Healthcare acute costing standards for England

Recommendations

October 2019

Summary

Introduction

The HFMA met with Chris Walters, Director of Pricing and Costing at NHS England and NHS Improvement (NHS E&I), in September 2019 to discuss the concerns raised by the HFMA Healthcare Costing for Value Institute members about the national cost collection (NCC) as outlined in their report.[1]

One area of concern was the healthcare costing standards for England for the acute sector (the standards), which members felt were too complicated and included elements which were unnecessary, impractical or impossible to implement. More experienced costing practitioners queried whether those newer to the profession would be costing accurately, given the complexity and length of the standards.

It was agreed that the HFMA Institute would review the standards and provide a list of recommendations.

The findings and recommendations in this report are based on:

- observations of members of the Institute Council
- meetings held with a sub-group of the Institute Costing Group
- a survey of the Institute's wider membership.

[1] https://www.hfma.org.uk/publications/details/national-cost-collection-views-of-institute-members-august-2019

The importance of robust patient-level cost data

The HFMA and its Institute have been strong advocates for robust patient-level cost data for a number of years.

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.

Costing standards

The HFMA recognises the significant progress NHS E&I has made in developing new costing standards. We welcome their ambition and note the significant undertaking to roll out patient-level costing (PLICS) to all sectors over a relatively short period of time.

2019 was the first year that all acute trusts were required to submit cost data using the new costing standards. Understandably the process has raised a number of challenges, in part due to the move from reference costs to PLICS where the greater level of granularity has unearthed a range of existing issues.

Our members' view is that this is a good time to reflect on the current set of standards, and consider what changes are required to ensure that a proportionate approach is taken to costing, delivering high quality comparable cost data for both national and local use.

What does good look like?

Members have developed a set of criteria against which to measure the costing standards. Figure 1 describes what they think good looks like.

Figure 1 What does good look like for costing standards?

Proportionate	The level of resources consumed to produce the cost data as specified by the standards needs to be proportionate to the benefits it provides.
Achievable	The standards should be achievable in all trusts using data that is already mandated in a national data set.
Deliver high quality comparable cost data	The standards and associated tools should support trusts to produce high quality cost data in a consistent manner. This includes providing clear messages on how and where to focus their efforts on improving the quality of costing.
Easy to understand	The standards should be easy to read and understand.
Provide useful information for local and national use	The standards should generate useful information for local use to support improvements in efficiency and patient care. At a national level the standards should generate data which is useful for setting prices and creating national benchmarking data sets.

Members' views are that the current standards do not currently meet this set of criteria. Their reasons are outlined in this report, together with recommendations on how to improve the standards.

The main messages are set out below.

Proportionate

The level of resources required to produce the cost data means that costing practitioners have little time to support clinical teams use PLICS data. A simplified activity/resource matrix and a greater focus on materiality would significantly reduce the cost of production. The number of cost allocation methods required would be reduced and the production process would be shortened. Removing the mandatory requirement to map the general ledger to the cost ledger would also reduce the cost of production substantially.

Achievable

Rather than being a core minimum set of standards which all trusts can achieve, the current standards are aspirational. The standards should be achievable by all trusts, only requiring activity and resource consumption data that is already available in a mandated data set. Aspirational approaches that will make a significant difference to the quality of the information produced should be included as 'superior methods.' As a norm, clinicians should be involved in standards development, thus ensuring that the approach is achievable and makes sense from a clinical perspective.

Deliver high quality comparable cost data

The costing assurance tool does not provide trusts with sufficient information to assess and improve the quality of their costing, nor allow trusts to identify the quality of cost data of other trusts when benchmarking. Our report lists the minimum information requirements needed to support trusts on how and where to focus their efforts on improving their costing.

Easy to understand

The current standards are very long, complicated and confusing, and often contradict each other. There is scope for a complete refresh on how the standards are compiled. This will increase compliance and improve the accuracy of cost data.

Provide useful information for local and national use

The volume of data produced by the NCC means that trusts struggle to use the outputs locally. A simplified activity/resource matrix would reduce the amount of data generated. There are concerns about the quality of the data submitted in 2019. Until the quality of the data has stabilised and improved, it does not provide a reliable date set for national use.

