

Costing Patient Care: Monitor's approach to costing and cost collection for price setting

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1. Executive Summary

The Health and Social Care Act (2012) gives Monitor and the NHS Commissioning Board joint responsibility for setting prices for NHS-funded services in England. Monitor will lead on developing the methodology for price setting, calculating prices, enforcing the pricing regime (through Monitor's provider licence), approving local modifications to national prices and setting rules for local pricing. The NHS Commissioning Board will lead 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 the NHS Commissioning Board will jointly agree the National Tariff before it is published.

Determining prices will be an important regulatory lever that Monitor will have in its new role to achieve its core duty of protecting and promoting the interests of patients. Understanding the cost of patient care is an essential element in determining and setting appropriate prices. High-quality costing is therefore a key area on which Monitor is now focussing as we take on our new price setting responsibilities. Other stakeholders, including service providers, the NHS Commissioning Board, the Department of Health, Health Education England and the NHS Trust Development Agency also have an interest in ensuring that costing data is of high quality.

The Department of Health has collected reference costs – the average costs of delivering different health care services – for all NHS providers since 1997/1998. These costs have been used to set prices since Payment by Results was introduced in 2003/04.

One key finding of a recent report commissioned by Monitor, [An evaluation of reimbursement systems for NHS funded care](#), was that the information underpinning the current reimbursement system requires significant improvement. Monitor therefore commissioned further research, published as [Strategic options for costing](#), which examined current costing and cost collection arrangements in more detail and made a number of recommendations about how these could be improved. We have engaged with stakeholders through a number of different forums, on both these findings and recommendations for improvement.

Building on this work, *Costing Patient Care* sets out our proposed approach to improving the quality of cost data on which prices are based. We propose to improve the methodology for costing, and the collection and assurance of cost data. At the heart of our approach is a proposal to collect Patient-Level Information and Costing System (PLICS)¹ data. We believe this has the potential to deliver more accurate and granular data, and open up opportunities for more sophisticated methods of price setting. An increasing number of providers now have PLICS; 80% of all NHS and Foundation Trusts have implemented, are implementing or are planning to implement these systems².

Moving to a pricing system using PLICS data is a long-term aspiration which will take time to implement. In the meantime, data collected through the current method (reference costs) will be used. Reference cost data therefore continues to play an important role and so we also set out proposals to improve the quality of this data.

¹ PLICS are IT systems which combine activity, financial and operational data to cost individual episodes of patient care.

² PLICS Survey, Department of Health (2012)

Costing Patient Care sets out Monitor's intentions on costing and cost collection for 2013, and the direction of policy for future years, to support our future responsibility for price setting for NHS services. This document comprises:

- a description and assessment of how NHS costs are currently collected,
- our proposed objectives for costing,
- our long-term vision, and
- a series of proposed policies and actions for 2013.

Alongside this document, today we are also publishing – for stakeholder comment – two draft chapters of Monitor's proposed new [Approved Costing Guidance](#). This guidance aims to consolidate and streamline existing guidance into a coherent framework, and should facilitate providers' compliance with the relevant aspects of the provider licence. The two remaining chapters of the draft guidance will contain the Healthcare Financial Management Association (HFMA) costing standards and the Department of Health guidance on reference cost collection, both of which are expected to be published in early 2013.

1.1. Long term vision and objectives

Our long-term vision is to move towards using the cost of treating each patient, rather than the average cost, as the main source of cost data informing how we regulate prices. We believe there is potential to use PLICS data to set prices, once we are confident data quality is adequate. The vision will help us to achieve six objectives for costing:

1. **Improve data quality**

Reference costs in 2011/12 described £53.4bn of NHS activity. Given the magnitude, it is important to ensure a continued focus on high data quality. This should also benefit providers as they seek to manage their organisations and achieve better value and higher quality patient care. One way we will seek to improve data quality is by aligning regulatory cost collections with the costs used by providers to manage their organisations.

2. **Increase comparability and consistency of data**

Cost data needs to be prepared consistently by all providers if it is to be useful to fulfil our pricing responsibilities. From a provider's perspective, more comparable data will make benchmarking exercises even more meaningful.

3. **Improve transparency**

A consistent message from stakeholders is that price setting needs to be transparent. We agree and our intention is to collect more granular data, which will enable providers to explore the detailed cost information supporting our pricing decisions.

4. **Develop the potential for new pricing mechanisms**

Currently, only average costs of delivering health care are reported through the annual reference cost collection, which supports a payment by activity method for setting prices, based on average costs. However other forms of payment mechanism are possible, such as potential year of care tariffs for patients with long term conditions.

5. Proportionate regulatory cost

We will seek to keep regulatory costs on providers proportionate, by ensuring that the benefits of enhanced cost collection outweigh the costs. One way we intend to achieve this is by aligning regulatory cost collections with costs produced by the sector for other purposes, such as patient-level costs, already reported for provider management purposes.

6. Improve the use of cost data by managers and clinicians

We are committed to supporting NHS providers to drive up the quality and accuracy of their costing. Effective clinical and finance engagement in costing within NHS organisations is pivotal to achieve this outcome. Better cost information will benefit providers, as well as Monitor, as they use this information to manage their organisations.

1.2. Approach for 2013

Consistent with the above objectives, we intend to take six steps in 2013 towards this longer term vision:

Collect patient-level costs. We will pilot a patient-level cost collection, initially from acute providers only, for admitted patient care on a voluntary basis. Draft PLICS collection guidance, part of the [Approved Costing Guidance](#) being published today, is included for stakeholder comment. Over time, patient-level data could replace the average costs reported through reference costs as the main source of information used to support price setting.

Develop costing methodology. We will advocate that all providers adopt the Healthcare Financial Management Association (HFMA) costing standards where possible and will consider mandating these standards in the future. These standards are developed by the HFMA in collaboration with health sector costing practitioners. We will continue to support the HFMA in developing the standards.

Improve assurance. We propose a self-assessment approach to assurance of next year's pilot patient-level collection. We may consider other assurance mechanisms such as peer review or external assurance in future. As a first step to developing a benchmark for data quality, we intend to collect Materiality and Quality Scores (MAQS), which provide an indication of how well costs have been allocated, and we will support their further development.

Conduct further research on sampling. Using the patient-level data that we intend to collect in 2013, we will conduct further research on the benefits and costs of sampling, to determine whether using a sample of provider data (rather than the current approach of using data from all providers) could be a desirable approach to price setting in the future.

Cost non-NHS patient care activities. We will aim to reduce the distortions caused to the reported cost of patient care by netting-off certain income streams, such as education and training, research and development, private patients and a range of other excluded items. We will begin by separately identifying the cost of private patients in our pilot collection of patient-level data.

Enhance the quality of reference costs. Working with the Department of Health, we will continue to enhance the quality of reference costs, for which we will be accountable from 2012/13. For example, we are proposing updated assurance measures such as a targeted external assurance programme, mandatory use of self assessment checklists and sign off from provider Boards. Reference costs will continue to be collected by the Department of Health during 2013 in parallel with Monitor's pilot collection of patient-level data.

While *Costing Patient Care* is primarily focussed on the acute sector, Monitor is keen to support the development of improved activity and costing data in the mental health and community sectors. We are working with the Department of Health mental health tariff development team and community tariff working group to promote better costing and recording of activity in these sectors.

1.3. How to respond

We welcome comments on all aspects of Monitor's costing proposals outlined in this document.

In particular, we appreciate your views and comments on the following questions:

1. Do you agree with our assessment of reference costs? Are there other strengths or weaknesses of the current process that we should be considering? (Page 13)
2. Do you agree with our objectives for costing and our long term vision set out in Section 4? (Page 19)
3. What is the most appropriate timing for the pilot PLICS collection? (Page 24)
4. Do you agree with the proposed actions set out in Section 5? Are there other actions we should be prioritising for 2013? (Page 31)

We also welcome your comments on the two chapters of the new draft [Approved Costing Guidance](#), published today. There are additional questions for stakeholders to consider about:

- Chapter 1: Costing Principles (Page 32)
- Chapter 4: PLICS collection guidance (Page 49)

To respond, please download and complete the [response form on our website](#) and return it by **5pm on Tuesday 11 December 2012**. We will consider your comments as we finalise the guidance for publication in early 2013.

This document was published on Monday 19 November 2012.

Please send your answers and/or general comments to pricing@monitor-nhsft.gov.uk. If you do not have internet or email access please write to:

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Please note: we may use your details to contact you about your response or send you information about our future work.

You can sign up to receive emails when we publish information on pricing, and on our proposed new role in general, [here](#) on our website.

