one direction

Building on recent developments in NHS costing, Monitor has set out a clear and ambitious roadmap to achieving comprehensive patient-level costing across all parts of the service

Monitor has set out plans for a new approach to costing in the NHS with an ambitious five year transition to the first mandatory collection.

Monitor has made no secret of its basic attraction to patient level costing since it set out to reform NHS costing more than two years ago. It has frequently identified patient cost data as a rich resource enabling analysis of the links between costs and patient outcomes and quality measures. It sees the data as being useful to inform its pricing role with NHS England and to support local decision making by provider trusts – and has started a voluntary annual collection of data from trusts already pursuing the approach. But it has now made this support official. Its proposed approach – set out in an engagement document, *Improving the costing of NHS services: proposals for 2015-21* – consists of:

- An improved, transparent and intuitive costing method
- Structures to ensure consistency
- A single, national cost collection.

Many NHS providers have been pursuing patient-level costing in recent years informed by the HFMA's *Clinical costing standards,* which were originally written by the Department of Health but more recently have been developed by the HFMA with support from Monitor. But there are significant differences in how Monitor suggests resources should in future be mapped from the general ledger through, ultimately, to patients. And perhaps the most pertinent decision is for the whole process to be mandatory, once value for money has been demonstrated.

Achieving consistency

While the HFMA standards have attempted to steer NHS providers towards good costing practice, both in costing at the patient level and for the annual reference costs collection, their application has remained voluntary. This has meant that local approaches to costing – while recognised by Monitor as being 'generally logical and explicable' – have varied across providers. Many practitioners have called for the standards to be mandated to improve the consistency of approach.

'Costing processes still vary considerably between care providers,' Monitor's roadmap document says. 'Their classifications of human and physical resources and activities, their costing allocations and the data sets they use for cost and quality management are not consistent. We also know from evidence that not all trusts' costing systems can provide

detailed information about costs at the level of individual patient care.'

'The costing method we are proposing to introduce will improve costing in the sector, it will be transparent and it will be intuitive,' says Glen Pearson, Monitor's costing and outcomes lead. The way that trusts spend money is: patient services are provided; activities are carried out to deliver these services; and resources are employed in these activities. So the costing method will mirror this with a simple three-stage process (see figure 1, page 25):

- Map costs from general ledger to trust's resources
- Map the costs from resources to activities
- Map the activities to patients.

New dictionaries will define standardised resource types, patient care activities and the defined groups of patient care (referred to as grouped patient activities). And 'clear and comprehensive' costing standards will define the rules for mapping ledger costs to resources and set out the allocation methods that should be used to assign resources to activities and activities to patients.

The first stage involves mapping costs from a trust's general ledger, which varies considerably from trust to trust, into a nationally standardised resource structure, to ensure a common starting point to the costing process for all trusts. Examples of these resource groups are likely to include: nursing; consultants; junior medical staff; blood; drugs and consumables.

"The costing method we are proposing to introduce will improve costing in the sector, it will be transparent and it will be intuitive"
Glen Pearson, Monitor

The HFMA has highlighted the benefits of a mandated chart of accounts in supporting the costing process (see *International approaches to clinical costing,* www.hfma.org.uk/costing). The detailed mapping exercise proposed by Monitor will aim to replicate these benefits.

It should mean that any cost comparisons made at any level are comparing like with like. For example, without such a mapping system, one trust might currently collect prosthesis/implant costs within its own cost pool. However, another trust may record these same costs within non-pay costs in theatres, because they were ordered by the theatres department. The mapping will provide a standard approach that will eliminate these different approaches and facilitate benchmarking. Monitor acknowledges that some general ledger systems may need to provide extra detail.

Assigning costs

In a second stage, the costs of each resource are assigned to the activities these resources carry out, so nursing resources would be assigned to ward care, for example, or medical supplies used in surgery assigned to theatres. This two-stage process would effectively replace the allocation of costs to cost pool groups, described in the HFMA *Clinical costing standards*, which were in effect a mix of both resource and activity groups.

In the third stage of the process, activity costs are allocated to patients. The greater granularity of costs held within the activity groups should allow for more accurate allocation of different cost types. So, for example, this would seem to allow for different allocation methods to be used to allocate general nursing costs and specialist nurse costs within a ward activity group, recognising that these resources will be consumed in different ways by different patients. General nurse costs could perhaps be allocated using length of stay and acuity, while specialist nursing could be targeted at patients with specific procedure or treatment codes.

