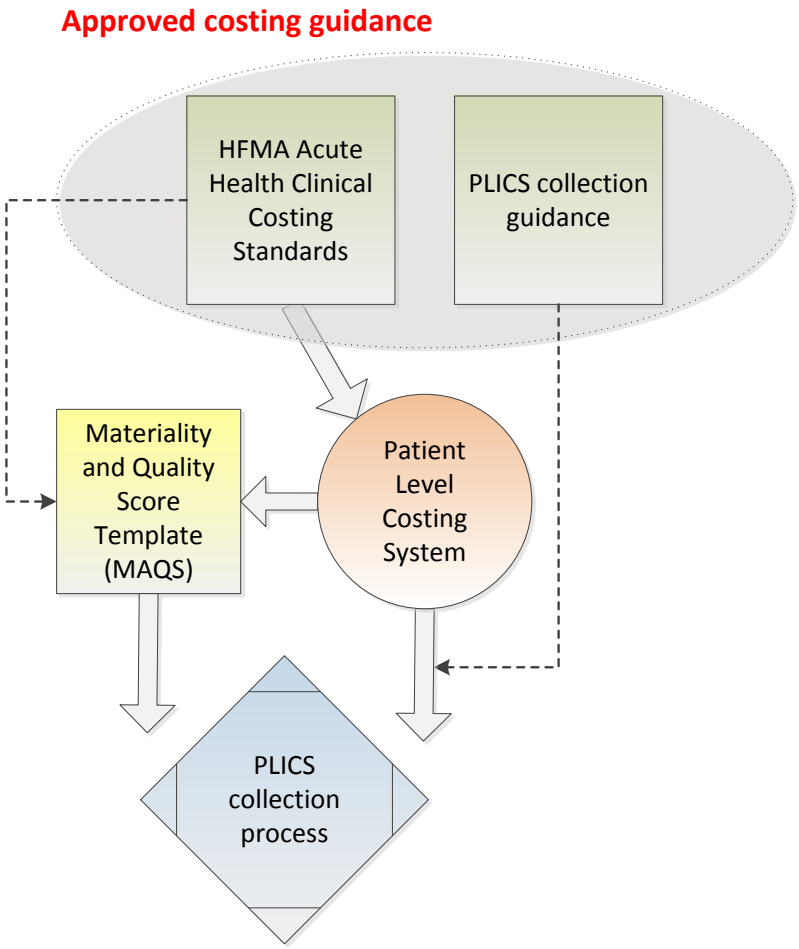
In the document we outlined an approach to collecting patient level cost data which would, over time, replace reference costs as the main source of cost information. Stakeholder response gave wide support for a move towards greater use of patient-level data in price setting.

In further response to the stakeholder feedback, to help us consider how PLICS data may be used and identify areas which may need further attention we then organised a pilot PLICS collection on a voluntary basis. We asked trusts to submit costs and activity data for admitted patient care covering the 2012/13 financial year.

As part of this process we also asked them to submit a self assessment Materiality and Quality Score (MAQS).

3. The patient level costing framework

Figure 1: The patient level costing framework



HFMA: Healthcare Financial Management Association

Patient Level Costing and Information System

We set up the 2012/13 PLICS collection to collect and analyse data from trusts that had already implemented PLICS for their internal management. The maturity of the systems ranged from early implementers dating back to 2006 to some who had implemented the system just months before the submission.

Approved costing guidance

Following a process of stakeholder engagement, we developed 'Approved costing guidance' to clarify the approach to costing and cost collection that we are encouraging providers of NHS-funded services to adopt. The guidance is designed specifically to support both the reference cost collection and the PLICS collection, and increase consistency across providers and includes PLICS collection guidance and the Acute Health Clinical Costing Standards.

The PLICS collection guidance section (Chapter 4) assembled by Monitor sets out the scope, data fields and other features of the PLICS collection.

The Acute Health Clinical Costing Standards section, which was developed by the Healthcare Financial Management Association (HFMA), sets out a common approach to producing clinical costs. We strongly recommended that providers use the HFMA standards where possible with a 'Comply or Explain' approach to help us understand the extent of compliance and to provide valuable information in understanding why different approaches may be necessary and where future support or guidance may be required.

Materiality and Quality Score (MAQS) template

With HFMA we developed the MAQS template to help organisations understand and report on the quality of their current costing data and provide a focus for areas that require improvement. We collected completed MAQS templates as part of the PLICS collection.

