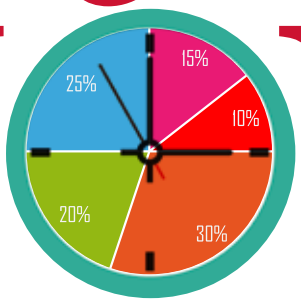
Costing's time is NOW



Changing clinical behaviour is the key to addressing the value gap – and robust, easy to understand costing data has a crucial part to play. Steve Brown reports

'We are in a really important time, when the costs really matter. The work you are doing really counts.'

Costing practitioners have probably heard statements like this before from various sources – NHS Improvement, their finance director or the HFMA would all be likely. But what made this comment refreshing on this particular occasion was that it came from a leading medical director.

Paul Buss, medical director and deputy chief executive at Aneurin Bevan University Health Board, led the cheerleading for the costing function at the HFMA's annual costing conference in April.

But he also warned that data needed to be in the right format and used as the basis for engagement with clinicians, not just produced to meet a central requirement. 'The work is really important, provided it doesn't just sit on a balance sheet, but is used somewhere in a discussion with clinicians,' he said.

Dr Buss suggested that cost data was vital for individual clinicians, who had to break away from simple demands for more resources and engage properly in the value agenda.

It was vital for teams – in his experience, discussion informed by meaningful cost data almost always led to redesign. And it was vital for organisations, whose financial health depended on economic literacy.

'[The information you provide] won't solve all issues relating to the economy, but it will blunt the trajectory of spend going forward,' said Dr Buss. His repeated message was for 'costing to be brought into the conversation', although he recognised that getting clinical engagement could be challenging.

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Paul Buss, Aneurin Bevan UHB

Rising costs were often an early warning of a potential service failure or incident, he added. Organisations, managers and clinicians had to get better at getting the data out in a timely way so that these warnings could be acted on.

Dr Buss said that a significant proportion of the value gap – the gap between projected health spending and whatever version of likely actual funding was used – could be addressed by making changes to clinical behaviour where different habits and styles had led to variation in practice.

'I can often tell where, and in what areas, people have trained by their style of practice and the investigations they use,' he said. '[Addressing the] gap needs to be informed by costing and put alongside outcomes to

understand the value we deliver. We have to influence clinical behaviour by getting costing into the discussion.'

He acknowledged that some clinicians would resist this initially, but that if done properly it could bring simplicity to the analysis of an otherwise complicated set of circumstances – leading to questions of 'how, why and what are we doing'.

Value agenda

Aneurin Bevan has been pursuing a value agenda for a number of years. Its former finance director Alan Brace, the HFMA's Finance Director of the Year in 2014, has had a significant role in this, following a study visit to Harvard Business School, where he learned about the work of value gurus Michael Porter and Robert Kaplan.

This work has grown substantially in recent years. There has been a focus on developing costing data and collecting outcome metrics, with a value team led by assistant medical director Sally Lewis. The board has also entered into a strategic alliance with the International Consortium for Health Outcomes Measurement.

And Dr Buss said clinical attitudes have changed from disinterested to enthusiastic. 'At the start doctors wanted to know what value was and now they want information on outcomes and costs,' he said. 'I don't have a week without a team wanting to get involved in a costing exercise or value-based healthcare initiative.'

