Response form for *Developing the Pricing Licence Conditions: Stakeholder Engagement Document*

If you would like any part of the content of your response (as distinct from your identity) to be kept confidential, you may say so in a covering letter.

We would ask you to indicate clearly which part or parts of your response you regard as confidential. We will endeavour to give effect to your request, but as a public body which is subject to the provisions of the Freedom of Information legislation, we cannot guarantee confidentiality.

Full name: Sarah Bence

Job title: Technical Editor

Organisation: HFMA

Nature of organisation:

The Healthcare Financial Management Association (HFMA) is the professional financial voice of the NHS. We are a representative body for finance staff in healthcare. Our members work predominantly in the NHS and our aim is to maintain and develop the financial management contribution to healthcare in the UK.

We have confined our comments to this response drawing on the expertise of the HFMA's Costing Special Interest Group, Payment by Results Special Interest Group and the members of our Policy Forum.

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Please write your answers to the following questions below. Please expand the boxes or continue on further sheets if necessary. Then follow the instructions at the end of this form to return your response to Monitor.

Question 1: Do you agree that requiring all licensees to record data on a consistent basis would result in benefits to patients? Please give reasons for your answer.

The HFMA would support an approach that requires all licensees to record data on a consistent basis and would suggest that any guidance issued is sufficiently detailed to ensure that this is the case. Consistent data (supported by a reasonable level of consistent data quality) can underpin benchmarking and help trusts identify where efficiencies can be made. In addition, it is our view that an excellent costing methodology will not deliver the required benefits unless it is supported by a good quality level of activity data.

The HFMA would therefore welcome greater emphasis on improving clinical coding: the accurate recording of clinical activity and the patient's pathway must underpin the consistent recording of

patient data. We also feel that it is important to ensure consistency in terms of the definitions of the healthcare services being recorded.

In our view, consistency of data collection and subsequent benchmarking are also important for commissioners: a consistent approach to data collection will support effective decision-making in local health economies.

However a practical approach would be needed in understanding organisations' current ability to deliver costing data and the different level of sophistication that exists in organisations current costing processes and systems. A realistic approach that clearly sets the expected direction of travel would enable organisations to understand how they can move from their current approach to meet the requirements of the new framework.

Question 2: Do you have any suggestions as to how we could reduce the costs associated with the requirement for all licensees to record data on a consistent basis?

The HFMA recognises that the financial burden of achieving data consistency must be minimised. Therefore, we would welcome an increase in the profile of the existing *Clinical costing standards* for patient level costing. Developed by the HFMA Costing Special Interest Group in conjunction with the Department of Health, the process has involved finance professionals from a variety of organisations.

The standards and supporting material can be found at: http://www.hfma.org.uk/costing

The HFMA believes that the clinical costing standards provide a cost-effective starting point for developing more detailed national guidance as they already exist, represent best practice for costing at the lowest possible level in the NHS i.e. the patient and are increasingly used, particularly in the acute healthcare sector. We would also like to draw attention to the draft clinical costing standards for mental health which have also been published for 2011/12 and which will be updated along with the acute standards in April 2012.

In the event that a sampling approach to cost collection is implemented, we would welcome consideration in relation to the reimbursement of organisations participating in the sample potentially through a small levy from those organisations not directly involved. However it would be important to have the same broad framework for cost collection for all organisations – both within and outside the sample. While this would not only encourage greater attention to robust costing across all NHS bodies, supporting better local decision making, it would also enable entry and exit to and from the sample to be more easily managed.

Question 3: Do you have any suggestions as to the level and type of stakeholder engagement and consultation we should conduct on our supplementary guidance?

The HFMA welcomes the consideration given to the need for such engagement and would welcome the opportunity for finance professionals across the NHS to be consulted in relation to proposed supplementary guidance. The HFMA through its Costing Special Interest Group would be happy to work with Monitor to develop this guidance in the future. The HFMA is already engaging with Monitor in this area. Representatives from Monitor attend both HFMA's Costing Special Interest Group and its Payment by Results Special Interest Group. This engagement should be built upon so that practitioners experience can be used to inform the development of costing and the tariff.

In our view it is also vital that appropriate engagement is as comprehensive as possible. We would therefore welcome consideration of how clinicians could be more involved in the formal costing process, for example as part of the sign off process for the costs in their area of expertise. There should also be engagement with : specialist providers; costing software and system suppliers;

contracting colleagues – both providers and commissioners; and information colleagues.

Question 4: Do you agree that licensees should be required to provide us with information in order to support the calculation of the National Tariff? Please give reasons for your answer.

The HFMA agrees with this proposal as in our view, it would be important for the price setter to understand the make-up of costing data on which future tariffs are to be based. This is particularly important if NHS providers are to compete on a 'level playing field' with private sector or independent healthcare providers. We are aware that private and independent providers are unlikely to have the same level of infrastructure costs as NHS providers supporting emergency and non-elective healthcare services.

Even if a sampling approach was taken, we think it would be important for all organisations to follow a consistent method of recording costs.

Question 5: How frequently do you think licensees should be required to provide this information?

We are pleased that the frequency with which licensees should provide costing data is being considered. However, in our view there is little argument for moving away from the current pattern of annual submissions.

Overtime, we would welcome further consideration of a multi-year fixed price once the system had stabilised, although we recognise there is a balance between tariffs based on costing data that reflect the most up-to-date practice as possible and price stability to underpin planning.

Even if there was a move to longer-term tariffs, we believe the recording of data should continue on an annual basis and could provide a reference sample to ensure that any multi-year tariff remained appropriate.