Monitor also says the costing process will apply to all activity, including non-patient care activities – education and training, research and development, and commercial activities. This will move away from netting off income for non-patient care activities as a proxy for costs and will build on work in recent years to improve costing in these areas.

The roadmap also signposts the end of separate national cost collections. In recent years, the annual reference costs collection has been supplemented by a separate education and training cost collection, in part to inform new education tariffs, and a voluntary patient level cost collection. These parallel collections would over time be replaced with a single, national collection. Monitor says it will work with the Department of Health and Health Education England to explore how they collectively move to an integrated cost collection.

But with some costing teams reporting they spend half their time currently on cost collection, Monitor believes this will 'release cost professionals at providers to spend more time analysing and managing

Landmark decision – but hard work ahead

The HFMA has been a vocal supporter of improved costing for many years and has overseen the development of the *Clinical costing standards* since 2010. Helen Strain, HFMA's head of costing (pictured), welcomed Monitor's new roadmap, calling it a 'significant landmark' in the journey to robust cost data in the NHS.

'Many providers are already producing costs at the patient level to a good standard, providing a sound basis for local decision-making,' she says. 'The granularity of this data means it is possible to really understand how costs and outcomes interact and means discussions to improve services can be based around patients rather than average treatment costs.

'This is far more meaningful to clinicians. What the proposed Monitor approach will give us – because it is mandatory – is a consistent approach across all providers. Only by having this consistency can the NHS access the wider benefits of benchmarking and more informed price setting.

'The HFMA has been a committed supporter of improved costing – and specifically of costing at the patient-level – and a mandatory basis is the only way we will see these benefits realised at pace. Having said that, the timetable is ambitious – moving to a first mandatory costing return within five years for the acute sector.

"There will need to be investment in system development, in costing teams and in improving the underlying information that supports costing"
Helen Strain, HFMA

'While the process described by Monitor builds on the approach described in the HFMA *Clinical costing standards*, it also sets out a slightly revised cost compilation process, tracking expenditure from the ledger via standardised resource types and standardised patient activities. This will provide challenges for some providers and for their costing system suppliers.

'There will need to be investment in system development, in costing teams and in improving the underlying information that supports costing – albeit investment that should pay off in terms of more robust cost data for pricing and to inform transformation and service improvement.

'This is not just about investing in a costing system but committing as an organisation to time and resources to produce valuable, robust cost data.

'The scale of challenge will be different depending on the starting place of the providers in terms of their current costing approach and system. The more advanced patient costers should be able to meet the proposed approach with relative ease, but for others, there will be significant changes to local processes and IT systems.

'And the challenge will almost certainly be greater for mental health and community providers, where costing is known to be less well developed and there are more fundamental challenges with ensuring the activity data is collected in a consistent and comprehensive way.

'There will also be challenges centrally in delivering the detailed guidance and dictionaries crucial to getting the tightly defined consistency. These will need to be developed in a timely way to keep the project on track.'

costs in patients' best interests – a crucially important job'.

Monitor would not need trusts to submit the full detail of the costs they collect. So while trusts may hold details of different types of staff delivering ward activities (including medics, ward managers, qualified and unqualified nurses and admin staff), it might only need to submit these costs grouped into consultant, nurse and admin.

Even so, with a detailed resource/activity matrix generated for each patient (see figure 2), there would be a significant amount of data involved. One manager pointed out that with more than 20 cost pool groups in the existing standards, costing submissions for his trust could run to 24 million rows if both inpatients and outpatients were included. (Currently the voluntary patient level cost collection only collects inpatient data). The matrix of data for each grouped patient activity could significantly expand this.

Ambitious timetable

The timetable is ambitious but Mr Pearson says it is 'achievable' and work on the long-term vision would be balanced with support for trusts in meeting costing requirements for the short-term and the existing system, which remains important during transition. Monitor believes it will take five years for each service area to 'complete its transformation'. For the more advanced acute sector, the clock would start ticking in April 2015. New costing standards and collection guidance would be published in January 2016 with the first mandated collection covering services in 2018/19 submitted in 2019. The first two years of this period would see 'roadmap partner' trusts working closely with Monitor on the collection process, with a wider voluntary collection in year three before the system goes fully live for activity in year four.

For roadmap trusts and other trusts choosing to implement early, the last reference costs submission would be 2017/18, with the final acutes (those waiting for the approach to be mandated before starting to implement) still making a reference cost submission in 2018/19.

