Costing webinar 27 May 2022

Comments raised by delegates

Introduction and summary

356 delegates registered for the webinar and 280 watched it live.

Delegates were asked to answer three questions, using Menti software. The HFMA have collated the responses into a number of themes under each question (see below). A list of all responses are noted in the following sections. In the last section comments and questions posted on BrightTalk are listed.

Q1 How should costing support the NHS over the next five years? (225 responses)

Costing processes and approaches

- Align with internal PLICS
- Data quality
- Information governance
- Consistency
- Costing standards should only use mandated data sets
- More frequent cost collection
- Outcomes
- Simplify the NCC
- Technology
- Time to use cost data locally

Staff

- Greater integration of costing in finance function
- Role of informatics in costing
- Costing teams
- Training

Use of cost data

- Benchmarking
- Contracting
- Decision making

- Efficiency
- Pathways across the system
- Planning
- Reporting
- Service improvement
- System working
- Understanding use of resources

Other comments

Q2 What new opportunities should we exploit with the advent of systems (ICSs)? (137 responses)

Approaches and processes

- Analytics
- Data
- Information governance
- NCC
- Reporting
- Consistency across the system

Staff

- Costing teams

Use of cost data

- Allocative efficiency/value
- Benchmarking
- Efficiency
- Health inequalities
- Outcomes
- Pathways across a system
- Population health
- Service improvement
- Contracting

Other comments

Q3 What improvements should we make to the way the NHS does costing to maximise its value? (394 responses)

Purpose of NCC

Listen to the views of costing practitioners

Feedback/reporting of cost data

Using cost data locally

Approaches and Processes

- Simplify the NCC
- Align NCC with business-as-usual (BAU) local costing
- Align NCC with other returns
- Costing standards should only use mandated data sets
- Materiality
- Automation
- Consistency
- Cost pools
- Data quality
- Costing guidance
- High cost drugs
- Chart of accounts and ledgers
- Medical staff
- More frequent cost collection
- Mental health
- NCC burden
- Outcomes
- Oversimplification
- Costs at service level
- Costing software
- Timing of NCC
- Unbundled costs

Other stakeholders

- Role of informatics teams
- Secure buy-in from other stakeholders
- Greater integration of costing in the finance function
- Role of the centre

Costing teams

- Funding costing teams
- Training and career path for costing practitioners
- Costing teams
- Learning from others

Other comments

How should costing support the NHS over the next five years?

Costing process

Align with internal PLICS

Move nearer to BAU / local PLICS that allows timely production, playback and benchmarking
Align it to BAU PLICS so only 1 process and production is needed otherwise staff will spend all their time on MFCC and not doing value adding activities with the data or developing costing models that support services internally.

Data quality

Better support with things such as information, etc which we're dependent on but not necessarily in control of.
Challenge trusts data upstream. Lots of problems could be solved with data challenges by NHS digital before it used for costing
Data quality improvement
EPR alignment
focus on data quality to allow accurate decision making
Help drive improving data quality across the whole system
Identify data quality issues
Show why (and how) activity data collection needs to improve

Information governance

Easier data sharing
Standardise the IG rules to make this easier
Yes - 100% on working to make the IG sharing of data - it is nigh on impossible at present.

Consistency

Consistency of approach not changing the requirements annually
By all providers providing costing information via the cost collection processes. This must be consistent and accurate. Adhere to standards but also inform the standards to make sure they are reflective of what the NHS requires (this has been quite a

Costing standards should only use mandated data sets

Mandate changes to data collection to NHSD first before asking Costing experts to collect it.
Mandate data sets nationally before expecting cost accountants to use them for costing, it shouldn't be the role of the cost accountant to try and get departments to record specific data which is mandated for costing but for no other reason.

More frequent cost collection

By giving Costing practitioners time to use the data within their Trusts, rather than forcing Costing practitioners to submit data more frequently.
Costing does not exist in a bubble, so the purpose needs to be clear, particularly for more frequent national collection.

Lets get things right before we have more collections Try and reduce the burden on finance teams. More collections is not the answer at the moment. Allow costing to look at the real benefits – Engage and add value to improve patient care.
Local costing done monthly or quarterly is not the same as a national cost collection more frequently than annually.
Making it business as usual for the quarterly submissions making it a lot more useful to benchmark and share best practices. Supporting boards to make use of more accurately costed data.
More often national cost collections will reduce ability of the costing team to engage with clinicians locally on improving clinical outcomes and costs
Not result in significant increases in corporate costs to deliver
Recognise the minimal impact that additional external reporting will have on internal use of PLICS data
We need to move to More frequent collections, as soon as possible.. Most providers produce this quarterly. Benefits to benchmarking

Outcomes

Bring outcomes within scope, allowing cross pathway comparisons of value e.g. QALY
Link to outcomes
Linking cost and activity data to outcomes data to improve care delivered to patients.
Needs to align with outcomes. Needs to align across the ICS.
outcome based costs

Simplify the NCC

Make the rules simpler. Get rid of unbundled elements
Make the rules simpler. I think rules around high cost drugs and chemotherapy are too complex
resources/activities - simplify to cost pools. only make it as complex as is useful
simplify NCC
Simplify the data.
The NCC process is an industry within itself, simplification and alignment to local reporting is needed. The real value add is the usage at a local level to identify opportunities. Allowing the teams time to use the info locally is key.
The Data Validation Tool and Submission platform can take a significant amount of time to get the “format” of data correct, this time would have normally been spent on improving and validating the cost return.

Technology

Using AI and latest tech to identify improvement and efficiency opportunities
Robotic Processes

Time to use cost data locally

Costing practitioners needs to have time to work with operational leads and clinicians to use the costing data.
Currently we have no time to develop data for use locally, all focussed on national submission - if to increase frequency this needs to be addressed as already seen as s burden within trust
More time for internal reporting Results back for benchmarking

Staff

Greater integration of costing in the finance function

Costing needs to be integral to the financial management of services in order to provide good use of resources and high-quality, efficient patient pathways. In order to achieve this the NHS should review the use of finance resources.
Costing should be linked to budgeting so that we can do some proper forecasting
funding and planning
more insightful forecasting
Needs buy in from the whole of the finance department and the rest of the organisation
Raise the profile of Costing in Trusts, so people take it seriously and use the information for Strategic and Business planning.
Take away from just budget management as a way to review costs
There needs to be review of the way finance resources are used. Move from FM to Costing.

Role of informatics in costing

Costing isn't just finance teams - engagement from Information teams -please promote
Ensure that requirement for the informatics team are required before costing requirements are required as it is backwards at the moment
More robust challenge to informatics and trust leadership around the data

Costing teams

Afraid to answer as we are a small team and more work will have to be shared. But of course crucial in saving money
fund costing teams & training
Invest in costing teams (information & finance)
Make Cost Accountants Higher banded specialists that will help.
More help with SQL and analysis tools to help deliver benefits to the organisation
More investment and incentives to attract accountants to become Specialist Cost Accountants, and succession planning to ensure we are training people for the future to ensure we aren't in the position we are now struggling to get experienced staff.
More money for NHS trusts to hire costing practitioners!
Recognise that non acute organisations do not have the same costing resource as acute trusts
A community of costing teams working together and able to easily share data rather than merging where in depth knowledge can be lost.
Adequate resourcing with tools and time to use the available information. Ability to mirror the centre's message and produce info locally to support that. Better links between the 4 x Costing, Coding, Counting and Collecting

Training

NHSEI implement regional representatives to support their care groups and assist with closer review of costing standards implementation
provide guidance training & tools to engage with PLICS
Provide guidance, training, & tools for using PLICS within organisations

