Monitor

Making the health sector work for patients

Improving the costing of NHS services: proposals for 2015 to 2021

Our response to feedback

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.

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1. Introduction

On 1 December 2014 Monitor launched an engagement exercise on 'Improving the costing of NHS services'. The proposals set out an approach to costing that would deliver significant improvements in the accuracy and comparability of cost information. This would lead to cost savings through efficiencies that could be reinvested to improve the quality of care for patients. The improvements would be gained through applying a standard methodology using detailed costing standards and a defined minimum dataset (MDS) with national data dictionaries describing the data to be reported. Monitor would support the transition to the standard methodology across the sector through a transformation programme, focused on improving the capabilities of costing practitioners and encouraging engagement from board members and clinicians.

The proposed costing approach built on the long-term vision and objectives for costing highlighted in 'Costing patient care: Monitor's approach to costing and cost collection for price setting' published in November 2012.

We are very grateful for the positive and energetic feedback on the proposals, and for all the constructive comments and suggestions received. In light of these responses, we have amended the costing proposals in 'Improving the costing of NHS services' where relevant, as described in this document.

This document sets out:

- the original proposals outlined in 'Improving the costing of NHS services'
- the engagement process and the feedback we received
- Monitor's response to the feedback
- the next steps for the costing proposals.

Section 6 is a 'question and answer' section based on the key questions asked during the engagement process.

2. Overview of initial proposals

This section sets out the approach to costing and cost collection we proposed to the sector in December 2014.

The approach comprises an improved, transparent and intuitive costing method, including standard definitions and rules to ensure that information produced by this method is consistent. Adoption of this approach across the sector would make it possible to undertake a single, national cost collection each year, instead of the three separate cost collections that currently exist (education and training, reference costs and patient level cost). We believe this approach would benefit the sector greatly by producing comprehensive, consistent and high quality cost information.

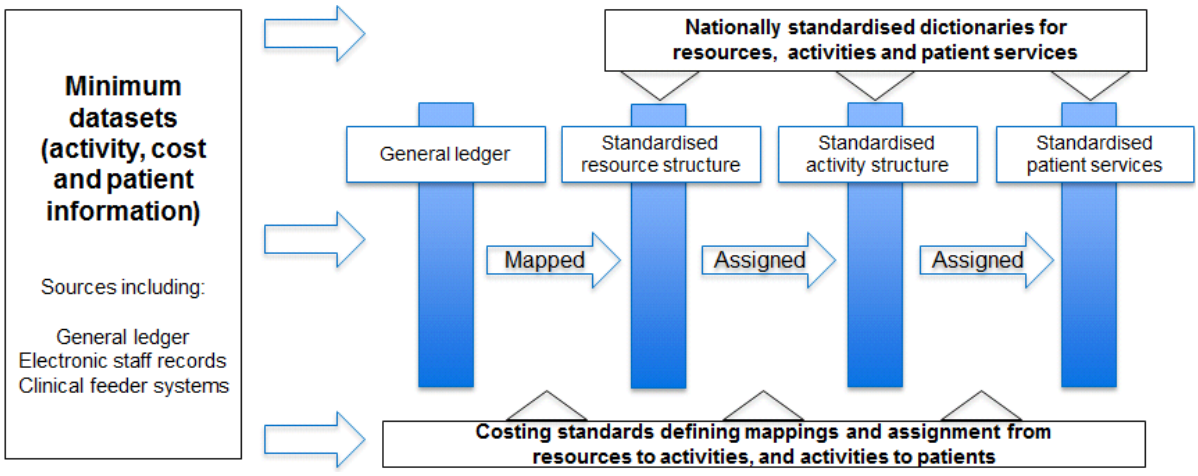
The full document containing more details on the initial proposals is available at:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/381990/Improving_the_costing_of_NHS_services_-_final.pdf

2.1. Proposed standard costing approach and single cost collection

The proposed costing method has three stages: Stage 1 maps the expenditure in a provider's general ledger to the human and physical resources. Stage 2 assigns specific resource costs to the activities that use those resources and Stage 3 assigns specific activities to the patients they relate to. Figure 1 illustrates the three steps for patient services; this approach also applies to non patient care activities.

Figure 1: The proposed costing method



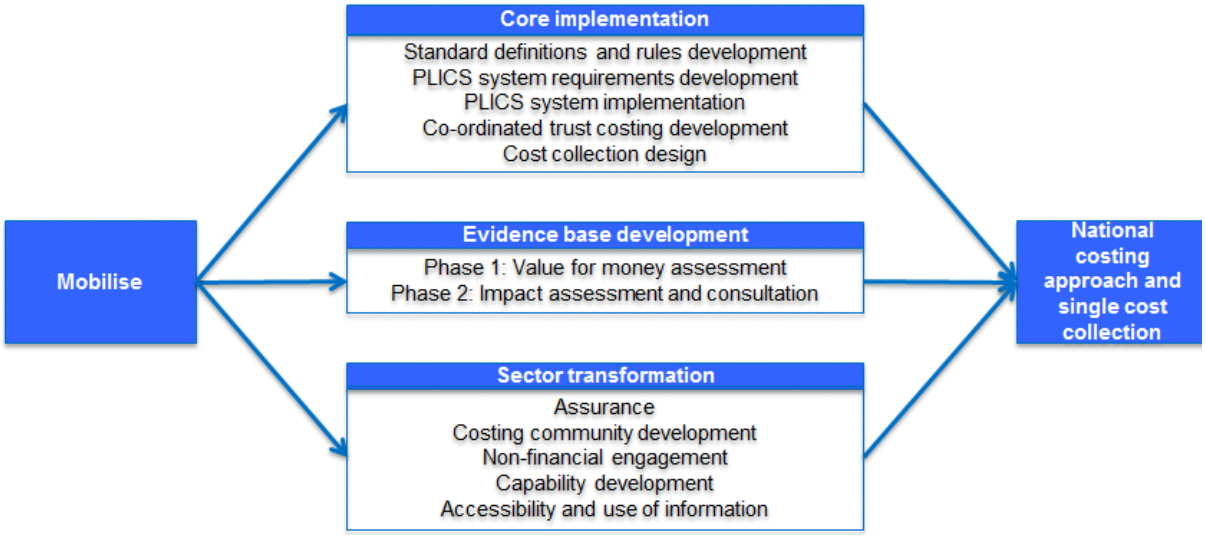
The 2012/13 patient level cost collection review noted that the costing processes currently used in different providers are generally logical but can vary significantly. To ensure a nationally consistent costing approach, we plan to introduce standardised data dictionaries, clear and comprehensive costing standards and minimum datasets. We also propose moving to a single annual cost collection

covering all provider activities. This would provide access to more detailed information than any current cost information held centrally in the sector.

2.2. How we propose to move to the costing method and single cost collection

The phased transition programme begins with a process of mobilisation. After this, several work streams − core implementation, evidence base work streams and transformation − run in parallel. See below.