The HFMA would also welcome a reduction in the inherent time delay between the collection of the cost data and the publication of the tariff based on that data (2012/13 tariff is based on the reference costs submitted for 2009/10).

Question 6: Do you think that it is necessary for us to be able to request assurance reports from licensees on information that they submit to us? Please give reasons for your answer.

The HFMA agrees that in principle third party assurance in relation to important data submissions would support improvement in the quality of the data concerned. This would also provide assurance that licence conditions continue to be met. However, we would welcome a proportionate approach to requiring assurance reports from licensees in relation to submitted information. In our view, a variety of sources of assurance could support this process including self-assurance and board certification.

We believe that it is important to balance quality against the additional cost of such external assurance work. We would suggest further consideration should be given to the use of the Materiality and Quality Score (MAQS) – a self-assessment tool included within the *Clinical costing standards* to help organisations assess the quality of their patient level costing data. Use of this self-assessment could be supported by external audit undertaken within a sample of organisations.

In our view, where external assurance is used, audits should be of sufficient detail and carried out by auditors with sufficient costing expertise to provide assurance for both the organisation and the regulator that processes and data quality are suitably robust to inform the national tariff.

Question 7: Do you have any suggestions as to how we could minimise the costs associated with requiring assurance reports without reducing the benefits we envisage?

In our view, the costs associated with requiring external assurance reports could be mitigated by making use of a variety of sources of assurance. This could include the adoption of stringent self-certification which may be tied to other quality and/ or governance indicators. The HFMA would suggest that this approach could make use of the Materiality and Quality Score (MAQS) as noted in question 6 above. This method of self-assurance already exists and enables organisations to self-assess the overall quality of their patient level costing information and provide assurance within the organisation about the quality of costing data. Organisations that have used the tool also report that it provides useful insight into where to target improvement efforts in their costing processes. The *Clinical costing standards* support the use of an annual MAQS assessment (Standard 9). It should be noted that the standards also recognise the need for organisations to undertake regular audit of their patient level costing systems and information (Standard 10).

It may also be appropriate to consider the role of peer group review perhaps through an annual panel to identify those organisations that have invested sufficient time and thoroughness to submit high quality data.

The HFMA recognises that external audit would provide a vital and independent means of assurance in relation to data that is going to be used to determine the national tariff. It does however attract a financial cost which many organisations may find an additional challenge. Therefore, in our view, such assurance would be best focused on high risk organisations identified by clear and transparent criteria, which could include a low MAQS score.

Question 8: Can you suggest other methods we could use to ensure that we obtain good quality information from licensees?

The HFMA supports the use of the *Clinical costing standards* for patient level costing across all NHS providers (foundation and non-foundation organisations). Patient level cost data can provide a powerful tool to understand cost variations and adherence to the standards will lead to greater consistency in assigning costs to patients and lead to an improvement in the underlying costs data used to inform tariff.

In our view, the increased use of the *Clinical costing standards* would provide advantages at both a local and national level although we recognise that a clear pathway to implementation across all organisations would be needed to achieve this.

In addition, if a sampling approach was to be taken to constructing the national tariff, we would support the use of data supplied by organisations using patient level costing data. Consistency through the adoption of the costing standards would also be maintained if the organisations that formed the sample changed over time. In our view, consideration would also be needed in relation to managing entry and exit from the sample.

The HFMA would also welcome a review of the data dictionary to ensure it dovetails with the latest PbR guidance. For example, the data dictionary currently suggests that a patient seen on the ward by a different consultant is an outpatient attendance whereas PbR considers tariff for outpatient attendances relates to pre-booked attendances. We would suggest that a consistency in terminology and the definitions used would be helpful.

Question 9: Do you agree that requiring licensees to comply with the National Tariff, even though it would already be a requirement of the Bill, would allow us to take timely and effective enforcement action? Please give reasons for your answer.

The HFMA agrees in principle that licensees should be required to comply with the national tariff through the conditions of their licence. It would also be helpful if the method by which compliance was to be assessed was also included within the Compliance Framework.

However, it would also be important to ensure there was clarity about allowable flexibilities, setting out if and when local health economies could deviate from tariff.

Question 10: Is there anything additional that you think we could or should do in order to encourage commissioners to comply with the National Tariff? Please give reasons for your answer.

We are pleased to see this question included within the consultation as it is important to recognise the role of commissioners in making a rules-based payment system operate effectively. We do have concerns however that if providers must comply with the national tariff or risk losing their licence, without further safeguards the responsibility will rest with the providers to make sure commissioners are compliant.

We acknowledge that Monitor has no role in the regulation of commissioners, however we feel it is important that the NHS Commissioning Board is in agreement with the underlying principles of a national tariff for the services it will commission and on behalf of clinical commissioning groups. It would therefore seem appropriate to expect the NHS Commissioning Board to hold commissioners to account in instances where they should but do not comply with national tariffs.

Linked to this concern, we would welcome its reflection in any future joint memorandum of understanding between Monitor and the NHS Commissioning Board.

Engagement process

Thank you for responding to this engagement document. Please save this document and email it to licensing@monitor-nhsft.gov.uk with 'Pricing Licensing Conditions' in the subject line.

Alternatively, you can fax your response to 020 7340 2401, or post it to:

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This document *Developing the Pricing Licence Conditions: Stakeholder Engagement Document* was issued on 16 December 2011. Please submit your responses to the questions and any other comments that you have by 5pm on 23 January 2012. There will also be subsequent opportunities to respond to our licensing engagement documents.

If you wish to do so, you can request that your name and/or organisation be kept confidential and excluded from the published summary of responses. Please tick this box to ensure confidentiality. ☐