Next steps

Our members' view is that a new set of standards should be worked on in time for 2021, which as a minimum should take account of the recommendations in this report. While this report focuses on the acute sector, most of the recommendations are relevant to acute, community services and mental health. The HFMA Institute members are keen to work with NHS E&I on the new set of standards.

In the meantime, we welcome the fact that NHS E&I continue to work on the current set of standards and look forward to the November release of draft standards and guidance for 2020. We will submit our views during the review and feedback process.

The following sections of the report provide further detail on each of the criteria, together with recommendations for change. The italicised quotes are from respondents to our members' survey. The final section provides a summary of all the recommendations.

Proportionate

The level of resources consumed to produce the cost data as specified by the standards needs to be proportionate to the benefits it provides.

The view of members is that the standards are not proportionate. The level of resources (figure 2) required to implement the standards is very high, which means that costing practitioners have little time to support clinical teams use PLICS data within their trusts.

Figure 2: Staffing resources required to implement the standards

Locally
Costing practitioners
Other finance professionals
Informatics
Clinicians
Costing software suppliers
Nationally
NHS E&I costing team
NHS Digital staff

> *'The burden of the national cost collection needs to be reduced. Costing teams need to be able to use their costing data internally and give some benefit back to the trust through deep dive processes looking at expenditure reduction and improved productivity. The best quality costing outputs come from trusts that have engaged clinicians/ service managers/ finance managers/ finance director etc – the larger the burden of the national cost collection, the less time costing teams have to use and improve the data internally.'*

The next sections discuss specific areas where we think there is scope to reduce the cost of production as follows:

- materiality
- activity/resource matrix
- mapping the general ledger to the cost ledger
- cost allocation methods
- data fields
- production process.

Materiality

The NHS E&I costing principles highlight that good costing should focus on materiality. Members would like materiality to be referenced throughout the standards, so that they focus on material items.

> '*The costing methods state that all areas of this guidance has equal importance. I do not believe this sends the right message. I think costing professionals should start with their most material costs and concentrate on getting the highest cost areas right first, before moving on to low value areas. Next - look at costs that make a material difference in a specific area.'*

The materiality threshold set by NHS E&I in the standards has an impact on the amount of work required. The current threshold of 0.05% of a trust's expenses is felt to be too low. Members' view is that setting the materiality level at 1% would significantly reduce the time taken to complete the NCC, reduce the number of data validation challenges they are required to review, and importantly not have a detrimental impact on the quality of the cost data produced.

Activity/ resource matrix

The central focus of an activity-based costing system is the activity/resource matrix. NHS E&I's approach has been to adopt a very large, but therefore very sparsely populated, matrix. This imposes a lot of work in defining rules for the very large number of intersections, produces a very high volume of lines of reported data and increases the run time for production.

While in theory this should result in very tightly specified and thus high-quality cost data, in practice it has increased the demands placed on those producing the cost data and almost inevitably reduces quality as there are too many details to be managed given the time and resources available.

An alternative approach would be to have a more limited and aggregated structure of resources and activities. This would combine more items together, therefore reducing the cost of production and reporting. In many cases the individual line items of the current activity/ resource matrix are likely to be financially immaterial and/or irrelevant from the perspective of exercises aimed at improving cost effectiveness and patient care.

A straw poll indicates that a small number of resource and activity IDs account for a very high proportion of the cost quantum (figure 3).

Figure 3: Small number of resource and activity IDs account for high proportion of cost quantum

'We use 139 of the 257 possible resource IDs, and 67 activity IDs out of approximately 200. Our total matrix of collection activity/resource is 17.7 million rows. 52% of the rows have less than 10p allocated and therefore in total these account for just 0.02% of the total value.'

'We are using 144 of the possible 257 resource IDs in our 2018/19 cost submission. Only 25 of our 144 resource IDs account for 80% of the total quantum. There are many resource IDs which only account for a few thousand pounds. If our trust wanted to know how much we had spent on patient data systems, we wouldn't look to the costing system for that data, we would look to the general ledger. If a service lead looks at the costs which contribute towards a patient's care, they aren't interested in how much has been spent on packing and storage, but will be interested in consultant and nursing costs.'

'We use 140 of the possible 257 resource IDs. 26 of them account for 80% of the total quantum, while 40 of them account for 90% of the quantum.'

Mapping the general ledger to the cost ledger

The costs in the general ledger need to be mapped to a defined set of resources, before resources are allocated to activities. The standards require the general ledger to be first mapped to a standardised cost ledger, before the costs are mapped to resources. Our members state that this is a time-consuming process that in their view adds little value.