2. Introduction

The Health and Social Care Act (2012) gives Monitor and the NHS Commissioning Board joint responsibility for setting prices for NHS-funded services in England. Monitor will lead on developing the methodology for price setting, calculating prices, enforcing the pricing regime (through Monitor's provider licence), approving local modifications to national prices and setting rules for local pricing. The NHS Commissioning Board will lead 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 the NHS Commissioning Board will jointly agree the National Tariff before it is published.

Determining prices will be an important regulatory lever that Monitor will have in its new role to achieve its core duty of protecting and promoting the interests of patients. Understanding the cost of patient care is an essential element in determining and setting appropriate prices. High-quality costing is therefore a key area of focus for Monitor as we take on our new price setting responsibilities. Other stakeholders, including service providers, the NHS Commissioning Board, the Department of Health, Health Education England and the NHS Trust Development Agency also have an interest in ensuring that costing data is of high quality.

This document refers to both "costing" – the methodologies providers use to trace and allocate their costs between different services – and to "cost collection" – the process where providers submit cost data to the regulator. We have distinguished between these two activities in the relevant sections of the document, but sometimes refer to both by the generic term of "costing".

2.1. Structure of this document

Costing Patient Care contains five further sections which cover:

3. Current approach to cost collection

Section 3 describes the current process for collecting and using cost data for NHS reimbursement and summarises Monitor's work on costing to date.

4. Long-term vision

Section 4 describes Monitor's objectives for costing and our long term vision for the future of NHS costing, which seeks to make greater use of patient-level cost data.

5. Approach to 2013

Section 5 describes Monitor's approach to policy making for costing and cost collection, and our proposed actions for improving costing in 2013. Finally we describe our approach to mental health, community service and independent providers.

6. Costing guidance

Section 6 introduces Chapters 1 and 4 of the new draft costing guidance, which are published separately for stakeholder comment.

7. Stakeholder feedback

Section 7 summarises the issues we would like stakeholders to comment on and describes the timeline for providing comments.

2.2. Costing guidance

We are separately publishing today drafts of Chapters 1 and 4 of the [Approved Costing Guidance](#) for stakeholder comment. The final guidance is expected to include four chapters:

- **Chapter 1: Costing principles** (draft published 19 November 2012)
This contains high-level principles which outline the approach that should underpin any NHS costing exercise, and steps to help providers apply these principles.
- **Chapter 2: Costing standards** (expected publication in early 2013)
This will link to the standards for clinical costing for acute and mental health providers developed by the HFMA for 2013/14.
- **Chapter 3: Reference cost guidance** (expected publication in early 2013)
This will link to the annual update of the reference costs collection guidance for 2012/13. This document is being prepared by the Department of Health.
- **Chapter 4: PLICS collection guidance** (draft published 19 November 2012)
This contains new guidance on collecting 2012/13 patient-level cost data. The collection will be open to all acute providers on a voluntary basis and, pending the outcome of the pilot collection, we hope to expand the collection in future years.

The final version of this guidance will enable providers to comply with the relevant aspects of the provider licence.

3. Current approach to cost collection

This section describes the current process for collecting and using cost data for NHS reimbursement and Monitor's work on costing to date.

3.1. Reference costs

The Department of Health has collected reference costs since 1997/98, following the publication of the 1997 White Paper *The New NHS*. The data has been used to support the Payment by Results (PbR) system since its introduction in 2003/04.

Reference costs are the average unit cost of providing NHS patient care, where the units of care are described in terms of either clinical classifications, such as Healthcare Resource Groups (HRGs), or a number of other currencies, such as outpatient attendances. The Department of Health collects average unit costs from all NHS and Foundation Trusts on an annual basis to calculate the national reference cost of each currency. All organisations individually calculate and report activity and unit costs. In doing so, they are supported by the *Reference costs guidance*, other guidance documents³ and a collection template.

The Department of Health uses this average cost information to calculate prices for the Payment by Results system. (The PbR tariff calculation methodology is set out in a step-by-step guide⁴.) There is up to a three year difference between the time when reference costs are incurred and when the prices come into force, for example the 2012/13 tariff is based on 2009/10 reference costs.

³ Reference costs guidance 2011/12, Department of Health (2012); NHS Costing Manual, Department of Health (2012); PLICS and reference cost best practice guidance, Department of Health (2012)

⁴ Step-by-Step Guide: Calculation the 2012/13 National Tariff, Department of Health (2012)

Figure 1: Current reference cost process

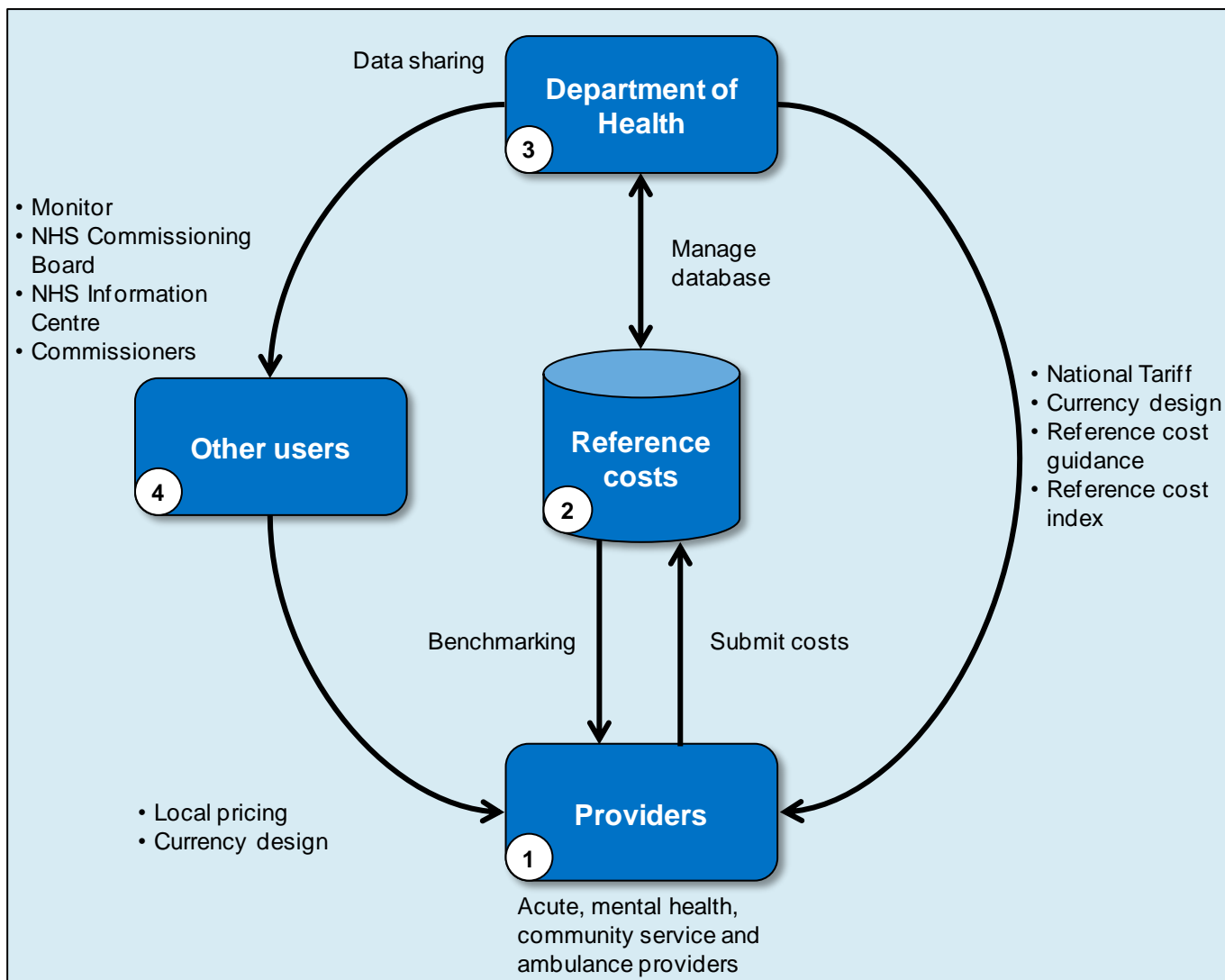


Figure 1 above describes the role of the Department of Health, providers and other users of the data in the reference cost process:

1. Providers

Acute, mental health, community and ambulance service providers prepare costs according to the reference cost guidance. They submit these costs to the reference cost database, via the Department of Health collection system Unify2. Providers are given access to cost data at the level of HRGs and other currencies from all NHS Trusts and NHS Foundation Trusts and can use this for benchmarking and other purposes.