PLICS collection process 2012/13

- **Invitations** to participate were sent to finance directors − April 2013.
- A **PLICS collection template** was made available alongside the 'Approved costing guidance' on the Monitor Website − June 2013.
- A **dedicated email address** PLICS_Collection@monitor.gov.uk was set up for any questions and feedback related to the process.
- In response to queries following the publication of 'Approved costing guidance' 'Approved costing guidance – Frequently Asked Questions' was published − June 2013.
- After the PLICS collection we performed a **validation process** on the submitted data and provided specific feedback to trusts where appropriate – September 2013.
- We hosted an **initial findings webinar** to provide an overview of the collection and provide feedback – November 2013.
- An interactive **PLICS and MAQS analysis tool** was released to allow trusts to compare their aggregated PLICS information with other PLICS collection providers – December 2013.
- We undertook a more **detailed analysis** of the PLICS collection and overall framework to identify key areas for development – January to July 2014.
- We release '2012/13 Patient level cost collection: review and lessons for the future' – August 2014.

4. Summary of participation

High level statistics

Figure 2: 2012/13 Acute provider patient level costing status

PLICS status*	Number of acute trusts
Implemented	110
Implementing	22
Planning	14
Not planning	15
Total	**161**

** Department of Health 2012/2013 Reference Cost Survey*

Figure 3: 2012/13 PLICS submission participation

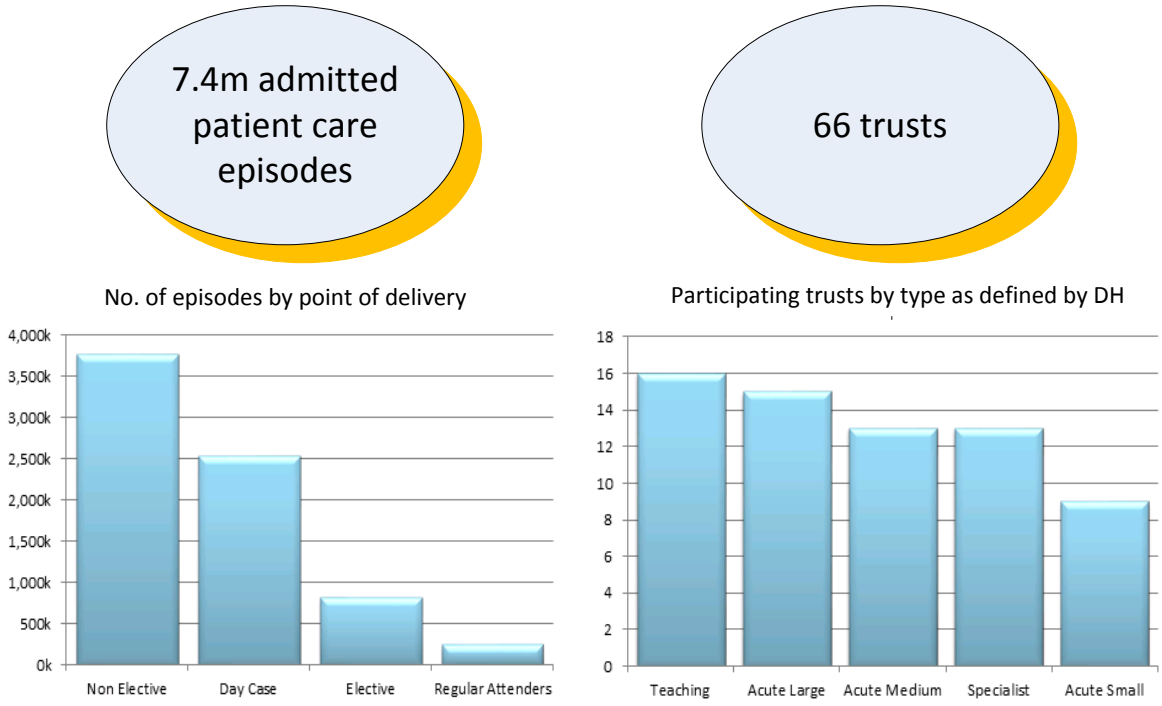
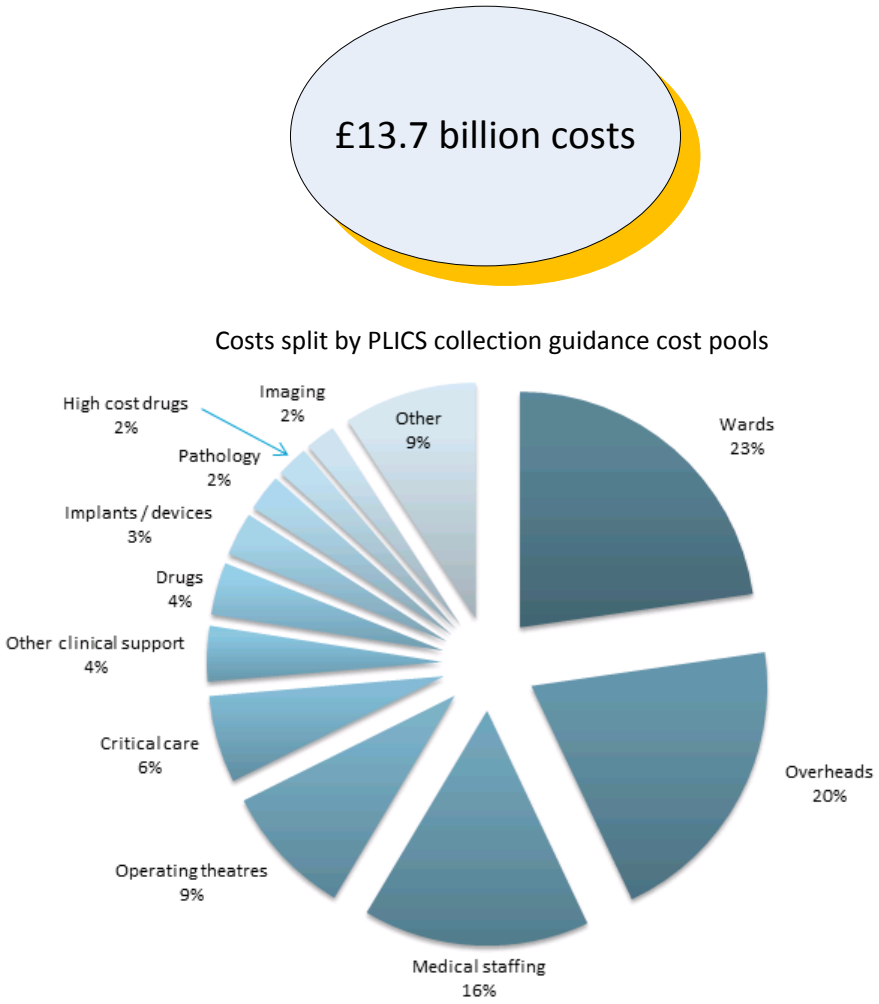


