About NHS Improvement

NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future.

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.
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1. Introduction

We issued the draft version of *Healthcare costing standards for England – acute focus*¹ (‘the standards’) in April 2016 for implementation by our acute roadmap partners only. Their experience will inform the next development version of the standards, which will be rolled out more widely across the acute sector. It will also be fed into the impact assessment to be undertaken as part of the development of our proposals to make use of the standards mandatory.

Although final decisions on the content and status of the standards are subject to further consideration and consultation with the sector, we would like providers to prepare now for the new approach. This would facilitate prompt, efficient and effective implementation: first on a voluntary basis from 2017, and subsequently on a mandatory basis if we proceed to make the standards mandatory in 2018/19. Any feedback you can give on the implementation of the draft standards will also help to inform our proposals. So, even if not a roadmap partner, we ask you to start preparing to implement the new standards, using this guidance and the issued draft version of the standards.

This document explains:

- our standard development approach
- the rationale for the content of the standards
- what you can do during 2016 to prepare for implementation of the next version of the standards.

Call for early implementers

We are looking for acute providers to volunteer to implement development version 1 of the costing standards in their costing systems and to take part in the patient-level information costing systems (PLICS) collection in September 2017. If your organisation is interested, please contact the costing team at NHSI.costing@nhs.net

If your organisation volunteers for this and has previously taken part in the voluntary acute PLICS collection, there is no obligation to continue with the latter.

The benefits to your organisation of early implementation are:

- access to our bespoke costing benchmarking tool
- support from our costing team during implementation

• opportunity to contribute to the development of future versions of the costing standards

• local availability of higher quality cost information for decision-making.

Your organisation will also be helping national bodies by giving them early access to better quality cost information for use in designing and developing currencies and the tariff.

We are also interested in your views. If you would like to contribute to future standard working papers or provide feedback on the draft standards, please contact us at NHSI.costing@nhs.net

2. Our approach to the development of the standards

We are developing the standards to achieve the three aims given in Costing NHS services: proposals for 2015 to 2021. These are for:

• providers to understand their own costs better and as a result to make better local decisions

• providers to benchmark effectively against their peers

• production of good quality cost information for tariff development and design.

We started by adopting a standard development approach based on the best practice of other organisations that have developed standards, such as the National Institute for Health and Care Excellence (NICE). We:

• took the intellectual lead

• collected evidence from costing, informatics and other professionals

• consulted on the proposed costing methodologies.

We reviewed the costing standards from countries which have already implemented patient-level costing and are using it for benchmarking and tariff development and calculation. We wanted to be sure we incorporated established national and international best practice, and did not ‘reinvent the wheel’.

We set out our framework for development of the standards in Costing NHS services: proposals for 2015 to 2021. In summary:

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4 New Zealand, Canada and Australia
• the costing process is at patient level
• prescribed information feeds are at patient level
• costs are mapped to a prescribed list of resources
• providers’ activities are mapped to a prescribed list of activities
• resources are allocated to activities using a prescribed method
• guidance is provided to cover the whole costing process and associated areas
• a costing glossary standardises costing terminology.

The framework also sets out that:

• standard development also supports:
  o new costing practitioners
  o improving provider financial reporting
  o tackling difficult-to-cost areas
• patient level can mean ‘a patient’ not ‘the patient’: that is, you know there was a patient but that patient’s identifier may not be available
• income should never be used to weight costs
• cost allocation to resources reflects how the costs have been incurred
• resource allocation to patients reflects how care/service has been delivered
• costing process reflects how costs have been incurred, not how the service is paid for
• patient unit costs should not be distorted by allocating unmatched costed activities to patients who did not incur those costs
• reconciliation items are introduced as it is not appropriate to allocate every cost to a patient and to do so would distort the patient unit cost.

2.1. How did we decide what to include in the draft standards?

We listed all the areas relating to the development framework, the items identified from our review of the international standards, and the nationally difficult-to-cost areas from feedback to the reference cost audits: there were 30 in total. We circulated 30 working papers to stakeholders, asking them to review the 30 topics and comment on the proposed approach to each. Stakeholders were asked to state whether they agreed the proposed approach was the best one or to put forward
evidence for an alternative approach that would better achieve the three aims in *Costing NHS services: proposals for 2015 to 2020*.