> *'The whole general ledger mapping process is very confusing and onerous – the guidance is long winded and confusing – there are too many iterative processes. We mapped the general ledger straight to the collection resources.'*

> *'We have several problems and concerns with the auto-mapper primarily being the coding based on descriptions which can be misleading. For example, last year following analysis with the management accounts team we had to change quite a bit of both the standard and auto-mapped ledger to ensure it was coded correctly. In our view trusts need to be given the autonomy to be able to map the general ledger appropriately using clear definitions of the resources.'*

> *'Mapping the general ledger to cost ledger adds significant amounts of time to the workload, without much benefit. I realise that the costing team should fully understand the general ledger, but this should be a part of the guidance rather than having to do an overly complicated resource mapping. For the past two years submissions we have attempted to complete this mapping (unsuccessfully). It took a significant amount of time that should have been used checking prices or allocations. This year, we mapped to the collection resources only (using the resources as a guide where there were queries). This has worked better as it means we didn't have to spend as much time on this process.'*

Rather than mapping the general ledger to a cost ledger and then mapping the cost ledger to resources, our members suggest directly mapping the general ledger to a defined list of resources.

One approach would be to use the recognised structure contained in the NHS E&I financial management returns (specifically the PFR worksheet). Organisations already categorise their costs within the general ledger using the PFR codes. Should additional levels of detail be required in order to analyse costs appropriately, most general ledgers have the capacity to do this within the hierarchy of their coding structure.

Cost allocation methods

The number of different cost allocation methods listed in the technical document creates a huge burden on costing practitioners.

> *'The technical document details a different allocation method for every single ledger line subjectively and identifies a different method for each. This is impossible and in reality most trusts will allocate all costs within a specific department (with the exception of consultant costs) using the same methodology. This needs to be simplified at least for the next two years.'*

> *'The level of costing required in some areas is impossible– for example SCM 13 Medical secretary – allocate these costs according to the number of letters typed!!!!'*

If the standards had a greater focus on materiality and the activity/resource matrix was simplified, this should reduce the number of cost allocation methods required.

Data fields

The current standards require trusts to collect activity data which is either not required for costing or of little value, creating additional and unnecessary work for trust staff, and increasing the cost of production (figure 3). This is discussed more fully in the next section.

Figure 3: Examples of data fields in the standards which are not required for costing or add little value

- medicines dispensed – dispensing healthcare professional code
- payroll feeds
- contrast agent
- clinical photography
- language code
- date/time for pharmacy, radiology, pathology
- critical care shift data
- start and end time of each individual procedure while the patient is on the table
- A&E treatment and investigation codes
- outpatients diagnosis codes
- did not attend

Production process

While trusts recognise that they have to undertake some additional work to submit their PLICS data nationally, members report that the complexity of the standards means that producing the information required for the NCC submission is a lengthy process. The amount of data and size of the files means it takes a long time to run the software. The volume of data produced causes storage issues on the network and stability issues on the server.

If the standards have a greater focus on materiality and the activity/resource matrix is simplified, this should reduce the run time for production.

Recommendations

1. Ensure all standards focus on material items only.
2. Raise the materiality threshold from 0.05% of a trust's expenses to 1%.
3. Reduce the size of the resource/activity matrix by grouping resources and activities. Focus on those items which are material and/ or relevant to initiatives aimed at improving cost effectiveness and patient care. Involve clinicians in determining the resources list.
4. Remove the mandatory requirement to map the general ledger to the cost ledger and give trusts the autonomy to map the general ledger appropriately to a clearly defined set of resources.
5. Reduce the number of cost allocation methods required by focusing on materiality and reducing the size of the activity/resource matrix.

Achievable

The standards should be achievable for all trusts using data that is already mandated in a national data set.

Currently the standards are aspirational, rather than providing a core minimum set of standards which all trusts should be able to achieve. Our view is that this should be reversed. The standards should focus on a minimum set of standards, which are achievable by all acute trusts.

Mandated data sets

The current standards require data feeds which are not already collected in a mandated data set.