Use of cost data

Benchmarking

NHSE&I to produce a standard suite of dashboards using the NCC (building upon PLICS Portal & Model Hospital) data which will enable all stakeholders to see the data presented in the same way with the ability to drill down and compare at a granular
Ability to benchmark timely and accurate information to help drive efficiencies and best practice. Support the national tariff
Benchmark locally over time
Benchmarking
Benchmarking
Benchmarking and local decision making. Improve patient pathways.
Benchmarking and variation between local Trusts
Benchmarking between trusts to see how cost efficiencies can be made. At strategic and operational levels.
Benchmarking costs at patient level.
Benchmarking locally and with other organisations
Benchmarking of quality outputs (annual) not quarterly which will be lower quality
Benchmarking purposes for adding value to stakeholders
benchmarking understanding regionally patients across the system
Benchmarking, annual planning, standardisation
Commissioners helping local providers learning from other cheaper peers
Detailed data to improve benchmarking and help inform local decisions
Find variation in funding, Benchmarking, Streamline costing
GIRFT
Improve access to benchmarking without each provider having to pay 5-figure sums to access tailored granular information
Improving access to granular data to allow detailed benchmarking
Internal and external benchmarking and decision making about clinical pathways and variations
More transparency so can align apples with apples when assessing benchmarking data
national benchmark data is only a start point for identification of local opportunity, MFCC provides a benchmarking trend but is not required for in depth service transformation
provide a common language for mental health to allow benchmarking
Provide core analysis to enable local to national/regional benchmarking by service area and activity type in a format that clinical service managers will understand
Through access to benchmarking Needs to underpin transition to contracting on cost base not tariff
Local intelligence for recognising unwarranted variation in trusts, so they understand their data and therefore can support ICSs in making system level decisions
Make it as easy as possible and relevant for local use. Identify the data variations of peer groups.
Providing robust visiting which can be used for benchmarking, local decision making, improving data quality in the organisation.
Consistent approach -agreed service lines

Contracting

Help provide local information to determine prices
Support the API contract model
Support the development of API contract agreements.
Be useable not too granular. Be able to support contract discussions, business cases, cost reduction programmes
Contract negotiations
Contracting
Contracting, Benchmarking, Internal consultation and benchmarking, Clinical standards improvement
Enable API contracts in MH and community to not just be block contracts under a different name
Enable systems and commissioners to build up API contracts for mental health and community that are no longer just block contracts
Support funding decisions. Support understanding cost implication of pathways and align with outcomes
Focus on costing linked to contract and income rules

Decision making

Assist with operational decision making
Assisting with local decision making
Decision making and end user cost understanding
Decision making within organisations and at system-level.=
Help with clinical and operational decision making
Improve decision making to maximise health benefit to patients
Local decisions across health economy
Population growth and costing for decision making
Supplemented with demographic and geographical data to add further value to decision making
Support business decisions
To aid better decision making and provide opportunities to benchmark.
To help make decisions

Efficiency

Delivery financial efficiency. Eroding variation and waste
Drive down inefficiencies to reduce unit cost per activity creating sustainable patient pathways
Efficiency Gains
Efficiency through benchmarking
Efficient pathways
Ensuring data can be presented and analysed to better help Trusts identify efficiencies.
Focus on support of internal functional role of Costing teams, allowing us to support the strategic development of Trust's and focus on maximising efficiency,
Help cost improvement programmes within trusts
High level productivity analysis - particularly @ system level. Not at greater and more granular level - look more @ pathways.
Identifying efficiencies
Look for efficiencies to be achieved in the NHS as a whole. Benchmarking as well

Organisational efficiency and transformation
Patient level data used to drive out cost inefficiency through understanding at a local operational level unexpected variation - financially and using non-financial indicators
Support system improvement and increased efficiency
To facilitate peers having comparable expenditure information to help identify areas where efficiencies could be explored
To help facilitate financial efficiency
Transformation of services for productivity and efficiency
We have designed reports specifically looking at the elective recovery programme and productivity which can be drilled to a very granular level. This will enable us to deploy resources to areas which are not performing to planned levels
Costing has been contributing to understand the fully absorbed cost of the services and its viability. however the focus has never been on profitability and value and in this area costing can be used to effectively analyse the data
Crucial to support the NHS to work more efficiently, allowing better understanding of costs nationally and engaging clinicians locally,

Pathways across the whole system

Able to understand and support patient care pathways across ICS's and beyond.
Allowing for a place based approach - understanding the costs of a patients whole journey through health and social care
being able to get system wide data for a patients pathways.
collecting data for every stakeholders (social care, LA, school, NHS, police etc. if possible) expenditure and costing to reduce duplication in resource
Costing provides the best information on how resources are used within a patient pathway.
costing whole patient pathways
Cross ICS financial intelligence
Designing more efficient patient pathways
Expanding the scope to local authority services gives a fuller picture of patient pathway and patient use of services
Focus on local systems. Pause education and training. Pathway costs. System level.
Helping clinicians view services across the ICS.
Increase coverage, e.g. primary care,
Keep reporting at local systems level pathways across the ICS's/ ICB's. NHSE/I to provide dashboards and tools so that individual trusts don't have the burden of developing these to report at an ICS/ ICB level.
Pathway costing
Pathway costing
Pathway costing across organisation, sharing of data within ICS
Support the decisions in how best to invest resources in order to get the best outcomes for patients. For example tracking the whole cost of a patient pathway and compare this to the benefits of different pathways to the patients' well being.
to support local decision making for ICB's / ICS's costing at a pathway level to help shape efficient local services and pathways to improve patient outcomes not to just feed the national ask. NHSE/I are not efficient enough to deliver the output
understand use of resources across pathways
population health management

Planning

business planning
By using national resource codes and collection resource codes costing can help inform discussions around resource planning and capacity planning

Reporting

Outputs from the NCC need to be published in a timely manner to be of use to inform local decision making and to benchmarking-for-improvement
Providers are expected to stick to submission dates and regulatory action can be taken if they don't, however there doesn't seem to be the same burden on NHSE/I in sticking to the expectations of Trusts in returning the output.
receive NCC results sooner
Reducing need for other reports
Results of cost collection to be released in a timely manner so we can use it locally whilst information is still relevant
Specifically NOT NHS England analytics, would be done better locally within systems
Faster data
Faster turnaround of data following collections

Service improvement

Costing information is key to service improvement. The granular data we hold is perfect to engage clinicians and when the data is refreshed regularly then it can be used to monitor improvements and identify further opportunities.
costing information is used to identify waste reduction and Quality Improvement initiatives as part of service improvement – this is key to making our services sustainable over the next 5 years
Costing is key to help individual trusts understand their services and help drive efficiencies etc. The costings should follow a national structure, although this is sometimes very time consuming.
Use the breadth of data and understanding of the resource required to treat patients to support organisational change
Identify clinical variation
Improve services locally
In order to provide increased access for patients we need to monitor value through costing.
It's a new world and we need to think outside the box and costing can help with this. Let's use the data to drive change by looking at what the data is telling us. Take one area at a time and then read the data to understand what works, what doesn't,
Local service improvement Improved use of data to inform decisions Support more robust budgeting
More forward looking at demand rather than activity than has happened
Move to focus to variation in activity that drives costs rather than the costs themselves
Move to value based healthcare
Reducing unwarranted variation
Supporting clinicians to improve services
system improvement that to link database collectively
To support internal multi-disciplinary teams improve their service or directorate. Improving the value of clinical care.
Understand unwarranted variation locally and nationally

Using Costing Data to make sure the Patient is the Centre of why we make changes to what we do, and to provide the best care to them as is possible.
Working with our Trusts and helping them to use the Costing data to make service improvements and savings, giving the patient the best experience and as much value as possible.

