Clear direction of travel

Delegates at the HFMA costing conference were told in no uncertain terms that patient-level costing was where the service was heading – and they should get involved sooner rather than later. Steve Brown reports

The NHS will adopt patient-level costing and the sooner organisations make the move, the better. This was the clear message from Richard Ford, director of costing for NHS Improvement when he addressed the HFMA costing conference in April.

Earlier in April, the newly constituted improvement body and regulator published a collection of costing guidance and publications to support its Costing Transformation Programme (CTP) – including *Case for change*, new draft acute costing standards and minimum requirements for software.

In essence the *Case for change* document, rather than putting forward the argument for patient costing, argued that the case had already been accepted. Numerous organisations and reports – including Lord Carter's work on productivity – had identified the need for robust costing data to support cost improvement and the elimination of unwarranted clinical variation.

Mr Ford trailed this view in an interview with *Healthcare Finance* (April 2016, page 16) and he reinforced the message at the conference. Trusts needed to 'realise this is the future, this is going to happen', he said. The primary reason for introducing patient costing is as a source of business intelligence, although the centre also has a vested interest in national collections to support tariff development.

The collection of costs at the patient level, using NHS Improvement's prescribed process, will become mandatory – due to be confirmed at the end of this year – but Mr Ford insisted that trusts should not wait to be pushed.

Lots of organisations have patient-level information and costing systems (PLICS). This ranges from fully engaged trusts already using patient data to inform change, to organisations that have 'bought a PLICS system to tick a box on a reference cost return'.

Signalling the move to mandatory status is about providing a clear message on direction of travel. 'I don't want it to be a regulatory issue,' said Mr Ford. 'I want you to adopt as early as you can, so that when mandation happens in December, it's not a big issue for anyone.'

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This will be backed up by audit, with discussions ongoing about getting costing onto the existing use of resources assessment

Buy a system or ensure your existing system is capable of meeting the required costing standards and then start optimising that system and apply the standards, Mr Ford said.

Helping hand

NHS Improvement is trying to make this easier in two ways. First, it has abandoned earlier plans for a costing system accreditation programme in favour of setting up a framework contract so that trusts can 'call off' systems rather than all go through an individual procurement process (see box).

'We want to create some transparency as well in what services are, so you can make informed decisions – do you want a Rolls Royce [system] or something else?' he told the conference. Second, the improvement agency and regulator wants to ensure the essential nature of buying a new system is recognised.

'If a trust is in financial distress, you will have to ask the Department of Health when you spend money. But if this is a PLICS system, we are working on the idea that you get a free pass – you don't have to go through the same process because this is the right thing to do. We are trying to set it up so that when you try to adopt [new systems and costing standards], there are no barriers,' he said, adding that NHS Improvement also had a team of people to support trusts looking to procure and implement.

NHS Improvement's approach will involve publishing costing standards in January each year covering the financial year from the following April, which require national submission in the following financial year.

So mandatory acute standards published in January 2018 will cover the 2018/19 financial year, leading to a first mandatory acute cost collection using the new process in September 2019. While that may seem a long way off, NHS Improvement is looking for substantial progress and engagement in the interim.

While the current draft standards are targeted very definitely at the six roadmap trusts helping NHS Improvement to fine tune the new system, they are also there to inform development across the NHS.

A further version of the standards will be published next January alongside a first draft for mental health and ambulance providers.

Alongside this standard development process, the annual voluntary collection of patient cost data will continue and NHS

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Two conference speakers: Sarah Butler and Richard Ford

Improvement wants as many organisations taking part as possible. 'The quicker we can get a data set to drive tariff, the quicker we can turn off reference costs,' Mr Ford said.

Sarah Butler, deputy director of the performance insight team at the Department of Health, which oversees the collection of reference costs on behalf of NHS Improvement, told the conference that misunderstanding about costing was rife. 'It's not about PLICS versus reference costs,' she said. 'One describes how you cost, the other is just the name of the national cost collection.'

The reality now was that many organisations were using patient-level cost data as the basis for their more aggregated level reference cost returns. The CTP was looking to broaden this – getting the whole service to focus on patient-level costs – while also ensuring it follows a tightly defined and consistent process.

Reference costs may become a thing of the past, but a national collection would very much be part of the future. There is also parallel work to ensure the right amount of costs are included in the process to start with. In particular, work in recent years has looked to end the practice of netting education and training income off the cost quantum. This process effectively assumed that E&T income equals E&T costs. Instead, the ambition is to have accurate costing of both service activities and education activities.

This year will see a significant step forward with this agenda, following two years of running a separate E&T costing exercise alongside the 'business as usual' reference costs. A first integrated collection will take place this summer, albeit continuing to run initially alongside the 'business as usual' process.

The implications of this integrated collection are two-fold. First, it will start to get to the bottom of any cross-subsidisation of costs between patient services and E&T activities. The separate E&T collections for the past two years have suggested that E&T costs are in fact higher than the income received. This could mean that service costs have been slightly inflated, which could have implications for tariff levels – although the position won't be fully understood until the integrated collection is properly embedded.

The second implication of the integrated collection is a potential reduction in the burden on costing departments once the separate collections can be shut down. This could free up teams to focus on the broader requirements of the transformation programme. With the integrated collection adding between eight and 16 working days to the national return process, according to a recent pilot, reducing this burden is a good incentive.

"The 2015/16 integrated cost collection won't be perfect, but it is important we learn as much as possible to make the 2016/17 collection as good as it can be"
Sarah Butler, Department of Health

A timetable highlighted by Miss Butler suggests that 2016/17 (collected in summer 2017) could be the last year of trusts being required to make two national cost submissions. She said that the move to a single integrated cost collection would depend on the quality of the data.

