Healthcare costing standards for England: the costing principles

January 2017
Delivering better healthcare by inspiring and supporting everyone we work with, and challenging ourselves and others to help improve outcomes for all.
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Introduction

These principles apply to all NHS costing. Used with the costing standards and other guidance, they will improve the accuracy, consistency and relevance of your organisation’s costing. The costing principles constitute recommended practice and we encourage all providers to use them. For future cost collections we propose that organisations will be required to apply the principles, so we encourage early adoption.

Our aim in developing good costing is to:

- help providers understand the costs of delivering services
- support effective benchmarking with peers
- support local and national decision-making.

The costing principles

We have developed seven principles (see Table 1) that should be applied to all NHS costing exercises.

Table 1: Costing principles

<table>
<thead>
<tr>
<th>No</th>
<th>Principle</th>
<th>Objective</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Causality</td>
<td>Use of the costing standards explains the ‘how much, why, where, what and who’ of an organisation’s costs.</td>
</tr>
<tr>
<td>2</td>
<td>Transparency</td>
<td>Ensure the cost allocation process is transparent to facilitate detailed analysis and validation.</td>
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<td>3</td>
<td>Consistency</td>
<td>Enable consistency of approach regardless of the NHS services offered.</td>
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<td>4</td>
<td>Accuracy</td>
<td>Ensure confidence in the patient-level costing model by basing it on reliable source data.</td>
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<td>5</td>
<td>Materiality</td>
<td>Focus costing effort on the materiality and variability of costs.</td>
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<td>6</td>
<td>Stakeholder engagement</td>
<td>Effective costing requires stakeholders to contribute to and actively use costing information.</td>
</tr>
<tr>
<td>7</td>
<td>Totality</td>
<td>Produce reliable and comparable results that include all an organisation’s costs.</td>
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Principle 1: Causality

Objective: The costing process and its outputs should be able to show the causality or relationship between activities that took place and the resources consumed to deliver those activities.

Causality of costs should be traced through the system:

- How much cost was incurred – as recorded in the general ledger?
- Why was the cost incurred – what resources were purchased with this cost, such as staff, space, consumables?
- Where were these resources used and for what purpose – the activity of admitting patients would be classified into the activity group of wards?
- What drove the need for this activity?
- Who incurred these costs?

Principle 2: The costing process should be transparent

Objective: Ensure the cost allocation process is transparent to facilitate detailed analysis and validation, and to increase audit and end-user acceptance.

At every stage of a costing process it is important that:

- costs are allocated transparently
- costs can be easily traced from one stage to another, or their origin can be identified by working back.

Without such transparency it is more difficult to get clinicians and managers to accept that the numbers are correct or to act on the results.

Transparency also makes it possible to audit a cost model to check that all costs have been accounted for at every stage of cost allocation, or to ensure that a cost submission is acceptable for use in an annual collection.

If software is to effectively facilitate the transparency required by this principle, it should satisfy the Minimum software requirements for the costing of NHS services in England.¹

¹ https://improvement.nhs.uk/resource/minimum-software-requirements
Keep documentation up to date as the costing process is continuously improved. The costing team should use the costing manual and the costing assessment tool (CAT) to assure the board about the process undertaken.

**Principle 3: Consistency of costing**

**Objective:** Enable consistency of approach regardless of the NHS services offered. This is essential if comparing costs within and across organisations is to help with, for example, benchmarking, tariff setting, service redesign and cost management.

**Supporting improvement:** Consistent cost allocation in an organisation’s costing system supports three levels of improvement:

- **Within the organisation:** An organisation’s ability to understand and link expenditure to patients and services year to year helps it trace and manage costs, monitor trends in costs against services, compare percentages of costs against different cost groups (e.g., support costs compared to bed days) and capitalise.

- **Between organisations:** If all organisations allocate costs against the same standard in the same way, each can compare their costs against their peers’, assess their performance and generate efficiencies in service delivery.

- **Across the service:** Service-wide consistency – where each organisation allocates costs consistently against the same standard – makes it easier for national bodies like NHS England, the Department of Health and NHS Improvement to improve the overall system. Consistency supports the creation of more accurate pricing models, specific local variations and better tariffs through better reference costs that drive sector-wide efficiencies.

**Quality of costing:** More consistent costing and better quality operational data will produce more reliable costs and less unexplained variability in what should be comparable results.
Principle 4: High quality and accurate base data underpins all costing

Objective: Ensure confidence in the patient-level costing data by basing it on reliable source data.

Increased data accuracy improves confidence in the resulting patient-level costs. However, as providers are generally organised into functional units, it is easy for those responsible for recording data in a timely and accurate manner to lose sight of the data’s purpose and not pay enough attention to its accuracy, especially if resources are stretched.

Responsibility for data accuracy: This sits firmly with those charged with inputting operational data and with their managers. Costing practitioners are their internal customers.