2. Reference cost database

The 2011/12 database covers £53.4bn of cost related to activities provided by 248 NHS Trusts and NHS Foundation Trusts. For the first time, the acute providers also reported some of their costs and activities by spell (the period from date of admission to date of discharge from the provider) in addition to by Finished Consultant Episode (a period of treatment led by the same consultant) and other units of patient care.

3. Department of Health

The Department of Health manages the reference cost collection and the database, publishes reference cost guidance and a collection template, calculates the Reference Cost Index (a measure of relative efficiency), calculates prices and shares the reference cost information with other national bodies and the public.

4. Other users

Monitor is using reference costs to prepare for our new price setting role. The NHS Information Centre use reference cost information to inform the design of HRGs, and commissioners use the information for determining the appropriate level of local tariffs. Reference costs are also used by the Office for National Statistics and various other research bodies⁵.

3.2. Issues with reference costs

Reference costs are a fundamental building block of the current PbR process. However, despite recent improvements, some issues remain, for example:

- **Data quality and credibility**

Reviews and analysis of reference costs have found issues with the data quality and credibility of the outputs. For example, the Audit Commission review of the 2009/10 reference cost submissions found that one in eight submissions were materially incorrect in total, and one in four submissions had one or more materially incorrect HRG unit costs⁶. There is also large variation in reference costs between providers, which is unlikely to be explained by variation in actual costs alone. For example, the Department of Health's reference costs 2011/12 publication showed that, for admitted patient care, 16% of all submitted reference costs were 50% or more away from the national average. In addition, the "top down"⁷ costing process commonly used for reference costs does not identify what drives cost. As a result, costs cannot be traced to individual patients based on the resources the patient used. This will impact on the cost outputs being less transparent and credible⁸.

- **Clinical validity**

Reference costs sometimes produce cost relativities (ratios between the costs of different HRGs) that are inconsistent from a clinical perspective. This suggests either the HRG design is incorrect or the cost data submitted is incorrect.

Figure 2 below gives an example of inconsistent relativities from 2010/11 reference costs. HRGs 2, 3 and 4 have the correct relationship between Category 2 severity and Category 1 severity, that is, the more severe (Category 2) HRG is more costly than the less severe (Category 1). However, HRG 1 has the opposite relationship.

⁵ Reference costs: review of uses by the Department of Health and national partners, Department of Health (2010)

⁶ Improving coding, costing and commissioning, Audit Commission (2011)

⁷ In the NHS context, top down costing refers to the process of allocation and apportioning costs from pooled costs to HRGs. Typically this process does not trace costs to individual patients.

⁸ Costing In National Health Services: from reporting to managing, Christopher Chapman and Anja Kern, CIMA publication

Table 1: Chapter H reference cost relativities

Source: Reference costs 2010/11

HRG	Category 1 (Less severe)	Category 2 (More severe)
1. Major Hand Procedures for Trauma	£3,047	£2,716
2. Intermediate Hand Procedures for Trauma	£2,256	£2,461
3. Intermediate Foot Procedures for Trauma	£3,969	£5,368
4. Minor Foot Procedures for Trauma	£2,309	£3,861

- **Granularity**

[Strategic Options for Costing](#) identified that the level of data aggregation in reference costs limits how they can be used for pricing. For example, reference costs do not contain a breakdown by different types of costs, such as medical staffing, drugs or wards (these are known as “cost pools”). Such information could be used to validate the accuracy of reference cost data. As reference costs are, by definition, the average cost per HRG per provider, they do not give any information on the variation of patient costs within a provider for the same HRG, or other relevant information such as the underlying diagnoses and procedure codes. Such information could help to improve currency design and enhance the usefulness of the data for other users.

- **Activity data**

Reference costs, and all other types of costing, are dependent on the data quality of the underlying inputs, especially activity data. There are concerns that the quality of clinical coding is still poor at some providers, leading to inaccurate activity data which subsequently impacts on reported costs⁹.

Question 1

Do you agree with our assessment of reference costs? Are there other strengths or weaknesses of the current process that we should be considering?

⁹ Right data, right payment, Audit Commission (2012)

3.3. Monitor's costing work to date

Costing Patient Care was informed by the report [Strategic options for costing](#) and by contributions to and responses from stakeholders to that work. The report assessed options and made recommendations for improving the methodology, collection and assurance of NHS costing. The key recommendations were:

1. Develop mandatory and more detailed standards for cost allocation, building on the HFMA clinical costing standards,
2. Collect patient-level cost data,
3. Use costs from a representative sample of providers only for price setting, which could improve data quality, and
4. Assure cost submissions using a combination of self assessment, peer review and targeted external assurance to improve data quality at a proportionate cost.

We presented the report in a joint [webinar](#) with PwC and HFMA attended by over 500 people from across the health sector. We also received 27 written responses to the costing report, which are described in our [Summary of stakeholder responses](#) document. These responses, and those from live voting conducted during the webinar, were broadly supportive of the report's recommendations. However, some stakeholders expressed concern over the proposal to collect costs from a representative sample of providers. There were also mixed views on the appropriate timescale for implementation.

4. Long-term vision

This section describes Monitor's objectives for costing and our long term vision for the future of NHS costing, which seeks to make greater use of patient-level cost data.

4.1. Objectives for costing

Understanding how and where costs are incurred should be a key area of focus for the management team of any provider, to help them to run their organisation efficiently. Providers themselves therefore should have a strong interest in improving the accuracy and granularity of their cost data. This has been demonstrated by the recent investment many providers have made in more sophisticated costing systems.

Price regulation will be one of Monitor's main levers for driving improvements in the quality of care for patients. More accurate and comparable cost data is a key input to the price regulation process.

Six specific objectives for costing and cost collection are described below, which should benefit all users of NHS cost data. Section 5 describes the policies and actions we expect will help us achieve these objectives.

- 1. Improve data quality**

Reference costs in 2011/12 described £53.4bn of NHS activity, and supported £28bn of reimbursement to providers through PbR. Given the magnitude, it is important to ensure a continued focus on high data quality. Better data quality will also benefit providers as they seek to manage their organisations and achieve better value and higher quality patient care. Section 5 describes some of our policies for achieving this objective, such as engaging clinicians, improving validation and assurance, and collecting costs used by management for other purposes.

- 2. Increase comparability and consistency of data**

Improvements to data quality alone will not deliver the cost data that Monitor, providers and other national bodies need to fulfil their respective responsibilities. Costs also need to be prepared to a consistent standard, which are comparable between organisations. From the provider perspective, more comparable data should make benchmarking exercises, where providers compare their own costs against those of other organisations, more meaningful. Our understanding is that benchmarking analysis is currently undermined by data quality and comparability issues which may mask true performance issues.

- 3. Improve transparency**

A consistent message from providers is that price setting, and other regulatory processes, should be transparent. The Department of Health has been working to improve the transparency of price setting, for example, by publishing the *Simple Guide to Payment by Results*¹⁰, and by collecting reference costs in terms of spells (which has the potential to simplify some opaque technicalities of the current system, in particular the episode-to-spell

¹⁰ A simple guide to Payment by Results, Department of Health (2011)

conversion). Our intention is to continue building on this transparent approach, by collecting more granular data, which will enable providers to explore the detailed cost information supporting our pricing decisions

4. Develop the potential for new pricing mechanisms

Currently, prices for a particular unit of care are based on the average cost of providing that unit across all providers who submit reference cost data. We believe a more sophisticated and robust approach to price setting is possible if we collect the appropriate data. For example, patient-level cost data should enable the costs of individual patients to be tracked over the course of the year. This information could be used to develop new ways of price setting for patients with long-term conditions. Currently, the cost data that would enable the development of such price-setting mechanisms is not widely collected. Our proposal is to collect data that creates more options for innovative price-setting mechanisms that will ultimately benefit patients.

5. Proportionate regulatory cost

Collecting cost data places a regulatory burden on providers. However, we believe some costs on providers are necessary to improve the quality of cost information. The regulation of NHS prices controls large funding flows and improvement in the way prices are set has the potential to deliver better value for tax payers and higher quality care to patients. We will seek to ensure that any costs incurred are proportionate to the benefits they deliver. One way we intend to achieve this is by aligning the regulatory cost collections with costs produced by the sector for other purposes, such as patient-level costs, already reported for provider management purposes.

6. Improve the use of cost data by managers and clinicians

We are committed to supporting NHS providers to drive up the quality and accuracy of their costing. Effective clinical and finance engagement in costing within NHS organisations is pivotal to achieve this outcome. Better quality cost information will benefit providers, as well as Monitor, as they use this information to manage their organisations.