She also said any delay in the move would have an impact on the broader CTP and the move to a national patient-level cost collection. 'The 2015/16 integrated cost collection

The right tools

The HFMA Healthcare Costing for Value Institute has published a patient-level information and costing systems (PLICS) toolkit for acute services. It aims to support providers and costing practitioners to turn the data generated by PLICS systems into powerful intelligence. Examples are provided of how data can be presented in different ways to different audiences including the executive team, clinicians and the wider finance team. It also provides 'top tips' from organisations that have made the most progress with patient costing to date.

PLICS toolkit for acute services – the basics is free for institute members. More details about the kit or Healthcare Costing for Value membership can be found at **www.hfma.org.uk/our-networks/healthcare-costing-for-value-institute**

System thinking

For system suppliers, the Costing Transformation Programme (CTP) presents both an opportunity and a threat. For a start, it pushes those trusts that have so far been reluctant to implement patient-level costing to make the move – so there will be completely new business. But it also creates a pressure for trusts to review existing systems. Some will decide to keep an existing system or upgrade to a latest version of that system; others may use the national requirements as an opportunity to opt for a different system.

Mark Smith, financial services product owner for costing system supplier CACI, says a framework instead of an accreditation approach will make little difference. It may delay a few trusts procuring systems, but given the clear messages that 'patient costing is happening', the procurements will take place.

The company claims the latest version of its costing system, Synergy 4, is CTP-compliant and flexible and is being used by a 'couple of the road map partners'.

Other enthusiasts among its 90-plus system users are keen to upgrade. But Mr Smith says: 'We anticipate a lot of traction after reference costs when trusts are gearing up for patient-level costing. Our feedback is that this will be staggered over a six-month period. Not everyone wants or is brave enough to make the jump initially. There is a natural caution to let a few go first and learn from their experience of the new model.'

Bellis-Jones Hill supplies the Prodacapo costing system to nearly 40 NHS trusts. Director Robin Bellis-Jones says the piloting process will be more important in getting the market moving than the change from accreditation to a framework procurement solution.

'The work with the roadmap partners over the next few months will be hugely significant because it will give evidence of the extent to which all software suppliers can conform with the software requirements and cope with the new costing standards,' he says. 'This will be quite revealing once this information becomes available and that may allow trusts to start making decisions.'

Gavin Mowling is the managing director of system supplier Healthcost, currently used by 25 trusts. He says most existing suppliers are already represented on existing framework contracts, either directly or through partners. He can't foresee any supplier not making the minimum level to be part of the new framework. But he says trusts should look beyond the minimum requirements.

'There is growing recognition that the use of costing data is changing,' he says. 'It is not about populating reference costs but about producing clinical engagement data and changing practice.' So, data needs to be detailed enough to drive change. For example, he says trusts need to be able to analyse when pathology or diagnostics are being undertaken to help reduce length of stay. Yet a system's ability to provide this time stamp to data goes beyond current minimum system requirements.

"The biggest challenge is training and retaining more people in costing. Trusts need to put the right commitment and resources behind the whole costing approach"
Steve Haines, Civica

Steve Haines is managing director of Civica's public sector costing division, which provides the Costmaster system to more than 60 NHS trusts. He says the costing system market has been extremely active. 'It's certainly as busy as I've seen it in the past four years,' he says.

This is despite some trusts 'holding back' to see how central policy develops. The activity comes when suppliers have been tasked with ensuring systems meet costing software minimum requirements, which were only in draft form until recently, and can deliver costing standards that have also just been published in draft.

But while getting the right system to fit local and national requirements is important, he says a system alone won't deliver better costing. 'The biggest challenge is training and retaining more people in costing. Trusts need to put the right commitment and resources behind the whole costing approach. While trusts need to get on with working towards compliance with standards, they shouldn't overlook the primary reason I believe they need to be developing their use of PLICS – to use the outputs to help with informed decision-making,' he says. 'The effort needed by trusts to fully embrace a costing system is significant and requires buy-in throughout an organisation.'

won't be perfect, but we know that it is possible, and it is important we learn as much as possible to make the 2016/17 collection as good as it can be,' she said.

While the focus was often on acute care in the plenary sessions – reflecting the earlier deadlines facing acute hospitals – workshops picked up issues relating specifically to community and mental health services.

With mental health often playing catch-up on costing compared with acute providers, Chris Cressey, head of financial delivery at Northumberland Tyne and Wear NHS Foundation Trust, said the materiality and quality score tool and template (MAQS), developed by the HFMA as part of its costing standards work, was a useful way of assessing 'where you are on your costing journey'.

'The real appeal of the MAQS is what's behind it – a list of allocation methods we can all strive for,' he said. He also urged mental health costing practitioners to engage with NHS Improvement as it develops mental health costing standards to avoid the adoption of an 'acute model tweaked for mental health'.

Limiting factors

There was also concern that aiming from the outset for 'gold standard' allocation methods – currently unachievable because of limited patient-level data – could put off trusts.

Back in the main hall, Chris Chapman, professor of management accounting at University of Bristol, broadened the conversation with a more semantic question. 'Is costing giving us the right language to facilitate improvement?' he asked.

While there were lots of good techniques emerging under the general banner of costing, was it actually helping to call these 'costing'?

'Cost' was too closely associated with 'reduction' and 'containment', he said. 'Costs tend to be things we want to get rid of.'

His point was serious, as cost data and

Chris Cressey: MAQS champion

analysis is about informing better value care and the success of this will depend on clinical engagement. His alternative – 'mobilising resources to deliver effective healthcare' – might capture the point of costing and appeal more to clinicians, but it is hard to see it being built into costing practitioner job titles any time soon.

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