System working

Be a key dataset for moving to a multi sector delivery of healthcare
Support of ICS management
Greater sharing of information and expertise across systems
It needs to be used locally within an ICS. Use local PLICS which can be turned round monthly
Joint working in ICS with learning and benchmarking
More sophisticated system conversations
Provide local ICS dashboards for benchmarking and ensure costing has a higher profile in Finance and Performance and Information teams linked into the Costing agenda
Take advantage of closer working relationships. Its still early days and in many ways, we don't know what this will look like but there will be joined up working inter sector which will give opportunities to look at things differently
use one costing system for all the providers in the ICS
wider system engagement
work closer with local health authorities

Understanding use of resources

Better understanding of how costs are being consumed so better Strategic decisions can be taken
Better use internally, business decisions, understanding costs, p and e
Increased understanding of how resources are utilised
Support understanding of services and cost Locally
To allow own Trust and local ICS to utilise the vast information available in systems
Understanding service cost drivers
Use costing to spot synergies and opportunities

Identify health inequalities
Better responses to costing queries from the national team, often we get told to do what we think when they don't know.
Be a central collection. Reduce things like the ERIC return for example
NHSEI to engage with Trust and ICS Leads
lessen the burden of the NCC
Better data which can be taken from ICS data feeds
Better alignment with annual accounts timetable. Think annual accounts should be finalised in may
Improve for meaningful reporting
Before Costing can support the NHS the NHS needs to support Costing
National collections should be secondary if not a tertiary priority
cash studies across ALL sectors on how costing can aid organisations (not just Acute Sector)

Happy to provide a 'tour' of Leeds Teaching Costing !
Standardised ledger system that aligns with cost ledger
To answer this question we need to find out what information the NHS requires.

What new opportunities should we exploit with the advent of systems (ICSs)?

Approaches and processes

Analytics

predictive analytics based on joined up data including costing data to understand how new referrals into the system will impact demand and capacity in the ICS
This has to be a collaborative and supportive system wide analysis so BI is becoming increasing important, having submitted granular data
Understanding variations in funding and delivery
Value chain analysis

Data

Get the quality of information developed to ensure people trust the information for decisions
Mandate the production of the data feeds needed by the costing Team into the BI Departments responsibilities
National coding system for general ledger/cost ledger

Consistency across the system

A consistent approach to costing assumptions
Alignment of process procedure and systems, standardisation if ways of working one NHS finance
centralise costing systems to ensure a consistent approach
Closer sharing of best practice costing techniques could be possible. It may be limited by differing data and systems, but also has the potential to enable closer alignment.
Consistency
Consistency across the ICS to allow system benchmarking, understanding local variations.
Consistency and validation of information used. Peer groups identified where possible b
Consistency of costing systems would be a great help
Consistent approach across ICS to inform decisions
Data quality Consistency and standardised approach to negotiate
harmonise systems
ICS based costing would promote consistency, which appears to be a national priority.
ICSs will need to standardise systems and processes between trusts to be able to compare data.
Interoperability of costing software so outputs can be aggregated
One costing system across the patch
The move to ICS should drive the standardisation of cost reporting across providers in order that cost information and be used effortlessly at a trust, system or national level.

Information governance

A standard IG package to allow sharing would help prevent having to work through all the associated paperwork
Ability to share data without issue re IG
Breakdown IG barriers
Broader sharing of data but information governance issues need to be addressed.
Data sharing and governance agreements are protected from prosecution
Easier IG structure to allow sharing of data!!
IG
IG is not just a legal issue - it's cultural as well!
Limitation of ICS work - must set up an appropriate information governance structure for this data.
Make sharing of data more straightforward and cost at system pathway level
Making it easier to share data across organisations is key. NHSi could help with this as currently this is a big barrier to costing teams sharing valuable data that can help improve patient pathways and have a big impact on cost of services and out
NHS England should protect data sharing agreements or establish a single and shareable model for data sharing
Use modern technology to share data securely
Governance opportunities
Provider to provider data sharing

NCC

Release data in a timely manner so it is useable, rather than a tick box exercise
Get results back quickly
Why do NHSE have to be the ones to share that information, why can this not be done directly from providers?

Reporting

A tool that shows each providers whole cost and activity. Not supressing activity e.g. NHS D rules
Standard reporting & analysis to maximize operational use of data – consider national metrics, focus and growth areas, provide modular templates to enhance use of PLICS as an information, rather than data, source
Dashboards that present back to us at overall ICS level
Reporting across ICS to allow standard view of data and pathways where shared across more than 1 Trust
Share data more regularly
Simplified data to allow analysis without the over burden of all the NCC resources down to pennies
System-level reporting: pathways, case mix, growth, opportunity;
Take automatic BAU cost data feeds more frequently
A concern would be the impact of part costs and identifying these on a broader spectrum
Don't lose need to also us cost data within trusts
ICS wide PLICS data sharing
Inter-Trust data sharing needs to be encouraged and facilitated by central bodies
Joined up costing data in more real

Staff

Costing teams

Centralising costing teams within a system, so the function is not isolated in small providers
Create ICS Costing Teams to cover all sectors
Create new ICS costing teams specifically to handle the costing as current costing practitioners are overloaded. There are difficulties in retaining existing costing practitioners and fewer new recruits in the sector, so you have a difficult task
Exchange of experience
merge costing teams to have one per ICS to give consistency across ICS
Merge costing teams to release cost savings.
Share costing knowledge and expertise across organisations more effectively
Sharing best practice across the ICS
Sharing best practise
Sharing knowledge amongst specialist teams
Sharing of costing team resource and experience
Transfer responsibility for costing to ICS.
A central team so we can work collaboratively together across the system.

Use of cost data

Allocative efficiency/value

allocative value
Realise economies of scale and ensure a more joined up Pathway for the patient
Reallocate resources across pathways - focus on high level interventions
Sharing PLICS information with system partners, to help inform allocation of resources decisions
System wide planning to better utilise resources within different providers of an ICS
The opportunity to redistribute resources for the benefit of patient pathways. Providers shouldn't be under pressure to hang on to the money they get when it could be better invested elsewhere. Joined up costing data should make these decisions clear
Use Costing data across ICS to minimise the need of secondary care and change the focus to keep patients well.

Benchmarking

Benchmarking across a whole ICS to identify wider unwarranted variation and improvement in best practice
Benchmarking and sharing of practices within ICS is key
Better transparency between providers should mean better benchmarking
Comparison of provider cost bases
We need to walk before we can run. Model health system is in place, let’s start with that.
Where local benchmarking shows variances, use the breadth of PLICS data to analyse issues in depth.

Contracting

Base new contracting agreements on what services actually cost.
Evidence to help moving away from block payments
Integrated blended payments with Costing outputs

Efficiency

Efficiencies across a wider footprint - economies of scale both in terms of clinical experience and purchasing power/workforce development to improve our ability to deliver activity
Organisations within the same ICS should work more closely together through local benchmarking to identify the most efficient locations for procedures to be completed. This may lead to model local hub and spoke centres

Health inequalities

Helping to cost the variances across deprivation indices to reduce health inequalities through disease trajectories etc
Supplement with demographic and geographical data to add further value to highlight inequalities, higher need and place focused investment

Outcomes

Incorporate outcomes in pathway reporting.
Patient pathways Vs outcomes

Pathways across a system

Analyse pathways across the ICS, to ensure efficiency and patient experience.
Better coding to highlight pathways across sectors
Better understand patient pathways, areas where we could provide more support to patient groups.
Bring in primary care information and social care if possible
Bring together patient level activity for multiple providers. This is being done with some costing suppliers already
Collect Costing information from all Organisations within the ICSs i.e. including Primary Care & Social Care
cost across pathways/ organisations
Create system patient pathways using map of medicine then overlaying the cost
Expand to primary care / social care to really understand patient pathway
Frequent flyers
Full costing through to primary care.
Greater integration of cost and information data throughout the entire health system
Improve service design through understanding patient flow
join up pathways between provider sectors and use cost information to inform on value for money when making decisions about funding
Joined up patient pathways across health economy, shared costing data through ICS
Link to patients not to organisation.
Looking at cost of full patient pathways to see if early interventions of the pathway may lead to reduction in patient care cost at later stages. Can use the acute patient data to identify potential patients in primary care settings.
Looking at costs and activity across complete pathways of care.

