

Feedback from consultation on mandating patient-level costing

February 2018

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

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Introduction

Between October and November 2017, we consulted on proposals to mandate NHS foundation trusts and NHS trusts to record and report the costs of acute activity at a patient level.¹

We received 73 responses from a range of organisations:

Acute trusts	Mental health/ community trusts	Acute trust costing group	External organisations	Other	Total
64	2	1	5	1	73

The consultation asked for views on two proposals:

- To what extent do you agree with mandating recording and reporting of patient-level cost data for acute activity, in line with the *Healthcare costing standards for England*, from 2018/19?
- Do you agree with the proposal for dual running of reference costs and patient-level costs for 2018/19 and 2019/20?

On the first proposal, 78% of respondents agreed, while 51% agreed with the second proposal.

After considering the consultation results, the impact assessment and the mandation project as a whole, NHS Improvement's board approved the proposals in January 2018. This means that, from 1 April 2018, it will be mandatory for NHS trusts and NHS foundation trusts to record and report costs at a patient level for acute activity in line with the *Healthcare costing standards for England*.²

This document summarises the feedback we received from the consultation and our responses to it.

¹ For details of this consultation, including the consultation document and accompanying impact assessment, see: <https://improvement.nhs.uk/resources/mandating-patient-level-costing/>

² For details of the standards, please see <https://improvement.nhs.uk/resources/approved-costing-guidance-standards>

We would like to thank everyone who responded, especially in providing information around the future option to increase the frequency of collections. We will take this into account in any future review on the frequency of cost collections.

We will also be working to spread patient-level costing across other sectors over the coming years.

Consultation feedback and response

Comment 1

You said

We are concerned about the costing standards. Specific issues include:

- the standards are still in a draft format and not final
- they seem to change significantly year on year
- issuing them two months before the start of the year for which they will be required is not giving trusts sufficient time to make the changes required.

In January 2018 we published the third and final version of the *Healthcare costing standards for England* for acute providers (the standards) as part of the Approved Costing Guidance.³ The standards cover financial years 2017/18 and 2018/19.

Future updates will be published ahead of the financial year to which they apply – so January 2019 guidance will cover financial year 2019/20.

Based on feedback from a consultation on the standards and from technical focus groups, the standards include a transition pathway. This proposes that, while the standards will be mandatory from 2018/19, the point at which we expect trusts to fully comply will be phased over three years. This will give acute trusts the opportunity to prioritise their efforts and, where there is significant work to be done, spread the workload. Details are available in the Approved Costing Guidance, or contact the costing team (costing@improvement.nhs.uk) for more information.

³ See <https://improvement.nhs.uk/resources/approved-costing-guidance-standards>

Comment 2

You said

The level of information required in the costing standards is significant, and feedback from those involved in the early implementer programme raises concerns that there is a significant burden in implementing these. Specific issues include:

- a. creation of a separate costing ledger
- b. use of overly detailed and complex costing methods – ‘resources’ and ‘activities’ for costing
- c. requirement for specific data feeds with information that many systems do not collect
- d. assumptions that trusts can get data in required format easily
- e. impact on other work undertaken by staff involved in costing.

We understand that implementing the standards is challenging. We have refined the standards to reflect learning from the early implementer programme and have published a transition path to enable trusts to implement the new standards in phases. We are also developing tools to automate some of the more resource-intensive work and we will continue to offer support to organisations implementing patient-level information and costing systems (PLICS) to help them embed the standards.

Our response to the specific concerns is as follows:

- a. The costing ledger is an important tool in ensuring all providers are costing using the same process. To support providers, we are working on a new tool to automate the mapping of costs to the cost ledger to reduce burden. We are committed to continuing to develop tools that will make implementing the cost ledger easier and more efficient.