Figure 2: The long-term development programme



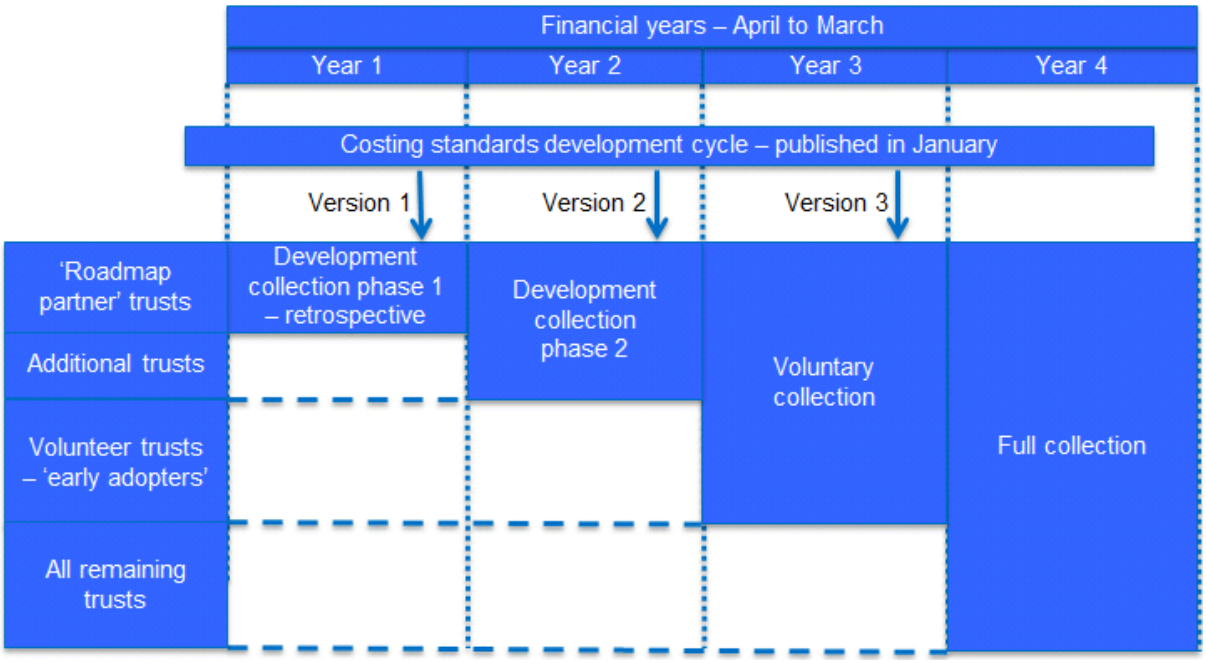
A key objective of the transition programme is to deliver change as quickly as possible. For this to happen, work needs to begin immediately on programme mobilisation, followed by costing standards and the development of Patient Level Information Costing Systems (PLICS) requirements. This involves a significant amount of transition work before the Value for Money assessment is complete. We are confident that these early work streams would provide a great deal of benefit to the sector as well as being necessary for the development of the proposed costing process, and should therefore not be delayed.

We proposed that service areas are developed in order, with acute and ambulance working towards national collections in parallel followed by mental health services a year later, and community services a year after that. Independent and integrated service providers would follow the same service-specific timelines. This means providers spanning service areas would need to develop costing following the service-specific timeline. Appendix 1 provides a high level illustration of the proposed timelines for each service area.

The proposed route to a mandated collection would take four financial years for each service area. ‘Development’ collections would take place in the first two years and be restricted to a few volunteer ‘roadmap partner’ providers that would work closely with Monitor to establish and test the new costing standards. The third year would include

a full voluntary collection and the fourth a mandated national collection. Providers submitting a patient level cost collection using the proposed method for the first time would also need to submit reference costs for that year. Once these are reconcilable to an acceptable threshold, there would be no further need to submit reference costs.

Figure 3: Four-year collection phasing



Depending on the results of these exercises, we proposed that the first year of mandated collection by the new method would be 2018/19 for acute and ambulance service providers, 2019/20 for mental health providers and 2020/21 for community service providers. If Monitor and NHS England decide to make the cost collection mandatory, the decision would be made 22 months prior to the cost collection year and would mean all foundation trusts, NHS trusts and independent providers subject to Monitor's provider licence would be required to implement the new costing method and collection process.

Transformation work streams would provide support for the core implementation by ensuring the quality of processes and outputs. Transformation includes the development of a framework for quality assurance and continuous improvement, as well as improving engagement of clinicians and senior managers.

3. The engagement process

3.1. Engagement methods

To gather feedback on the proposals, we ran an engagement process from 1 December 2014 to 16 January 2015, which was later extended to the end of January. It started with the publication of 'Improving the costing of NHS services' and included a series of events including:

- a live webinar and online survey[1]
- three provider and commissioner workshops in Birmingham, London and Leeds[2]
- a forum with costing software suppliers
- a roundtable discussion with representatives from organisations such as the Royal College of Nursing, British Medical Association and the Healthcare Financial Management Association
- an additional workshop for ambulance service providers. (Early feedback from ambulance service providers indicated that they had specific concerns about the proposals so we organised an extra workshop on 29 January 2015 specifically to discuss the proposals and further understand their concerns.)

We also invited and received written responses to the proposals.

3.2. Key themes

We were open to views on all aspects of the costing proposals but framed the engagement around four key themes:

- the pace of change built into the programme
- implementing the proposals by service area (the proposal for mandated cost collections for acute and ambulance services initially, followed by mental health, then community services)
- the merits of an accreditation process for costing systems
- perceived programme delivery risks.

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1 For more detail on respondents to the online survey, see Appendix 2
2 For more detail on the provider and commissioner workshops, see Appendix 2

3.3. How we analysed the feedback

Monitor's costing team collated, summarised and reviewed all the comments received throughout the engagement process. We grouped the feedback under the features of the costing proposals, such as single cost collection, Value for Money, and minimum requirements and accreditation for local PLICS systems, in order to construct recommendations. We then discussed the recommendations with the Costing Policy and Advisory Group (CPAG)[3], which helped us finalise the changes to the programme.

[3] CPAG is made up of representatives from across primary, secondary, community and mental health services (including clinicians). It was set up to advise Monitor and NHS England on the development of costing practices across the health sector.

4. What the sector said and our response

As mentioned above, we asked for feedback on four specific points, outlined below, but we welcomed views on the whole proposal.