Figure 4: 2012/13 PLICS submission cost summary



Submission summary

We have accompanied this document with a table summarising the data collected. This gives episode average costs for each of the cost pools specified in the PLICS collection guidance aggregated by 2012/13 Reference Cost Grouper Finished Consultant Episode HRG and Point of Delivery.

Please note that the 2012/13 PLICS collection was a pilot voluntary collection so the data should be used for information only and as a comparative tool to enable trusts to identify possible inconsistencies within their data. The data have not been subjected to a full cleansing process and should not be compared to the 2012/13 reference costs because the guidance for each collection specifies different inclusions and exclusions. For example, the reference cost will exclude the costs associated with chemotherapy, critical care, high cost drugs and diagnostic imaging, while the PLICS average will include these costs. Similarly reference costs is net of income for training, education, research and commercial activities while the PLICS submission excludes reporting these income streams within the patient cost.

5. Findings and learnings

Overall, we have been very encouraged with both the level of participation and the content of the data provided in this pilot year. As a sector we clearly have an excellent platform on which to move forward.

With a framework in place and a significant number of organisations producing regular patient cost data we are well placed to make significant improvements in the integrity and use of costing data in the NHS.

As a national dataset the 2012/13 PLICS data are at a relatively early stage in the process of national alignment although at individual trust level they may be mature and well developed. We understand the challenges that providers face and our aim is to work through some of the challenges together. The fact that 66 organisations were willing to contribute to a voluntary collection signals a healthy desire to participate and improve cost information across the sector. This has been further reflected by the willingness of organisations to respond further to the questions we raised during the analysis phase and we fully appreciate the efforts of all trusts that took part.