> *'Some fields may be potentially be helpful for either matching, weighting or driving costs, but mandating them in the standards won't necessarily make them appear if they're not already being collected. As costing professionals we are only secondary users of clinical data and we can't ask clinicians to record data where it's solely for the purpose of costing and there is no clinical requirement.'*

Costing practitioners are secondary users of the data, and the standards need to be written on the assumption that, as a baseline, costing will only be able to draw on data that is already mandated in a national data set. NHS E&I need assurance from the primary source of the national data sets that the fields required are properly populated to a reasonable level of accuracy.

This approach will leave some significant gaps in the data required to measure the driver of resource consumption, for example in theatres, outpatients and pathology. In such cases, national standard weightings should be provided until such data becomes part of a mandated data set. This will ensure a more consistent approach to the use of data in costing.

Minimum data fields

As noted above, the current standards require some data fields which are not relevant or of little value to costing. The core minimum set of standards should focus on:

- patient identifier
- date
- value (for example, number of tests, minutes).

For matching purposes it would also be useful for the minimum set of standards to require:

- location
- specialty
- consultant.

Aspirational standards, which should be separate from the core minimum set of standards, can then enable pioneering trusts to use data feeds which are not mandated where they are able to demonstrate they are accurate and improve the detail of costing data.

Clinical involvement in developing standards

Members noted that a number of the costing approaches are robust and achievable because clinicians were involved in developing them. This is not the case for all costing methods/approaches, for example critical care and A&E.

> *'We have had several meetings with the senior critical care nursing teams and the clinical director (lead consultant) and the consistent message from them is that patient costs do not have a direct correlation to how ill the patient is.'*

> *'Discussions with our senior A&E management team felt that the methodologies recommended did not represent the services that they provided. They felt that approaches were too arduous and meaningless. We have developed local methodologies.'*

It should be the norm that clinicians are involved in the development of the standards. This will help ensure that methodologies are achievable and make sense to clinical services.

Recommendations

6. Publish a core minimum set of standards which should be achievable by all trusts. The standards should only require activity and resource consumption data which is already in a mandated data set, and focus on the minimum data required to cost. National standard weightings should be provided where data is required that is not currently mandated.

7. Involve clinicians in developing the standards.

Deliver high quality comparable cost data

The standards and associated tools should support trusts to produce high quality cost data in a consistent manner. This includes providing clear messages on how and where to focus their efforts on improving the quality of costing.

Our members' view is that the costing assurance tool (CAT) does not provide them with a good methodology to assess and improve the quality of their cost data. As a result, the CAT is not fit for purpose for trusts wanting to know the quality of cost data of individual trusts when benchmarking. Appendix A provides members' comments on the CAT.

Costing practitioners require a tool which measures:

- how accurately costs in the general ledger are mapped to the defined set of resources
- the quality of the cost driver (costing allocation methodology) for allocating resources to activities
- how well patient-level data sources (such as ward time, theatre time and drugs) are allocated to individual patients (matching rates) and the number of iterations taken to match.

The tool should weight the financial resources used by each cost type so that trusts know where to invest their cost system improvement efforts where the costs are financially material.

The tool should also focus on two other elements which have a significant impact on the data quality of costing:

- the extent to which informatics scrutinise and validate the quality of data
- the extent to which the end users scrutinise and validate the quality of data.

Recommendations

8. Develop a tool that allows trusts to measure the quality of their costing, identify where to focus their improvement efforts, and understand the quality of other trusts' costing data for benchmarking purposes. As a minimum the tool should include the elements listed above.

Easy to understand

The standards should be easy to read and understand.

Standards which are easy to read and understand will increase compliance and improve the accuracy of costing data.

Members' views are that the current standards are too long, complicated, and confusing. Some members admitted that as a result, they are not reading the standards in full. Some parts of the standards contradict other parts and there is duplication in places.

> *'At the moment the standards are very lengthy and detailed - they need to be simplified and brought together so that they are useable by the service, and can be easily put into practice, with focus on the material items.'*
>
> *'CTP guidance has grown into its own industry. It has become very large, making it difficult to follow, and very complex, making it difficult to know what to implement when much of it doesn't seem to be relevant.'*
>
> *'The acute technical document is full of incorrect information, missing information and conflicting information.'*
>
> *'The technical document is unnecessarily complex. It could be summarised and simplified - one sheet with resource and activity combinations and all the required codes would go a long way. Summarise categories as only those needed and accepted in DVT.'*
>
> *'It is very difficult to know what each of the standards is meant to cover. The documents reads like every paragraph needs to be read in conjunction with three or four other documents or spreadsheet pages, which similarly only have limited references to the topic you are trying to find. You become very quickly swamped in paperwork.'*

Our members' view is that there should be a core minimum set of standards published as one document which would act as the complete reference for costing practitioners.