Making sure primary care costs are captured and included in analysis
Mandation so that pathway costings can be implemented accurately
Need to come back to the vision of pathway costing that was starting to be discussed 20 years ago - ICSs could open some of the silo barriers on governance
Pathway costing across organisational boundaries
Pathway costing Data quality Standardised quality of care
Pathways. Particularly including GP data. understand the 'upstream' and see the impact downstream
System level discussions about patient pathways
This would give a chance to look at the costs of a whole patient pathway, irrespective of which provider they are treated by
Understand variations in pathways between local trusts.
Understanding pathways and improving them by working together
Understanding the impacts across the ICS
Use data from wider ICS i.e. Police/Local Authority/ Third Sector
Whole pathways view
Inform more flexible approach to whole healthcare not just organisations

Population health

Mapping it to population data
Provide data to that can support population health management
Share submitted data to help with Population Health rather than add to cost accountants burden
Understand cross sector activity and public health management implications

Service improvement

There should be collaborative working between Trusts in a system in order to help improve the quality of the service provided to patients
Understanding transformation involves many different partners e.g. vcse local Authorities other providers
Wider benchmarking to inform contracting commissioning support financial balance , service transformation
Linking data with delivery of the long term plan

Other comments

Understanding benchmark variances cannot always be done through analysis alone and therefore open and honest discussion in arena based on shared interest and co-operation.
Capacity planning across whole ICS rather than a single organisation
Clinical buy in to why costing is important
Make it universal.. I.e. make a NHS costing system instead of having to rely and pay suppliers
Training for ICC on costing, f they not worked in provision do not understand service provision

Use ICS's to support Mental Health Currency development
What do systems do want to support them?

What improvements should we make to the way the NHS does costing to maximise its value?

Purpose of NCC

It requires objectives alignment, Centre seems to have different objectives to internal expectations
NHSEI to make clear what the purpose of collecting the data is, if it is not tariff related.

Listen to the views of costing practitioners

Always say you are listening but then suggest more burdensome plans
Canvass opinion and collaborate with trusts out of London. Each patch should be fairly represented
Come and see where the work is done - without a national chart of accounts it won't be possible to automate
Ed, please go to visit Nottingham UH, Leeds TH and the Royal Free, they are working with PLICS data to improve their service. It is about helping others do this.
Ensure full 360 engagement…. Trusts fts and also software providers
Feedback to engagement is non existent which is frustrating
Focus on the practicalities of adopting the standards through much more targeted discussion with teams. If the standards can't work fit the majority, then they need to be modified/simplified
Full discussion with costing staff on the ground what is important & materials for each.
Happy to give a 'tour' of Leeds Teaching Costing, all welcome!
Have a representative from NHSEI for different areas actively engaging with Trusts
If a delay in reporting back is due to "not understanding" what the data elements mean, then work with some identified practitioners to validate, rather than sit on "Julian's desk"
Look at some of the Trusts that are doing some really good stuff with costing such as Leeds, Nottingham, Plymouth and go and see what they do. Thats what HFMA do so they should be able to point you in the right direction
Look at what some of the trusts are doing well already with their engagement and what they use rather than prescribe from the centre
Meet with Trusts individually to get a feel of the problems they face. Data, engagement, quality, Board etc
No auditing but have people come out to understand what is possible not what is the ideal and understand the issues we have even virtually
When we brought this up with our Deputy DoF with our concerns they just said do NHSE actually listen to us
will there be more forums like this? we sometimes feel we have no forum to discuss our concerns with the direction
work in partnership with the costing community LISTEN
Work together - costing community do not feel that their expertise and concerns are listened to by central team
Work with and use the knowledge in the HFMA costing community

Work with Costing Practitioners / DoFs / HFMA Institute to see what Trusts want out of the PLICS data. Trusts employ the costing practitioners so their needs should be the priority, this will result in better information being produced
would be good if you travelled out of London
Build good relationships with costing community - we have lost trust and respect between all stakeholders

Feedback/reporting of cost data

As well as speed, the data needs to be returned in understandable and useful format.
Availability of benchmarks
Create national averages and averages by ICS too - make benchmarking easy
Dashboard don't show what we want, we just need the data
Get the results back to us quickly
I know we don't want to go back to Ref Costs but having national averages per service area/activity type was really useful and managers understood where efficiencies could be made. Patient Level Costs need aggregating up makes it much harder to do it
increase the turnaround of data - achieve in real time
It does NOT take 4-5 months!!! That is a local issue, which needs to be looked at. We need feedback from the outputs! So we have a strong feedback loop. People need to see and have it, only then they can use it and see the value!
It would be lovely to not have monthly meetings with my CFO explains why NCC hasn't been published.
Just give us the data back.
Keep benchmark data simpler and quicker to get so we can use it properly. NHS e gets distracted with fancy analytics that it isn't good at
Make it easier for the data to be used locally - speed of return of data and ability to cut it / present it in locally relevant ways
More timely outputs from submission results nationally.
Produce a standard set of output dashboards that you recommend we share with boards (i.e. peer data etc) This will save duplication in us creating similar dashboards locally
provide analysis back to costing teams on the completeness of the data you are attaching plics to i.e. you analyse our data against MHSDS but we don't the same locally so we don't know how complete our MHSDS is
Provide standardised internal reporting that can use the same format of data as you require for the NCC. Then boards would be encouraged to resource their costing teams to provide that kind of data as BAU.
Publish outputs quickly. Make inputs much easier so we are all submitting the same. The PLICS portal is very poor, we submit more data and get very little back.
Publishing the index figures in a timely manner.
Quicker feedback
Quicker turnaround of outputs from submissions
Release data in a timely manner so it use useable, rather than a tick box exercise for NHSE
Release outputs in a more timely manner, Model Health is a very useful tool that is not utilised due to the delay in updating the information
Release the outputs more timely. Get that right before moving to more frequent collections.
Remove barriers between NHSEI and NHSD to get the national data back more quickly

spec pod hrg covers most benchmarking. Clinicians and services want to know their costs and activities, having NCC drugs in 2 places, devices in another, data cut out to an extent it doesn't match what they know
Speed of return of information / benchmarking
Standard reporting & analysis to maximize operational use of data – consider national metrics, focus and growth areas, provide modular templates to enhance use of PLICS as an information, rather than data, source.
The centre's data has to be timely, accessible, downloadable and in a format we can use...we are 5+ years on and still can't get access to the basics
The whole thing needs to be quicker. Some of us submitted quarterly costing to a benchmarking group and got it back within a month.
Timely access to submitted data
We cannot go on with the current situation where the data is not published in a timely manner. There is no point in MFCC if the data is going to be published over a year after the period end, which has happened for the last two NCC submissions
Whole data release after the submission. NHSI PLICS portal tends to only include information where trust's costs are higher than the national value. Benchmarking where costs are lower is just as important in identifying issues.
Why does it take so long to get feedback
Work with Trusts to develop a reporting tool that provides them with the information they want and that is easy to use, as the current PLICS portal does not do this

Using cost data locally

Less time submitting more time taking it out to the trust
Less time submitting nationally and more time using the output in our Trusts. Costing Teams are often 1 or 2 people
Change the focus from collections to helping Costing teams embed Costing within their own Trusts to drive change
Change the focus to use the information in the wider organisation and how best to achieve this
Encouraging local cost collection and ... more importantly ... ensuring costing data is then USED locally
Ensure costing practitioners have time to work within the own Trust to use costing data, rather than spending significant proportion of time on NCC
It would be better to mandate USING the data instead of more frequent collections.- the two conflict as competing for the same resource.
Let us use and understand our data with clinical teams - The plan cannot be we are asking Palantir
Let us use our own data to improve productivity, Palantir is of no use if we don't even have time to understand our own data.
Making costing more than just bean counting - why are we not seen as being involved (from a national perspective) on transformation, strategic and planning basis?
More time spent on quality and using it at local level - most of time is currently taken up with meeting national standards and submissions - trust sees costing team as a burden whom only meet national requirements and don't contribute at trust level
Move away from the emphasis on costing for the sake of national returns towards costing as a way of adding local value
robust costing that could help decision making at clinical level and commissioning level
Tick Box exercise currently. No time to review data
Train finance business partners in using the cost data