We have looked in detail at the collected data, met costing teams in provider trusts and emailed trusts for clarification on specific points. The analysis covered some of the key elements of the costing process and the results now give us an indication of some of the difficulties and what may be required to overcome them. Our aim is to ensure that we continue to make positive steps towards the long-term goal of robust, comprehensive and consistent cost information and have a framework in place that allows organisations to easily understand what to do and get assurance that they are doing it in the most appropriate way.

Our analysis identified eight key focus areas.

The rest of this chapter covers each of these areas using the following structure:

- What element of the costing process are we talking about?
- Why is this important?
- Findings and observations
- What action do we recommend trusts take for the 2013/14 collection?
- What action will Monitor, HFMA and the trusts consider for the 2014/15 collection?

Collection content

Collection content refers to the completeness and accuracy of the non-cost information for each patient episode within the submissions.

It is important because:

- Patient attribute information helps to classify the patient and the type of care they have received. From this we can identify and investigate the cause of differences in costs for patients with comparable characteristics.
- It is helpful in validating the accuracy of the information which may include checking that expected costs exist against specific patient groups. We would expect for example that all elective admissions grouped to 'HB21C − Major Knee Procedures for Non-Trauma, Category 2, without CC' would have operating theatre costs. Analysis of the submission showed that over 5% had zero operating theatre costs.

Findings and observations

- Overall the non-cost elements of the data submitted were of good quality.
- There were issues with the completeness of data in some areas but no material widespread issues. For example, although one trust reported no patient ages, and some trusts had a few episodes with patient ages missing, age data were largely complete across the collection. Similarly, a small proportion of trusts had a few episodes with no start or end dates.
- We identified some issues and gaps relating to procedure, diagnosis and Healthcare Resource Group (HRG) coding. A small number of trusts submitted a significant number of episodes with U-code HRGs (U-codes are the result of missing or invalid clinical codes which cause the National Grouper software to generate a UZ01Z – 'Data Invalid for Grouping' HRG), and two trusts reported a U-code HRG on all episodes.
- Ten trusts failed to flag NHS vs non-NHS patients which will affect our ability to identify the total cost of NHS-funded care and in the future would affect our ability to reconcile to reference costs.
- There is some evidence that the validity of the reported operating theatre minutes for some trusts is questionable – this is shown by missing operating theatre times; very high reported times; the same time reported across every episode with operating theatre costs. The same issues existed for critical care length of stay.

What action do we recommend trusts take for the 2013/14 collection?

We have set up a central validation process with ‘same-day’ feedback reports. We encourage trusts to submit early, review the feedback report, address the issues, and resubmit as many times as necessary to assist the quality of the submission in the collection window.
Trusts who participated last year should review the validation feedback from last year in the distributed analysis tool, and aim to address the issues highlighted.
Trusts should review episodes with a U-code HRG and address issues if possible before submission. We recommend in the short term that each trust aims for considerably lower than 1% of U-codes in their submission.
Trusts should ensure that the non NHS flag on the template contains 0 for NHS episodes and 1 for non-NHS. We request that trusts populated this column even if they have opted to exclude episodes of non-NHS patients from the submission.

What action will we consider for the 2014/15 collection?

We will consider:

- the continued development of the central validation processes informed by engagement with trusts to understand how the validation process can be of most assistance
- specific validation processes to assist in assessing the quality of theatre times and critical care length of stay
- collection of additional data to enable the central HRG grouping of PLICS data to provide a richer set of patient attributes for analysis.

Cost pool classification

Cost pool classification refers to the groupings that are applied to costs on the general ledger to enable a patient episode costs to be split into meaningful categories, reflecting their use of hospital resources.

They are important because they enable identification of general input components of patient costs, providing meaningful groupings to analyse and use for benchmarking purposes.

Findings and observations

- Trusts are classifying indirect and overhead costs inconsistently, and this materially impacts on the ability to compare costs across trusts.
- Parts of the cost pool structure where the name of the cost pool and the costs that should be included are inconsistent and have the potential to confuse. For example, the 'medical staffing' cost pool suggests that all medical staff would be reported there, whereas current standards require some medical staffing to be reported in other cost pools. The same is true for nursing costs.
- 'Other clinical support' contained significant amounts of cost (4% of the collection total), which suggests it should be split down further for additional granularity.