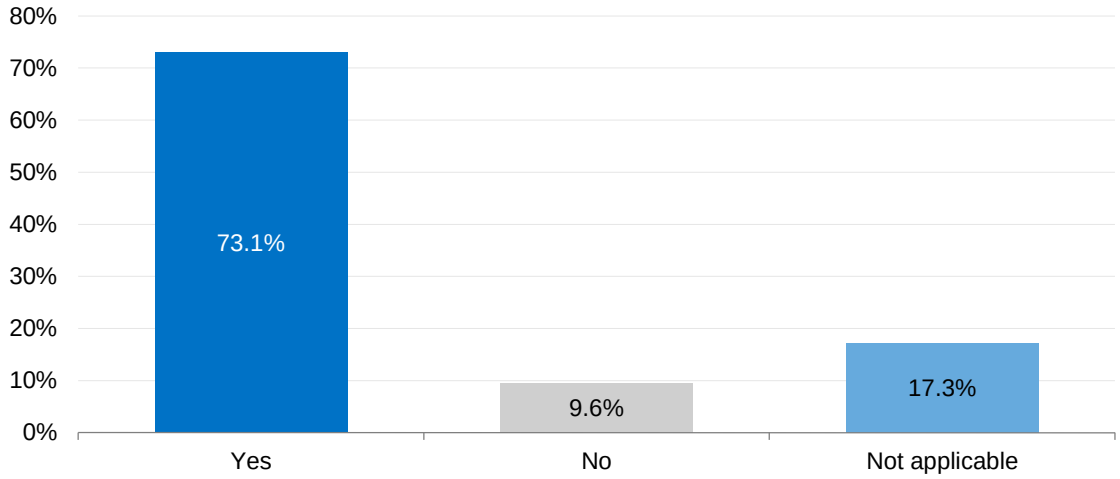
4.1. Pace of change

The pace of change refers to the four-year development cycle for each service area: two development cost collections for roadmap partners only, a voluntary cost collection open to all providers and a mandated cost collection in the fourth year.

4.1.1. Survey results

Survey respondents were asked whether the pace of change proposed was achievable in their organisation. A total of 43 people responded yes or no, with 88% of those believing the pace is achievable.

Figure 4: Survey responses to the question 'Do you think that the pace of the programme of implementation is achievable for your organisation?'



4.1.2. Summary of responses

The general consensus from the three workshops, emailed responses and the survey results was that the pace of change is achievable. However, some responses indicated that the pace was too quick and not achievable, and a small number suggested the pace should be faster.

Ambulance trusts strongly suggested that they were not well prepared for an immediate transition to patient level costing, and as a result the pace of change was too fast. Ambulance providers identified a number of issues that need to be addressed for consistent costing:

- an approach to consistently capturing patient identifiers, especially when patients are unconscious when they come into contact with them

- ways of classifying comparable services where local variations exist, such as providing GP services on ambulances, to generate meaningful benchmarking and tariff calculation
- a business rationale for patient level costing as ambulance providers currently cost at the incident or journey level.

Commissioners offered mixed responses, with some asking for a quicker pace of change and others arguing that speeding up the programme might compromise the accuracy of costs submitted. Some mental health service providers expressed concern that cost information may be used by commissioners before standards and consistency have been fully established.

Independent providers also offered mixed reactions, with some saying the pace of change was too quick, but others suggesting they were well placed to implement the proposals.

Respondents across all services recognised that trusts which currently have costing systems and experience of patient level costing would be better placed to meet the timescales proposed.

4.1.3. Our response

It is encouraging to see the positive feedback and the general view that the pace of change is achievable. The feedback from ambulance providers was very valuable and as a result we have re-phased the proposed implementation programme by one year for them. This would mean that the mandated collection for ambulance providers would move from 2018/19 to 2019/20 (please see Appendix 1 for the ambulance timeline).

Re-phasing would allow us to engage further with ambulance providers before we start to develop the standards, allowing us to better understand the particular challenges for ambulance providers designing a patient level cost collection.

We have noted independent providers' concerns around the pace of change and will take them into account in the design process. In particular, we will look at ways to support these providers to implement the proposals within the timescales.

4.2. Sequencing

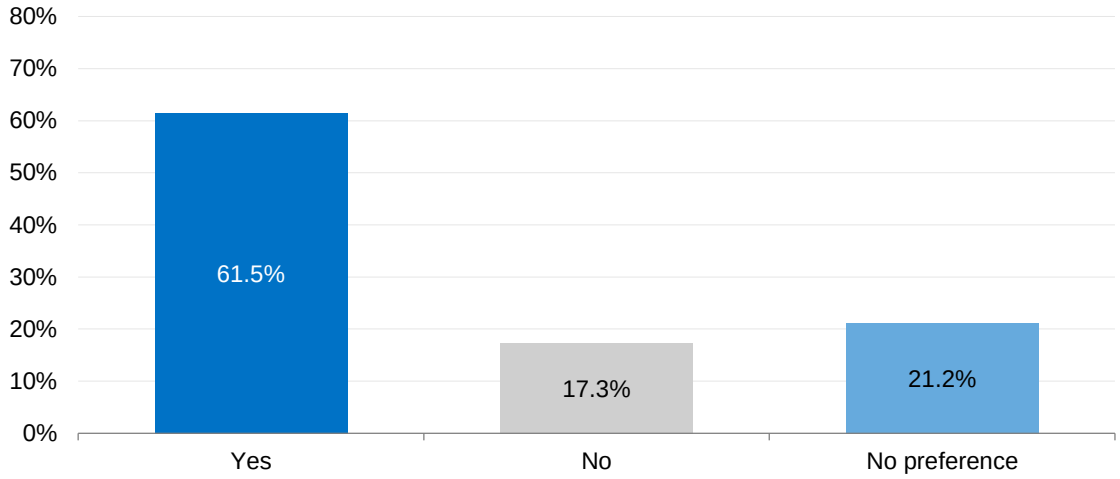
Sequencing refers to the order in which a mandated cost collection is required for the different service areas. The proposed process starts with acute and ambulance services, followed by mental health and then community services.

4.2.1. Survey results

Survey respondents were asked whether they agreed with the proposed sequencing by service type. A total of 43 people answered yes or no, with 78% of those agreeing

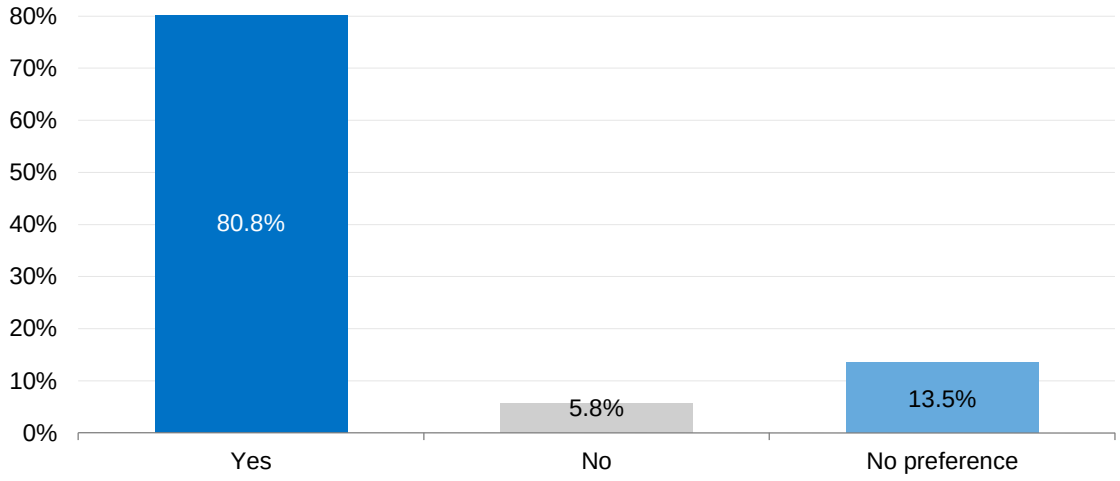
with the proposed sequencing. Those disagreeing with the proposed approach spanned all service areas.

