Healthcare Costing for Value Institute

HFMA's response to *Mandating patient-level costing for NHS community services* consultation document[1]

January 2021

Who we are

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA's Healthcare Costing for Value Institute champions the importance of value-based healthcare for supporting the delivery of high-quality financially sustainable healthcare. Through its member network, it supports the NHS to improve costing and make the most of patient-level cost data to drive improvements in patient care and deliver efficiencies. By bringing together senior finance and clinicians to explore what value means, the Institute helps the NHS to turn the theory of value into practice and make value-based healthcare a reality.

[1] NHS England » Mandating patient-level costing for NHS community services

Introduction

The HFMA and its Institute have been strong advocates for robust patient-level cost (PLICS) data for a number of years. We therefore fully support the mandation of PLICS across NHS community services. However, we do not support the mandation of PLICS in line with the methodologies and approaches in the current Healthcare Costing Standards for England, nor the move to a quarterly cost collection.

The remainder of this paper explains our reasons for these views, and addresses the questions included in the consultation document.

The Healthcare Costing for Value Institute's Council and Costing Group are keen to work with NHS England and NHS Improvement on all aspects of costing and welcome further involvement in future costing developments.

To what extent do you agree with mandating patient-level data for community services in line with the methodologies and approaches in the Healthcare Costing Standards for England from 2021/22?

We fully support the mandation of PLICS for community services.

Costing has a major role to play in supporting the delivery of sustainable services across the NHS. It should underpin decision-making, ensuring local decisions made by clinical teams are informed by a clear understanding of current costs and the likely costs of new ways of working. Good cost and activity data at the patient level can help health economies to understand variations in care between different patients, helping to optimise service delivery.

Robust cost data for acute, mental health, ambulance and community services is crucial to delivering the right care to the right patient in the right place. PLICS information is integral to the decisions that need to be made across multiple services, pathways and organisations in order to manage current services and determine the future models of care. It is also key in understanding the underlying financial positions of systems and supporting the renewed focus on the efficiency agenda.

The absence of PLICS data for community services could lead to the value of community care not being well understood and potentially overlooked when considering service transformation within local health economies.

However, we strongly disagree that PLICS for community services should be mandated in line with the methodologies and approaches in the Healthcare Costing Standards for England.

In October 2019 we wrote a paper for Chris Walters, setting out what HFMA members think that good looks like for costing standards and explaining how the current standards fall short against these criteria (*Healthcare acute costing standards for England – Recommendations October 2019*[2]). While our recommendations focus on the acute sector, the conclusions apply to all sectors including community services.

[2] hfma-institute-recommendations-ncc-acute-standards-oct-2019.pdf

The HFMA published a briefing in December 2020 *The future NHS financial regime in England: recommendations*[3] reconfirming our views about the current costing standards, noting:

'There should be a review of the current national costing requirements for all sectors of the NHS. Robust costing information is essential and costing standards must follow the principles of being proportionate, achievable, deliver high quality comparable cost data, easy to understand and provide useful information for local and national use. The current arrangements fall short when assessed against these principles.'

Do you agree with the proposal to cease collection of reference costs for community health activity from 2021/22?

If PLICS is mandated for 2021/22, then we agree that the collection of reference costs should cease from 2021/22. The small costing teams in community services would struggle to produce two submissions if reference costs were to run in parallel with PLICS.

However there are likely to be some services where patient-level data is not collected or available in the required format, so there may still need to be a reference cost workbook to submit aggregated costs and activity for these services.

Do you have any comments on our assessment of the likely costs?

Members reported a number of factors that need to be taken into account when considering the likely costs:

- It is hard to quantify as input is required from informatics staff, management accounts, service managers and costing.
- Not all trusts start at the same place. Trusts who also have acute services will have a better starting position as they have already produced patient-level costs for acute services. In contrast, community trusts will start from a lower starting position, as they are less likely to have invested in costing resources in recent years.
- It should be recognised that additional resources are needed not just in the costing team, but also within the informatics team to improve the level of data quality required.

In principle, do you support the move to a quarterly cost collection for the community health sector?

We strongly oppose the move to a quarterly cost collection for the community health sector.

We understand the need for, and support in principle, the move to timely costing information being made available nationally. However, our members have expressed significant concerns about the burden of submitting cost data on a quarterly basis. Costing practitioners already find the annual cost collection onerous for a number of reasons:

[3] The future NHS financial regime in England: recommendations (full report) (hfma.org.uk)

The current costing standards are not proportionate

The level of resources consumed to produce the cost data as specified by the standards is not proportionate to the benefits they provide. This has an impact on the quality of the costing data and means that there is little time for costing data to be used locally to support improvements in efficiency and value.

Further detail on why members say the current costing standards are not proportionate can be found in *Healthcare acute costing standards for England – Recommendations October 2019*[4].

Trusts are often running two PLICS systems

A significant proportion of the members of the Institute Costing Group run two different PLICS systems in order to:

1. be able to meet the National Cost Collection (NCC) requirements; and

2. provide data in a format asked for by local finance directors and clinical teams.

The annual national submission takes up a lot of time, requiring significant manual interventions, but the data submitted is not used locally. The move to quarterly collections would result in costing teams spending a disproportionate amount of their time producing NCC returns with very little time to engage with clinical teams.

The recruitment and retention of costing staff is a challenge

Our members report that they struggle to recruit and retain finance staff with costing skills, which means that small costing teams struggle to meet the requirements of the NCC and support the use of cost data locally.