4.2. Use of patient-level cost data

In the long term, we propose to move towards using patient-level cost collection as the main source of cost data informing price setting. Providers have increasingly invested in sophisticated IT systems to cost at the patient-level. PLICS have been implemented at 93 trusts across the NHS and 80% of all NHS and Foundation Trusts have implemented, are implementing or are planning to implement PLICS¹¹. We believe there is potential to incorporate this development more substantially into price setting, subject to suitable data quality. The granularity of PLICS data has many additional uses for benchmarking, validation, currency design and price setting.

We intend to maintain the overall approach of collecting costs used by the Department of Health, which is:

- A central body provides guidance and a template for the preparation of costs;
- Providers calculate their costs for collection using this guidance;

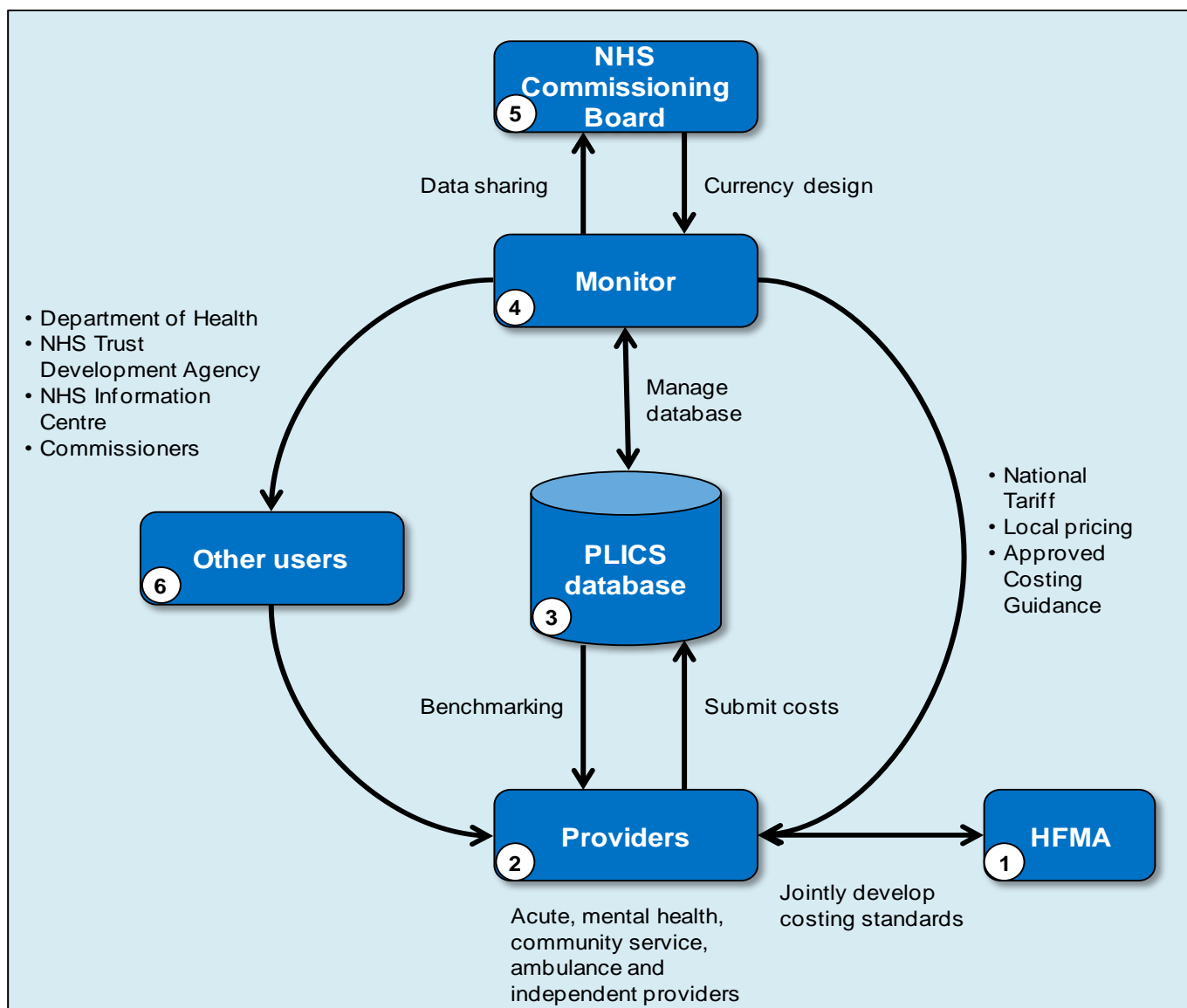
¹¹ PLICS Survey, Department of Health (2012)

- Providers submit their costs to a central body for validation and cleansing; and
- The central body uses this information to inform price setting and shares the data with other policy makers.

A national PLICS database could also be a valuable source of information for other users, such as providers (for benchmarking purposes), the Department of Health and the NHS Information Centre (as shown in Figure 2 below). Appropriate safeguards and controls over the data would need to be put in place to protect the confidentiality of patients and providers. Our current intention is to pilot a collection of PLICS data in 2013, and use patient-level data to inform price setting in the future. This transition is likely to take several years, and is dependent on the outcome of the pilot. In the interim, Monitor will rely on reference costs collected by the Department of Health to inform price setting. We will also work with Department of Health colleagues and the sector to ensure the quality of reference costs continues to improve. The increased uptake of PLICS could also facilitate the introduction of more accurate bottom-up costing methodologies, such as Time Driven Activity Based Costing as described by Kaplan and Porter¹².

¹² How to Solve the Cost Crisis in Health Care, Harvard Business Review, September 2011

Figure 2: Long term vision for the future of NHS costing



As shown in Figure 2, the role of each organisation in our vision is:

1. Healthcare Financial Management Association (HFMA)

The HFMA continues to develop acute and mental health clinical costing standards, jointly with service providers. In future, these could be extended to community and ambulance providers. Monitor would then adopt these standards as part of our *Approved Costing Guidance*. In the future our requirements for costing could differ from the HFMA standards in certain areas because of our specific requirements for price setting. In this case we would develop additional documentation to support the *Approved Costing Guidance*.

2. Providers

Acute, mental health, community service and independent providers prepare costs according to Monitor's *Approved Costing Guidance*, including the HFMA standards. They would submit data to a national PLICS database.

3. **PLICS database**

The national PLICS database is a rich source of information for policy makers and providers. Monitor could make aggregated or anonymised data available in the public interest, but providers and patients would be protected by appropriate information governance arrangements.

4. **Monitor**

Monitor will issue the *Approved Costing Guidance*, manage the PLICS database including data sharing where appropriate, and work with the NHS Commissioning Board and other national bodies on pricing. Monitor would use the PLICS data to inform the setting of prices.

5. **NHS Commissioning Board**

The NHS Commissioning Board would use the database to understand, at a granular level, the cost implications of currency design.

6. **Other users**

The database could also support the requirements of other users such as the NHS Information Centre and potentially commissioners (subject to appropriate safeguards).

Question 2

Do you agree with our objectives for costing and our long term vision set out in Section 4? (Page 16)

5. Approach to costing and cost collection

This section describes Monitor's approach to policy making for costing and cost collection, and our proposed actions to improve costing in 2013. We also describe our approach to mental health, community service and independent providers.

5.1. Consideration of options

We have considered a wide range of options to improve costing and cost collection. Our policy analysis has been informed by Audit Commission reports on the data quality of reference costs, work we commissioned including the [Strategic options for costing](#) report, insights from other regulators and academics, and the views of stakeholders. We believe this transparent and evidence-based approach to regulation will lead to better policy formulation.

In the process of formulating our approach to costing, some options were eliminated because they were inconsistent with our objectives (outlined in section 4.1). They are described below.

Hypothetical costing

One option to understand costs is to estimate costs using a hypothetical model of an organisation, without fully absorbing all costs incurred by providers, an approach used by regulators in other sectors. In this approach a patient pathway would be separated into activities, and the resources supporting those activities are identified and costed. Although this approach could be valid for estimating costs, we rejected it as a basis for price setting as complex and potentially diverse models of delivery of patient care would be difficult to model accurately. One consequence of this approach could be that estimated costs might not in practice reflect the actual costs incurred by providers, which would be inconsistent with the objective of improving data quality.

Centralised costing

Another option considered but rejected is centralising the calculation of reference costs. Monitor could obtain the general ledger from each provider and use operational data (e.g. head count, activity, theatre minutes) to conduct our own cost allocation. This option was eliminated because it would reduce the transparency of price setting. It may also undermine costing capabilities of providers and reduce clinical involvement in the process, which we would wish to avoid because having a first-class understanding of the costs incurred helps providers improve the efficiency and quality of patient care.