The stakeholders we asked to comment included:

- acute roadmap partners
- stakeholders with wider acute costing expertise
- stakeholders with ambulance, community and mental health costing expertise.

If the feedback consensus was that an approach should be adopted, it was included in the draft standards. If there was no consensus, we reviewed the feedback and decided which approach to adopt based on the evidence.

We recognise that some of the methodologies in the draft standards depart from current practice. Their implementation by roadmap partners will allow us to test whether the standards meet the following criteria:

- practical
- achievable
- implementable in the real world
- produce meaningful results.

If the roadmap partners find they do not meet the criteria, we will revise the methodology until they do.

### 2.2. Consultation on the draft standards

We ran a six-week preliminary consultation on the draft standards, inviting feedback from stakeholders including:

- roadmap partners
- costing professionals from providers of acute, mental health, community and ambulance services
- wider NHS Improvement costing team
- NHS Improvement pricing teams
- software suppliers
- members of the costing advisory group.

We received over 900 points of feedback. We reviewed these and either revised the draft standards as appropriate or deferred the issue to the next development version.
We will also consult the wider acute sector this summer and we plan to publish our findings in September 2016.

3. Overview of the standards

The standards fall into five categories that cover all aspects of the costing of NHS services:

- costing principles
- IR – information requirements
- CP – costing process
- CM – costing methodology
- CA – costing approach.

The standards should be read in conjunction with the technical support document.5

3.1. Costing principles

The costing principles underpin the whole costing process and are applied to all the standards.

3.2. Information requirements

Costing begins with good quality source activity data. These standards describe the activity information required to implement the other costing standards, and how costing teams can work with informatics and service departments to obtain good quality data for costing. You should share these standards with your informatics department and those departments providing activity data for costing.

Standard IR1: Collecting information for costing purposes

The costing transformation programme (CTP) aims to standardise the collection and use of information in costing. This standard prescribes the minimum 15 patient-level feeds for implementing the standards. As providers may not currently collect all this information, we recognise a lead in time is required before all of it is available for costing. We also recognise that these 15 patient-level feeds do not cover all the activity a provider delivers. We will add to the minimum number of patient-level feeds in future versions of the standards.

Standard IR1 gives guidance on identifying the information you need for costing and how it should be used.

5 https://improvement.nhs.uk/resources/costing-standards/
**Standard IR2: Managing information for costing purposes**

We recognise that as costing practitioners you are not responsible for the quality of your organisation’s activity data. However, you are ideally placed to flag data quality issues identified through the costing process and you are often the first port of call for a clinician or other user of cost information when a data quality issue is spotted. This is important because a single data quality issue can adversely affect the overall accuracy of the cost information and be a huge distraction when costing practitioners share and discuss cost information with clinicians and other users.

The Healthcare Financial Management Association (HFMA), commissioned by Monitor (now part of NHS Improvement), published *Improving the quality of information for costing for acute and community services* in February 2016. This document lays the ground work for the improvement in data quality which is required by the CTP. It spells out the importance of the quality of the underlying information to the quality of the costing information, and provides helpful guidance on how providers can improve their data quality.

Standard IR2 builds on this by providing further practical guidance on how you can manage the information you get and how you can help your organisation to improve its data quality.

**3.3. Costing processes**

These standards explain the steps of the costing process, from the general ledger through to the final patient unit cost and reconciliation to audited accounts. They should be applied to all the services provided by an organisation.

**Standard CP1: Understanding the general ledger**

The general ledger is where the costing process starts. We recognise that general ledgers are structured to meet the financial requirements of the provider and not necessarily for the costing process. However, you need to understand the structure of your organisation’s general ledger and the types of costs reported in its different sections.

*Understanding the general ledger for acute and community services* lays the ground work for the CTP by helping you to understand how your organisation reports its costs.

Standard CP1 builds on this by providing more detail to help finance colleagues to understand how the general ledger is used in the costing process. You should share this standard with them.