This would include some general principles that can be applied to any type of cost being allocated (for example is patient level activity available, if not, what is an appropriate weighting of cost to service/patients?). The standards sections would focus in detail on the different areas that are being allocated to patients, and should be developed and implemented based on materiality, comparability and the ability to influence decision making. This would remove the need for the separate information requirements standards, as the standards would focus on the information requirements for the individual cost types and would enable practitioners to read and implement standards in isolation as appropriate.

Appendix B provides further suggestions on what a well-structured document might look like and contain.

Recommendations

9. Ensures that the new set of standards are easy to read and understand.
10. Publish a core minimum set of standards as one document.
11. Ensure that the standards and the cost collection guidance are consistent.

Provide useful information for local and national use

The standards should generate useful information for local use to support improvements in efficiency and patient care. At a national level the standards should generate data which is useful for setting prices and creating national benchmarking data sets.

Local use

Members report that they struggle to use the outputs generated by the NCC locally.

Volume of data

Due to the amount of resource and activity detail inputted into the collection, the size of the data being generated from NCC is unmanageable and our members are unable to easily share the data with clinical teams in a format and language they can relate to. As a result, some members have created two versions of PLICS: one for the national return, and one which they are using locally. Others are struggling to use any PLICS data locally.

If the resource/activity matrix is considerably reduced in size and there is a greater focus in the standards on materiality, this should reduce the volume of data and start to make it easier for trusts to use the data locally.

File format

The current format of the files that are required for the NCC submission are in a format that trusts cannot use locally, and it is not possible to sense check the outputs. Replacing the XML files with SQL tables would mean that trusts could interrogate the files and use them internally with a business intelligence tool.

Members suggest that the data required for the NCC submission should be more closely aligned to the PLICS data generated for local use.

Overheads

The NCC support costs methodology means that the user cannot unpack the total patient cost to understand what the overheads are. To encourage comparability and clinical engagement, it is important to be able to see ‘the costs that can be influenced’.

Overheads are a material cost, and users want to be able to identify overhead costs by category, for example depreciation (buildings and equipment), estates and facilities and other material corporate overheads. Such information is also required for integrated care systems considering service redesign across the local health economy.

National use

The data needs to be of a consistent quality before it can be reliably used at a national level. The Institute report *National cost collection – views of Institute members August 2019* noted a number of areas of significant concern, which are likely to have an impact on the data quality of the cost data submitted in 2019. The issues are summarised as:

- standards and guidance are too complicated
- late notices of changes to guidance
- poor version control of guidance
- slow responses to queries and conflicting answers
- substantial time spent on cost collection, with less time to check the quality of the submission.

Until the quality of data has stabilised and improved, it does not provide a reliable data set for national use.

Recommendations

12. Change the format of the files required for the NCC submission so that trusts can use the data locally.

13. Ensure overheads are identifiable at patient level.

14. Ensure users of the NCC at a national level are aware of the potential data quality issues.

Summary of all recommendations

Proportionate

1. Ensure all standards focus on material items only.
2. Raise the materiality threshold from 0.05% of a trust's expenses to 1%.
3. Reduce the size of the resource/activity matrix by grouping resources and activities. Focus on those items which are material and/ or relevant to initiatives aimed at improving cost effectiveness and patient care. Involve clinicians in determining the resources list.
4. Remove the mandatory requirement to map the general ledger to the cost ledger and give trusts the autonomy to map the general ledger appropriately to a clearly defined set of resources.
5. Reduce the number of cost allocation methods required by focusing on materiality and reducing the size of the activity/resource matrix.

Achievable

6. Publish a core minimum set of standards which should be achievable by all trusts. The standards should only require activity and resource consumption data which is already in a mandated data set, and focus on the minimum data required to cost. National standard weightings should be provided where data is required that is not currently mandated.
7. Involve clinicians in developing the standards.

Deliver high quality comparable cost data

8. Develop a tool that allows trusts to measure the quality of their costing, identify where to focus their improvement efforts, and understand the quality of other trusts' costing data for benchmarking purposes. As a minimum the tool should include the elements listed in this report.