These challenges mean that our members are concerned about the proposal to move to a quarterly collection of PLICS. However, we believe that it is possible to significantly reduce the time spent on national cost collections while improving the standard of costing outputs and their use. We would welcome the opportunity to work with NHS England and NHS Improvement on this.

Building the foundations for community services

In addition to the points made above, it should be noted that significant work is needed to get the basic foundations (see next section) in place before many trusts will be able to produce robust community PLICS data annually. A quarterly collection would mean that trusts would not have the time to build the foundations, which would result in data being submitted which was not reliable or accurate enough to be used to make decisions on.

[4] hfma-institute-recommendations-ncc-acute-standards-oct-2019.pdf

Do you have any other views or comments to make on the proposals?

We feel that three further items should be taken into account:

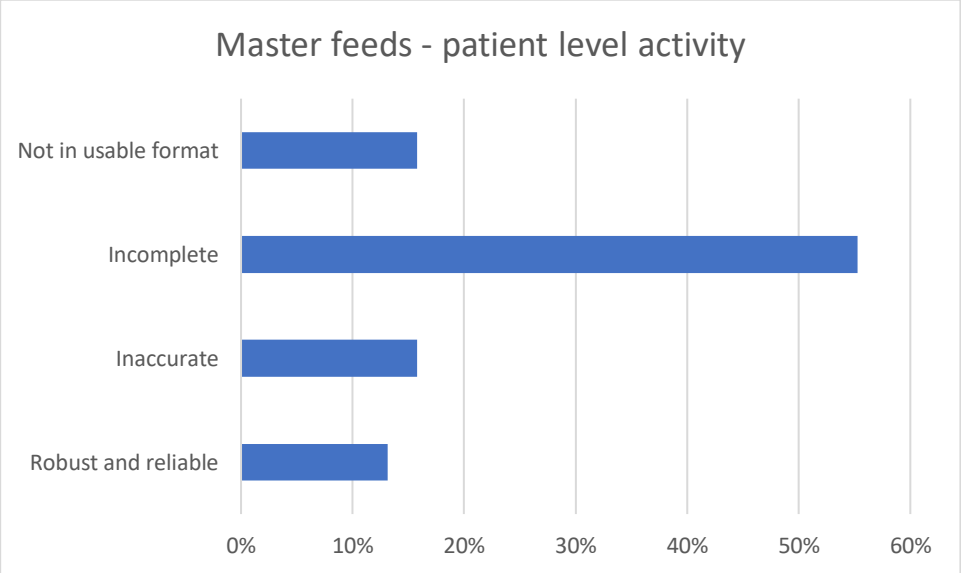
- the quality of non-financial data required for costing
- currencies for community services
- readiness of community services to implement PLICS

The quality of non-financial data required for costing

To generate reliable and robust cost information, costing accountants need access to high-quality data that describes the needs of the patients and the treatments received. Even with the best costing processes in place, if the data from the clinical and operational feed systems is of poor quality, this will lead to inaccurate cost data.

To gain a better understanding of the current practical challenges in obtaining good quality data for use in costing, the Institute surveyed its members in July and August 2020. We received 38 response from trusts with community services. They reported significant concerns about the quality of the core patient-level activity feeds required for costing, with only 13% of trusts reporting the data as robust and reliable (figure 1).

Figure 1: Quality of core patient-level activity feeds – community services



Source: Institute survey of members July – August 2020

Members report that data completeness and quality are huge issues for community services, with some services still using paper records. Historically the level of investment in informatic infrastructure in community services has tended to be low, as income has not been dependent on the quality of the recorded quantity of healthcare outputs. Not all activity carried out is captured, and where it is the quality does not always reflect what the teams actually do.

While we agree that the implementation of PLICS and the use of cost data by clinical teams will drive improvements in the quality of non-financial data, the very poor quality of the current data should not be underestimated. Until data quality improves substantially, some of the benefits of implementing PLICS in community services are unlikely to be delivered, for example understanding the use of healthcare resources across patient pathways and multiple organisations.

Currencies for community services

The NHS defines a currency as '*a way of grouping patients' activities into units that are clinically similar and have broadly similar resource needs and costs. Each unit of currency must be evidence-based and analytically identifiable, but most importantly it must be clinically meaningful. The currency must be rooted to the care the patient receives and be practical to implement.'* [5]

The current currency for community services are care contacts, which are the units costed to generate PLICS.

'A Care Contact is a general term for a contact or appointment between a person and a care professional. At a care contact, one or more care activities may take place, such as an assessment or a minor procedure. Contacts may take place face to face or via another means, such as online or by telephone.'[6]

Contacts are not considered to be a robust currency for community services, providing little information on the nature of the care provided, and not necessarily consuming similar levels of resources.

We are aware of the work being undertaken to develop community currencies. Until a robust set of currencies is rolled out for community services, some of the benefits of implementing PLICS for community services cannot be fully realised, for example reducing unwarranted variation and supporting the development of new models of care.

Readiness of community services to implement PLICS

Compared with the acute sector, community services are significantly behind in terms of technology and the recording of data. What proportion of organisations with community services have taken part in the voluntary submission process? Has it provided NHS England and NHS Improvement with enough information to understand how well the rest of the sector will cope with the mandation of PLICS?

[5] NHS, *A New Approach to Supporting Community Healthcare Funding*, May 2019
[6] Care contacts - NHS Digital

Contact

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