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Standard CP2: Producing the cost ledger

‘Cost ledger’ is new terminology for the costing process. As the general ledger is not generally set up for the costing process, most costing practitioners will need to move costs to their correct starting positions for costing. ‘Cost ledger’ just puts a name to this preparation work.

The purpose of the cost ledger is to ensure costs are aggregated or disaggregated to the appropriate level to start the costing process, and all costs are in the correct ‘starting position’ for the costing process.

This cost ledger supports one of the aims of the CTP – to provide transparency from beginning to end of the costing process.

Standard CP3: Allocating costs to identified resources

This standard provides the prescribed list of resources that costs need to be mapped to. The resource list needs to be detailed enough to allow all costs to find a natural home, but not so detailed that it becomes burdensome to the costing process. Work continues to refine the prescribed list of resources.

Standard CP4: Identifying activities

This standard works closely with the information requirements standards as you need to identify the activities performed by your organisation and then map these to the prescribed list of activities provided in this standard. We recognise that the 15 patient-level feeds prescribed in the information requirements standards do not cover all the activities performed by acute providers. However, all activities should be mapped to the prescribed list of activities and costed regardless of whether they are supported by a patient-level feed or not. We are planning to expand the number of prescribed patient-level feeds in future versions of the standards.

Standard CP5: Allocating resources to activities

This standard provides the costing allocation methodology for each resource and activity combination. There is only one prescribed allocation for each combination. This is important to ensure that the costing process is standardised as far possible to allow meaningful benchmarking. We understand that providers may not be able to meet the prescribed costing allocation methodology at this time. In this case providers may use a locally relevant methodology and document this in their costing manual. Providers will also need to demonstrate they are working towards achieving the prescribed allocation methodology.

We understand that providers may be using allocation methods superior to those prescribed in the standards. We are in the process of putting together a list of ‘superior’ costing methodologies. Providers will need to document in their costing manual where they have used such a methodology. We are also producing a list of
costing methodologies that we will not accept as superior, including local work arounds which use income or national averages to weight costs.

**Standard CP6: Matching activities to cost objects**

We recognise that matching of costed activities to inpatient episodes, outpatient attendances and contacts is crucial for accurate patient unit costs. An aim of the CTP is to standardise the costing process at every stage. This ensures that the results can be benchmarked as any cost variation will be due to service delivery decisions rather than variation in the costing methodologies used to calculate the costs.

To support this aim we have produced prescribed matching rules to reduce ‘false-positive’ matches: that is, when the costed activity is not matched to the event it took place in. We will continue to refine the matching rules, recognising the complexity of the process because each activity may take place in many different care scenarios.

We have adopted matching principles that depart from current practice. Unmatched costed activities should not be absorbed by patients who did not incur these costs. We will never establish the true cost of any procedure if patient unit costs are inflated by costs that were not incurred during the delivery of that procedure.

The volume of unmatched costed activity is a good measure of the accuracy of the data used for costing purposes. It is an aim of the CTP to improve the quality of this data. Reports of unmatched costed activity and the reasons why activity could not be matched can be helpful in illustrating to informatics and other departments the importance of good quality data to costing. As data quality improves, unmatched costed activities can be expected to reduce.

It is appropriate that some costed activities are not matched to any inpatient episodes, attendances or contacts because they were not part of this care, eg replacement orthotics ordered on behalf of the patient. The cost group ‘reconciliation items’ has been adopted to record these costed activities so patient unit costs are not inflated.

**Standard CP7: Reconciling to annual accounts and other sources**

Reconciliation is important for user confidence in the cost information. Reconciliations give assurance that the cost information aligns with what the provider reports both internally and externally. It increases confidence in the accuracy of the cost information and therefore its use in strategic decision-making.

**Standard CP8: Assigning income to costed activities**

This standard supports:

- new costing practitioners
• improvement in provider financial reporting.

It is for guidance only as we will not be collecting information on income or surplus and deficit positions of services in the cost collections.

As the standards help organisations to better understand their costs, they also improve the service line reporting (SLR) quality. As income is an integral part of SLR, its appropriate allocation will help to make a provider’s SLR as accurate as possible.