What action do we recommend trusts take for the 2013/14 collection?

Trusts should utilise our PLICS analysis tool (2012/13 participant trusts only) and the data tables accompanying this document, to help identify any significant inconsistencies with other trusts, which may relate to issues relating to cost pool classification.
Trusts should provide a comment on the narrative column of the MAQS template with details of any known deviation on cost pool classification and the reasons why this was necessary.
Trusts should pay particular attention to indirect and overheads costs, follow Standard 1 of the Clinical Costing Standards, and ensure that all overheads costs are allocated to the overheads cost pool. Indirect costs should be allocated across relevant cost pools, and not included in the overheads cost pool.

What action will we consider for the 2014/15 collection?

We will consider:

- working with HFMA on Standards 1 and 2 to:
    - Consider how we can raise the profile of the treatment of overheads by including them as a discrete cost pool grouping section within Standard 2
    - provide clarity on how indirect costs should be allocated and which cost pool(s) they should be reported in
    - create additional granularity within the medical staffing cost pool and other cost pools that include medical staffing to ensure we can identify it. We will consider the same for nursing staff.
- requesting further breakdowns of the services reported in ‘other clinical support’ to help us decide if it is necessary to extend the existing cost pool groupings.

Allocation methodology

Allocation methodology refers to the method used to allocate cost pool costs to patients.

It is important because:

- The use of patient level costs requires confidence that cost variations result from genuine differences in the resources used in the care of the patient, rather than differences in the allocation method used.
- Accurate and consistent allocation of cost enhances the information available to clinicians and supports clinical engagement.

Findings and observations

- The MAQS templates show that trusts are applying a variety of allocation methods.
- Some trusts have reported that they are using methods which do not relate to those suggested in the MAQS template.
- The Clinical Costing Standards do not provide full details of the allocation methods stated in the MAQS template.

What action do we recommend trusts take for the 2013/14 collection?

Trusts should make use of the new facility in the MAQS template that enables multiple allocation methods to be recorded within each cost grouping.
We would encourage trusts to take time to ensure the MAQS template is completed and accurately reflects the approaches used. Please use the narrative column on the MAQS template where necessary if you feel that your approach is not sufficiently explained by the allocation methods provided.

What action will we consider for the 2014/15 collection?

- We will work with HFMA to consider restructuring Standard 3 so that all allocation methods are clearly laid out for each cost group.
- We will aim to allow trusts to record allocation methodologies that deviate from the standards in the MAQS template to enable identification of non compliance or potential methods of best practice.
- We will work with HFMA to give early indications of future minimum standard methods acceptable for high quality benchmarking and as a basis for pricing. We will also consider identifying methods we believe trusts should be aiming for in the long term.

Matching

Matching refers to the process of linking records from departmental utilisation activity (systems managed by departments) to the main patient episode.

It is important because:

- The matching process is at the core of patient level costing and provides the basis of attributing costs to specific patients based on their actual resource use.
- Low levels of matching or incorrect matching will significantly distort individual patient costs and therefore undermine the validity of patient level cost data.
- Unmatched activity will create distorted patient level costs through:
    - the unmatched patient not having the cost of the care activity attributed to them
    - patients that did not necessarily receive the care activity receiving the costs of the unmatched activity. This will result in significantly inflated costs where trusts opt to allocate the unmatched activity to previously matched patients.

Findings and observations

- It is clear that trusts taking part in the PLICS collection have made great progress in reaching high levels of matching. There are still instances of low levels of matching reported in the MAQS such as one trust reporting 30% for blood products and a number of trusts reporting approximately 70% for imaging.
- The ‘Clinical Costing Standards’ do not currently provide sufficient clarity on how to handle unmatched activity. As a result trusts are adopting different approaches.

What action do we recommend trusts take for the 2013/14 collection?

We would encourage trusts to use the narrative column in the MAQS template to specify the method they used to handle the cost associated with unmatched activity.

What action will we consider for the 2014/15 collection?

We will consider:

- development of a principled approach to the treatment of costs associated with unmatched activity, for inclusion in Standard 8a
- extending our central validation rules to highlight episodes that are missing key cost information based on procedure coding.

Work in progress

Work in progress refers to the approach trusts should take to providing costs for patients whose treatment does not entirely fall within the collection year.