Training on how to analyse national costing outputs rather than just the process of submission
Trust Boards don't care about the output collections - you need to change this
We need to provide targeted costing education to operational clinical managers and how it can impact their roles positively.
What is the use for the collection when the time taken to deliver it means we'd add no value to our actual Trust, we wouldn't have the time to do other useful things
When looking at what costing has to offer, we are becoming overshadowed by the more frequent outputs from Model Health System

Approaches and processes

Simplify the NCC

Agree with dropping the number of resources/activities - very painful to populate these especially when the trust has organisational change which creates thousands of new ledger lines!
Burden = too much manual work to create some of the information required for the NCC (year end adjustments, annual leave, CMDT, screening programmes)
Clarity of guidance and simplifying the process. Voluminous documents to get through
Communicate changes clearly and give sufficient notice; make documentation easy to find in a single location; focus on material costs; remove requirement for trusts to collate and submit activity data twice.
Length of documentation is not the primary issue - it's the amount of time required behind the scenes to achieve the standards that create the burden
Make the process simpler and remove unnecessary and non value adding activities
Make the whole process easier - it currently takes much to long to do the NCC
All these resources and activities.... WHY? There are only a few drivers of costs so make the process simpler to help both the NCC and any future more regular collections
Get rid of all of the standards and excel spreadsheets. We just need guidance that is no more than 100 pages in how to collate the data. Monitor used to do this at episode level.
Having costing experience is also crucial for those taking decisions and seems to think the additions to the requirements are just adding few fields.
Make NCC more simple
More concise guidance and support. The OLP has lots of data but it can be difficult to find anything as things are saved in different places.
Significantly simplify the costing standards
Simplification of NCC. It should not take 3 months to produce the annual submission each year.
Simplify
simplify activities collected
Simplify and aim for higher quality of return rather than more frequent
Simplify and shorten guidance
Simplify guidance
Simplify the guidance
Simplify the guidance and collection process. Also increase the timeliness of publishing outputs and results
Simplify the NCC
Simplify the process by aligning national view of PLICS with that required internally by hospital management
Simplify the returns and the guidance) and ensure results are published quicker.

Simplify the standards, there so much info and I can never find the bits I want or need when I actually need them.
Simplify the standards.
Standardise and simplify where you share all the costing info. There are so many systems and different places info gets posted. Keep thinks simple
Stop changing the requirements, simplify the standards, get the data back to us quicker
Streamline the guidance and ensure guidance consistency across different documents
The complexity around the guidance is,in part,due to the number of documents we cross reference between to get the whole picture. Better to publish digitally where the detail is via linked screens to facilitate our read through
The way in which cost data is reported and collected needs to be simplified such that each patient attendance/episode just results in a single record of data.
there may be fewer pages but still not clear if in vol 1, 2, 3, tech doc, schema, extract, IR 1 &2, CA, CM, CP, or FAQ ...still too much - HFMA had it down to about 50 pages
Too many back end codes to map out which constantly changes for example, complex guidance, no time for sitting back and looking at the bigger picture. Automation sounds great but just another job to upkeep.
Too many collection activities in the guidance
too many guidances to get through for one collection
Too much data makes it difficult to use plics
With Reference Costs we used to have the Workbook and one guidance document. With the NCC there are 60+ different guidance documents, tools, appendix documents. The sheer volume of reading is ridiculous.
Some of the small NCC changes require significant amounts of work in the background to get the data into the right format / requirement.
To make easier only collection resources & activities not national and collection
Too many people think that costing is just a press of a button. It's much more than that.

Align NCC with business-as-usual (BAU) local costing

Align closely to BAU costing.
BAU and NCC is supplier models is not always the same ours does not attach CTP activities for example except for NCC
BAU PLICS and NCC need to be produced via one costing model
Building NCC models takes 2 weeks because it is so different to BAU. Monthly BAU PLICS is processed and released to the organisation in 5-7 working days by contrast
Make it so our BAU = Collection and isn't a separate task.
Make NCC work the same as we use BAU. The differences make any benchmarking very difficult.
Make requirements for NHSE/I return NCC etc be more similar to BAU. Simplify guidance, and get timely feedback
making NCC data process the same as normal quarterly processing
One version of the truth. Narrow the gap between the national ask and local use.
Quarterly data could be achievable if it is in alignment with local reporting.
Reduce the burden of collections being different from BAU PLICS so that we are working primarily for our Trusts to embed Costing and improve DQ. Collections could just fall out of what we do.
Use local PLICS. NCC takes to long to produce.
Use the Technical Document as the ‘Costing Bible’. If a system utilises these tables for codes and linkages. This can the been standard across BAU and NCC.

Burden = running two very different models. The NCC model is very resource intensive and provides no information for local use, nor aid any form of clinical engagement
NCC takes 6-8 weeks to produce on top of BAU due to guidance and unbundling
Frequency is easy to achieve if the process of the approach is the same as what is in place now
MFCC needs to drop out of BAU plics and no more than an additional day to output. Free practitioners to use their data not feed the treadmill of data requests from the centre
Drop NCC. Just take our local PLICS. Do you even still need resources and activities? Do you even need cost pools?
All trusts doing one costing model for use locally. then the NCC is one output done from that model.
Move forward with Quarterly plics so internal is our external work also. Move the NCC method closer to local PLICS reporting

Align NCC with other returns

Align collection resources to monthly PFRs submitted by finance teams
Aligning cost collections to other data sources will automate the cost classifications. For example, aligning resources to other national returns such as the PFR and PWR returns
Be consistent in categorisation across all data collections, not just costing. We shouldn't need to map between collections to make sense of them.
Consistency across the NHS Digital and NHSE&I data submissions e.g. currently datasets use different data items for the same field
Greater harmonisation between costing, counting, coding and collecting - why have different coding and income codes and then a different set for collecting for areas like audiology
Ledger should map to the PFR categories not 43k rows of permutations. There's 4k rows to explain 2 rules of mapping admin grades...madness
Link costing with the annual planning process
We need to be able to link to national collections… I shouldn't need to submit theatre time when you can and should link to it internally in your data lake.
Collect data that can be used for everything, just cut in different ways.

Costing standards should only use mandated data sets

All data requirements should match mandated datasets only. This will improve efficiency and reduce the burden
Any data feeds required for costing should be mandated, as it should not be the role of Costing Practitioners to have to obtain data required for costing
Better align the mandatory data collected with the transformation to costing returns to reduce burden.
Better Flow for changes , e.g. CCMDS not at daily level.. but SWC is at daily level. Sort CCMDS (and monitor and enforce) , before asking it to be mandated for Costing
mandate all activity feeds and fields needed for costing
Mandate and govern the use of information fields. This should not be a costing problem but a NHSE/D problem
Mandate information requirements instead of Costing practitioners having to ask for it
Mandating of the data required to produce costing submissions
Only requiring costing to use mandated data and fields to help with consistency
Some of the data requirements need to be mandated for the activity submission to SUS etc before asking for it to be submitted in National Costing Return.

Cost accountants should not be responsible for data transformation such as Daily Adult Critical Care data. This should be mandated as a data collection with information before added in PLICs
digital - community related - mandating datasets that are currently required but not enforced in any way for not completing these, data quality of these, rejecting errors

Materiality

Burden = National resources are created but never collected Materiality from 0.05% to at least 1% A locally usable output (1 data set not 2!)
Do we actually have to fully map to the ledger not just our main primary activities I.E. what we want to benchmark against
Encourage the system to focus costing projects on areas which are nationally material and present regional/national strategic challenges to improve the quality of the data being output to improve pathway decision making going forward.
Focus on material areas, simplify standards and submission process
Focus on material areas.
Focus on materiality
Focus on materiality. Work with software to focus on automation and use this to inform approach
Look at materiality, instead of us spending all our time on small areas of our data, we could be making the bigger areas more accurate.
Some sensible materiality Community only 0.2% of costs but using up costing resource to submit for NCC
Think 80/20 rule. Does everything have to be perfect (for example reconcile to the annual accounts) let's get data in and shared to be used.