Easy to understand

9. Ensure that the new set of standards are easy to read and understand.
10. Publish a core minimum set of standards as one document.
11. Ensure that the standards and the cost collection guidance are consistent.

Provide useful information for local and national use

12. Change the format of the files required for the NCC submission so that trusts can use the data locally.
13. Ensure overheads are identifiable at patient level.
14. Ensure users of the NCC at a national level are aware of the potential data quality issues.

Appendix A

Additional comments on the costing assurance tool (CAT)

Information Requirements

- Data fields in Year 1, 2 , 3 are an unnecessary exercise
  - You either have them or need to work on getting them irrespective of the year so you can measure your progress.
  - NHSI have reset the clock, so although we are 3 years into the process we are still counting this as year 1. Comparability is therefore compromised
  - What happens in year 4?
- Under Timeliness, why do you get 100% for 'by day 5', but 50% for 'by day 10'? Surely the quality of the data is the important thing, not how quickly it is available. In fact, you could argue the later data is available the better the quality will be, because of the improvement in the completion / depth of coding.
- Data fields in costing system – whilst the information is not in the costing system it might not always be required. At some trusts the activity data comes pre-matched to episodes/attendances in the data they receive from the information team. However certain field in the data feeds are solely required for matching and not for costing or the collection.

Cost Classification

- Understanding the general ledger - section ok
- Producing the cost ledger
  - Has no bearing on the quality of the costing process
  - (Dis-)Aggregating ledger lines to produce the cost ledger - this is what our costing software is set up to do, NHSI's original focus suggested we should be doing all this outside the costing software in excel which is both unnecessary and prone to error

Cost Allocation

- By collection activity
  - Filled in by sheets Sup 1 & 2 - this doesn't provide any assurance around reconciling back to the quantum loaded
  - The scores are meaningless for comparison/judging improvement
- Other questions checklist
  - The only section to ask about allocation methodology
  - The response options are too binary
  - Some questions relate to standards that have been contested as unreasonable
  - Some questions are too sweeping and general to be a useful measure
- The percentage implemented is a subjective view, which is likely to vary between providers. Do we really need to do this at such a granular level? i.e. Recommend looking at Diagnostic Imaging and Pathology rather than at the individual Imaging Modality and Pathology Lab.

Matching

- Prescribed matching rules are not the most efficient and it is unreasonable to suggest any deviation from these needs to be documented. The focus should be on costing and evolving, not documenting each variation.
- Matching rates are a useful measure but are better in the context of knowing the average number of iterations required to reach the level.
    - We could all have 100% matching if we were prepared to allow false matching by running the process on ever wider criteria until a match was made.
- Matching rules implemented percentage is a subjective view and difficult to quantify.

Reconciliation

- Why do we need to have separate activity reconciliations to PAs and SUS/HES submission?
- Need to ensure not asking for things that have not been sorted out
    - Income in 5 categories (CM12)
    - All references to E&T

Governance & usage

- Questions are too ambiguous to answer. Responses are very subjective and difficult to quantify.
- This is not about NCC information but internal PLICS which is vastly different
    - But then asks about using the PLICS Portal for benchmarking
    - Separate NCC and Internal PLICS questions to allow proper feedback on the two
- Focus on Board usage - this group are the least likely to directly use the information whereas information presented to them may well have been prepared using internal PLICS.
- No focus on finance or clinician usage or engagement.

Appendix B

Suggestions for improving the readability of the standards

Purpose of the Standards

- To facilitate the provision of high-quality cost information for use by trusts in internal decision making and performance monitoring and to enable comparability of information at national level.
- To ensure that the technical requirements of the NCC are clear and applied consistently.
- To promote the use of best available information in cost allocation, recognising that not all trusts will have access to the same information, but to provide achievable alternatives.
- To provide a basis of cost allocation:
    - where there is a nationally mandated data set that enables identification of activities and assignment of cost at patient level, to detail minimum standards that must be adhered to in national cost collections
    - to provide examples and guidance on where there may be local data sets that are sufficiently robust to be used to identify activities and assign costs at patient level, but recognise that these will be subject to individual circumstances
    - where data is not available at patient level, but is related to patient facing activities, to give clear guidance on how to allocate, for example, using relative value units
    - for other support costs and overheads to provide an achievable method of allocation.