5.2. Approach for 2013

Strategic Options for Costing developed and assessed options for improving the quality of cost data used in price setting. We have considered the recommendations of the report, and developed our approach further with input from stakeholders. The process of policy development is ongoing and we continue to refine our approach on the basis of feedback from stakeholders to this document and in other forums. Our proposed policies for achieving our objectives (outlined in section 4.1) are set out below, as well as the rationale behind these policies and our proposed implementation actions for 2013.

5.2.1. Collect patient-level costs

Our proposed approach is to collect patient-level cost data, which could, over time, replace reference costs as the main source of cost information used to support price setting.

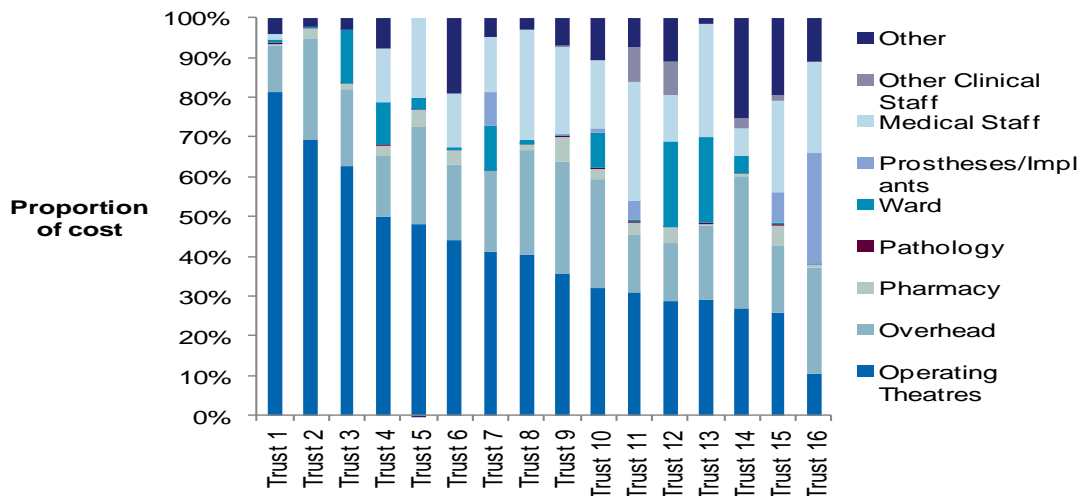
Rationale

Collection of a patient-level data set could support clinical engagement in costing, improve benchmarking and provide a more detailed and reliable data source for price setting. The key benefit of PLICS is that it records the actual resource usage of patients, and allows users to explore the cause of cost variation at the granular level of episodes, diagnoses and procedures.

In Figure 3, we illustrate analysis of PLICS data, based on data provided by the Patient Cost Benchmarking group. PLICS data allows the costs of an HRG to be broken down by cost pools. In this example for a cataract HRG, there is a broad range in the proportion of costs classified as operating theatres between providers. From a price setting perspective this information is useful because it enables us to create extra validation – for example we could develop a template that does not permit providers to submit costs in inappropriate cost pools for that HRG. From a provider perspective, this type of analysis is useful for improving costing and benchmarking services. A recent [report by the Nuffield Trust](#), argued that when used correctly PLICS can help providers find efficiency savings, although further evidence may well be needed to demonstrate the full benefit of PLICS.

Figure 3: Cost pool as proportion of total cost by trust for BZ02Z (Cataracts)

Source: Monitor analysis of Albatross Patient Cost Benchmarking data



Implementation of PLICS is increasing rapidly across the NHS. 145 trusts have implemented or are implementing PLICS, up from 126 in 2011. 80% of all trusts are now planning, implementing or have already implemented PLICS compared to 71% in 2011. The Department of Health has promoted the benefits of PLICS for providers in terms of better financial management and engagement of clinicians. Costing at the level of individual patients improves the accessibility of the data to clinicians, and clarifies the relationship between treatment and cost. In previous years the Department of Health considered moving to greater use of PLICS data to support price setting, however there was insufficient coverage of PLICS across NHS organisations. This is no longer such a limiting factor for the acute sector, although PLICS is still rare for mental health, community services and ambulance trusts (as Table 2 shows below).

Figure 4: Number of organisations implemented or implementing PLICS 2007-2012

Source: Department of Health

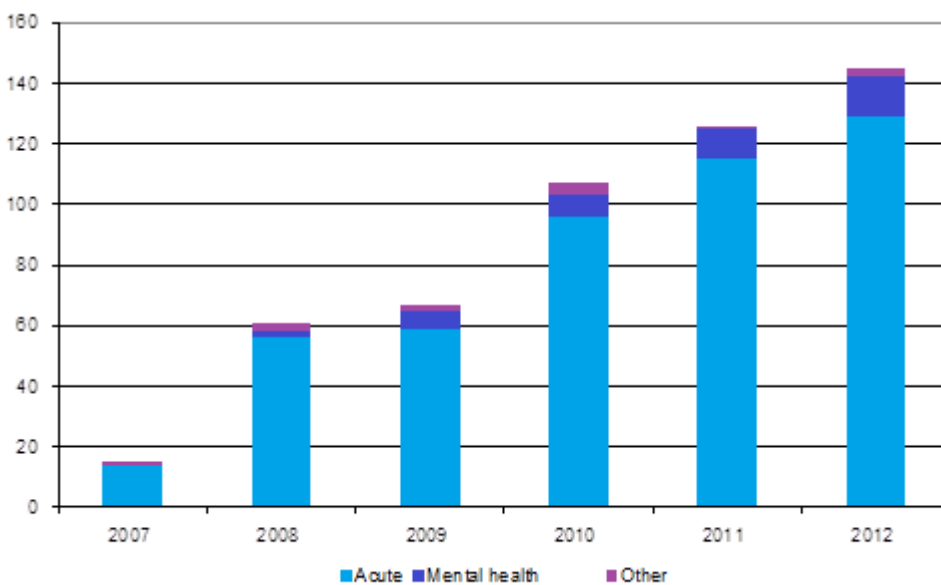


Table 2: 2012 PLICS implementation status by provider type

Source: Department of Health

Status of PLICS	Acute	Ambulance	Community	Mental health	All trusts
Implemented	88	0	0	5	93
Implementing	41	1	2	8	52
Planning	15	0	5	33	53
Not planning	21	10	9	10	50
Total	165	11	16	56	248

Proposed actions

We propose testing the feasibility of making greater use of patient-level data to regulate price setting.

Our proposed actions in 2013 to support this approach are:

1. Issue guidance and a template to support a PLICS collection

We have drafted PLICS collection guidance and are developing a template to support a pilot 2012/13 PLICS collection. The PLICS collection guidance (published today) explains the scope of the collection, required data fields, and how to complete the template. The data fields include cost broken down into cost pools and basic patient characteristics. Our intention is only to collect non-patient identifiable characteristics, and the patient identifiers will be pseudonymised in our collection process. We will ensure that the collection process is informed by the latest thinking on Information Governance, including findings from the Caldicott review¹³. Our intention is to revise this document based on further comments from stakeholders and issue finalised guidance in 2013. See Section 6 for further details on the new guidance documents.

2. Pilot a PLICS collection from acute providers

Using the guidance and template described above, we will conduct a voluntary PLICS collection of 2012/13 data from acute providers (admitted patient care only) in 2013. We encourage all acute providers to submit data to us, where possible. The data will help us to further our understanding of the feasibility of using PLICS data in price setting. In the future we may make this collection mandatory or consider collecting data from a representative sample of providers. The data collected in 2013 will be used for analytical purposes, to develop our collection capability, and potentially to inform price setting in 2015/16. Subject to satisfaction of commercial confidentiality and competition requirements, our intention is to make some collected data available to other organisations for research purposes. We want to schedule the collection shortly after financial year end but recognise that providers have other commitments such as the reference cost collection.

¹³ <http://caldicott2.dh.gov.uk/>

Question 3

What is the most appropriate timing for the pilot PLICS collection?

3. Continue to analyse the PLICS data collected from benchmarking groups

We asked some existing benchmarking groups to provide us with 2011/12 cost data for analysis. We are currently analysing this data to further our understanding of how PLICS could be used in price setting and how to improve the quality and consistency of the data. We do not intend to use this data for price setting in 2014/15, but it will help us to determine how patient-level data could be used for price setting in future years. It could also assist us in assessing the feasibility of using a sample of costing data to set prices.

5.2.2. Develop costing methodology

We propose to advocate strongly that all providers adopt the HFMA costing standards where possible and support the HFMA to continue developing the standards. In time we will consider moving towards mandating the standards, if appropriate.