Each provider's final reference costs submission would be in parallel with a submission using the new process. Subject to the trusts being able to reconcile the two submissions to an acceptable level of accuracy, they would then cease reference cost submissions the following year, with the new data submission used to populate the reference cost return where this is still needed..

The same process would apply to mental health and community, albeit with later start times to take account of the longer time needed to develop costing standards and undertake other preparatory work, for example on data availability and definition of services. Under the timetable all providers in the NHS would be using the new costing processes and using the data to make national cost submissions by 2021

(covering 2020/21). Monitor also has also committed to demonstrating the need for sector-wide consistent costing approach and that the investment of time and resource represents value-for-money. However there is an expectation that this will be proven and, to ensure the service implements the changes as soon as possible, this case will be developed in parallel to the implementation programme.

Mr Pearson is clear that the proposals will need a sector-wide approach. 'It will be critical to work with the sector to enable what we are proposing,' he says. 'We need to develop a thriving costing community – we know this already exists in pockets. And we need to ensure the costing community is at the right scale and has the right capabilities. We recognise that there are many skilled costing professionals in the sector, but we don't believe that, as yet, there are enough to carry out the required transformation and ongoing costing development. This will need to be addressed by trusts if we are to embed the principles of the proposed costing process in trusts nationally.'

There is a huge amount of work to be undertaken by the centre, local providers and their costing system suppliers – a point stressed by HFMA head of costing Helen Strain (see box). But the direction of travel is now completely clear. All providers know where costing is headed. Now they will have to assess their current costing processes and systems and start to understand how they can deliver to the tight timescales involved.

Figure 1: The proposed costing method for patient care

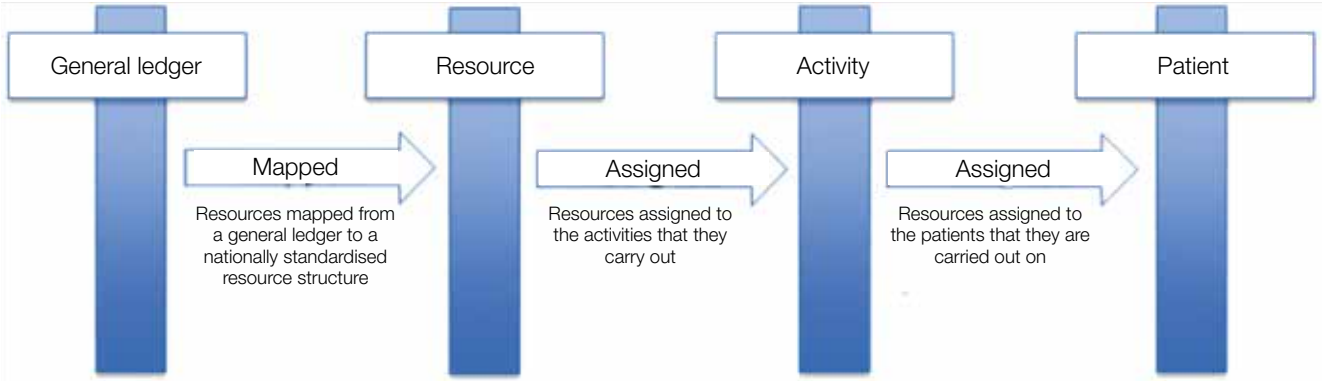

Figure 2: Example of patient resource /activity matrix

		Collection activity groups												
		Theatre care	Ward care	CCU care	Pathology	Radiology	Outpatient care	Pharmacy	Radiotherapy	Chemotherapy	Endoscopy	Therapies	Other diagnostics	Total activity cost
Collection resource groups	Consultants		500		30									530.00
	Junior medical staff													0.00
	Ward managers		10											10.00
	Nurses		50											50.00
	Specialist nurses													0.00
	Allied health professionals													0.00
	Professional and technical				60			5						65.00
	Portering staff													0.00
	Admin and clerical		30		5			0.27						35.27
	Specialty management		8		1			0.07						9.07
	Directorate management		5		0.82			0.05						5.87
	Trust management		3		0.41			0.02						3.43
	Drugs		5											5.00
	Consumables		10											10.00
	Blood													0.00
	Implants													0.00
	CNST		9		1			0.08						10.08
	Utilities		5		1			0.05						6.05
	Equipment		21		3			0.19						24.19
	Buildings		17		3			0.15						20.15
	Total resource cost	**0.00**	**673.00**	**0.00**	**105.23**	**0.00**	**0.00**	**5.88**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**784.11**