Figure 5: Survey responses to the question 'Do you agree with the order by service area of the implementation programme, ie first acute and ambulance services, then mental health and community services?'



The survey also asked if independent providers should follow the same timescales and requirements as NHS providers based on their service areas. Again, 43 people answered this question with a yes or no answer. 93% of those agreed with this proposal. One independent provider took part in the online survey and answered no preference to this question. The independent providers' opinions were mostly captured during the three workshops.

Figure 6: Survey responses to the question 'Do you agree with the proposal that independent providers should be subject to the same requirements, and should follow the same timelines, as NHS trusts and foundation trusts?'



4.2.2. Summary of responses

The majority of respondents in the survey, workshops and emails agreed with the proposed order of implementation by service type, with a few exceptions.

There were mixed views on where integrated providers should sit in the sequencing. Some suggested they should follow the proposed sequencing, ie first acute and ambulance services, then mental health and then community, but others stated that they would prefer not to go through the same process twice. Those respondents wanted to be able to apply the costing approach for all services in one implementation, and not be constrained by the proposed staggered timescales.

Many at the workshops and through the other avenues of engagement flagged up the delay in the start of the development phase for community services as a major concern. They felt it needed to start as early as possible for the following reasons:

- robust data specification is currently being developed on activity, costs and patient outcomes, which means that more time is required to define the MDS that would underpin the cost collection
- not all providers are collecting data or have the appropriate procedures and systems meaning new data-capturing mechanisms need to be established before robust costing or cost collection can take place; this would take time for some trusts to establish
- there is a need for a uniform national collection of data with clear and consistent data definitions. As a result this phase of development would need to be longer for community services than for acute or mental health services.

Some providers expressed concerns that the start date of mental health services was too late. Specifically, they highlighted that delaying the development of standards and minimum datasets could delay the whole programme.

There was strong consensus that independent providers should be mandated to work to the same timescale of implementation as set out for their specific service area. A large number of these comments came from NHS providers.

4.2.3. Our response

We will bring forward the implementation programme for community services so that early preparation work can begin, effectively stretching the development phase, with the eventual mandated collection remaining as proposed in 2020/21. This would allow services and data definitions to be defined and give providers more time to pull together activity data and costing processes (please see Appendix 1 for the community timeline).

The proposals to begin the development phase for community services at the same time as acute providers would help align the development work for integrated

providers of these services. We have noted the responses from integrated providers and will further consider within the detailed design of the programme how we can reduce the burden on them.

Mental health timescales would remain unchanged, as the strength of response was not so great, and the development is due to begin much earlier, in late 2015.

We will keep to the original proposal for independent providers to follow the same implementation timescale as their service area dictates.

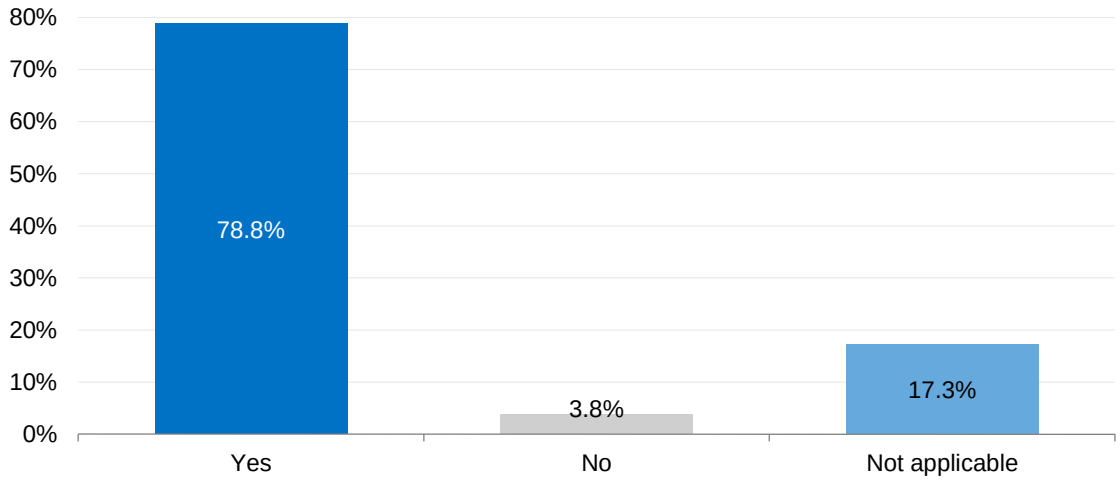
4.3. Accreditation of PLICS

The pre-engagement identified a strong desire for accreditation for costing systems so we looked for wider input on this point through the engagement process.

4.3.1. Survey results

Survey respondents were asked whether they would appreciate help in assuring local PLICS systems through the development of a central accreditation system. A total of 43 people replied yes or no, with 95% of them welcoming an accreditation process.

Figure 7: Survey responses to the question 'If you represent a NHS trust, foundation trust or independent provider, would your organisation appreciate assistance in the assurance of local PLICS systems through the development of a central accreditation system?'



4.3.2. Summary of responses

The survey responses to the question on accreditation mirror the overwhelming consensus from the workshops and via email responses, welcoming accreditation. Respondents said it would help improve the transparency and quality of the costing data, plus providers getting software from an accredited supplier would provide assurance that the software is compliant with Monitor's costing proposals.

Providers raised concerns about what would happen if their existing supplier wasn't accredited. They asked if they would be forced to switch supplier if accreditation was mandated. Some providers also felt that accreditation should cover the support contract with suppliers and possibly the costing process itself (ie their own costing team).

Most of those who participated in the engagement raised a number of accreditation design points including:

- should the accreditation test the costing software's compliance with the new costing standards and single cost collection
- should dummy data be used to help validate the costing system as part of the accreditation
- should accreditation be a one-off process or apply over a period of time
- should there be levels of accreditation, for example bronze, silver and gold.

4.3.3. Our response

We plan to develop a process for accrediting costing systems as part of the costing approach (please see Appendix 1 for the accreditation timeline). This means, as a minimum, having a structured process to test and certify costing software to ensure it is suitable for providing costing information in line with the proposed costing approach. The work stream would also examine the likely impacts of accreditation on providers before the mandated cost collection.

The accreditation work stream would focus only on the costing system. It would not cover any aspects of support contracts with costing software suppliers, such as the response time to deal with queries.

The work stream would also not extend to the costing process or costing teams within trusts. These aspects will be assured through appropriate audit and support processes developed through the quality assurance work stream.

4.4. Risks to the delivery of the programme

A number of risks were identified. These are very helpful in understanding the challenges the sector would face in trying to implement the new costing approach.

The survey asked 'What do you believe are the most significant risks to delivery of the programme?' In the workshops this question was expanded, asking participants to categorise the risks into local and national risks.

Most people identified the risks described below and in the majority of cases reinforced our views on the key risks to the programme.

4.4.1. Summary of responses

The main concern people raised was the lack of prioritised funding for the programme. Given the financial pressure many organisations are facing, trusts believed that they would find it extremely difficult to secure the funding to acquire sufficient costing and information staff to support the implementation. In addition, IT procurement would be difficult to prioritise for many, as NHS funds are stretched across the sector. The lack of funding was also linked to the risk of a lack of board engagement, if executive teams have not bought into the concept of patient level costing.