Rationale

For cost data to be useful for price setting or benchmarking purposes, it needs to be prepared using a consistent methodology. The HFMA, in partnership with the sector and the Department of Health, has developed ten costing standards for acute and mental health services¹⁴. These define a standardised methodology for the allocation and treatment of costs, and are not currently mandatory.

In *Strategic Options for Costing*, it was recommended that we mandate the use of the HFMA acute and mental health clinical costing standards after consulting with a wide range of stakeholders. This recommendation was strongly supported from other stakeholders in the written responses to the costing report. For example:

“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.”

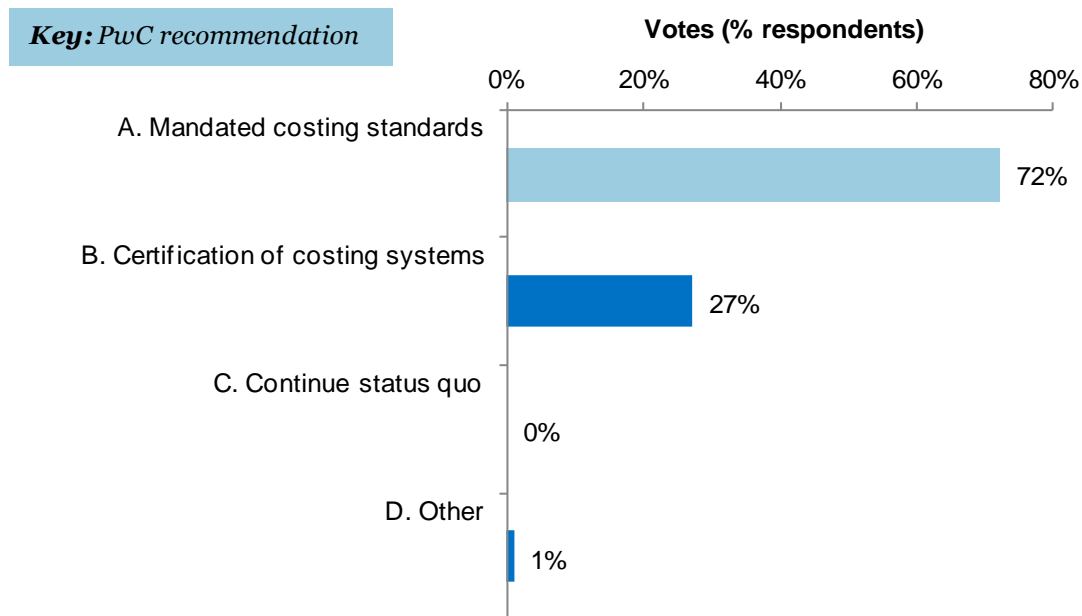
Source: Summary of responses to the *Strategic Options for Costing* report

As shown in Figure 5, the majority of attendees on the webinar also supported mandating costing standards:

¹⁴ Acute Health Clinical Costing Standards 2012/13, Mental Health Clinical Costing Standards 2012/13, HFMA (2012)

Figure 5: Webinar voting results

Source: Monitor/HFMA/PwC costing webinar voting, 129 respondents



The vast majority of providers with PLICS are already using the HFMA costing standards. For example, the most recent Department of Health PLICS survey found that 84 of 93 trusts with PLICS were using the standards. However we do not know the extent to which providers are complying with all ten of the costing standards, and 155 providers have not yet implemented PLICS. As a result we believe it is not appropriate to mandate the standards at this time, but we are open to the possibility of making standards mandatory in future years.

Proposed actions

For the 2013 pilot PLICS collection, our intention is to promote the HFMA costing standards as recommended practice, and ask participating providers to confirm that they are compliant with the standards, or explain where there are differences to these standards, and the reasons for these differences. The HFMA will continue to be responsible for the clinical costing standards, and we are engaging with, and supporting, the HFMA in progressing their further development.

1. Include the 2013/14 HFMA standards in the costing guidance

We strongly recommend that providers use the HFMA 2013/14 standards where possible, and we will integrate the standards into our overall guidance to ensure consistency where possible.

2. Adopt a “comply or explain” approach

It is not known to what extent providers are complying with the existing HFMA costing standards. As a result our intention is to ask providers participating in our pilot 2012/13 PLICS collection to comply with the 2013/14 HFMA standards where possible or, where they cannot comply, provide comments and explain the reasons for non-compliance. This will give us and the HFMA valuable information in understanding why different approaches may be necessary and where future support or guidance may be required.

5.2.3. Improve assurance over data quality

Our proposed approach is to focus on self assessment for assurance of the PLICS collection in the pilot stage, and consider using other forms of assurance (such as peer review or external assurance) if the collection is continued in future years.

Rationale

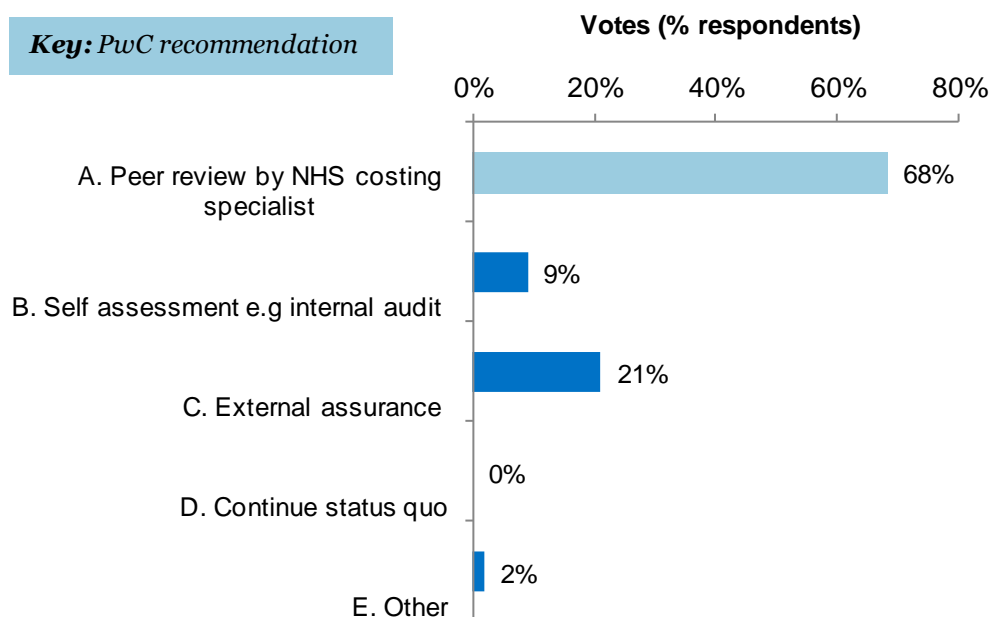
We considered three options for assurance: self assessment, peer review and external assurance. Assurance is costly and should be proportionate to the benefit it delivers. We believe some assurance costs are justified for reference costs because of their importance and the financial scale of PbR. If the PLICS collection replaced reference costs for use in price setting in the future, we would consider an external assurance programme for the PLICS collection.

The *Strategic Options for Costing* report recommended the use of peer review, one-on-one assessment by NHS peers, to give assurance over costing. As shown in Figure 6, this recommendation was supported by stakeholders on the webinar. However peer review – as described in this report – may not be feasible due to concerns raised by other stakeholders about commercial confidentiality. An alternative that is now emerging is greater coordination of provider costing groups.

Previously, Strategic Health Authorities have hosted training sessions on reference costs to brief providers on changes to the collection. We are concerned that, as the Strategic Health Authorities are dissolved, some local costing groups may be lost. However, there are a range of other local and national costing groups which help providers to share best practice, and we are working with the HFMA and the Department of Health to catalogue the existing groups, and considering whether more could be done to support these groups going forward.

Figure 6: Webinar voting results

Source: Monitor/HFMA/PwC costing webinar voting, 129 respondents



While the PLICS collection is still in the pilot stage, we are proposing to focus on self assessment only as an assurance mechanism. Self assessment is not an independent method of assurance, but for the purpose of the pilot PLICS collection only, we believe a low cost assurance programme is proportionate to the intended use of the data.

Actions

We are proposing two forms of self assessment in the collection:

- 1. Self assessment checklist**

We propose creating a self assessment checklist to help providers complete the PLICS return in the collection template. This would be similar to the checklist used to support the reference cost collection.

- 2. Materiality and Quality Scores**

Materiality and Quality Scores (MAQS) are a tool developed by the HFMA to help providers self assess the level of development of their costing approach. In the future a MAQS threshold could be used to assess data quality. We recognise stakeholder concerns with MAQS and we are working with HFMA to deliver potential improvements to the tool. The HFMA is updating the MAQS methodology for the 2013/14 standards which should address some of the concerns raised by stakeholders regarding subjectivity. We are intending to trial a collection of MAQS either through the PLICS collection or through reference costs in 2013.