This is important because:

- If dealt with incorrectly:
  - some of the costs of such patients can be counted twice or not at all, which can distort the true cost of patient care, especially for long-term patients
  - there is the potential for patient stays spanning two financial years to be excluded from all collections.
- It can act as a barrier to reconciling collections to trust accounts, which is an important source of assurance.

Findings and observations

- By analysing patient episode start and end dates, we observed that there were a number of trusts that incorrectly stated their work in progress level.
- We believe that this results from a lack of clarity in Standard 5 of the 'Clinical Costing Standards' which is confounded by the number of options.
- We also recognise that different approaches are taken to work in progress across the reference costs and PLICS collections.

What action do we recommend trusts take for the 2013/14 collection?

Trusts submitting in 2013/14 who participated in the 2012/13 pilot collection should continue to use the approach they previously adopted.
Trusts that are taking part for the first time in 2013/14 should contact us if they are unclear how to cost work in progress for the PLICS submission.

What action will we consider for the 2014/15 collection?

- We will work with HFMA to update work in progress standards, based around the principles of:
  - reporting undistorted, complete patient costs
  - avoiding repetition or duplication of costs, and
  - ensuring that the episodes reported on, when combined with work in progress, allow the information to be reconciled with trust accounts.
- We will work with HFMA to reduce the number of options in the 'Clinical Costing Standards' to avoid confusion.
- We will work with the Department of Health to consider aligning approaches across reference cost and PLICS collections.

Non patient care activities

Non patient care activities refer to the income and cost associated with any clinical or non-clinical activity where the organisation's patients are not the primary reason for the activity. This would include research, clinical training and education, as well as commercial activities such as rental of space, car parking, catering and the provision of services such as pathology to other organisations.

Why is this important?

- The costs and income from non patient care activities have the potential to affect the comparability of patient level costs.
- The introduction by the Department of Health of a mandatory education and training collection and the commitment within the reference costs guidance to work towards the exclusion of costs rather than income for these funding streams means the PLICS collection needs to address these requirements.
- The costs associated with non patient care activities are funded in different ways, so correct and consistent treatment of this area is essential to avoid cross subsidisation.

Findings and observations

- Some trusts have allocated non patient care activities cost across the cost pools and others have included the cost in the non patient care activities column.
- This is probably because of conflicting sets of guidance on the treatment of costs and income for non patient care activities:
    - 'Reference costs collection guidance' − the cost and income associated with non patient care activities are included in the reported cost of patient care.
    - 'Clinical Costing Standards' − the cost and income associated with non patient care activities should not be allocated to patients but reported separately.
    - 'Calculating the cost of education and training collection guidance' − the gross cost of education and training, including a share of overheads and indirect costs, is reported.
    - 'PLICS collection guidance' – income related to non patient care activities should be reported separately in the non patient care activities column. Costs related to non patient care activities should remain within the relevant cost pools.

What action do we recommend trusts take for the 2013/14 collection?

To maintain a consistent approach for this year, trusts should follow the 'PLICS collection guidance' and report only income related to non patient care activities in the non patient care activities column. Trusts should remove this income from the other cost pools. Non patient care costs should remain in the relevant cost pools.
Trusts should ensure that the total cost column on the PLICS template matches the sum of all the individual cost pool columns excluding non patient care activities.

What action will we consider for the 2014/15 collection?

We recognise that education and training, research and commercial activities should be dealt with in a way that ensures the cost of patient care is not distorted. We will therefore consult with HFMA and Health Education England to consider the appropriate treatment of key elements of non patient care income and costs for the 2014/15 PLICS collection guidance.

Critical care

Critical care refers to the treatment of the cost associated with time spent in critical care units.

This is important because time spent in a critical care unit can be a high cost element of patient care and a cause of significant cost variations. Patients are usually admitted to critical care because of the severity of their illness, rather than solely on the underlying diagnosis, so isolation of the cost of critical care within patient level costing is key to effective benchmarking.