Clinical engagement was also identified because trusts are unlikely to achieve benefits in efficiencies and improvements in care without clinical involvement, as clinical experts are needed to make this happen.

A shortage of skilled costing practitioners was also identified: some providers were concerned that, with an increase in providers undertaking patient level costing, there would be increased demand for a small pool of skilled costing practitioners.

A number of providers were concerned about whether costing software suppliers would be able to cope with the increase in demand. A particular concern was whether they would be able to grow their resources in time to manage the increase in workload and help update costing models for new and existing clients.

Competing work pressures were flagged because respondents wondered whether costing practitioners would have enough time to spend on the costing developments, particularly in trusts that only have 0.5 whole time equivalent for supporting the costing function, or no costing support at all.

Data quality was also seen as a major obstacle to the success of the programme. The concern here was a lack of patient level information to feed the costing systems across providers, which would lead to inconsistencies among organisations. In addition, incorrect data capturing and coding at the outset would cause aggregated data quality issues. It was mentioned that trusts currently submitting data for Monitor’s PLICS submission suffer from data quality issues even though they have been costing in this way for several years. Some respondents questioned whether the programme would fix such issues.

4.4.2. Our response

There were lots of helpful comments on risks that we will carefully consider and build into the implementation design for each work stream. There are also work streams within the current proposals that deal with some of the risks identified above, such as data quality, clinical and board engagement and costing capabilities.

To help the sector through the transition period and to mitigate some of the risks identified, we will ask all organisations involved to submit their implementation plans.

We would then be able to monitor their progress and more proactively support them along the way if needed. We would also co-ordinate phasing sections of implementation along the same path, allowing software suppliers to release updates that can be applied to all their users at one time, to reduce burden and duplication.

Given the extent to which we would need the support of our roadmap partner providers, we would set aside a budget to help them allocate their resources to the programme of development work. This should help to alleviate the funding and practitioner's time risks identified above, enabling them to inform the design work required for standards development, PLICS minimum requirements, development cost collections, etc.

4.5. Additional comments

There was general support for the proposals throughout the engagement, with the majority of respondents to the online survey and those who attended the workshops agreeing with the costing approach.

A number of points raised did not relate to the overall proposals but were specific design suggestions about the elements of the programme. We have noted all these comments and will take them into account as we further develop the relevant work streams. Below is a summary of these points.

4.5.1. Summary of responses

- There was some concern around Monitor's capacity to cope with the size of the data collections and server space required to capture the data. Some providers questioned whether it would be feasible to upload all the data that Monitor requires.
- There was also some anxiety around data sharing due to the current information governance rules, with providers questioning whether this would prevent the linking of patients across providers.
- Some providers questioned whether the current timescales provide enough leeway to identify research and development (R&D) costs, and continue the development of education and training, as well as the development of patient level costing.
- Providers warned that we need to be alert to ensuring that we have a good balance of dedicated community and integrated trusts involved in the community services design process.

4.5.2. Our response

There are two development collections built into the development structure and this allows us to learn and adapt our data-capturing method in preparation for the mandated cost collection for each service area.

We will work closely with the Health and Social Care Information Centre and providers to understand how we can capture patient-identifiable information that would allow us to link patients' activities across providers.

We have taken into account the need to identify R&D and commercial costs, as well as developing patient level costing alongside education and training, in the timescales. This should enable all the above to happen in time for the mandated cost collection for each service type.

We will also generate a robust roadmap partner selection process to guarantee that we have the right mix of providers to support the development of the costing approach.

5. Next steps

Work continues on scoping out the work streams that are scheduled for delivery in 2015. The three immediate work streams are:

- development of the minimum requirements for local costing software: defining the necessary costing system capabilities for it to support the proposed costing process
- acute standards development (which includes defining MDS and data dictionaries): defining the costing methodology, outlining in detail how costs should be treated and what activities they should be matched to
- Value for Money: determining if the proposed costing approach will generate sufficient benefits for the sector to justify the cost to implement and maintain.

During the first quarter of 2015/16 financial year, we will let the sector know the process for becoming a roadmap partner and what this will entail.

In autumn 2015 we will publish a detailed implementation plan for costing transformation. This will outline the detailed work stream plans, programme governance structure and main timelines.

From now on, we will refer to the proposals reflecting the sector's feedback as the Costing Transformation Programme (CTP), marking their progress from a set of costing ideas for discussion to a change programme for the healthcare sector.

6. Questions and answers

Here are answers to some of the questions posed during the engagement process.

Q1 Will we need to invest in new IT systems to support the new minimum datasets (MDS) for costing?

A *The costing MDS will build on existing MDS and should not create a need for major IT procurement. If there are changes to the MDS, they are likely to be tweaks to the existing MDS and mainly based on information already captured in IT systems.*

Q2 What happens if I have to buy a new pathology or radiology IT system to support the costing process?

A *The standards development work will factor in what systems trusts already have and, as above, should not create a need for major IT procurements. If however, you feel your trusts will have to procure a new system to comply with the MDS then please contact us at costing@monitor.gov.uk to discuss.*

Q3 Will Monitor provide funding to help pay for implementing the new costing approach?

A *No. This is because having a clear understanding of the costs of providing services is crucial to successful long-term sustainability. A detailed costing process is an expected component of satisfactory provider management and should be built into the organisation's budget.*

Monitor is proposing to provide project support to enable roadmap partner trusts to participate in the early developments of the new costing approach.

Q4 Will the scope of the programme cover GP and social care services?

A *No. GP and social care services are outside the scope of the programme. Only acute, ambulance, mental health and community services fall under the CTP.*

Clear guidance on which services will be included will be released as part of the standards documentation. We are aware that as services are redesigned the lines between healthcare and social care become less distinct and as a result services will need to be clearly identified.

Q5 Will there be a standard chart of accounts?

A *No. A standard chart of accounts, which is a standardised list of codes used in an organisation's ledger to categorise transactions, is outside the scope of this programme. We will outline what costs need to be coded under the resource classifications, but it is up to providers to determine how they arrange transactions in their ledger to be compliant with our resource list.*