Structure of the standards

There needs to be a clear distinction in the standards between the practicalities and technical aspects of achieving and submitting an NCC output, and the process of achieving robust and accurate allocation of costs. This recognises that technically anybody with a costing system should be able to produce a cost output at patient level, but the quality of that output will depend on availability of data and compliance with the principles of cost allocation highlighted above.

At the moment, it feels like these two areas are blurred in the documentation and the split into different documents adds to the confusion. An example of this is that the acute costing methods contains a very detailed and generally helpful section on how to allocate theatre related expenditure, but then also has a section on cost classification which is a technical guide to classify costs into fixed, semi-fixed and variable and while useful, best practice is not currently included in the national cost collection and does not influence cost allocation methods.

There needs to be a single document broken down into the following sections:

1) Costing principles and structures – to include the technical aspects of cost classification, clearly identifiable costs, mapping costs to resources and activities etc.
2) National cost collection specifics - sections 1 to 7 of the current *National cost collection guidance* are probably the areas that cover this, but the workbook user guide and details of DVT need to be brought into this main document as well.
3) Costing standards for material areas of expenditure – this is the section that needs to be practical and achievable and would be more likely to be expanded and developed over time. Each standard should stand alone and should be able to cross reference the evidence for how

they have been written (for example, sources of external data; clinical involvement in allocation methods).

4) Costing approaches – this is where the best practice guides for specific services should be developed, to complement the costing standards.

A single document may be large, but if well-structured would provide a single point of reference.

Included below are the details and principles that it would be useful to have in the costing standards.

Standards for cost allocation

Each area of cost allocation (for example, theatres, pathology, wards, medical staffing, support costs, overheads) should have a distinct section in the standards, which can be read in isolation from the rest of the document. While this may lead to some repetition, it would make the document far more useable. Each standard needs to identify whether there is an expectation that activities can be costed at patient level (which should only be mandated if the data set is mandated for other purposes).

If there is an expectation that it can be costed directly at patient level then the standard needs to include the following details:

- what data feeds should be available in the organisation (both mandated and possible local feeds)
- what data fields are required from those feeds to enable matching to core episodes
- the matching algorithm and parameters
- suggestions for allocating the different types of cost using the matched data, and whether there is a need for additional information (for example to allocate radiology you may need the matched data plus the relative value weights that you have separately calculated for each examination type).

Where it cannot be costed directly at patient level the following may be useful and needs to be clearly presented:

- alternative methods need to be explained including examples of how different types of expenditure may be allocated to different patient groups
- it would be useful to have a checklist of what sort of information is needed for the relative value units (RVUs) and/or the best people to talk to for that information
- a nationally prescribed set of RVUs would help but it should be stated that these should be a guide and overridden by local circumstance (for example an RVU for inpatient therapies may assign 30 minutes physiotherapy per day to orthopaedic elective patients, but local intelligence may change this to 60 minutes for joint replacements and 10 minutes otherwise).

In all cases, where the standards prescribe how to get and use information, there should be a clear alternative where there is a possibility that this is not available. Where a part of the cost allocation is also covered in a different standard, it may be more appropriate to cross reference to the core standard for that cost.

If the standards were presented like this, it should remove the need for the Information Requirements Standards and possibly some sections of the technical document (although this could be kept as a single point of reference with all matching algorithms etc). The technical document should therefore become the only additional document that readers need to access, and this should only be necessary when getting into the detail of implementation.

About the Healthcare Costing for Value Institute

HFMA's 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.

hfma.to/costingforvalue

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff working in healthcare. For 70 years it has provided independent support and guidance to its members and the wider healthcare community.

It is a charitable organisation that promotes the highest professional standards and innovation in financial management and governance across the UK health economy through its local and national networks. The association analyses and responds to national policy and aims to exert influence in shaping the healthcare agenda. It also works with other organisations with shared aims in order to promote financial management and governance approaches that really are 'fit for purpose' and effective.

The HFMA is the biggest provider of healthcare finance and business education and training in the UK. It offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The association is also an accredited provider of continuing professional development, delivered through a range of events, e-learning and training. In 2019 the HFMA was approved as a main training provider on the Register of Apprenticeship Training Providers and will be offering and developing a range of apprenticeships aimed at healthcare staff from 2020.

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