3.4. Costing methodologies

These standards provide detailed methodologies to cost high volume and high value areas within an organisation. These supplement the costing process standards.

Standard CM1: Allocating overheads

This standard adopts approaches that depart from current practice. The first difference is that costs are classified as either direct or overhead (supporting); the indirect classification is not used.

Costs are driven in two ways only: by the cost objects (direct) or by other resources/activities (overhead/supporting). The indirect classification relates to organisation structure, not how costing is undertaken. Its inclusion is a management classification, which is separate from the costing process and should be achievable by attributing the different resources/activities in the model.

For example, the cost of a radiology scan can be directly attributed to those patients who were scanned. Within costing, it is directly driven by the cost objects. For management purposes, it is an indirect cost as the scan is a clinical support service provided at the request of a main speciality such as trauma and orthopaedics.

Our international research also showed that those countries which have already implemented PLICS do not use the indirect classification. Feedback from stakeholders was that costing practitioners can find the classification of indirect costs confusing as some costs can legitimately be classified as both indirect and overhead. The focus of the standards is the costing process, not the classification of costs.

Organisations are at liberty to class costs as indirect for internal purposes, but we will not provide guidance on this or collect indirect costs in this version of the standards. Our roadmap partners will review this practice during the implementation of the costing standards over the coming months, reinstating indirect cost classification if it is shown to be critical to producing good quality cost information.

We have adopted three different ways to allocate overheads to cost components. This is because detailed analysis of the overheads indicated that a 'one size fits all' approach does not accurately reflect how overhead costs are incurred. The use of
three methodologies does reflect this and attempts to allocate overhead costs at the appropriate point in the costing process.

**Standard CM2: Relative weight value units**

We recognise that relative weight value units do not always represent accurately the actual cost of a particular activity. However, we also recognise that providers are at different stages on their costing journey and have different levels and quality of information available to them for costing. Relative weight value units are an intermediate step to facilitate costing in the absence of better information. As the quality and quantity of information available for costing improves, the need for them will decrease.

**Standard CM3: Private patients and other non-NHS England patients**

Patients of the NHS in England can only be costed and reported accurately when private patients and other non-NHS England patients are also costed and reported accurately. This helps to identify any areas of cross-subsidisation and to ensure NHS England patient unit costs are not distorted.

**Standard CM4: Other activities**

Providers undertake many activities in addition to those which deliver services to patients. Correct costing of these other activities is important for quality cost information and to ensure patient unit costs of the NHS in England are not distorted.

**Standard CM5: A&E attendances**

This standard adopts an approach that departs from the current practice of some providers, basing the allocation of resources on the treatment procedures a patient receives. This is because we recognise that the time a patient spends in A&E is not a good proxy for allocating costs. This standard only covers activity reported under treatment function code 180, although the principles apply to all A&E activity.

**Standard CM6: Outpatient procedures**

Our 2014/15 reference cost audits highlighted outpatient procedures as an area where costing could be improved. In response, this standard provides practical guidance to improve the quality of costing outpatient procedures.

**Standard CM7: Theatres**

This standard adopts the methodology of sessional costing for theatres, which is not the approach used by many providers. We reviewed several approaches to costing theatres and the evidence contributed was that sessional costing effectively addresses some of the challenges in costing theatres, such as overruns and cancellations. This is the starting point for investigating the methodologies to include
in future versions of the standards that more accurately cost overruns and underruns, as well as out-of-hours and emergency theatre work.

**Standard CM8: Critical care**

This standard adopts the methodology of costing by nursing time and acuity, not number of organs supported. We reviewed several approaches to costing critical care and the evidence contributed was that this approach more closely reflects how costs are incurred. The results using this methodology will be reviewed during the implementation of the costing standards by roadmap partners over the coming months.

