# fast track

**With growing impatience about how long it could take to deliver patient-level costing in the NHS, NHS Improvement has responded by hitting the accelerator on its transformation programme. Steve Brown reports**

Next year there will be a major acceleration of the NHS Costing Transformation Programme (CTP) as NHS Improvement looks to use a window opened up by the setting of a two-year tariff to make a big step forward in patient-level costing.

The tariff for 2017/18 and 2018/19 has been derived from the 2014/15 reference costs. This creates capacity at the centre and reduces the urgency for the 2016/17 reference costs, which would normally be submitted in July 2017, creating the potential for trust costing teams to make more progress with patient-level costing implementation. So NHS Improvement has decided to go for it. 'The two-year tariff gives

us the opportunity to see if we can accelerate patient costing and get it into the next tariff calculation process – using patient-level costs rather than reference costs or patient costs to supplement reference costs,' says Richard Ford, costing director at NHS Improvement.

'Next summer we don't need reference costs to be all submitted in July, so the aim is to get a cohort of trusts using patient-level information and costing systems (PLICS) to submit patient costs to us.'

If successful, this would be a significant step forward for the costing programme – under the previous timetable, the first tariff to be informed by new acute patient-level cost data would have been for 2021/22. This recent push would potentially gain the service two years on those original plans.

This would be welcome. A recent audit of NHS reference costs has again underlined the poor state of existing healthcare resource group-level costing across England. And while the transformation programme has received broad support, there is a general feeling that it could or should be delivered quicker.

Lord Carter's report on productivity called for 'the use of a standard patient-level costing system in all trusts by April 2017' – substantially ahead of actual programme requirements. And the Public Accounts Committee has called for rapid improvements in the quality of cost data.

So this is the fast-track plan. More than 60 acute trusts have volunteered to be in the fast track. This already includes 31 of the 36 trusts that are vital – in terms of healthcare resource group coverage – for tariff-setting. So the other five 'vital' trusts have been asked to get involved too. These nearly 70 trusts will be supported through a rapid implementation plan starting in February and leading to a patient-level cost collection in July.

There will be monthly deadlines and each of four regional groups of trusts will be supported by its own account manager.

NHS Improvement is also putting together a central specialist team to support the whole cohort and provide intensive support where needed. There will also be a programme of webinars.

It is a big undertaking. This point is underlined by this year's patient cost submission by NHS Improvement's roadmap partners – six acute trusts that implemented the new costing standards early and went through a test submission. 'The six partners were some of the best in the sector but, despite their best efforts, there were still inconsistencies in the data they submitted,' says Mr Ford.

## Roadmap lessons

There have been lots of useful lessons from this roadmap process. For a start, the standards have changed (see box), but it has also underlined the importance of whole organisations committing to costing transformation, not just the costing team.

'Ultimately this is about the quality of people and how engaged the whole organisation is – how supported the costing team is,' says Mr Ford. Some organisations simply ran out of time to implement all the standards, he adds. 'There has to be a readiness to do the hard miles.'

He wants NHS providers to understand this. There are significant benefits – for organisations and the NHS more broadly – from better, more granular cost data. But it is not something that can be achieved in a half-hearted way.

To make room for these organisations to concentrate on patient costing and the new submission, they will face a relaxed reference cost submission timetable. Trusts outside the early implementers will face the normal timetable. In fact, in a step up from last year, they will have to submit an integrated reference costs return – including both their standard reference costs and their education and training costs – in July.

In contrast, the patient cost trusts will have until September to submit their reference costs. To ease the burden for all providers, there will be no reference costs spell return for 2016/17 costs – with the return being focused on finished consultant episodes.

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The ambitious aim is to have patient-level cost data delivered to the tariff creation team by the end of 2017 to be fed into the tariff creation process for 2019/20 (which starts with engagement with HRG expert working groups). The current expectation is that the patient data will inform prices, rather than directly set them, and there are likely to be support arrangements to enable a smooth transition to what could be quite different prices.

For the costing transformation to work, a number of issues need to be addressed. 'The biggest issue for us is that the actual complement of costing practitioners across the service is in the upper 200s,' says Mr Ford. 'We need it to be 500-plus and maybe up to 700.'

This message – that the costing function needs to grow in size and capabilities – has been consistent since Monitor (as it was) launched its transformation plan at the end of 2014. Now, however, NHS Improvement has tried to put in place some of the mechanisms that will support this growth and development.

The HFMA is launching two diploma qualifications at this year's annual conference, which will provide a pathway to an MBA in healthcare business and finance. NHS Improvement is in discussion with the association about developing a costing module or modules as part of these diplomas.