Findings and observations

- The PLICS collection and reference cost collection approaches to critical care are quite different.
- The PLICS collection guidance (in line with the 'Clinical Costing Standards') requires trusts not to unbundle critical care costs, instead adopting the approach of collecting critical care unit costs in a manner similar to ward costs – nursing salaries, medical and surgical supplies, goods and services.
- Reference costs adopt the approach of unbundling costs related to the care of a patient during their critical care unit stay, therefore also including costs such as medical staff and diagnostics.
- The approach currently taken in the PLICS collection provides less granularity of critical care costs, and arguably this reduces the ability to understand this important area of costs.
- Finally, six trusts adopted the reference cost collection approach rather than following the PLICS collection guidance which caused problems comparing across PLICS sites.

What action do we recommend trusts take for the 2013/14 collection?

To ensure comparable information, for 2013/14 we ask that trusts do not unbundle critical care and report it within the episode and follow the Standards with regard to the treatment of the cost pools.

What actions will we consider for the 2014/15 collection?

We will work with HFMA to consider the benefits of identifying all costs incurred during a critical care stay which would enable reconciliation between reference costs and PLICS.

Materiality and Quality Score calculation method

The Materiality and Quality Score calculation method refers to the MAQS template developed by HFMA and Monitor to allow trusts to document and measure the quality of their costing process.

It is important because:

- The MAQS template is a key tool for internal process review and as an aid to targeting improvement efforts both locally and nationally.
- The template is an important part of the PLICS collection process and assists us with assessment of the robustness and the quality of the methods underpinning the data.

Findings and observations

- Seven trusts did not submit a MAQS return, and one return was incomplete.
- Some trusts filled in MAQS for admitted patient care only, others for whole trust costs, reducing the ability to compare across trusts.
- In some cases trusts were not able to define their methodology as one of the options provided in the MAQS template, leading them to pick an option that was not relevant. One trust reported choosing the wrong methodology when questioned.
- Trusts requested that it be possible to recognise more than one allocation methodology to a cost pool group.
- The MAQS calculation is based on the allocation of cost pool costs to patients, but does not currently provide an indication of the appropriate classification to cost pools.
- The scores do not always sufficiently reflect the relative benefit of the costing method used. The implementation of a system that requires therapists to record each contact, for example, has the same incremental benefit as moving from a specialty-based time average to an HRG-code based time average.

What action do we recommend trusts take for the 2013/14 collection?

As outlined on page 59 of the 'Approved costing guidance', trusts should complete the template on the basis of **all** PLICS costs not just admitted patient care. This is a change to last year's requirement.
The layout of the MAQS template has been adapted to enable organisations to select more than one methodology for each cost pool group and service. We would encourage trusts to make use of this additional functionality.
In instances where your cost allocation approach does not match one of the options provided please choose the closest method and use the narrative column on the MAQS template to explain your approach.

What action will be considered for the 2014/15 collection?

We will consider:

- adapting the MAQS template to allow organisations to reflect a deviation from the standards: this will provide us with a greater understanding of where the Standards are not being followed and identify potential application of best practice methods
- in consultation with HFMA, development of the MAQS calculation and template to:
    - incorporate an assessment of the allocation of costs to cost pools
    - move from a linear scoring scale to one that more directly reflects the benefit of the specific cost allocation approach being used.