5.2.4. Conduct further research on sampling

We propose conducting further research on the benefits and costs of sampling, using the patient-level data we have collected already and the data we intend to collect in 2013.

Rationale

There is a trade-off when choosing the number of providers to collect costs from between data quality and representativeness¹⁵. Currently it is not appropriate to use the full population of data in pricing as some providers do not have sufficiently accurate costing data. In reference costs, all NHS Trusts and NHS Foundation Trusts are represented in the collection but, as already noted, the data includes some poor quality submissions. One alternative approach is to collect costs from a sample of providers with good data quality. The sample could be stratified by provider type to ensure it is representative. Sampling could improve data quality in the short run. Over the longer term, the sample could be expanded as costing improves at more providers. Sampling is used in other countries such as Germany¹⁶.

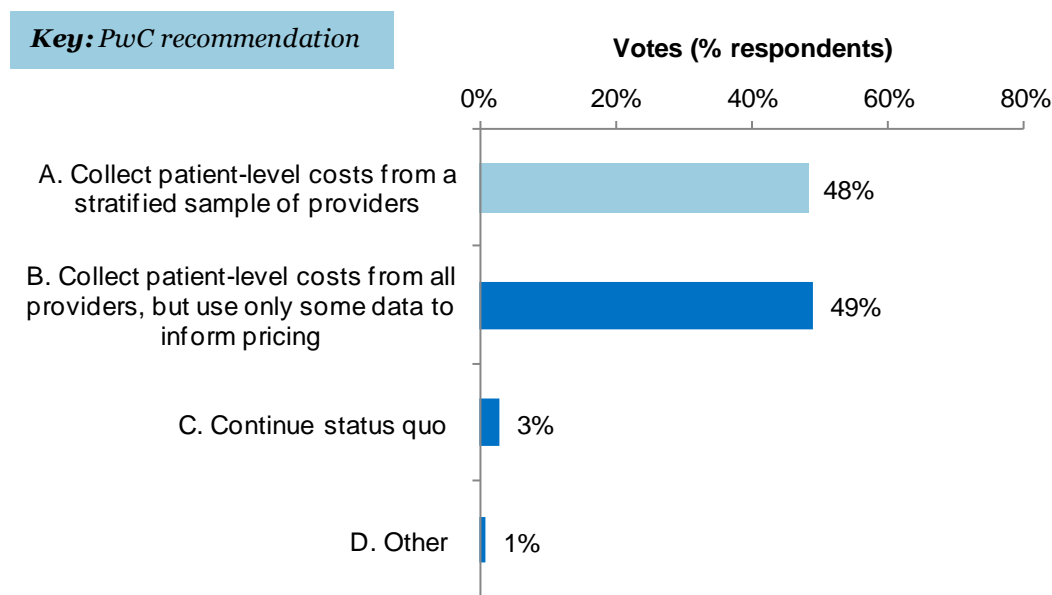
Stakeholders have expressed concern about the viability of sampling through both the webinar voting (as shown in Figure 7) and in the written responses to *Strategic Options for Costing*. We need to conduct further analysis of cost data (including the data we collect from the 2013 pilot PLICS collection) and engage further with stakeholders before making a policy decision on sampling.

¹⁵ Methods to determine reimbursement rates for diagnosis related groups (DRG): A comparison of nine European countries, Schreyogg (2006)

¹⁶ Diagnosis-Related Groups in Europe - Moving towards transparency, efficiency and quality in hospitals (2011)

Figure 7: Webinar voting results

Source: Monitor/HFMA/PwC costing webinar voting, 113 respondents



Proposed action

We propose to continue to analyse the patient-level data we have already collected, and analyse the data we collect in 2013, to improve our understanding of the implication of sampling before making a policy decision.

5.2.5. Cost non-NHS patient care activities

We propose to reduce the distortion caused to the cost of patient care by “netting-off” income from non-NHS patient care activities (termed non-contractual income).

Rationale

Education and training, research and development, revenue from private patients and a range of other excluded items are not reimbursed through the national tariff and as such are excluded from reference costs¹⁷. The following funding streams must be excluded, for example:

- Medical and dental education level (MADEL),
- Service increment for teaching (SIFT),
- Non-medical education training (NMET),
- Some research and development funding, and
- Revenue from private patients.

When preparing reference costs, providers are required to net-off the income associated with these funding streams, as well as other non-contractual income, from the cost quantum before calculating reference costs. If the income is more than the associated costs of providing these services, at a national level this would have the impact of lowering reference costs (and tariff) below the average

¹⁷ Section 14: Non-contractual income, Section 15: Services excluded from reference costs, Reference cost guidance for 2011/12, Department of Health (2012)

cost of providing patient care. Furthermore it would disadvantage providers with below average income from non-tariff sources. Similarly, if income from these sources were less than the associated costs of providing these services, at a national level this would have the impact of raising reference costs (and tariff) above the cost of providing patient care.

We acknowledge the risk of distortions in reference costs and tariff created by netting-off, and we would prefer that the cost of providing the service, rather than the income from the service, was excluded in the future. This would help to reduce the risk of tariff distortion. We will continue to engage all relevant stakeholders including providers and the Department of Health on this issue and will aim to change the netting-off requirement in future years. The HFMA clinical costing standards (Standards 6 and 7) define an approach for the treatment of income and separate identification of costs, which we hope providers can adopt. In 2013, the netting-off requirement will still apply to reference costs.

Proposed actions

The simplest of non-contractual income streams to cost is private patients. For our pilot PLICS collection we propose including private patients in the collection, accompanied by a flag to indicate whether patients are NHS or privately-funded. This will enable us to exclude the costs, rather than the income, of private patients from pricing analysis.

5.2.6. Enhance the quality of reference costs

We propose to parallel run the pilot PLICS collection with the reference cost collection, support the Department of Health to deliver improvements to reference costs, and continue to emphasise the importance of assurance for reference costs.

Rationale

Monitor is accountable for reference costs from the 2012/13 collection. We have been learning from providers and other stakeholders about reference costs, and are keen to help direct further improvements to reference costs, building on the work of the Department of Health and others. The Department of Health will continue to manage the collection on our behalf. We continue to value the input of stakeholders into the reference cost process, and rely on the advice of the Reference Cost Advisory Group, the NHS Commissioning Board and other relevant stakeholders.

The Department of Health has worked over a number of years to improve the reference cost collection. It is the most comprehensive and detailed record of NHS spending, and is a valuable source of information for price setting. Some of the recent improvements the Department of Health has introduced to reference costs include:

- A major overhaul of the 2010/11 reference cost guidance to improve accessibility for users, such as by introducing hyperlinked terms and streamlining the document,
- The collection of spell level cost data to improve the transparency of the tariff calculation,
- Introduced a new guidance section to support reconciliation of the reference cost quantum back to the financial accounts, and
- Established a national role to develop effective clinical and finance engagement in the NHS and conducted two national surveys (in partnership with HFMA) between November 2011¹⁸

¹⁸ [HFMA clinical-financial engagement survey – Finance Managers \(autumn 2011\)](#)

and February 2012¹⁹ to understand the current state of clinical-financial engagement and how well clinicians and finance professionals understand each other's business and share and use clinical and cost data on routine basis. As a result, the Department of Health devised four levels of engagement in the NHS²⁰ from purely board level (level 1) through to full engagement at different levels and across all clinical specialties (level 4).

Proposed actions

Monitor, the Department of Health and the NHS Commissioning Board are discussing a number of potential improvements to reference costs for the 2012/13 collection. As normal we are seeking the advice of the Reference Cost Advisory Group, and other stakeholders on these measures. Some of the improvements we are considering include:

1. Further updates to the guidance to improve usability

Stakeholders have told us the costing guidance needs to be clearer, more accessible and consolidated into fewer documents. The Department of Health is decommissioning the NHS Costing Manual and consolidating the necessary text into either the HFMA costing standards or the reference cost guidance.

2. Updated assurance measures

- **Targeted external assurance programme**

External assurance should be targeted at providers that appear most at risk of submitting lower quality data, to achieve the best value for money. We are considering appropriate risk factors for triggering external assurance, which could incorporate a broad range of financial and non-financial indicators. We will announce further details on external assurance of reference costs in 2013.

- **Provider Board approval of the process for submitting the reference cost return**

We propose elevating approval of the process for submitting the reference cost return to Board level to raise the profile of costing. Approval could be on the process and methodology of costing rather than the calculated costs themselves.