**Standard CM9: Outpatient DNAs and telephone calls**

This standard adopts approaches that depart from current practice. We have included did not attend (DNA) costing in the standards because one of the aims of the CTP is to accurately cost all activity. We know that providers currently do not collect information, or collect information but do not cost it, on much of the activity they undertake. The costs incurred for these activities are reported in the general ledger and then have to be absorbed into other activities, distorting the final patient unit cost. If we are to identify the true cost of any procedure, then only costs incurred in the delivery of that care should be allocated to that procedure. To achieve this, all costs and activity need to be correctly identified and reported, regardless of whether a tariff applies for an activity or not.

DNA information is already collected but is not costed. Organisations need to understand the costs of DNAs to them. In addition, there is a national requirement to know these costs to answer information requests from the Department of Health and Parliament, and questions from ministers and members of the public.

We recognise that as services are redesigned to deliver care more efficiently and closer to a patient’s home, with less time spent in the acute setting, telephone calls are becoming increasingly important to deliver virtual care. Therefore, we believe it is important to include this type of activity in the standards to ensure it is accurately costed for future strategic decision-making purposes.

### 3.5. Costing approaches

These standards provide detailed guidance on the costing of difficult-to-cost areas. Analysis of cost collections has shown variation in their costing, in part because of the recognised complexity of these services. These standards are designed to help you identify all the relevant costs in these areas, and to work with informatics and the service departments to obtain the required information for costing.

Initial feedback from costing practitioners is that these standards are particularly helpful.
You should share these standards with the departments providing these services.

**Standard CA1: Tonsillectomy, 18 years and under**

Tonsillectomy in those aged 18 years and under was selected for a costing standard because it is a high volume area for providers of this service. As the CTP is also concerned with improving the cost information in the short term (that is, of reference costs), it is appropriate to provide guidance on high volume areas.

**Standard CA2: Cochlear implant surgery**

Audit results show this to be an area where the quality of cost information could be improved. In particular, implant costs of around £15,000 are often missing from reported cochlear surgery costs.

**Standard CA3: Renal dialysis**

Renal dialysis was identified as a difficult-to-cost area due to the variety of delivery settings.

**Standard CA4: Cancer MDT meetings**

As the CTP aims to improve the quality of cost information in the short term (that is, of reference costs), it is appropriate to provide guidance on services which are reported separately in reference costs, such as cancer multi-disciplinary team (MDT) meetings. The aim of this standard is not to take the costs of MDT meetings to the patient level, but to cost, collect and report them at meeting level.

**Standard CA5: Chemotherapy procurement and delivery**

Chemotherapy was identified as a difficult-to-cost area due to the complexity of the service. Feedback from contributors also highlighted difficulties with the currency and this has been shared with NHS England.

4. **What providers can do to prepare for implementation of the standards**

We ask all providers to start preparing to implement patient-level costing. We have provided the following guidance to support providers in preparing for implementation of the costing standards to be published in January 2017.

4.1. **Differences between current and proposed new costing processes**

There is a huge amount providers can do over the next nine months to prepare for implementation of the costing standards (on a voluntary basis) in 2017, and possible mandatory implementation in 2018/19.

The first step is to read the draft costing standards. Although these are draft standards, the high-level costing process described in Standards CP1 to CP9 will not
change. Providers need to set up and document their costing ledger, map their costing ledger to resources, identify their activities and collect the patient-level feeds as a minimum.

We encourage you to undertake a gap analysis of how your current costing processes differ from the new costing standards (see Appendix 1). Knowing where there are gaps will help you to identify where you need to collect additional information or include other departments in implementation discussions.

We also encourage you to discuss your plans for implementation with your software supplier. It is likely to have provided software to one of our acute roadmap partners that has gone through the implementation process as part of the standards development, and so can provide valuable insight into implementation.

4.2. Review the information available to you and identify your organisation’s activities

The information requirements standards describe the 15 patient-level feeds required for the new costing process. We recommend that you review these standards with your informatics department and identify what information is:

- collected and available for costing
- collected but not yet available for costing
- not yet collected.

Once you have identified your organisation’s information gaps, you can work with your informatics department and other relevant departments to obtain this information for costing.

We appreciate there will be a lead time from when new information is first collected to when it is available for costing. This is why we are encouraging you to speak to your informatics department as soon as possible, to put processes in place for information collection if required. While information is unavailable for costing, you will need to use a local work around that is representative of how the activity is performed and agreed with senior finance colleagues.