- b. Costing at a resources and activities level is a fundamental part of the costing process, based on research commissioned by Monitor and accepted by Monitor as policy.⁴ We accept that this is a significant change but we believe this will future-proof the process.
- c. We recognise the challenges in both information coverage and quality. However, the standards are set to deliver what is considered 'good costing'. We continue to work with colleagues both within NHS Improvement and the sector to improve information for costing.
- d. We have produced a transition path giving providers three years to put in place systems to collect information not currently collected. This transition path is included in the Approved Costing Guidance.
- e. We believe that consistent costing will provide a 'single version of the truth' that will improve the accuracy of data used for charging, planning and submitting returns to regulators. At trusts with PLICS already implemented, much of the detailed work on validating costs and pathway information is completed by service/general managers with their finance and clinical staff as part of their regular financial meetings. Trusts implementing PLICS should look to embed the patient and cost information by making the validation of the information part of the trust's operational arrangements.

Comment 3

You said

The arrangements for education and training (E&T) are unclear.

- a. Little, if any, time is freed by not collecting E&T information in 2017/18 if trusts are still expected to calculate this. How will NHS Improvement ensure that any momentum around E&T is not lost with data not being collected?
- b. How will E&T work in PLICS?

⁴ *Costing roadmap: summary report and findings*, July 2014, BDO. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/381719/Costing_Roadmap_-_FINAL_Engagement_Summary_080914.pdf

- a. We believe the break in submitting E&T information will allow trusts to look at their processes for collecting this information. This can take place over a longer period as there is no deadline for a submission.
- b. We will collect E&T data as part of PLICS with some providers. This will enable us to work with Health Education England to ensure the proposed collection processes and guidance are fit for purpose.

Comment 4

You said

We cannot see how feedback is being reviewed, addressed and actioned. There are specific concerns about how feedback from the following has and will be actioned:

- roadmap partner submissions in 2015/16
- findings from the early implementer programme in 2016/17
- feedback from technical focus groups and their subcommittees.

Over the last few years, we have asked the sector to comment on three versions of the standards published in 2018. After each of these consultations, we produced 'consultation responses' in which we outlined 'you said' 'we did' and demonstrated how the feedback was used. We hope this makes our response to the feedback transparent. While we have not published this document, it is available on request and covers all feedback received. Please contact costing@improvement.nhs.uk if you would like a copy.

We have taken into account findings from other work, including roadmap partners, technical focus groups and the costing assurance programme.⁵ We have also responded to issues raised in the PLICS consultation.

⁵ <https://improvement.nhs.uk/resources/costing-assurance-programme/>

Comment 5

You said

The voluntary collection is not the same as the mandated return – therefore the assumption that the costs, etc will be the same is incorrect.

The estimates for costs in our impact assessment⁶ include the cost of dual running as well as the cost for replacing reference costs with patient-level costing. Our adjustments, as noted in the assumptions for each option considered in the impact assessment, include:

- verifying output with clinicians and others
- input from information teams
- review of submission by senior staff, including board sign-off.

We used information from the 2015/16 detailed costing survey (part of the reference costs submission), from the early implementer work programme and from on-site audit visits to calculate the time required to produce reference cost returns and a patient-level cost submission.

Comment 6

You said

You have not included costs for IT-related issues, including:

- a. costing systems upgrades
- b. cost of new costing systems
- c. cost of new activity information systems
- d. costs of IT support.

⁶ <https://improvement.nhs.uk/resources/mandating-patient-level-costing/>

- a. We included an average cost for upgrades to current PLICS costing systems based on feedback from suppliers and early implementers. We are working with suppliers to make sure these costs are kept to a minimum.
- b. The estimate for costs includes an estimate for implementing PLICS where trusts do not already have a system. This is based on business cases and information collected as part of the impact assessment.⁷
- c. The cost of any upgrades to information systems was not included as this will vary depending on each trust, its various systems and whether these can produce the required level of information.
- d. Our estimate of costs for producing fully costed data includes IT departments' costs. This was based on feedback in the 2015/16 detailed costing survey (part of the reference costs submission).