- **Self assessment against an enhanced quality checklist embedded in the collection return**

The checklist would help providers to self assess their reference cost submission, and would be supported by evidence of the processes undertaken that Boards of providers could use when making their self certification declarations.

3. Collection of HRG costs by cost pools, based on the definitions in the HFMA standards

Cost pool data would be used for validation purposes and will provide a richer data set for benchmarking. An alternative option we are considering is to collect this information through the pilot PLICS collection.

4. Collection of Materiality and Quality Scores

Materiality and Quality Scores (MAQS) are a tool developed by the HFMA to help providers self

¹⁹ [HFMA clinical financial engagement survey – clinicians \(spring 2012\)](#)

²⁰ http://www.hfma.org.uk/publications-and-guidance/publications.htm?sort=3&keyword=&categories=info_8

assess the sophistication of their costing. An alternative option we are considering is to collect this information through the pilot PLICS collection.

Question 4

Do you agree with the proposed actions set out in Section 5? Are there other actions we should be prioritising for 2013?

5.3. Mental health, community services, ambulance services and independent providers

Costing Patient Care is primarily focussed on the acute sector. Mental health and community providers generally have less well developed activity and costing systems than the acute providers. So far only 5 mental health trusts have implemented patient-level information and costing systems, although another 41 are implementing or planning to implement PLICS in the future²¹. In part this may be due to the absence of a PbR system in these care settings, which means that there are fewer incentives for a granular understanding of the costs of delivering patient care.

Monitor is keen to support the development of improved activity and costing data in mental health, community services and is working with the Department of Health to develop appropriate costing methodologies. Costing in community services will become increasingly important as payment methods to deliver integrated care are designed and implemented. Monitor is part of the community tariff working group and we are using this forum to promote better costing in community services. Monitor is also supporting the long term condition year of care pilot site with a cost collection.

We recognise some ambulance service providers have good costing and activity data already, and we will engage with ambulance trusts to promote good practice.

In the future, we intend to collect cost data from the independent sector, to understand better the full range of costs incurred by providers of NHS services. We will draw on the experience of other regulators in cost collection from private companies, and we will continue to engage with providers on this issue.

²¹ PLICS survey, Department of Health (2012)

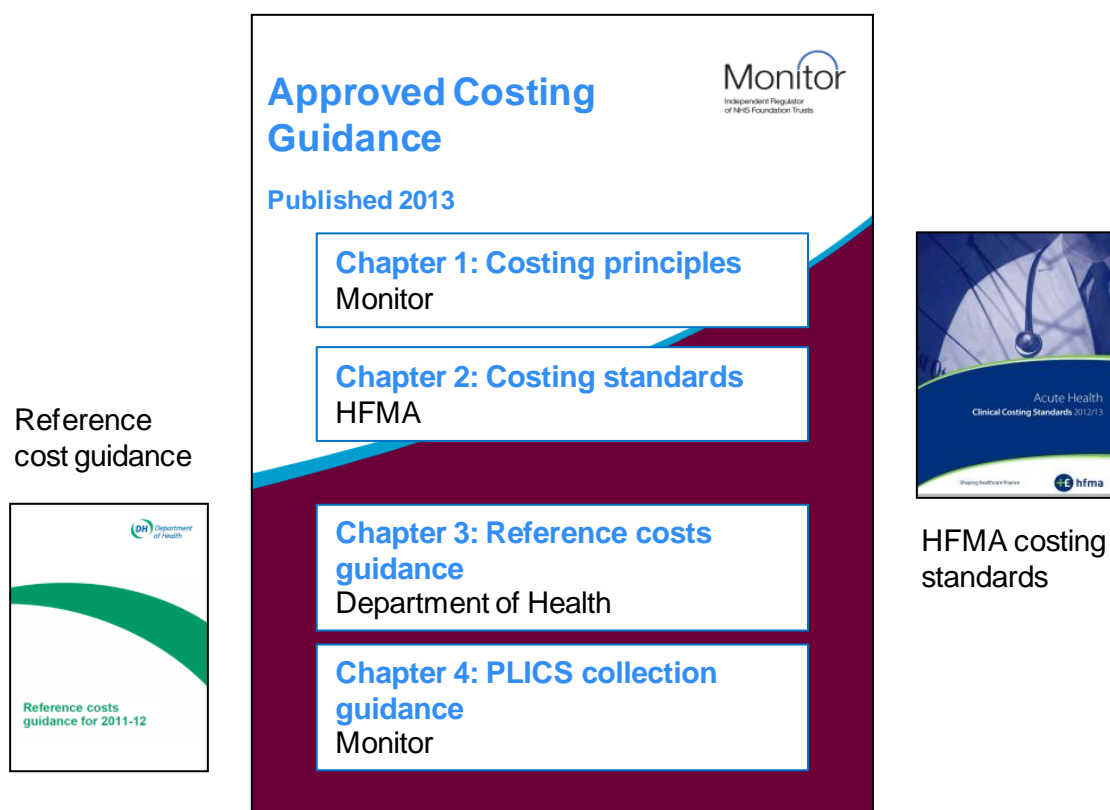
6. Costing guidance

This section introduces Chapters 1 and 4 of new costing guidance, published separately for stakeholder comment [here](#).

We believe there is scope to consolidate the existing costing guidance and improve the clarity and accessibility for users. The current proposal, detailed in the recent consultation on the provider licence, is that Monitor will issue its own [Approved Costing Guidance](#), setting out requirements for providers. NHS costing guidance has evolved over time as it changed to meet different needs. The reference cost guidance and NHS costing manual have been revised annually to meet changes to the collection, and the HFMA costing standards have been introduced. We believe Monitor's involvement in costing is an opportunity to review all costing guidance and improve the overall guidance package.

We have published two draft Chapters of *Approved Costing Guidance* for stakeholder comment. The new document is intended to bring together existing NHS costing guidance into a coherent framework, and is expected to be supported by the provider licence when it comes into force. As shown in Figure 8, the guidance contains four chapters covering costing and cost collection. Chapters 1 and 4 are published today in draft form for stakeholder comment. We would particularly welcome stakeholder comments on these documents as they mark a significant departure from the previous guidance, with a new focus on activity-based costing, and collecting costs at the patient-level.

Figure 8: Draft Approved Costing Guidance



Chapter 1: Costing principles

This contains principles and steps of NHS costing. The high-level principles outline an approach that should support any NHS costing exercise. The steps give an indication of how providers can apply these principles, with a particular focus on activity-based costing. This Chapter also explains the structure of the *Approved Costing Guidance*, and how to use the various documents. Chapter 1 is published in draft for stakeholder comment.

Chapter 2: Costing standards

This will contain the costing standards for acute and mental health clinical costing standards. The 2013/14 standards are expected to be published in early 2013. We strongly recommend that providers adopt these standards. For those participating in the pilot PLICS collection, we will be adopting the standards on a comply or explain basis. Providers will still be able to submit data where they are non-compliant, but we will ask for comments to explain non-compliance, as this will help us address bottlenecks in NHS costing, and help the HFMA develop the standards and consider future support if appropriate.

Chapter 3: Reference cost guidance

This will contain the reference cost guidance and is being prepared by the Department of Health. The 2012/13 reference cost guidance is expected to be published in early 2013 as per the normal timetable.

Chapter 4: PLICS collection guidance

This contains a new document to support the 2012/13 patient-level cost collection. This document is focused on the scope of our pilot collection, and gives details on how to use the collection template. For the preparation of costs, participating providers must use the HFMA standards where possible. This new Chapter is published in draft today for stakeholder comment. The collection template is available on request for testing, and we are continuing to test the template at provider pilot sites.

7. Stakeholder feedback

We welcome comments on all aspects of Monitor's costing proposals outlined in this document.

In particular, we appreciate your views and comments on the following questions:

1. Do you agree with our assessment of reference costs? Are there other strengths or weaknesses of the current process that we should be considering? (Page 13)
2. Do you agree with our objectives for costing and our long term vision set out in Section 4? (Page 19)
3. What is the most appropriate timing for the pilot PLICS collection? (Page 24)
4. Do you agree with the proposed actions set out in Section 5? Are there other actions we should be prioritising for 2013? (Page 31)

We also welcome your comments on the two chapters of the new draft [Approved Costing Guidance](#), published today. There are additional questions for stakeholders to consider about:

- Chapter 1: Costing Principles (Page 32)
- Chapter 4: PLICS collection guidance (Page 49)

To respond, please download and complete the [response form on our website](#) and return it by **5pm on Tuesday 11 December 2012**. We will consider your comments as we finalise the guidance for publication in early 2013.

This document was published on Monday 19 November 2012.

Please send your answers and/or general comments to pricing@monitor-nhsft.gov.uk. If you do not have internet or email access please write to:

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