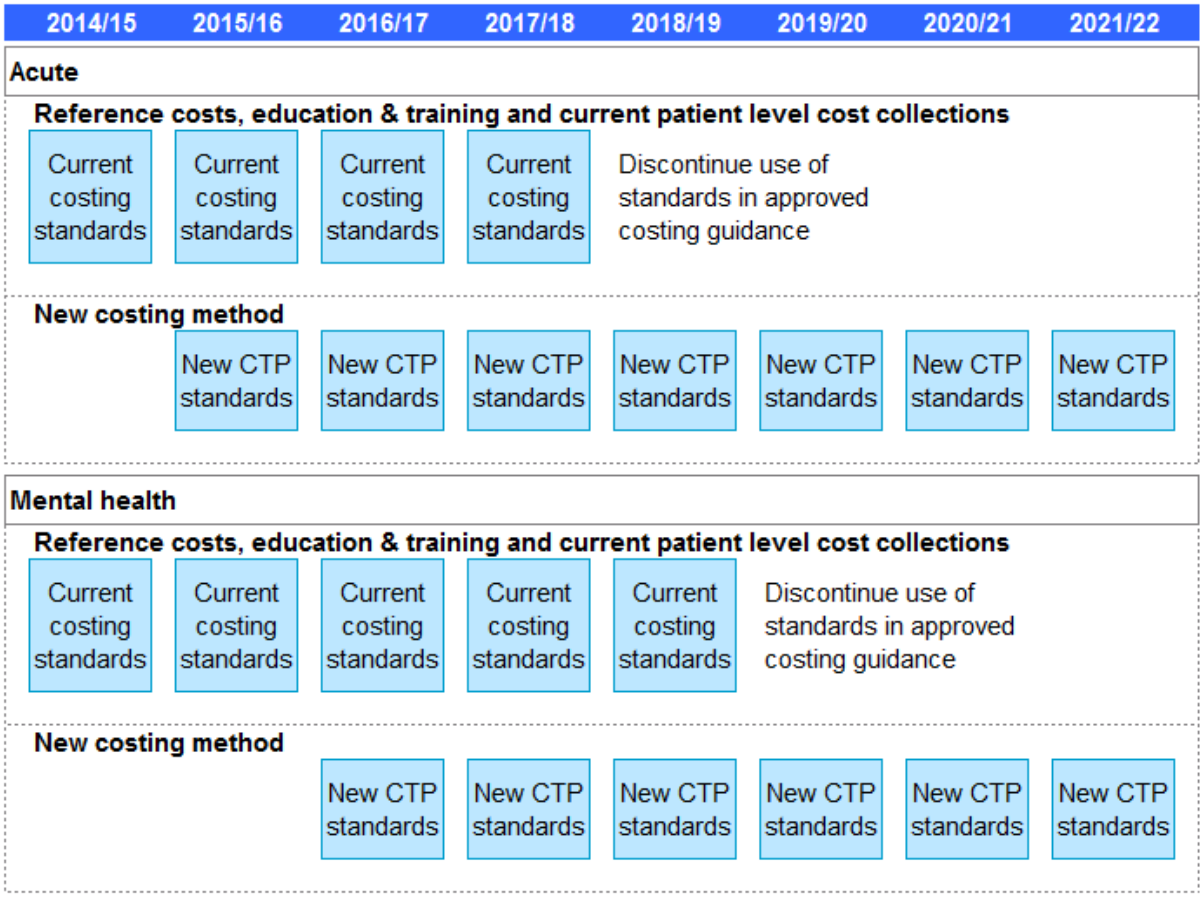
Q6 Do I still need to submit reference costs during the development of the new costing approach?

A *Yes. Reference costs will still have to be submitted using the reference cost template, and education and training costs will have to be submitted using the education and training template. This will remain until the single cost collection can be reconciled to both the reference cost and education and training cost collections, at which point reference cost collection would not be necessary, with reference costs being generated from the single cost collection.*

Q7 What happens with the current HFMA costing standards?

A *We envisage that the Healthcare Financial Management Association (HFMA) costing standards will remain a part of the Approved Costing Standards until the first mandated cost collection, at which point all trusts will be asked to follow and comply with the newly developed standards. For acute services, for example, the new standards will be first mandated for the 2018/19 collection (see Figure 8 below which maps out the transition path from the current costing standards to the new CTP standards).*

Figure 8: Evolution from current standards to the new CTP standards



Q8 Will the costing standards be an ongoing development or will they be set prior to commencing the process?

A *The standards will be an ongoing process, updated each year to deal with constant changes within the NHS (as demonstrated in Figure 8 above). The standards would be released in January each year so that organisations can update their costing systems with the required changes for a cost collection in the summer of that year.*

Q9 When will the data from the cost collection inform the national tariff?

A *The earliest the new costing approach can inform the national tariff is as follows; for acute services 2018/19 cost collection would inform 2021/22 tariff, mental health and ambulance services 2019/20 cost collection would inform 2022/23 tariff and community service 2020/21 cost collection would inform 2023/24 tariff.*

Q10 How will Monitor ensure consistency in costing methodology for costs that span education and training and patient activities, ie the treatment of their shared overheads.

A *Monitor will work closely with DH, Health Education England and providers to agree a method for separating out costs to patient care and to education and training, which will include how overhead costs should be treated. This will form part of the new costing standards.*

Q11 For trusts that are currently in the process of procuring, changing or thinking of implementing a costing system, what should they do now?

A *For any provider that wants to progress their costing model ahead of the pace proposed in the costing proposals, we ask them to bear the proposals in mind when choosing a costing supplier. It is important to understand how suppliers are planning to comply with the new costing approach and whether there will be extra charges relating to model changes that will be required for the software to comply with the new standards. Trusts may also wish to consider a development plan with their software suppliers to factor in the required changes to their costing model that will follow the release of the new standards, ensuring the proposed changes are factored into the supplier's diary.*

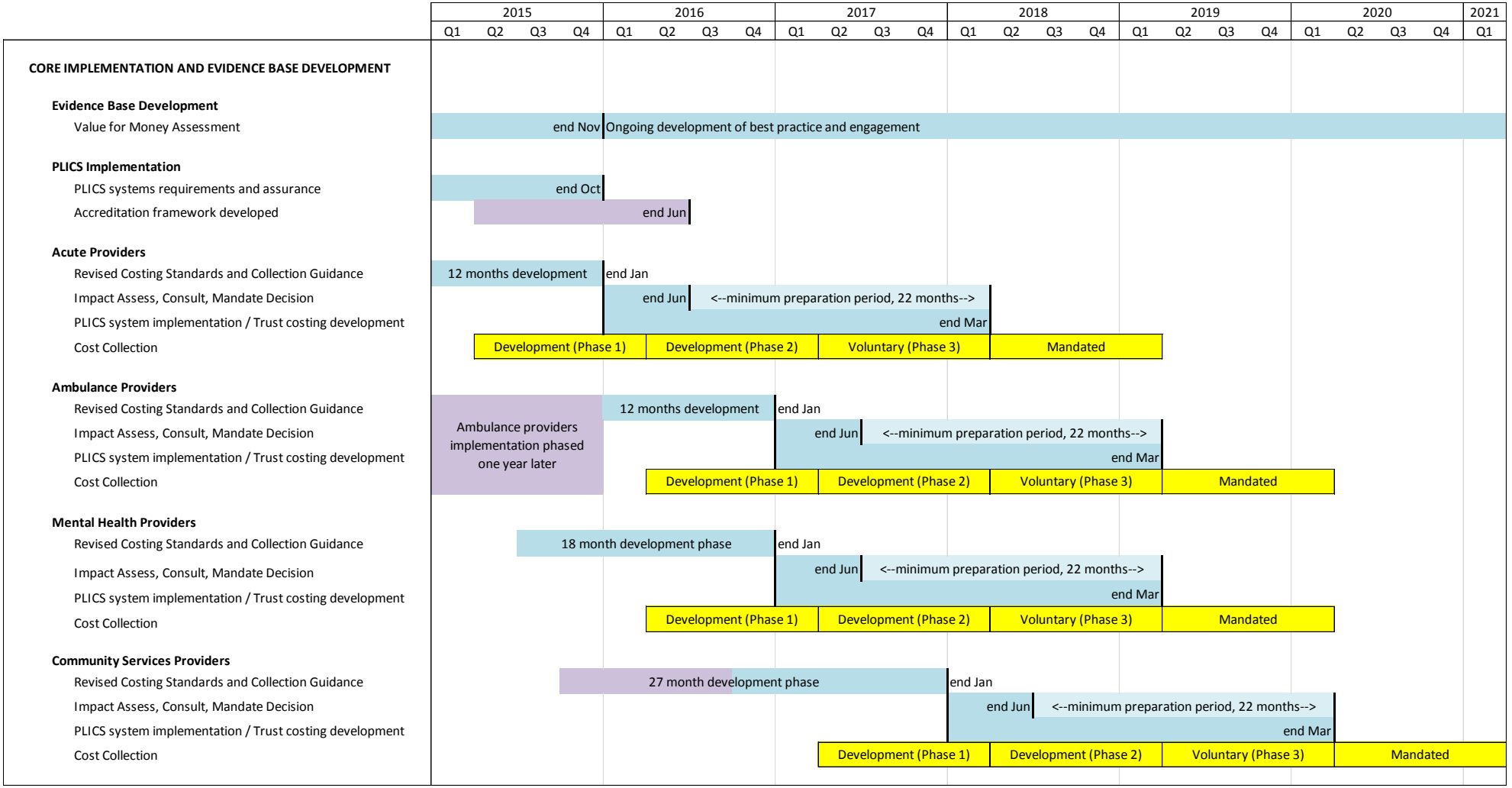
Q12 Will there be a cost collection for research and development?