Automation

Automation in obtaining the data will be key for costing
Automation. Some suppliers have this already!!!
You could automate the collection of activity data and then provide these official feeds to costing teams to allocate costs.
Work with software providers to automate

Consistency

Keep things consistent
Let costing settle for a few years - let people catch up
Let CTP finish and move forward then a stable base
So many changes within the trust, hard to keep up when further changes are being made to the guidance too
Standards need to avoid ambiguity so everyone costs the same way
stick to one properly thought out approach
Use of the same costing methodologies throughout the NHS so that the data can be compared
Why are there differences between the (long) standards and the collection guidance? Do the teams not work together????

At no point have we had a year/period where guidance is settled for NCC. This makes year on year comparisons hard. Through any long process there should be a period of reflection. I don't feel we have done that for the NCC/CTP
Consistency of the collection not changing requirements each year e.g. LD in in 1920 and 2021 but out 2122
Assess how Trusts are interpreting and applying the standards in reality - is there really consistency of approach?

Cost pools

Burden - we don't need to map the ledger to the nth degree. Simple cost buckets such as Theatres, Pathology, Radiology, Wards are what we want to benchmark so that I can see which bits of our services are less efficient that other Trusts.
Bring Cost Pools back into analysis - this is more understood by clinicians and non-finance colleagues (Decision makers)
Keep it simple, publish regularly – go back to cost pools and the Albatross benchmarking product as we all understood that and used it to good effect.
Moving from cost pools to resource codes has made things a lot more complicated and time consuming.
resource/activity - simplify to cost pools that are useful and relevant. only as many as is useful. PLICS very beneficial so don't want to return to aggregate records.
The old Monitor template which was an episodic collection by cost pool was a far better collection for benchmarking than the current NCC.
When you talk to clinicians they understand cost pools of Wards, Theatres, Pathology, Radiology, Medical Staffing, Therapies etc The matrix or resources/activities is far too complex.

Data quality

Problem isn't the processing of data it is the finding of good quality data & working around the gaps takes the most amount of costing resources so without standard ledgers & information no one will be able to make this more efficient.
Quality of information should be consistent, counting & coding of activity should be consistent too. Without consistent information the benchmarking will have limited use.
Reduce burden of cost collection, DQ within trusts is challenging, activity data and use of ledger and reporting
There is no onus on the systems where the data feeds PLICS to provide consistent data
Using of the information to benchmark is the key but accuracy, quality and consistency needs to be improved. Improving accuracy is more important than producing frequently to help manage services as financial management is there for that purpose.
We focus on accurate costs but there is no focus nationally on collecting accurate patient activity, e.g. community dataset

Costing guidance

For the guidance, is there a summary guidance document with good references to where you can find more detailed guidance. Even with fewer documents I struggle to find targeted guidance when I need it.
Guidance is in too many documents which cross reference each other making it too difficult to follow or find things
guidance is too long and broken up, a lot to digest. one document
Guidance overload, website, OLP - disconnected at times
Improve some aspects of the guidance to be able to understand without raising queries

publish guidance based on principles, not detail.
Return to one guidance document, rather than having to search through multiple documents to find the section you want to refer to
AE relative weight value table is a good example, it is a huge ask and suddenly it's not mandatory any longer, clear rules and less ambiguity would help
NHSEI guidance should focus more on collection format and less on teaching the costing community with detailed and prescriptive approaches on how to set up their models

High cost drugs

Base income tariffs on costing sooner, line up income and costing rules and regulations - why have we different pbr high cost drug lists to costing high cost drug lists
Stop duplication of work in cost submission i.e. identify high cost drugs at patient level costing & then reporting separately, what difference does it makes reporting critical care cost within episode and reporting separately?
Not assuming costing teams are able to map high cost drugs (the chemical nomenclature is not something we are trained to understand) e.g. Liposomes vs methylates etc

Chart of accounts and ledgers

Central mapping of ledgers to resource codes - anything we can do to standardise will strengthen benchmarking
Burden around ledger adjustments - pension, year end adjustments, payroll recodes, takes a significant amount of time, days and days
a standardised GL that can be used directly in costing
Can NHSE mandate a national chart of accounts? If all trusts used the same expense codes, it would aid automation and mapping for both costing and annual accounts, PFR etc
Costing Ledger to be part of Financial ledger requirements to allow the mapping in Tech doc to come out as part of ledger output.
General ledger mapping is a huge burden
National chart of accounts
National chart of accounts mapped to costing resource and activities done automated
Reduce ledger burden - to fill all the requested paperwork would take nearly 3 months to work through and type out
the cost ledger is way too prescriptive

Costing software

Be brave and commission 1 system for all. Will hugely help with support across organisations, training and cross working
Get the suppliers who can't do the granular/more detailed collections to improve
Work with system providers to make a requirement to be able to produce standardised inputs into plics

Medical staff

Material area is medical staffing so need up to date completed job plans which can inform costing system automatically
Biggest cost in NHS is staff (Medical Staff) but we don't measure how the highest resource cost is used so all costing is very approximate irrespective of whether you have 5 pages or 5,000 pages in the guidance!

More frequent cost collection

Actually using the information available from combining costing data and other productivity items is very resource intensive - using that resource to do MFCC is not good for the individual providers
Aggregate data is not easier to produce than detailed data
Coverage and accuracy much higher up improvement list, rather than frequency
Drop More frequent cost collections and concentrate on the NCC to make it more robust and sleek and information that is useful for trust decision making. Currently the information differs massively to local costing outputs.
I would like to hear how you think the MFCC will reduce the burden for Costing practitioners? How do you think more work somehow results in less work. It doesn't. MFCC = more work = an increased burden.
Instead of mandating more frequent submissions, how about mandating quarterly recording locally?
MFCC needs to have clarity around what is collected - quarterly or year to date? Similarly, there needs to be a clear process for what to do with work in progress
MFCC will actually take time away from a cost accountant ability to impact their local trust
MFCC will not let Costing Practitioners analysis, improve & engage data internally/system wide
More frequent collections makes it a less interesting job. We need time to use the data.
Setting up MFCC will actually lose the value of PLICs locally as less time can be spent getting it out in the organisation. You will likely find more cost accountants leave which we've seen in recent year due to the burden of NCC
Submit average costs at a national level quarterly if required. Allow individual organisations and ICS to agree local PLICS strategies
Understand the amount of work that would go into more frequent collections Some Trusts have a small reporting team who deal with many aspects of reporting not just costing get the current process correct before requesting a more frequent submission
We are losing more and more Cost Accountants with the burden of NCC. Having more submissions feels we'd be even less appealing as a career
Do we need NCC if we do quarterly PLICS - blended payments means we don't need NCI feeds

Mental health

Some of the elements for MH providers are just of no interest e.g. unbundled radiology etc
Share with us how you are attaching data to MHSDS so we can learn from you locally
Clarity on currencies for mental health
Make a decision about MH Clustering which is apparently not mandatory anymore so clinicians are not collecting it but I don’t know what is happening around the national MH currencies for 2022-23 submission even if we can submit it next year

NCC burden

As it stands doing the NCC takes 4-5 months, impossible to do this more than once a year. We'll lose a lot of experienced costing practitioners and therefore lose quality of submissions in the long run
Burden - 3months from start to finish to complete a quarter , no development time, no time to actually use the data internally to make pathway improvements
If you do not understand the burden you should spend a year in a Trust understanding the process. The burden is massive, and often staff give up evenings and weekends for weeks if not months at a time.

Outcomes

Guidance for PLICS+ linking costing data to other systems/datasets such as patient outcomes etc
To determine value, need to measure outcomes. Costs on their own don't really add much value.