The next step is to identify your organisation’s activities and to map these to the prescribed list of the activities. Not every activity your organisation performs will be on a patient-level feed, so you will need to ensure that you have the correct information to allow resources to be allocated to the activities in the correct proportion.

The prescribed list of activities will be updated, informed by the implementation experience of the acute roadmap partners. However, if during mapping you identify activities that do not have a corresponding activity on the prescribed list, please let us know about these and we will review them.
4.3. Set up the cost ledger

As previously mentioned, good costing starts with a good understanding of the general ledger. We recommend you go through the lines of the general ledger with your finance colleagues to understand what costs are coded where. For accurate costing, the starting quantum of cost for each resource must be accurate. The cost ledger will help ensure this accuracy.

For transparency in the costing process, you need to document how you move costs from the general ledger to the costing ledger. Movements include the combining of general ledger expense lines into one cost ledger cost account code, and the disaggregation of a general ledger expense line into two or more cost ledger cost accounts.

We recommend you set up a costing manual for your organisation that documents all the decisions you make during implementation.

4.4. Map the cost ledger to the prescribed list of resources

This is the most labour intensive part of implementation for you, but the time you invested in understanding the general ledger and setting up a transparent cost ledger will now pay off as you map the cost ledger to the most appropriate resource. The correct quantum of cost needs to be mapped to the correct resource to ensure that resource is allocated in the correct proportion to the right activity.

The prescribed list of resources will be updated, informed by the implementation experience of the acute roadmap partners. However, if during your mapping you identify resources that do not have a corresponding resource on the prescribed list, please let us know about these and we will review them.

Every cost in the cost ledger needs to be allocated to a direct resource or an overhead resource, or be classified as a reconciliation item.

Once you have completed the above four stages, we recommend you discuss upgrading your costing system for the new costing process with your software supplier. You then need to work with your software supplier to implement the standards in your costing system.

We recommend that the costing standards are implemented in the following order:

- information requirements
- costing processes
- costing methodologies
- costing approaches

and in numerical order within each of these four categories.
Appendix 1: Comparison of the HFMA clinical costing standards with the draft healthcare costing standards for England

- Costing approaches in ten of the NHS Improvement standards do not have an HFMA equivalent: these are new approaches for costing practitioners
- Costing approaches in three of the HFMA standards do not have an NHS Improvement equivalent: no action is required to transfer these to the NHS Improvement standards
- 12 of the NHS Improvement standards cover costing approaches that will be familiar to costing practitioners but prescribe different methodologies from current practice
- One major task is the mapping of costs to resources, a core principle of the new costing process: this new requirement is a large but one-off exercise
- Due to the prescribed nature of the standards, the second major task rests with the software suppliers that need to include all the rules in the costing system

