Strategic Options for Costing – Monitor's stakeholder engagement August 2012

Submission from the Healthcare Financial Management Association (HFMA)

Introduction

The HFMA is the representative body for finance staff in healthcare and – for the past sixty years – has provided independent and objective advice to its members and the wider healthcare community. We are a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through our local and national networks. We also analyse and respond to national policy and aim to exert influence in shaping the wider healthcare agenda. We have a particular interest in promoting the highest professional standards in financial management and governance and are keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

Our comments draw on the expertise of finance directors and costing practitioners across the NHS as well as the HFMA's national committees.

Summary of key points

- HFMA supports the development of a standardised costing methodology across the NHS. HFMA have revised and updated the clinical costing standards on behalf of the Department of Health for the past two years, in recognition of the need to develop guidance to support patient level costing and to standardise costing methodology.

- HFMA would welcome the opportunity to work with Monitor going forward, to build on and further develop the clinical costing standards for acute and mental health organisations.

- HFMA would support mandating the clinical costing standards in order to achieve greater consistency in costing.

- However, HFMA recognises that mandating a standardised costing methodology will not in itself result in accurate cost data, there will be other factors to consider alongside this.

- HFMA is broadly in agreement with a representative sampling approach. We recognise that in the shorter term working with a smaller group of organisations

will allow Monitor to develop the guidance and collection capabilities to process patient level cost information.

- However, in the longer term Monitor should aspire to cover as many of the provider population as possible. There is a danger that a sample will not be seen to be representative. (The sample would need to be representative in terms of geography, teaching versus non teaching, specialist versus non specialist and cover the range of specialties. At the same time, it would need to comprise organisations with good, detailed patient level costing in place). There is also the risk that organisations outside the sample may disinvest in costing, resulting in increasing self selection in the sample.

- HFMA would support Monitor continuing to collect cost information from all organisations not only to enable the calculation of the national quantum but also to encourage all trusts to continue to invest and develop their costing capability.

- HFMA supports the move towards a patient level cost data collection rather than relying on the submission of average costs. However, members have expressed concern over the timescales set out in the report. They will be incredibly challenging.

- In theory, HFMA supports a process of self-assessment and peer review. The MAQ score is a useful tool to use as an indicator of costing quality. HFMA is undertaking a programme of work during 2012 to test the MAQ score and receive feedback on its practical application. HFMA would be happy to work with Monitor on this programme of work to accelerate this process and ensure the MAQ score is fit for purpose.

- HFMA would also support the use of peer review, in order to gain assurance over the quality of cost data. However, this will require careful thought and planning in order not to place undue burden on patient level costing professionals (who are already currently limited in number) and to ensure that all peer reviewers have the skill set required to assess different organisations facing different issues.

- The HFMA do not see any reason why the principles set out in the report should not apply to mental health and community organisations and services. However, we would express caution over the timescales for achieving this because of the relatively low baseline from which costing in these organisation is developing from, and the range of issues facing the development of costing in these organisations.

1. Introduction

1.1 The HFMA is pleased to contribute to Monitor's strategic options for costing review and would be very happy to elaborate on any of the issues raised if that would be helpful. HFMA is also happy to work with Monitor in the coming months to use the costing expertise available to support the development of Monitor's costing strategy.

1.2 Our submission is based on the views of our members who work across the NHS and reflects their experience of delivering tangible improvements in the financial and operational environment year after year. We have focussed on those issues highlighted by Monitor in the June "strategic options for costing" report.

1.3 The HFMA fully supports PWC's recommendations to improve the quality of costing within the NHS. We believe that the report accurately reflects the current and medium term issues and recommends pragmatic solutions on how to move forward.

1.4 We also believe that the improvement in the art and science of costing will better equip the NHS to better evaluate emerging care models as providers and commissioners deal with the changing economic and demographic landscape (for example, year of care, value based healthcare).

1.5 The three main concerns raised by our members are:

- Collecting costs from a representative sample only for tariff calculation purposes. The main concern relates to how a representative sample will be determined.
- The challenging timescales set out for implementing the recommendations in the report.
- The timescales for developing costing to mental health and community organisations and services given the future direction of price setting is still in development.

2. Stakeholder engagement questions

2.1 **Do you have any comments on the need for further development of a standard costing methodology?**

2.1.1 HFMA fully support the development of a standardised costing methodology across the NHS. HFMA has revised and updated the clinical costing standards on behalf of the Department of Health for the past two years, in recognition of the need to develop guidance to support patient level costing and to standardise costing methodology.