For more information see our detailed impact assessment.⁷

Comment 7

You said

There is a significant cost to upgrading or implementing PLICS, and this may be an issue in trusts with financial difficulties. This will include running two separate costing systems (PLICS and reference costs) during dual running and until all sectors are covered by PLICS.

Understanding costs is essential, especially for organisations with financial difficulties. Our impact assessment⁷ found that the information from PLICS, including understanding patient pathways, will help trusts identify productivity improvements, leading to better use of resources. Our impact assessment includes the costs of upgrading systems and implementing new systems in the few trusts that do not currently have a PLICS system. These costs are based on feedback from trusts, which we collected as part of our detailed impact assessment work, using data from business cases and information from PLICS suppliers.

⁷ <https://improvement.nhs.uk/resources/mandating-patient-level-costing/>

We are aware of the impact that dual running of reference costs will have, and we plan to move to a single collection as soon as possible. We will be undertaking work on the 2017/18 submission to assess whether we can recreate reference costs from PLICS. If this is successful, in 2018/19 there will be a single collection of acute cost data. If unsuccessful, we will try to align the returns for 2018/19 so that we move to a single cost collection as soon as possible.

Even with this, there may be some dual running until all sectors implement patient-level costing, but we will continue to work with you to minimise this as much as possible.

We are working with suppliers to reduce the impact for cost accountants by making sure all submissions can be run from a single system.

Comment 8

You said

As with all new processes, it will take time to ensure the accuracy of information is reasonable and consistent. How will this be taken into account when using patient-level costs for setting the tariff and other uses of the information?

We have several processes to ensure the accuracy of costing information, including giving providers access to the data they have submitted through our PLICS portal and the data quality tools.⁸

The next tariff will be based on reference costs but, where applicable, we will also look at the patient-level costs to understand any deviations and costing/coding issues in the data available.

The plan is that the subsequent tariff will be based on patient-level costs. This would allow time for trusts, NHS Improvement and other stakeholders to ensure the data is of a satisfactory standard.

⁸ For details of these tools, see: <https://improvement.nhs.uk/resources/tools-for-using-costing-data/>

Comment 9

You said

The impact assessment talks about cost savings, but in reality this could lead to additional activity for which no funding is available.

Improving the consistency and accuracy of costing and patient flow will allow providers and their commissioners to more effectively manage and monitor their contracts. This may lead to an increase in activity in some services (and a reduction in others). However, it is our belief, based on early implementers' experience, that efficiency savings will offset the organisational overhead incurred in delivering PLICS.

Comment 10

You said

Why are independent sector providers not included in this process?

Independent sector providers have not submitted cost data in the past, and the tariff has been based on cost information from NHS organisations. Because there are various types of independent provider, with different governance and legal requirements, further work is required both internally and with other regulators to understand how a decision to mandate a cost collection can be implemented.

We are currently working with independent providers and other organisations to agree a methodology, timetable and process (including costing standards) to collect costing data.

Comment 11

You said

There are significant issues with the quality of data feeds.

Trusts have raised this as part of the early implementer process. This is why we are encouraging trusts to be involved in our early implementer programme.

Comment 12

You said

The information being collected under PLICS is not consistent with the way many trusts operate – meaning trusts will be producing internal and external PLICS. This is a significant burden on providers.

One original objective of the costing transformation programme⁹ was to have the cost collection output as a direct product of the costing process. This is still our aim, but we are following a pragmatic transitional approach to achieve our other main objectives of having a single integrated collection and switching off reference costs to reduce the burden of collections.

Because of the historical baseline calculation of reference costs, and how national bodies make use of reference costs, we need to reassure reference costs users that patient-level costs are a credible alternative source of health cost data that meets their needs. This will affect how we collect cost data during the transition to a single integrated collection.

The standards team will continue to provide guidance to help organisations understand the costs of all the services they provide. Similarly, the collection requirements will continue to be developed to meet end users' needs and to support the policy decision of moving to patient-level costs as the main source of national health cost data.