Fixing poor data quality: While a user may be tempted to fix a quality problem on finding it, this fails to address the cause of the error and does not establish a ‘feedback’ loop from which the organisation can learn. Where a data error is identified, good practice is to report it to those responsible for that data, and for them to fix it and establish routines that prevent it recurring.

Measuring accuracy: Management is responsible for data accuracy. It should be routinely measured and reported to management. Improvement programmes should be set up where necessary, and progress tracked.

Data definitions: The inconsistent classification of routine short-stay elective patients as either day-case or outpatient activity continues to affect the accuracy of data underpinning cost collections. Similar issues can be found in the classification of short-stay non-elective activity in ambulatory care or clinical decision units, where the intention is to avoid fully admitting the patient to hospital. Previous work with national organisations responsible for payment\(^2\) found that these inconsistencies can be avoided by ensuring that activity data from the NHS minimum datasets is recorded correctly according to the \textit{NHS Data Dictionary}.\(^3\)

\(^2\) \textit{Improving the data definitions and their use in the NHS.} Audit Commission, 2012.

\(^3\) \url{www.datadictionary.nhs.uk/}
Principle 5: Focus on materiality

Objective: Focus costing effort on the materiality and variability of costs.

If all patients and their treatments were identical in every organisation, costing activity would be simple and add little insight. It is the variability among patients and their treatments that makes accurate costing so important in understanding how costs are incurred.

Those responsible for resources can manage them more cost-effectively in patients’ interest if they understand what drives the need for the larger elements of cost. As management is a scarce resource, it should focus on managing the larger elements of cost to make the most difference; this could be a large individual cost such as a scanner, or a large aggregate cost such as medical staffing.

Apply a materiality threshold of 0.05% of your organisation’s expenses, and document procedures for dealing with costs below this threshold. These costs must still be included in the costing process, but focus on high value or high volume areas first.

Similarly, understanding how costs vary is important for patient and/or management decisions. If the variation in costs is wide, pay particular attention in the costing process to understanding and explaining it, and to quantifying its implications for the costs incurred.

Costing guidance should provide clear instruction on how to identify and treat materiality and variability.

Principle 6: The need for stakeholder engagement to inform improvements in costing and to embed the use of the data within the organisation

Objective: Effective costing requires stakeholders to contribute to and actively use costing information. This includes clinical as well as non-clinical staff, frontline teams and departments providing clinical support services.

Stakeholder engagement is the most critical principle for productive use of costing information. When combined with clinical feedback and actively used by frontline staff, costing information is a powerful tool with which to drive service efficiency.

By actively engaging with stakeholders, costing teams can:

- understand the audience for costing data – who uses it, how they use it and where effort will achieve highest impact
• ensure costing is more accurate, locally relevant and actually used by clinicians to drive improvements

• improve business intelligence by working with those delivering patient care, and so develop an understanding of how resources are consumed and could be better used.

Stakeholders who should typically be involved in costing are:

• **boards and executives**: executives need to be confident using cost information, both in their own decision-making and throughout the organisation – there should be a governance framework to review and sign off the costing processes used and the collection returns whether voluntary or mandatory

• **clinical staff**, including consultants, therapists, nurses and staff from clinical support services: they can provide information about service delivery that enables accurate allocation of costs to patients

• **staff from the informatics and clinical coding departments**: they can help automate the extraction of patient activity information from various systems, speeding up the costing process and supply of accurate activity data

• **finance staff**, including financial management, income accounts and capital accounts: they are crucial for providing the correct financial information from the general ledger and interpreting the ledger coding

• **non-clinical staff** involved in service delivery, including operational managers, education and training colleagues, and research and development colleagues: they can ensure cost information is reported to support decision-making

• **commissioning and contracting staff** can help verify patient activity information and identify income at a more detailed level to assist allocation.
Principle 7: All costs should be included in the costing process, and all costing outputs should be reconcilable to the source information and the organisation’s reporting position

Objective: Produce reliable and comparable results that include all an organisation’s costs.

**Cost quantum:** The total cost an organisation’s cost model should reconcile to its audited accounts. Any expenditure defined as extraordinary for costing purposes should be traced to specific cost objects, ensuring all relevant operational expenditure can be analysed and traced to its respective cost units. This totality ensures a consistent baseline for each organisation.

**Netting off income:** Income should not be netted off against costs. Show all costs as gross, and show any related income against the relevant cost units.

**Full-period costing:** Include all activity and all costs in a period, not just those for completed patient episodes, as it will make the calculated incomplete patients events position more accurate. This in turn will allow you to assess more accurately the costs of the activity undertaken in the period. It also removes ambiguity in approach and comparison.

**Activity quantum:** Reconcile all activity included in the costing output to the source activity inputs and to the organisation’s reporting position.

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4 There are a couple of exceptions to this rule, as noted in *CP2: Clearly identifiable costs.*