It believes these modules (whether as part of the full diploma or not) will provide existing costing practitioners with opportunities to expand their skills and to get their costing credentials formally recognised.

For new or non-costing practitioners, NHS Improvement is developing a foundation course to provide an introduction to costing

for more general finance managers and perhaps technician-level accountants. Mr Ford believes this will help expand interest in and understanding of costing and 'help bring the converts in and increase the cohort of costing practitioners'.

Even if this increases the pool of appropriately qualified, potential costing practitioners, there will still be a requirement for boards and finance directors to back the programme by increasing the costing budget to enable teams and skills to be expanded.

'First, we recognise that we need to talk to directors of finance and chief executives and promote the programme,' says Mr Ford. 'But we are also working with NHS England to explore and develop a best practice tariff for costing.'

## Investment incentive

This could be in place for 2019/20 and the incentive for trusts is that if they make the necessary investment in systems and costing function now, they should be well placed to receive that new tariff payment if it gets the go-ahead.

Mr Ford says this is not dissimilar to the approach used in Germany to support the costing expenses of providers involved in a pool of organisations that submit patient costs to support tariff-setting. The difference is that all NHS hospitals would have the potential to earn the best practice tariff.

A smaller incentive will see providers that are in deficit (but still under their control total) able to invest in a costing system (again remaining within the control total) that nominally increases their deficit.

November's audit report on NHS reference costs for 2014/15 (see news, page 4) showed that 49% of acute trusts were non-compliant with the *Approved costing guidance*.

This follows a similar conclusion the previous year, when 49% of trusts were found to have submitted materially inaccurate costs. Given that the whole acute sector has effectively been audited over the two years, this is pretty damning.

The report concluded that 'many trusts still treat costing as a standalone regulatory exercise and do not use costing information to make management decisions' and that 'not enough resources are devoted to ensuring that the information is accurate'.

Mr Ford said it was a disappointing assessment, but in many ways the poor consistency in reference costs and the low priority given to it by providers were known issues. 'But it also makes the case and provides greater impetus for the changes we are making,' he says.

The audit report is a reflection of underinvestment in costing. But it clearly has the potential to demoralise costing practitioners and undermines arguments for greater use of cost data in decision-making. NHS Improvement is determined this will change.

The acceleration of its transformation programme is perhaps the best possible response.

# First submissions

Six roadmap partners submitted patient-level costs in September and October, becoming the first real users of the new draft costing standards published in April. A report will be sent back to these organisations towards the end of the year, but Paul Howells, costing transformation lead at NHS Improvement, believes that, even with just six providers involved, useful information is emerging.

'We've been able to track a patient across a number of the [London-based] partners across the financial year in different care settings,' he says. 'One patient had close to 20 outpatient appointments at one trust, three inpatient episodes at another and also attended a third accident and emergency department.

'We can track the patient across care settings and see what has happened – how much time in critical care, how much time in theatre, how many tests they had – and we can break down the cost of each element.

'And when we bring in mental health, ambulance and community data, we will be able to link up across the whole spectrum – and that could have ramifications for the tariff in the future and for regional decision-making.'

This 'whole pathway' view of patient costs may not have been the prime purpose of patient-level costing, but it could be a powerful additional benefit.

Using the standards has also led to them being revised. Perhaps the key change is a reduction in the number of components into which each patient's costs have to be broken down for submission to NHS Improvement. The initial requirement was for providers to map costs from the ledger to approximately 80 resource types and then to allocate these resource costs across more than 120 activities.

With practitioner input, this has been rationalised down to a 20 x 50 matrix (resources x activities), with major rationalisation around how overheads are reported.

Some trusts found it difficult to categorise all their costs across the original wider range of components, which also created collection challenges. Some file sizes submitted were as large as 100 gigabytes and the total database for six trusts was 747 million lines. Compare this with an estimated 12,000 lines of data in a reference cost submission across six trusts and the step change in detail becomes clear.

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These revised standards for acute services are part of NHS Improvement's *Approved costing guidance*. This will also include first standards for mental health and ambulance services, details of a new costing assessment tool (CAT) and the traditional reference costs collection guidance.

The CAT aims to help practitioners and boards understand how good their costing is, how closely they are following the standards and where they should focus improvement efforts. An early version has been revised following practitioner feedback and now takes more account of materiality. All early implementers will complete the assessment next year.

There are also plans to develop a portal, providing NHS providers with a way to compare their own detailed costing data to that of peer providers. A similar tool has been used to good effect in Australia (see *Healthcare Finance*, July/August 2016) and there are clear links with NHS Improvement's wider model hospital project, which could see reference costs replaced by patient costs when possible.