⁹ <https://improvement.nhs.uk/resources/transforming-patient-level-costing/>

Comment 13

You said

How can we ensure board commitment to the process?

Work by the Model Hospital team and Getting it Right First Time (GIFT) project has raised the profile of costing. Costing also forms part of the Use of Resources assessment. We have a team that regularly meets trust board members at regional meetings or through arm's length bodies.

However, if you feel your organisation needs a specific meeting, we have several experts who would be happy either to meet board members on a one-to-one basis or present at a board meeting. If you are interested in this, please contact costing@improvement.nhs.uk

Comment 14

You said

Is PLICS cost-effective?

The findings from our impact assessment,¹⁰ and feedback from trusts that have already implemented PLICS, indicate that the costs of implementing and running the system are recouped through better use of resources.

We have also produced case studies and are publishing interviews with clinicians on how helpful they have found patient-level costing. You can find more information on our website¹¹ or email the team at costing@improvement.nhs.uk

¹⁰ <https://improvement.nhs.uk/resources/mandating-patient-level-costing/>

¹¹ <https://improvement.nhs.uk/resources/using-costing-information-to-support-better-outcomes/>

Comment 15

You said

There are concerns that suppliers do not have the resources to make the changes and support trusts through the process of implementing PLICS.

We are working with suppliers to ensure they can provide costing systems that are consistent with the minimum software requirements¹² in a timely manner.

Comment 16

You said

The timetable for submitting PLICS and reference cost information must be made clear as soon as possible, but there needs to be some flexibility, especially around dates, holidays and resubmissions.

We recently issued a draft national cost collection¹³ document to all providers. This set out the proposed timetable for the submission of patient-level data in 2018 and the planned approach to move to a single collection as soon as possible.

Comment 17

You said

Many trusts requested more detail on the costings for each option.

Our impact assessment¹⁴ includes details of how we produced costings, including:

- the assumptions – both generic and for each option assessed
- what the assumptions were based on

¹² <https://improvement.nhs.uk/resources/minimum-software-requirements/>

¹³ https://improvement.nhs.uk/uploads/documents/Costing_collections_in_2018_final1.pdf

¹⁴ <https://improvement.nhs.uk/uploads/documents/ImpactAssessmentMandatingPatientLevelCosts.pdf>

- details of evidence used to calculate costs
- how we allocated trusts into three categories (specialist, large and teaching and others) for costing purposes.

Comment 18

You said

There is a limited pool of costing staff in the NHS. How will NHS Improvement address this?

We have provided training to increase the number of costing staff in trusts. We will also provide support, training and tools as part of the early implementer programme and during the initial stages of mandation.

Comment 19

You said

How will patient-level costing support trusts with capitation or block arrangements?

Understanding a trust's costs becomes even more important where there is a capitated or block contract. This is especially true where capitated budgets have risk-sharing arrangements to ensure they are set at a reasonable level and monitored effectively. Where there is a block contract, trusts and commissioners will need to monitor and manage demand to ensure that key national and locally agreed targets are maintained.

Comment 20

You said

How will you minimise the impact of phased transition on multi-service providers?

The rollout of patient-level costing is by sector (acute, mental health and community). This allows us to work with the sectors over a few years to draft, test and finalise the standards. It will also allow us to ensure there is consistency between sectors.

We acknowledge that many trusts will still need to produce reference costs until all activity is moved to patient-level costing. The benefits of this include:

- allowing trusts to look at the arrangements for other services they provide as part of the phased implementation and ensure data is available at the required level
- providing PLICS suppliers time to produce and test changes to their systems.

We hope our plan for the early move to a single collection will reduce the need for dual running – from two years (after mandation) to just the pilot year in 2017/18. If this is unsuccessful, we will try to limit the dual running to 2018/19 by attempting to produce reference costs from PLICS.

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This publication can be made available in a number of other formats on request.