2.1.2 HFMA would also fully support mandating the clinical costing standards to achieve greater consistency in costing. At present the guidance is published as best practice. If organisations only choose to follow sections of the guidance it makes comparing patient level cost outputs problematic.

2.1.3 However, HFMA recognises that mandating a standardised costing methodology will not in itself result in accurate cost data, there will be other factors to consider alongside this. These include:

- The adoption of costing methodologies by software suppliers.
- Investment by organisations in underlying information systems.
- Acknowledgement of the importance of, and some of the inconsistencies in coding and the application of the grouper. This is particularly important to support the identification of specialist services. The availability of finance professionals with expertise in patient level costing.

2.1.4 HFMA acknowledges that at present the clinical costing standards provide guidelines on how to cost. In order to provide greater accuracy in cost information, more detail will be required on "how" to cost. It is our view, that this detailed guidance could be incorporated into the current clinical costing standards. For example, standard 3 –

allocating costs – provides the principles for allocating costs. However, more detail could be incorporated in sub-chapters focusing on the most material cost pools first. For example, how to cost theatres (looking at costing emergency capacity, costing consumables, costing the true staff input into theatres), costing wards (focusing on nursing acuity etc). HFMA would be happy to discuss these ideas with Monitor and work through the timescales by which further detail could be incorporated.

2.1.5 We would like to note that the HFMA clinical costing standards are prospective in their application. The standards for 2013/14 will be published just before the start of that financial year, to allow organisations to implement any changes required or put in place new data capture systems and processes. Cost collection guidance, which will be retrospectively applied, will still be required to support a patient level cost collection to set out the format of costs required for submission.

2.1.6 HFMA members have requested that detailed guidance around the quantum of costs to be included in cost submissions and which costs should be included and excluded is developed as part of more detailed costing methodology guidance

2.2 Do you agree that Monitor should move towards collecting a representative sample of more granular patient level data to inform price setting?

2.2.1 HFMA fully support moving to a patient level cost data collection to support tariff calculation. This will provide more granular data on which to set prices and provide greater transparency of data submissions and data quality. The increased granularity may also allow for a more sophisticated analysis of separation from the mean or median and use of standard deviation and standard error in the calculation of prices.

2.2.2 HFMA are broadly in agreement with a representative sampling approach. We recognise that in the shorter term working with a smaller group of organisations will allow Monitor to develop the guidance and collection capabilities to process patient level cost information.

2.2.3 In the short term, HFMA would suggest that the MAQ score could be used to set the "bar" in terms of the quality of an organisation's costing.

2.2.4 However, in the longer term Monitor should aspire to cover as many of the provider population as possible. There is a danger that a sample will not be seen to be representative. (The sample would need to be representative in terms of geography, teaching versus non teaching, specialist versus non specialist and cover the range of specialties. At the same time, it would need to comprise organisations with good, detailed patient level costing in place). There is also the risk that organisations outside the sample may disinvest in costing, resulting in increasing self selection in the sample.

2.2.5 HFMA would support Monitor continuing to collect cost information from all organisations not only to enable the calculation of the national quantum but also to encourage all trusts to continue to invest and develop their costing capability. Collecting data from all organisations may be seen as onerous however, it sends out a strong message that costing is a "core" function for organisations. HFMA can assist in

the communication of "why" and support in the "how", which will be crucial in getting the deep engagement of organisations and their practitioners in order to achieve the high quality outputs.

2.3 Do you agree that assurance processes should be focussed on self-assessment and peer review with targeted approach to external assurance?

2.3.1 HFMA supports the recommendation for board level sign off of reference costs in principle. We feel this would be an important development for two reasons:

- To ensure board awareness of costing development as an important feature of tariff setting
- To ensure proper resources are focused upon the task,

2.3.2 However, the timing of this sign off may need to be considered. Organisations may be required to convene a specific board meeting in order to obtain sign off or the board may require evidence before signing off that may not be available until June / July when cost calculations and reviews are complete. We would suggest that boards would be able to sign off on the processes undertaken to calculate costs rather than the actual costs calculated within current reporting timescales.

2.3.3 We believe that assurance should come from the mandating of key items – such as mandating costing guidance such as the HFMA clinical costing standards. We also believe that tangible measures should be mandated to assess an organisation's competence in costing (e.g. use of the MAQ score) rather than just a subjective checklist approach and that all organisations should be required to calculate and report the MAQ score (even if they don't score well).