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<th>HFMA – 10 standards</th>
<th>NHS Improvement – 24 standards plus the costing principles</th>
<th>Action required by costing practitioners (CPs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No equivalent</td>
<td>Costing principles</td>
<td>These will be familiar as they formed part of Chapter 1 of the Approved costing guidance</td>
</tr>
<tr>
<td>NHS Improvement and HFMA in 2015/16 together produced a guidance paper for acute and community services on understanding the general ledger. This paper was published in January 2016 and laid the ground work for Standard CP1</td>
<td>Standard CP1: Understanding the general ledger</td>
<td>CPs should have implemented the principles in the HFMA guidance paper. Standard CP1 will take them to the next step in preparing to produce the cost ledger: Standard CP2</td>
</tr>
<tr>
<td>Standard 1 – Classification of costs into direct/indirect/overheads</td>
<td>Standard CP2: Producing the cost ledger Costs classified into direct and overheads Indirect classification does not feature in the new standards</td>
<td>Indirect costs will need to be reclassified in line with definitions in the costing glossary</td>
</tr>
<tr>
<td>HFMA – 10 standards</td>
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<tr>
<td>Standard 2 – Cost pools</td>
<td>Cost pools are not used in the standards Standard CP3 states all costs need to be mapped to resources</td>
<td>Cost pools can be removed from the costing system (unless the provider decides to keep them for internal reporting purposes) All costs in the general ledger will need to be mapped to resources</td>
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<tr>
<td>Standard 3, 3a and 3c – Allocating costs</td>
<td>Standard CP4: Identifying activities, Standard CM1: Allocating overheads and Standard CP5: Allocating resources to activities provide a single cost allocation methodology for each resource/activity combination</td>
<td>CPs will have to identify activities CPs will have to review their cost allocation methodologies and replace these with the new costing methodology where there is discrepancy</td>
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<td>Standard 3b – Theatres</td>
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<td>Further guidance to improve the accuracy of the costing of this area</td>
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<tr>
<td>Standard 4 – Classification of costs into fixed, semi-fixed and variable categories</td>
<td>No equivalent</td>
<td>No action</td>
</tr>
<tr>
<td>Standard 5 – Work in progress</td>
<td>• In-month work in progress is covered in Standard IR1: Collecting information for costing purposes • Across year start/end dates are not covered</td>
<td>• CPs will need to obtain the ‘patients not discharged’ feed • No action</td>
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<td>Standard 6 – Treatment of income</td>
<td>Standard CP8: Assigning income</td>
<td>Further guidance to improve the accuracy of the income allocation at a local level</td>
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<td>Standard 7 – Treatment of non-patient care activities</td>
<td>Standard CM3: Private patients</td>
<td>Further guidance to improve identification of these activities so as not to distort own patient costs</td>
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<td>Standard 8 – Information</td>
<td>Standard IR1: Collecting information for costing purposes and Standard IR2: Managing information for costing purposes</td>
<td>CPs will need to collect the 15 patient-level feeds described in the new standards</td>
</tr>
<tr>
<td>HFMA – 10 standards</td>
<td>NHS Improvement – 24 standards plus the costing principles</td>
<td>Action required by costing practitioners (CPs)</td>
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<tr>
<td>Standard 8a – Data matching</td>
<td>Standard CP6: Matching activities</td>
<td>CPs are asked to implement the prescribed matching rules</td>
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<td>Standard 9 – Quality assessment and measurement (MAQs)</td>
<td>Standard CP5: Allocating resources to activities provides a single cost allocation methodology for each resource/activity combination</td>
<td>CPs will have to identify activities CPs will have to review their cost allocation methodologies and replace these with the new costing methodology where there is discrepancy</td>
</tr>
<tr>
<td>Standard 10 – Review and audit of cost information</td>
<td>No equivalent</td>
<td>No action</td>
</tr>
<tr>
<td>No equivalent</td>
<td>Standards CA1 to CA5: Costing approaches for specific procedures Standards CP7, CM2, CM6, CM8 and CM9</td>
<td>Further guidance to improve the accuracy of the costing of these areas</td>
</tr>
<tr>
<td>Glossary of terms</td>
<td>Costing glossary</td>
<td>CPs will need to familiarise themselves with the definitions of the costing terms as used in the new costing process</td>
</tr>
</tbody>
</table>
## Appendix 2: Implementation checklist

<table>
<thead>
<tr>
<th>Checklist</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gap analysis of current costing process to new costing process</td>
<td></td>
</tr>
<tr>
<td>Discuss your plans for implementation with your software suppliers</td>
<td></td>
</tr>
<tr>
<td>Review the IR standards with your informatics department</td>
<td></td>
</tr>
<tr>
<td>Review the prescribed list of activities. Identify your organisation’s activities and map them to the prescribed list of the activities</td>
<td></td>
</tr>
<tr>
<td>Meet your finance colleagues to go through the lines of the general ledger to understand what costs are coded where</td>
<td></td>
</tr>
<tr>
<td>Set up the cost ledger</td>
<td></td>
</tr>
<tr>
<td>Set up your organisation’s costing manual</td>
<td></td>
</tr>
<tr>
<td>Map the cost ledger to the prescribed list of resources</td>
<td></td>
</tr>
<tr>
<td>Meet your software supplier to discuss upgrading your costing system for the new costing process</td>
<td></td>
</tr>
</tbody>
</table>
NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

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