A *No. In the first instance we will seek to separate out a reasonable estimate of R&D costs to provide an undistorted view of patient care then as part of the cost collection, seek to report the total costs relating to R&D on a separate line. The same will be required for commercial activities.*

Q13 How will income be treated in the system?

A *The standards and cost collections will be focused entirely on the expenditure of providers not the income.*

Appendix 1: Proposed timelines with changes highlighted



Changes to the initial timelines are shown in purple

Appendix 2: Organisations that submitted responses in the engagement

Engagement workshop participation

Provider and commissioner engagement workshops were held on 10 December, 18 December and 13 January in London, Leeds and Birmingham respectively. A total of 158 delegates attended, representing 108 unique organisations.

A profile of delegate attendance by organisation type is shown in the table below. Although only a handful of community-specific trusts were represented, a significant number of the acute providers also provide community services.

Table 1: Workshop attendance profile

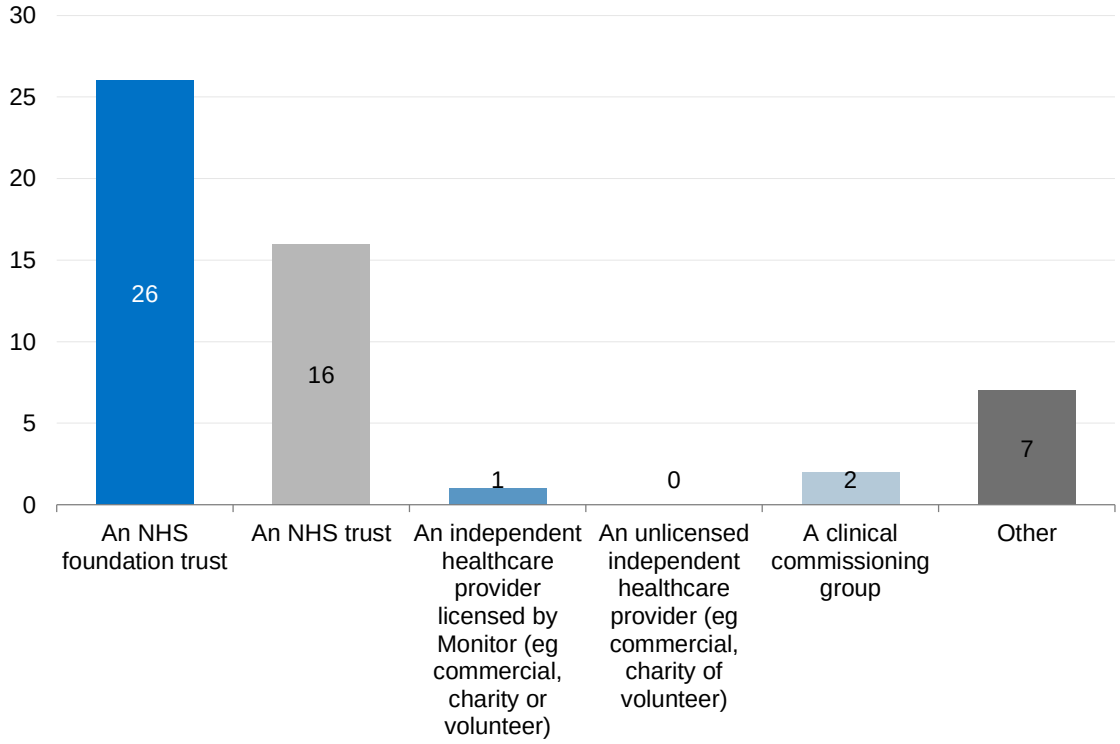
Event	Acute	CCGs CSUs	Independent providers	Mental Health	Specialist	Community	Total
London	13	6	3	7	13	1	43
Leeds	38	6	2	4	5	1	56
Birmingham	26	8	10	5	8	2	59

A further workshop specifically aimed at ambulance services was held in London on 29 January. Sixteen delegates attended this event with representatives from all ten ambulance services in England.

Online survey respondents

There were 52 respondents to the online survey; a breakdown by organisation type is shown below.

Figure 9: Survey responses to the question 'Are you from…'



Organisations that participated in the engagement exercise

Acute providers
Aintree University Hospital NHS Foundation Trust
Airedale NHS Foundation Trust
Alder Hey Children's NHS Foundation Trust
Basildon and Thurrock University Hospitals NHS Foundation Trust
Birmingham Children's Hospital NHS Foundation Trust
Birmingham Women's NHS Foundation Trust
Bolton NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Brighton & Sussex University Hospitals NHS Trust
Buckinghamshire Healthcare NHS Trust
Burton Hospitals NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
Central Manchester University Hospitals NHS Foundation Trust
Chesterfield Royal Hospital NHS Foundation Trust
The Christie NHS Foundation Trust