6. Themes

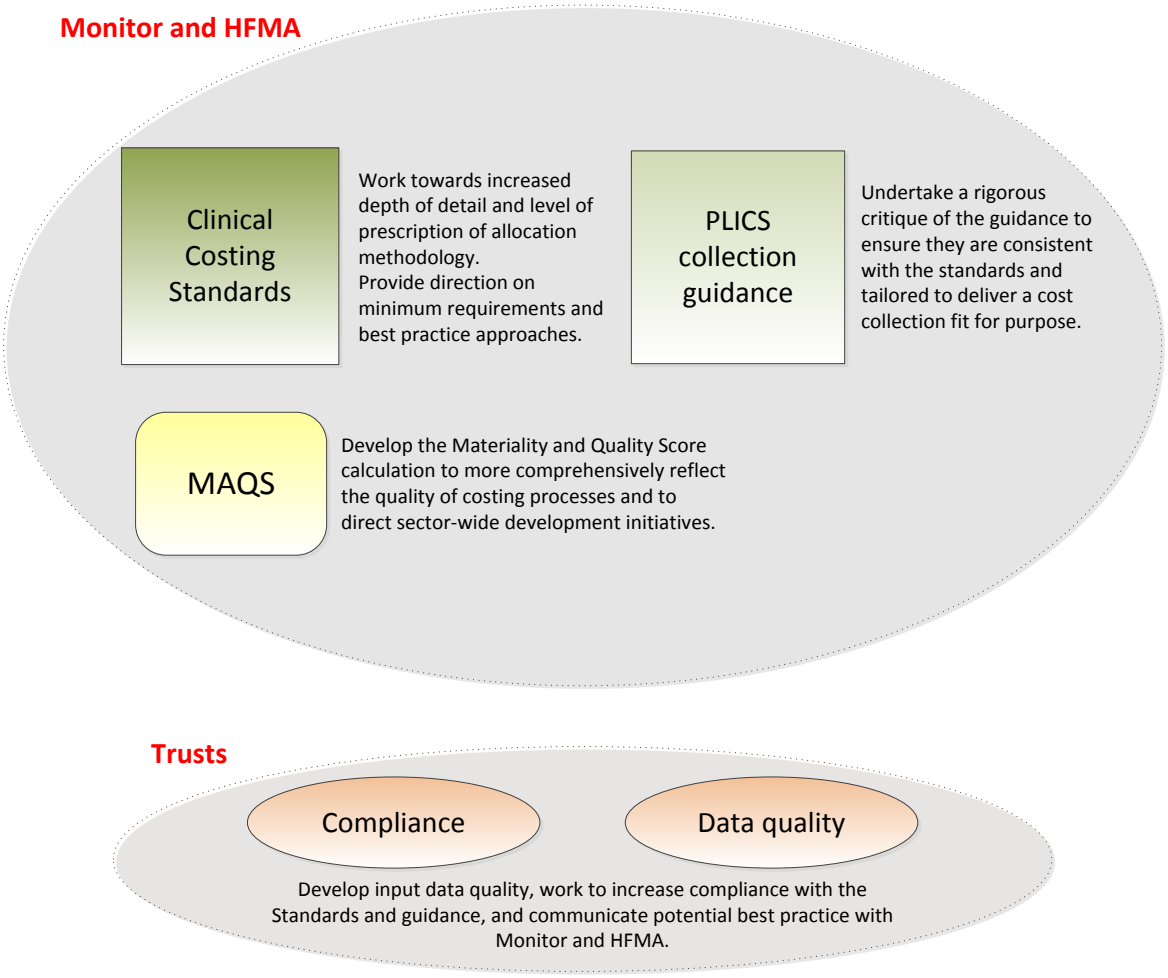
The 2012/13 pilot PLICS collection demonstrated that trusts have made excellent progress in producing information that supports local trust cost management. This has been achieved through the efforts of trusts and supported by the work of HFMA in developing the clinical costing standards over the past four years.

The benefit of carrying out a national cost collection is that it allows us to take a national perspective. We can then identify different approaches being used in costing and assess the resultant level of comparability.

The main theme emerging from the analysis and conversations is that costing practices are generally logical and can be clearly explained but that approaches vary significantly between trusts.

As we move towards a robust, consistently generated patient level dataset of cost information capable of feeding the payment system and benchmarking initiatives, it is clear that we need to focus on consistency of approach and the comparability this will deliver. To achieve this all organisations involved in the production and collection of cost information must make a contribution.

Figure 5: Immediate development priorities for the production and collection of cost information.



7. Next steps

2013/14 collection

- Same day **central validation process** for the 2013/14 collection during the collection window – July to October 2013
- 2013/14 **collection window closes** – 3 October 2014
- **Validation summary reports** will be sent to trusts to summarise both the automated validations and the additional checks we are continuing to develop after the submission closes – November 2014
- An update to the **PLICS and MAQS analysis tool** will be issued and will include year-on-year comparisons – November 2014
- **Webinar** to share early findings from the 2013/14 Collection – November 2014
- **2013/14 report on findings and learnings** – December 2014

Future development

In early 2014 we commissioned the development of a 'costing roadmap', which aims to define ambitious goals for the future of costing in the health sector, taking particular care to build on the significant progress to date. It sets out:

- the cost information needs of the sector
- a recommended costing and cost collection approach to meeting these needs and
- the transition path towards this recommended approach.

This work involved significant engagement with providers across acute care, mental health, community and ambulance services, and included commissioners, independent providers and central bodies.

We are currently reviewing the recommendations, and will publish a 'costing direction of travel' document in October. We will seek further engagement on the proposed direction in November 2014.

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

 Publication code: IRG 21/14