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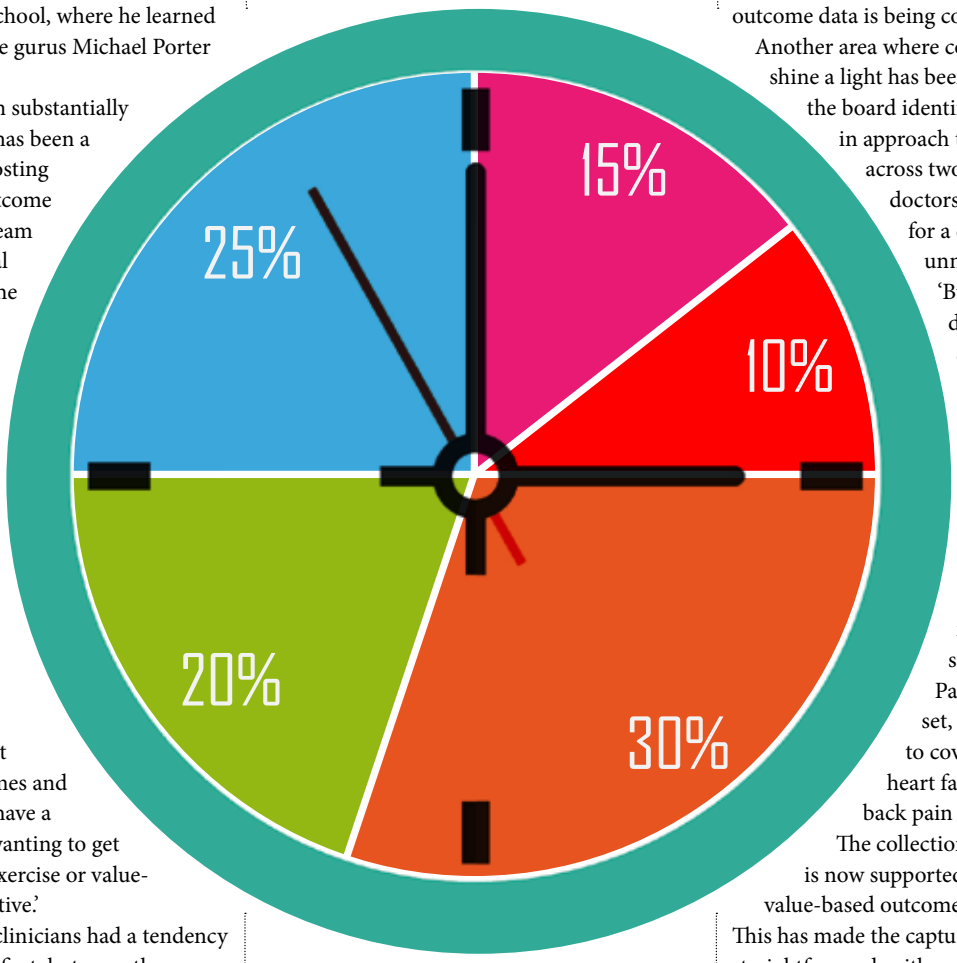


He recognised that clinicians had a tendency to 'rubbish the data' at first, but once they overcame that reaction, clinical directors could really start to influence behaviour.

And while cost data needed to be meaningful, it was similar to medicine in involving an iterative process of improvement.

'The work you do has to get better and better,' he said, with each iteration more accurately portraying clinical behaviour.

One area explored in Aneurin Bevan has been within its dementia services. Dr Buss said there was huge variation in referrals from primary care to start with, but once within the system, there were major pathway differences across the five boroughs covered by the board. These involved 'different pre-assessments, different diagnostics and different follow-ups'.

Combining the different pathway analysis with costing data revealed a 1.7 times difference between the cheapest and most expensive aspects of the service, before outcomes were even factored in. He said that costs were the key to helping the board 'focus our minds on why we were doing what we were doing' and to highlighting the differences in the styles of practice and their financial consequences. The teams have started to implement changes and more standardised approaches, even while more meaningful outcome data is being collected.

Another area where costing has helped to shine a light has been cardiology, where the board identified major differences in approach to cardiac pacing across two hospital sites. 'Some doctors admitted patients for a day, others saw this as unnecessary,' said Dr Buss. 'But we also noticed differences in nurse staffing levels and the kit procured.' This could all be discussed and addressed by the clinical teams involved.

The health board has also done a lot of work on outcome measurement. This started with ICHOM's Parkinson outcome data set, but has expanded to cover cataracts, stroke, heart failure, dementia, lower back pain and lung cancer.

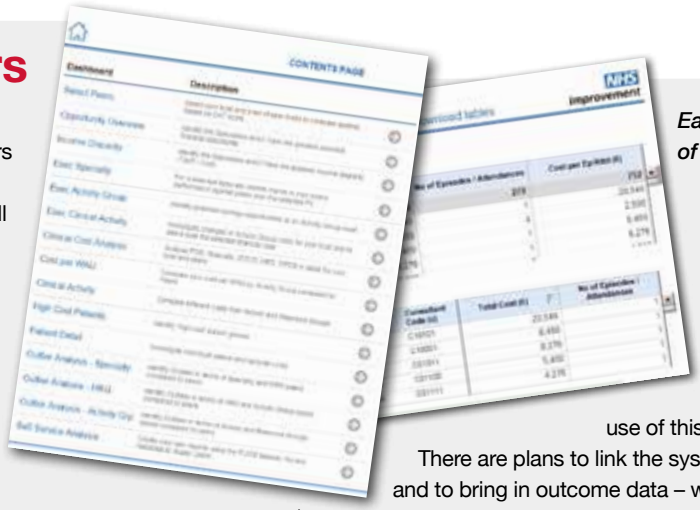
The collection of outcome data is now supported by a dedicated value-based outcome capture platform. This has made the capture of data much more straightforward, with patients being able to input some measures directly themselves.

Whole system costs

He said the board was on a value journey with costing and cost data central to its success. 'In future, we need to be looking at whole system costs – that will be a real challenge but we must rise to it,' he said.

