NHS Improvement

Feedback from consultation on mandating patient-level costing for the ambulance sector

December 2018

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

Contents

Introduction

Between August and September 2018, we consulted on proposals to mandate NHS foundation trusts and NHS trusts to record and report the costs of 999 activity at a patient level[1].

We received five responses from two types of organisation:

Ambulance	Other NHS	Other Non-NHS	External organisations	Total
4[2]	1	0	0	5

The consultation asked for views on two proposals:

- To what extent do you agree with mandating patient-level data for all incidents going through 999 call centres or dispatch centres at a "proxy patient/ incident" level in line with the methodologies and approaches in the Healthcare Costing Standards for England, from 2019/20?
- Do you agree with the proposal to cease collection of reference costs for 999 activity from 2018/19?

On the first three of the respondents agreed. However, the feedback on ceasing reference costs was split with two agreeing, two disagreeing and one abstention[3]. None of the respondents provided reasons why they were in favour or not of keeping reference costs. Anecdotal evidence is that there are concerns around the initial accuracy of the patient level data and whether this would impact on contracting discussions with commissioners.

Though respondents were divided on whether to maintain dual running of reference costs, NHS Improvement have decided to cease the collection of ambulance reference costs, with the last year of collection being 2018/19. Findings from the impact assessment work indicted that most providers were in favour of ceasing

[1] For details of this consultation, including the consultation document and accompanying impact assessment, see: https://improvement.nhs.uk/resources/mandating-patient-level-costing-ambulance/
[2] One partially completed for questions 1 and 2
[3] Abstention from non-NHS organisation.

reference cost collections as soon as possible and that this would allow trusts to concentrate on a single cost return. This is also consistent with mandating patient level costing in the acute sector, where reference costs will not be collected in 2018/19 for those covered by the mandation.

After considering the consultation results, the impact assessment and the mandation project, NHS Improvement approved the proposals in November 2018. This means that, from 1 April 2019, it will be mandatory for NHS 999 ambulance providers to record and report costs at a patient level for acute activity in line with the Healthcare costing standards for England.

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

We have included the responses to the three additional questions included in the consultation on the future direction of travel for costing in the ambulance sector. These are provided for information only.

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

Though we agree with the proposal and are taking part in the voluntary collection for 2017/18, users need to be aware that the data collected during early years of submissions will be subject to data quality improvements as we embed the process of PLICS.

Data will be made available to trusts to review and benchmark their costs in the PLICS portal. The granularity of data will help identify areas for improvement in costing and underlying data. We will also

- produce tools, such as the data validation tool and costing assessment tool, which will support you in improving the quality of your data
- extend the Costing Assurance Programme to include ambulance providers.

The findings from these will be used to provide targeted support and improve tools and guidance for trusts.

Comment 2

You said

We broadly agree that moving to patient level costing is sensible, however there will be significant issues with cases. Examples raised include where:

a. patient's details cannot be taken (i.e. where patient is unconscious),

b. in a patient scenario (e.g. road traffic collision) where we can only trace the main patient

c. where we do not currently know which patients have been transported to onward destinations.

Concerns were also raised around

a. the fact that the current collection does not identify the 'uniqueness' of patients leading to costs still being “averaged” and

b. there are instances where activity may be incorrectly recorded due to how the sector operates – for example where two vehicles are used but only one patient is being transferred (i.e. due to staffing requirements)

We will continue to work with you to agree how to improve the completeness and consistency of the data collected. Being able to link to other providers (i.e. acute accident and emergency departments, community or mental health providers) will help improve the information.

As part of the future direction of travel questions and working with the Ambulance Technical Focus group, we have signalled the plan to move from proxy to real patients. We will work with you to identify how this is collected and verified.

Comment 3

You said

We do not understand how the costs have been calculated as they are significantly different to the costs incurred for both reference costs and patient level costing at our trust

The costs included in our impact assessment are not an additional cost which a trust would incur, it is the average cost of a trust producing either a reference cost

or patient level cost return. We have provided additional information on how staff time and cost, plus system cost have been estimated over the 10 years of the assessment.

We used information from the early implementer work programme and information from on-site audit visits to calculate the amount of time required to produce reference cost returns and estimate the time that would be required to produce a CTP PLICS submission. We have also 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
- an estimate for costs includes an estimate for implementing PLICS where trusts don't already have a system. This is based on business cases and information collected as part of the impact assessment.
- And an estimate of costs for producing fully costed data includes an estimate IT department's costs and senor officer review and sign off. This was based on feedback in the 2015/16 detailed costing survey (part of the reference cost submission)

Responses to future direction of travel questions

We asked	Your response
Do you agree patient-level costing returns for the ambulance sector should, in time, be submitted quarterly?	In principle it seems sensible to collect data on a more regular basis but this • must to be balanced against time and effort involved • needs to be guidance on how to deal with year-end adjustment to allow for timing issues in financial records • automating this process would allow this to be implemented and allow for closer monitoring of recent trends in benchmarked information.
Do you agree with the plan to move to from incident costing to patient-specific costing at some point in the future?	Ambulance data is collected on an incident level. Moving to real patient level information would require a nationally consistent electronic patient record system to capture data at the point of care (at scene) but this needs to be managed to avoid local inconsistencies
Do you agree with the proposal to collect patient-level information for non-999 services in the future?	This information is commercially sensitive as these contracts are commercially let. More information is required on how this would be managed by NHS Improvement The focus should be on delivering quality outputs for the 999 services in the first instance rather than divert efforts from limited resources into these other areas.

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