2.3.4 In theory, HFMA supports a process of self-assessment. The MAQ score is a useful tool to use as an indicator of costing quality. HFMA is undertaking a programme of work during 2012, to test the MAQ score and receive feedback on its practical application. HFMA would be happy to work Monitor on this programme of work to accelerate this process and ensure the MAQ score is fit for purpose.

2.3.5 HFMA would also support the use of peer review, in order to gain assurance over the quality of cost data. The review of cost data by costing experts would allow a greater depth of review and would also facilitate the sharing of best practice amongst costing professional.

2.3.6 However, this will require careful thought and planning. At present finance professionals with experience in patient level costing are limited in number. It will take time for the supply of finance professionals with this skill set to increase. HFMA is committed to support costing professionals in their development and the vital role they play within organisations.

2.3.7 There are a number of issues with peer review that will require consideration including:

- Training for those participating.
- Compensation for those organisations participating.
- How detailed a peer review would be.
- Moderating process to ensure consistency of application by reviewers

2.3.8 HFMA would also still see a role for external assurance. This could be applied to organisations where there is the greatest concern about the quality of data, as identified by the MAQ score or by the peer review process.

2.4 Do you have any comments on the practicality of implementing the recommendations in the timescales indicated in this report?

2.4.2 HFMA support the need to change the way costs are collected to support tariff calculation. However, the timescales set out in the report are very challenging. HFMA would support a pilot collection in 2013 in order to test costing guidance and collection on a smaller number or organisations.

2.4.3 HFMA would request that the burden to organisations of submitting reference costs and also a sample data collection in 2013 is considered.

2.4.4 We would like to note that the HFMA clinical costing standards are prospective in their application. The standards for 2013/14 will be published just before the start of that financial year, to allow organisations to implement any changes required or put in place new data capture systems and processes. Cost collection guidance, which will be retrospectively applied, will still be required to support a patient level cost collection to set out the format of costs required for submission. Therefore if any changes will be required to the 2013/14 clinical costing standards there is a small window of opportunity (between now and the end of the calendar year) to consider these prior to publication in early 2013.

2.5 Do you agree that the recommendations in this report are also applicable to MH and community services and do you have any views on how they could be implemented in these settings?

2.5.2 The HFMA fully supports the development of costing and costing guidance in mental health and community services. This will obviously need to be linked to emerging thinking on “currencies of care”

2.5.3 We will need to recognise the emerging landscape of community providers (some being linked to local acute hospitals, local mental health hospitals and community foundation trusts. There will be a lot of new work in emerging care packages liberating the possibilities of care closer to home.

2.5.4 However, we acknowledge that costing is currently being developed in these services from a lower baseline, and that timescales would need to be carefully considered. HFMA is currently discussing how to develop costing guidance for community services with member organisations. We understand that the activity data available in

many services is not readily available to support patient level costing. Activity data has to be collected from disparate systems and paper collections.

2.5.5 In addition we understand that guidance / rules on how to record activity data for community services is not as developed as the acute sector. This would need to be considered before the development of collection of cost data.

2.5.6 In theory, patient level costing in mental health would produce a daily cost per patient. These costs could then be aggregated into clusters depending on how the cluster is to be defined in time terms. However, feedback from our members suggest that greater clarity is required on how cluster prices will be set in terms of time in order to facilitate the development of costing systems to support this.

2.5.7 The HFMA clinical costing standards for mental health were fundamentally reviewed during 2011. However, there is still a significant amount of work to be undertaken. Mental health organisations have only started to collect the activity data to support clusters during 2011/12 and the capture of this underlying patient activity will take time to develop. Patient level costing will also only improve in its accuracy once electronic data regarding patients, interventions and treatment is captured and accurately recorded.

2.5.8 Therefore the timescales for inclusion of mental health services in a sample for price setting will require careful consideration. However, HFMA's mental health costing practitioners group would welcome the opportunity to discuss this further with Monitor.

2.6 Other Comments

2.6.2 HFMA would fully support the collection of patient level cost data at cost pool level. HFMA will be reviewing standard 2 – creation of cost pool groups during 2012. HFMA would welcome the opportunity to work Monitor on this, to ensure that there is absolute clarity about what costs should be included within each cost pool group.

2.6.3 Whilst HFMA understands the recommendation to collect reference costs at a cost pool level, we would question whether this would place an undue burden on organisations to achieve this, when time and resource would be better spent developing patient level costing systems and information flows.