Dr Buss added that the Welsh integrated structure offered some benefits in looking across whole pathways, but that England's approach to costing – with the Costing

The transformers



Early screenshots of the portal

This summer's patient-level cost collection – involving some 86 providers implementing new costing standards ahead of mandatory requirements – will be a 'massive' milestone, according to Richard Ford*, NHS Improvement's costing improvement director and head of the oversight body's Costing Transformation Programme.

'We'll have some tangible information that we can play back and all the people interested in costing will be able to see it and make comparisons,' he told April's HFMA costing conference. 'We'll move from selling off a plan to selling from something that is real.'

There is already a lot of excitement about the potential for robust, patient-level cost data to drive improvement. The Model Hospital team, also at NHS Improvement, talks about the move to patient-level cost data rather than reference costs as having the potential to 'revolutionise' its work. And the *Getting it right first time* programme, which has now broadened its focus beyond variation in orthopaedic surgery, is also reported to be enthusiastic to access data that can accurately reflect how different activities contribute to total costs and how costs vary from patient to patient.

A new patient-level information and costing portal – developed by NHS Improvement – also clearly demonstrates the potential power of the data once delivered back to providers. This detailed cost benchmarking system – fed by providers' patient cost data – will provide executive overviews of providers' costs compared to selected peers and then enable users to drill right down to patient level for their own activity, exploring high-cost procedures and healthcare resource groups or tracking patients – and their costs – across the whole pathway. Access will be restricted to trusts submitting data.

Introducing the portal, Paul Howells, collection and analysis costing lead at NHS Improvement, highlighted the power of the data to help improve services inside organisations and across whole health systems. For example, the data enabled a single patient to be tracked across four separate providers over a year, involving more than 20 outpatient appointments, an accident and emergency visit and a couple of inpatient episodes, incurring total costs of nearly £48,000.

NHS Improvement is convinced this 'operational intelligence' – scaled up across all acute providers – could be used to identify opportunities to provide better care and reduce overall costs. 'And when we can bring in mental health, ambulance and community services, we'll be able to track across all settings,' said Mr Howells. 'This is really good information for us nationally and you [locally] – and we need to find ways to make use of this information.'

There are plans to link the system to the Model Hospital and to bring in outcome data – with an aim to include patient reported outcome measures, patient experience metrics and friends and family test scores.

As clever as the system appears, its value will be judged on the quality of data that it is populated with. This is where the CTP is crucial as it aims to ensure all providers use a consistent methodology in compiling patient costs – so providers use the same definitions of, for example, theatre costs and then allocate them to patients using the same methodology.

Following an acceleration of the programme announced at the end of last year, NHS Improvement is now supporting the 86 acute early implementers in preparing for their first cost submission using the new costing standards and approach. It is also working towards pilot cost collections with roadmap partners in mental health and ambulance services (towards the end of the year) and community services in autumn 2018.

Work is ongoing to finalise standards in these non-acute sectors, with developmental versions only published earlier this year. There have also been changes to the costing audit process. While this will focus on early implementers this year to maximise the learning, it will be based more on validation gateways and quality metrics.

Mr Ford said NHS Improvement, which also oversees the ongoing reference cost programme, recognised this year's combined national cost collection was a major burden on costing teams. This will see collections of education and training (E&T) costs, reference costs net of E&T income and reference costs net of E&T costs all submitted at the same time in a single workbook.

The timetable, which was already different for early implementers and non-early implementers, has been further challenged by delays in releasing the new reference cost grouper. Non-early implementers who felt they would struggle to meet their July deadline were encouraged to talk to NHS Improvement.

**Richard Ford was due to leave NHS Improvement at the end of April*

Transformation Programme (see box) and the finance systems being developed – was also a major asset.

He ended with three specific challenges for organisations and systems serious about taking value-based management forward. 'Are your medical director, finance director and you [the costing lead] meeting regularly to discuss what value-based systems look like? You have to have that co-ordinated approach,' Dr Buss said. Clinical cost leadership was another key issue. 'We have to have a fundamental shift in the training of medical and clinical directors to bring in their responsibility to understand more about costing frameworks,' he said. 'We need more joint learning.'

And finally, and most important, he believed the service had to get much more involved with value analysis.

Over the next year, Aneurin Bevan would be 'marrying up seriously informed cost data with internationally validated outcome data.'

'We have to start asking questions of this merged data,' he said. And over time that should lead to establishing the characteristics of the service the NHS wants to provide – in particular the balance between health maintenance and intensive treatment activities. Costing data needed to be at the heart of this 'optimising value' discussion,' he said.

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