Colchester Hospital University NHS Foundation Trust
The Countess of Chester Hospital NHS Foundation Trust
County Durham and Darlington NHS Foundation Trust
Derby Hospitals NHS Foundation Trust
Doncaster and Bassetlaw Hospitals NHS Foundation Trust
The Dudley Group NHS Foundation Trust
East and North Hertfordshire NHS Trust
East Sussex Healthcare NHS Trust
Gateshead Health NHS Foundation Trust
Great Ormond Street Hospital for Children NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Heart of England NHS Foundation Trust
The Hillingdon Hospitals NHS Foundation Trust
Homerton University Hospital NHS Foundation Trust
Hull and East Yorkshire Hospitals NHS Trust
Imperial College Healthcare NHS Trust
The Ipswich Hospital NHS Trust
James Paget University Hospitals NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust
Liverpool Heart and Chest Hospital NHS Foundation Trust
Liverpool Women's NHS Foundation Trust
London North West Healthcare NHS Trust
Maidstone and Tunbridge Wells NHS Trust
Mid Yorkshire Hospitals NHS Trust
Milton Keynes Hospital NHS Foundation Trust
Norfolk and Norwich University Hospitals NHS Foundation Trust
North Cumbria University Hospitals NHS Trust
North Middlesex University Hospital NHS Trust
North Tees and Hartlepool NHS Foundation Trust
Northampton General Hospital NHS Trust
Northern Lincolnshire and Goole NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust
Nottingham University Hospitals NHS Trust
Oxford University Hospitals NHS Trust
Papworth Hospital NHS Foundation Trust

Peterborough and Stamford Hospitals NHS Foundation Trust
Plymouth Hospitals NHS Trust
Poole Hospital NHS Foundation Trust
The Princess Alexandra Hospital NHS Trust
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
The Rotherham NHS Foundation Trust
Royal Berkshire NHS Foundation Trust
The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust
Royal Brompton and Harefield NHS Foundation Trust
Royal Devon and Exeter NHS Foundation Trust
The Royal Liverpool and Broadgreen University Hospitals NHS Trust
The Royal Marsden NHS Foundation Trust
Royal National Orthopaedic Hospital NHS Trust
The Royal Wolverhampton Hospitals NHS Trust
Salisbury NHS Foundation Trust
Sandwell and West Birmingham Hospitals NHS Trust
Sheffield Children's NHS Foundation Trust

Sheffield Teaching Hospitals NHS Foundation Trust
South Devon Healthcare NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust
South Tyneside NHS Foundation trust
South Warwickshire NHS Foundation Trust
St George's Healthcare NHS Trust
St Helens and Knowsley Teaching Hospitals NHS Trust
Stockport NHS Foundation Trust
Surrey and Sussex Healthcare NHS Trust
United Lincolnshire Hospitals NHS Trust
University College London Hospitals NHS Foundation Trust
University Hospital of South Manchester NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
University Hospitals Coventry and Warwickshire NHS Trust
University Hospitals of Leicester NHS Trust
University Hospitals of Morecambe Bay NHS Foundation Trust

University Hospitals of North Midlands NHS Trust
The Walton Centre NHS Foundation Trust
Warrington and Halton Hospitals NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust
West Suffolk NHS Foundation Trust
Wirral University Teaching Hospital NHS Foundation Trust
Wrightington, Wigan and Leigh NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust
Ambulance providers
East Midlands Ambulance Service NHS Trust
East of England Ambulance Service NHS Trust
London Ambulance Service NHS Trust
North East Ambulance Service NHS Foundation Trust
North West Ambulance Service NHS Trust
South Central Ambulance Service NHS Foundation Trust
South East Coast Ambulance Service NHS Foundation Trust
South Western Ambulance Service NHS Foundation Trust

West Midlands Ambulance Service NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust
Commissioners − clinical commissioning groups and commissioning support units
Airedale, Wharfedale and Craven CCG
Arden CSU
Barnsley CCG
Bolton CCG
Brighton & Hove CCG (via CSU)
Bristol CCG (via CSU)
Central London CCG
Coastal West Sussex CCG (via CSU)
Crawley CCG (via CSU)
Cumbria CCG
Dorset CCG (via CSU)
Fareham & Gosport CCG (via CSU)
Horsham & Mid Sussex CCG (via CSU)
Isle of Wight CCG (via CSU)
Milton Keynes CCG
NHS England
North and East London CSU
North East Hampshire and Farnham CCG (via CSU)

North Hampshire CCG (via CSU)

North Somerset CCG (via CSU)

North West London CSU

Portsmouth CCG (via CSU)

Sheffield CCG

Somerset CCG (via CSU)

South CSU

South East CSU

South Eastern Hampshire CCG (via CSU)

South Gloucestershire CCG (via CSU)

Southampton CCG (via CSU)

Staffordshire and Lancashire CSU

Sunderland CCG

Surrey Heath CCG (via CSU)

Telford and Wrekin CCG

West Hampshire CCG (via CSU)

Yorkshire and Humber CSU

Community providers

Birmingham Community Healthcare NHS Trust

Derbyshire Community Health Services NHS Foundation Trust

Lincolnshire Community Health Services NHS Trust

Shropshire Community Health NHS Trust

Independent providers

Barchester Healthcare

Baxter Healthcare

BMI Healthcare

Care UK

Circle

G4S

MIND

Nuffield Health

Ramsay Health Care UK

St Andrew's Healthcare

Tollgate Clinic

Turning Point

Mental health providers

2gether NHS Foundation Trust

5 Boroughs Partnership NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust

Central and North West London NHS Foundation Trust

Cornwall Partnership NHS Foundation Trust

Coventry and Warwickshire Partnership NHS Trust
Derbyshire Healthcare NHS Foundation Trust
Dorset Healthcare University NHS Foundation Trust
Dudley and Walsall Mental Health Partnership NHS Trust
East London NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
Lancashire Care NHS Foundation Trust
Leicestershire Partnership NHS Trust
Lincolnshire Partnership NHS Foundation Trust
Manchester Mental Health and Social Care Trust
Mersey Care NHS Trust
North East London NHS Foundation Trust
Northamptonshire Healthcare NHS Foundation Trust
Northumberland, Tyne and Wear NHS Foundation Trust
Nottinghamshire Healthcare NHS Foundation Trust
Oxford Health NHS Foundation Trust
Rotherham, Doncaster and South Humber NHS Foundation Trust
Sheffield Health and Social Care NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust
Southern Health NHS Foundation Trust
Surrey and Borders Partnership NHS Foundation Trust
Sussex Community NHS Trust
Costing software suppliers
Albatross
Ardentia/IMS
Assista
Bellis Jones Hill
CACI
Civica
Genesis
Healthcost
Jeton Systems
PowerHealth Solutions
Other
ABHI
Brain Injury Rehabilitation Trust
British Medical Association

Cardiff & Vale University Health Board
Cerner Ltd
Chartered Institute of Management Accountants
Clinic for Dissociative Studies
Concept Strategy
Consolidated Consultancy Limited
Department of Health
Dudley Metropolitan Borough Council
GK Strategy Ltd
GlaxoSmithKline
Guild of Healthcare Pharmacists
Health and Social Care Information Centre
Health Education England
Health Service Journal
Healthcare Financial Management Association
Johnson & Johnson Medical Ltd
KCA
London Mental Health Tariff Programme
Marie Curie Cancer Care
Medtronic
Midwives Mutual
MSD
National Institute for Health and Care Excellence

NHS Confederation
NHS Improving Quality
NHS Trust Development Authority
The Royal College of Emergency Medicine
The Royal College of Nursing
The Royal College of Physicians
St Richard's Hospice
WL Gore and Associates
Waltham Forest, East London and City Integrated Care Programme

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