Oversimplification

Oversimplification isn't the right approach as the ability to utilise the data for analysis and true benchmarking would disappear. Nothing can be learned by just knowing theatres are more expensive, costing data needs to be used to understand why
Don’t simplify! The granularity is really important and question those who want it simplified as this should be their job

Timing of NCC

Agreed for the timing - not only is it over the summer holidays which is really unhelpful for any of us with a family, but also it puts pressure to get information i.e. financial information in a timely manner.
At smaller Trust's the senior practitioner usually does Income too so their time is taken up during April so summer submission is massively time-pressured
Consider timeframe - accounts completed 22nd June Mhsds submission end of may with work to get into the system means it’s very tight
Don't plan the NCC submission window over the school holidays like this year. If costing staff cannot take annual leave during the school holidays they will not want to continue working in costing.
Ensure final guidance is available a lot earlier that April/May to give us time to prepare data earlier
Faster support for collections. We still haven't got the DVT for this year, and the reconciliations meeting is next week, when most of us are beyond that point now.
for example, on timings the final financial position still isn’t due until June, but costing has been brought forward.
If guidance was published for the coming year rather than the previous year we could produce NCC model alongside BAU.
More consideration for how collection timetables clash with school holidays, but also year-end, and contract planning deadlines.
Release the guidance earlier
Timing of summer submission, too close to audited accounts deadline
Why does NCC have to take place in summer? Parents get constantly shafted
Why would anyone want a job where you never get a summer holiday?

Unbundled costs

Any national submissions need to be more in line with Trusts BAU PLICS i.e. do away with unbundling. There also needs to be consistency in what costs are included in the costing quantum
Easy questioner not narrative suggestion of exclusion i.e. unbundling HCD
no unbundled costs would be really useful
Prioritising the unbundling suggestion
Reduce unbundling within costing. Focus on patient, not episodes, unbundled days, unbundled imaging, Chemotherapy...
Remove unbundling
Remove unbundling and cost the patient as a whole episode / attendance
Removing Unbundling would lighten the burden ...

Unbundling would be good for everyone to aid transparency in identifying costs Needs to be tied to coding and local necessity
Use Activity Collection IDs as a way of unbundling instead of more feed types or artificial episodes such as SI & SWC
Why don't operational systems work so unbundling isn't necessary. Make them align to what is needed as an output not an input

Costs at service level

collect costs at a service level for a quick turnaround to give timely indicators
patient level gives a spurious level of accuracy - data is more reliable at service level not even at HRG level. let's be realistic about this. Bring it up a level and look at services not individual patients. this will simplify, speedup & costless
stop focusing on costs at patient level and focus on costs of services

Other stakeholders

Role of informatics teams

Increase its importance in the information/IT departments
Info/Data Warehouse teams need to be held responsible for providing PLICS date feeds, costing practitioners spend an inordinate amount of time collating and cleansing data before we even start the modelling and reporting
Involve IM teams more rather than focusing on costing practitioners, I think this would get IM on board more?
Involve informatics teams, and move the focus of the requirement for information feeds from costing to informatics as costing have very little influence over this
Joint conferences targeted at BI teams and Costing teams - create a landscape where experts come together to help reduce duplication of analysis
Mandate integration between GL, Payroll and HR (job plan) systems via the BI teams
NHSE/I need to support information teams directly rather than indirectly through costing teams. Also 'selling' costing and PLICS to senior managers within a Trust
NHSi to make data quality a priority to boards to achieve accurate Plics
PLEASE stop thinking of costing as an isolated area - to maximise costing it has to be wider than tiny costing teams - Get Business Intelligence Teams/Informatics more involved
Push responsibility to accurate data to those who provide it
Put pressure on CIO and CCIO to improved data quality and completeness.
Stop directing the requirements for activity data at Costing Team but have a more joined up way of getting / using activity data in the required format directly from BI Teams
Communication to business intelligence teams regarding changes to activity requirements.
Get IT/Information teams more involved
The mandate for providing the data should start with the Informatics Department. Perhaps you should try to collect the un-costed data from IM rather than relying on small, costing teams to try to gather it all.
We struggle to get community activity data as there is no external enforcement on our BI team - shouldn't be for the costing team to enforce

Secure buy-in from other stakeholders

Also more involvement of NHSE in getting senior management to buy into NCC and MFCC
can you speak to our board about what we are doing and why and encourage them to support us

Clinicians are only interested, as are Directorate Managers, if we say there is a chance of increasing resources or even having resources reduced, if there is no buy in.
Costing is important - we need to be able to take it out and use it.... Also, you need to help us make costing more important to our senior leaders....
Costing must have a seat at the table so why isn't NHSE looking at costs when we look at the financial performance of the trust? This will raise the profile!
Engagement! Costing are the bottom of the list of everyone's priorities so we struggle to advance our data via engagement.
Finance directors to recognise importance of costing
Getting senior management to focus more resources on costing teams
Have costing / PLICS as part of the training of Junior Doctors, which will hopefully improve future clinical engagement
Hold NED's/Chief Exec's to account for utilising costing data - help the costing c community to get our voices heard
Increase it's importance at board level - so it receives a priority within Trusts
Make costing more of a priority to help Trust's get engagement internally.
Make costing more visible
National team conversations with Board members to support and promote costing.
Need to ensure CFOs are on board with the importance of costing and the support that costing teams need.
Presentations at Director of Finance audience conferences on the benefits of costing.
Show Boards what they can get out of costing and how it can be used to get more funding
Some Trusts do not have dedicated team, have to work on PLICS on top of day job so NHSI could support to ensure Trust Board recognises importance and resources
stop talking about these plans with costing accountants and make it a priority for CFOs and CEOs
talking about costing as a finance tool is a major turn off for non clinical managers
What do FDs and clinical directors require
Tell DoFs they (and not just the costing team/accountant) will be asked to explain why there costs are inaccurate, late, outliers etc.

Role of the centre

NHS England do a lot of the processing?
NHSEI to do some things centrally e.g. 1 company provides the Heartflow scan so why have 180 organisations asking for that data and processing it NHSEI could that , then only 1 organisation needing to contact Heartflow
Provide more hands on support rather than publishing lots of guidance which no one has time to read.
Centralize the reconciliation burden so that costing departments can concentrate on the allocation of costs, not balancing the quantum to the final accounts.
Have a central NHSIE team to do the costing. SUS data is already submitted and final accounts, ledgers and additional data can be shared if schemas are provided.
National template to cost radiology exams and pathology tests for example not reinvented 140 plus times
Collect the data feeds that go into our plics models. You are the best place to oversee just how different everyone is costing and completeness of data
Imagine that!! A central server where data is put and improvements can be made
It sometimes feels like we work for NHSEI. We add little value to our own organisation where we spend a quarter of the year submitting an NCC + EQC

Yes a shared server

Costing teams

Funding costing teams

A little bit of investment in each trust would help costing practitioners to feed the data back locally to the service managers and lead clinicians.
Additional funding for costing teams, workload and demands are increasing, but resources are the same....
An interesting suggestion I've had from a colleague was why don't NHSE/I just employ as we do barely any work for our own Trusts
Can we get central funding which is specifically for costing to improve systems and team sizes?
Funding within Trusts for costing dedicated teams
Fundings to expand the costing team if more frequent collection is a must. Considering the size of most costing teams, even with one staff leaving, it's a huge hit to the team and huge burden left on the rest....
investment at trust level on data systems and technologies.
More funding for costing teams to recruit adequately for more efficient processing
National investment in costing, standardisation, one system used by all, nhse to take data from system rather than having to submit, as annual out of date quite quickly
Need to invest in costing teams but have no support in defending our case to our trust
provide Trusts with specific funding to increase costing teams
Ringfenced funding for costing teams
The original case for change committed NHS organisations to spend millions of pounds on staffing resources and systems in order to reap the benefits of enhanced management information and local engagement. Stick to the transformation plan

Greater integration of costing in the finance function

Costing Accountants are often isolated in their teams - they should be fully integrated and valued alongside other decision making support teams like BI and Financial Management
Costing can’t be improved by just one or two people working in small costing teams so it is important to have collective approach, finance ledgers need to be aligned with clinical specialties to identify the correct cost in first place.
Ensure Costing is understand to be as important in a Finance Team as Financial Management / Financial Services / contracting.
Financial Management have over 40 staff - Costing has only 2..... this needs to be changed

Learning from others

Create an easier costing chat forums to connect costing practitioners across sectors
Help Trusts learn with each other how they can maintain costing processes in the face of constantly changing services.

Training and career path for costing practitioners

Costing jobs are not a clear career path. You could help by identifying why that is and helping address it.
Create an accredited training course for costing practitioners - recognise the community as a team of experts

Dedicated SQL Training sessions - think wider than just the NCC - support practitioners to have the right skills needed i.e. Dashboard visualisation skills, etc
Highlight how Costing practitioners can develop their careers in an organisation - we can't attract staff because never considered as an area where you can become CFO
Making learning and training around the process easing
Support training and development of cost staff in a more co-ordinated way rather than assuming/hoping orgs will pick up costing skills largely just by own knowledge acquisition, causing massive discrepancy in expertise and resources across orgs.
You could work better with us by providing skills training in data, SQL, excel innovations, knowledge of data sets etc. Not just the costing standards.

Costing teams

Important to note that some teams are combined income and costing teams. Therefore requirements of contracting and (never-ending) planning can add to burden.
Some teams are combined income and costing teams. Impact of never ending planning submissions adds to burden of our team.
Costing's complexity (PLICS) has made it very difficult to attract good practitioners to the core
Give recommendations about the size of the costing team in terms of Trust size and level of specialist services
Make team size standardized and ensure trusts recruit to this. Teams are too small and pressured.
Promote existing costing staff rather than bringing in external staff - increase costing practitioner grades
Recommendation of Costing team wte to take to the Board
Teams are too small for such big project
There are 15+people getting final accounts which is money only. Yet only 1-3 people have collate the whole network of the data requirements into the costing system which is a time consuming element of the burden
To grow costing community, you need to make NCC much better
Trusts won't invest in costing practitioners .. finance is the first to suffer .. in a deficit trust
Upbanding costing roles.
We cannot grow cost accountants locally either
Cost Accountants, consider rebranding as Data Engineers
If we are moving to blended tariff can it be mandated Nationally that priced activity is not required any longer therefore resources currently can be moved to costing teams and informatics to get the data better
Spend less time on the exemplar trusts who do costing well and provide more support for the trusts still struggling to bring the whole sector up a level
Still a cottage industry in most Trusts

Other comments

At present it seems national and local requirements are not compatible, the two should be aligned
Benchmark activity streams that drive costs rather than costs themselves e.g. theatre minutes per procedure etc
"Aggregate" submissions do not mean less burden. Cost accountants have to cost at the patient clinical transaction level in PLICS, they then have to group this up to do the aggregate submission so there isn't a time saving here
Reduce the amount of data collected for interim collections

We should have little or no manipulation required to data from the primary sources.
Work with other NHSE teams, e.g. mental health / MHSDS to ensure that work to automate data collections elsewhere, aligns with costing requirements, so it doesn't have to be duplicated
Forget bringing back the E&T return
Bring in income to costing returns
An effective tool to measure success that acknowledges the different levels of progress in costing.
Working with Palantir seems a huge data governance risk given their roots in the U.S
Do it once, do it right.
DVT issues earlier to review on previous year to iron issues out early
If costing is to be increasingly linked to productivity, then that profile needs to be emphasised.
Move the cost collection away from a format determined by the way the tariff is/was formatted and towards a methodology that actually describes what is really going on.
focus on spell costs not episodes, the definition of episodes are not standardised across the NHS
Non clinical service lines used locally e.g. R&D, Education, Commercial - all recognised as services in their own right, rather than netting income as per national guidance.
Scan for safety - make this mandatory in Trusts
A lot of this has already been outlined in the paper produced by the HFMA Healthcare Costing for Value Institute in September 2021 (What does good look like for costing?)
NHSi to praise costing teams back to Trust boards for all the hard work in the background
Standard annualised hours contracts would help with R&R.
stop using management consultants and start using some common sense
Submit data at device lines which ties to the long term plan / CCG mhis collections that's what people want to use to understand at systems
Would love to know who said it doesn't take 4 months, what sorcery are you pulling off?

Questions and comments posted on BrightTalk

If Local costing teams aren't given more time to understand their own data, how will ICSs be able to make intelligent decisions that can then be implemented correctly locally?
One of the major concerns raised at the HFMA Costing Conference related to the serious issues associated with recruitment and retention of Costing Practitioners. What are NHSEI going to do to help resolve this issue.?
We really need to focus on streamlining and simplifying the process and not expanding the resource required.
Back in early 15/16 / when CTP was announced, there was a goal & vision to have and move towards quarterly collections. This is good and we need to move towards this and not be held back by Trusts who keep lagging behind. The data is very valuable to front line services and useful a variety of stakeholders. Can we therefore move quickly to have a bi-annual collection and then later to quarterly by 2025/6. Thanks.
The role is being turned into working full time on â€˜churning€™ data for the centre, which does not add any value to the Trust that employs them. This takes them away from the interesting part of the job, which is meeting with the clinical staff to discuss PLICS data and in the long term will lead to the deterioration in quality of the data. How do you square this with the concept of MFCC?

Allowing trusts to understand their cost base and how that compares to other trusts and what opportunities we might have to improve our cost base, improve patient care
Making information sharing easier, can't do anything at patient level at the moment with IG limitations.
The guidance needs starting from scratch - its based on a tariff collection. Look at the HFMA Costing Guidance that served very well before CTP. Costing was much more consistent prior to CTP
"The primary role of costing is for local decision making" however we are being asked to move towards quarterly returns which we won't use for local decision making. I'd far rather have a high quality annual output which can be benchmarked nationally and locally to support transformation and service development. Quarterly or MFCC won't achieve this.
I think that it is a good point that cost accountants can't be grown; the challenge may be to ensure that we don't eliminate them, and what can be done to avoid that..
Automation to old RC method is going backwards in terms of patient level costing.
Is there any evidence of what impact the comparability at a national level, that can't be done at local level, has made?
get rid of unbundling (Crit Care, Drugs, Radiology etc)
If more frequent cost collections happen, then in at least for the first year the maximum it could be is half yearly. This is due to costing practitioners would be working on the previous years NCC during the time scale of when Qtr1 would be
I work at a Trust that uses PLICS to drive service improvement and have to se we don't use the PLICS portal at all. We use GIRFT and Model Hospital which I know uses NCC data but the PLICS portal is pointless in its current format
Allow costing teams to catch-up and develop our costing system instead of just keeping up with changes in guidance, data capture
Biggest cost in NHS is staff (Medical Staff) but we don't measure how the highest resource cost is used so all costing is very approximate irrespective of whether you have 5 pages or 5,000 pages in the guidance!
Use PLICS information for strategic decision making. Looking at full cost of services, patient pathways, procedures etc. focus on material cost elements & identify what drives these costs & how can delivery of patientcare be improved for better outcomes. PLICS only can highlight/identify areas of interest & clinicians need to come up with solutions.
Comment not a question - the tone within this webinar is very different to the webinars previously. Finally feels like we have moved to a more collaborative space. Thank you for listening to us.
there is a lot of talk regarding aligning with BAU. Please remember there are many trusts who do not do costing above the annual collection.
Costing is a great team to work for as you get time to work with amazing clinicians. National collections take us away from this and make the costing jobs more process driven. Thankfully me Trust sees the value of costing internally over the national collections

In relation to them talking about the (financial) cost of MFCC: • What do NHS E/I think about the cost to practitioners mental health? • What do NHS E/I think about the cost of making being a costing practitioner less desirable? • Do NHS E/I feel the programme is ready enough and stable to progress to MFCC?
Does the costing team have any other solutions to this other than sending NHS data to Palantir?
Looking at cost of full patient pathways to see if early interventions of the pathway may lead to reduction in patient care cost at later stages. Can use the acute patient data to identify potential patients in primary care settings before they become too ill so conditions can be managed, planned and early treatment at less cost compared to emergency non-elective treatments will benefit whole ICS and it is better for the patients as well.