Costing in the NHS

How it happens and why it matters

June & July 2020

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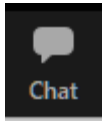
Housekeeping

- The presentation usually lasts 30 minutes, plus about 15 minutes for questions
- But we are happy to stay online as long as you want us to ☺
- Ask questions as we go, using 

at the bottom centre of the Zoom screen
- All slides are on our web site – link at the end
- If you're using someone else's invite, please make sure we have your email address if you want details of further courses

What we will cover…

- The new financial context
- Why look at a provider's costs?
- How activity drives costs (or not)
- How provider costing systems work
- Approved Costing Guidance & National Cost Collection (aka reference costs)
- Good benchmarking principles
- Drawing the right conclusions

The new financial context

- National Tariff originally payment by volume at a fixed national price
- Currently suspended under COVID-19 guidance
- But even before COVID, NHS gradually moving away from payment by volume…
- Towards **block contracts** and/or **blended payments**
- Mental health, community, ambulance, etc never part of national tariff anyway!
- The wider context – ICS working collaboratively on real change rather than debating who is following national tariff guidance

What does all this mean?

- National Tariff is moving away from a rigid national system of set prices
- Now more of a ‘national approach’ to pricing
- Each ICS uses the national framework to incentivise its locally agreed priorities
- National prices provide starting point or benchmark for ICS payment approach
- To use them effectively, you need to understand how provider costs behave as patient activity changes
- (PS you should have been doing this for non-acute providers all along ☺)

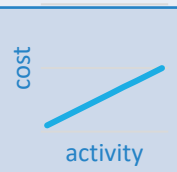
Does activity drive costs?

Accountants would say ‘it all depends’… Consider:

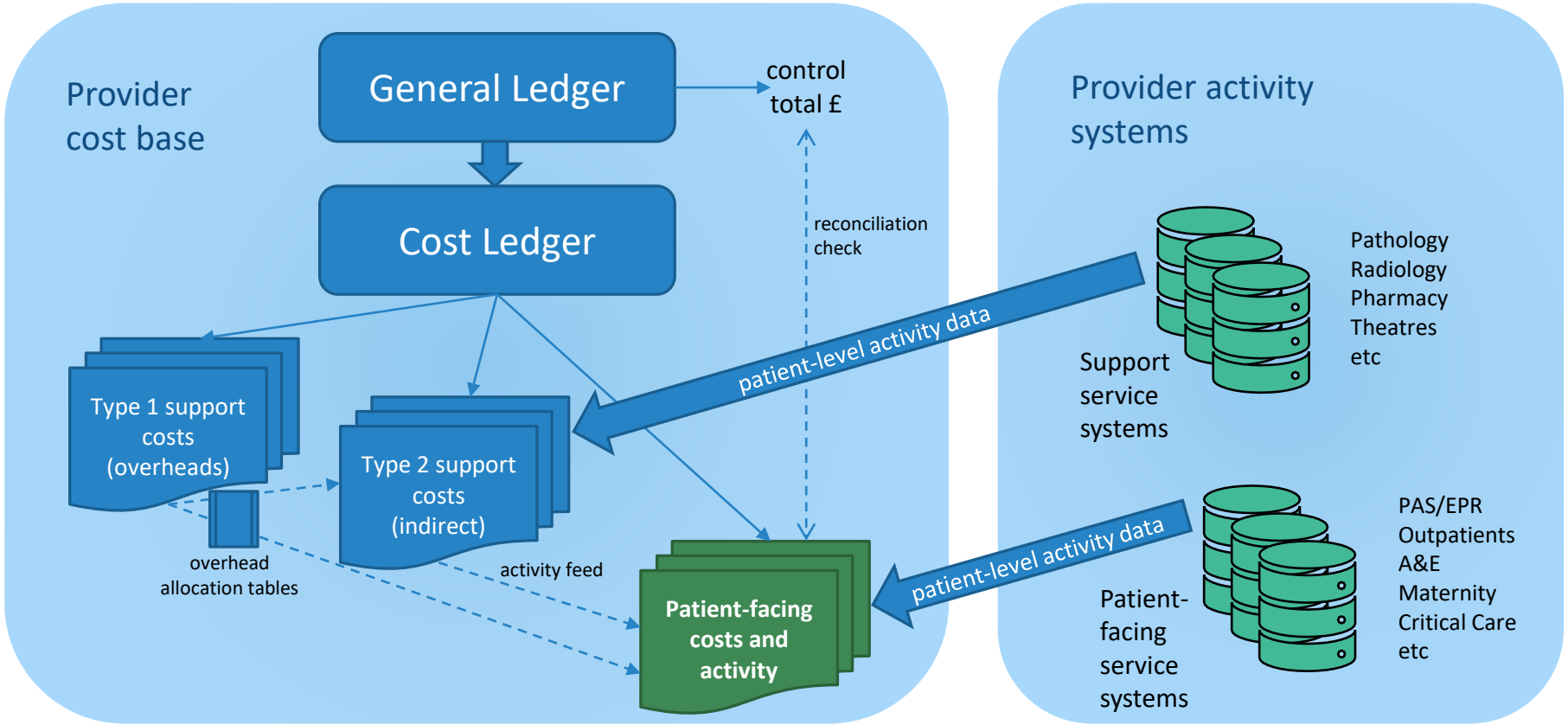
- 1 patient stays on a ward for 10 days = 1 spell
- 2 patients stay on a ward for 5 days each = 2 spells
- National Tariff would normally say 2 spells cost twice as much as 1 spell
- But in fact the 2 examples may well cost roughly the same = 10 occupied bed days
- **Which measurement of ‘activity’ drives cost?**

- An Emergency Department is staffed up to a budget of £4m, calculated on an activity plan of c55,000 attendances pa
- Due to successful ICS demand management, only 52,500 attendances take place
- Has the provider saved any £? Still the same staffing rota needed for a safe 24/7 service!
- **Which costs are fixed and which are variable?**

How does activity drive costs?

Cost Type	Cost Behaviour	Examples
Variable costs	Change in proportion to activity 	Consumables, e.g. drugs Bed linen Patient meals
Semi-fixed costs	Change with activity, but in 'steps' as activity passes thresholds 	Staff costs (clinical teams) Utilities, e.g. electricity Cleaning
Fixed costs	Do not change as activity changes 	Staff costs (corporate teams) Capital charges CQC registration

How do provider costing systems work? Top-down processing



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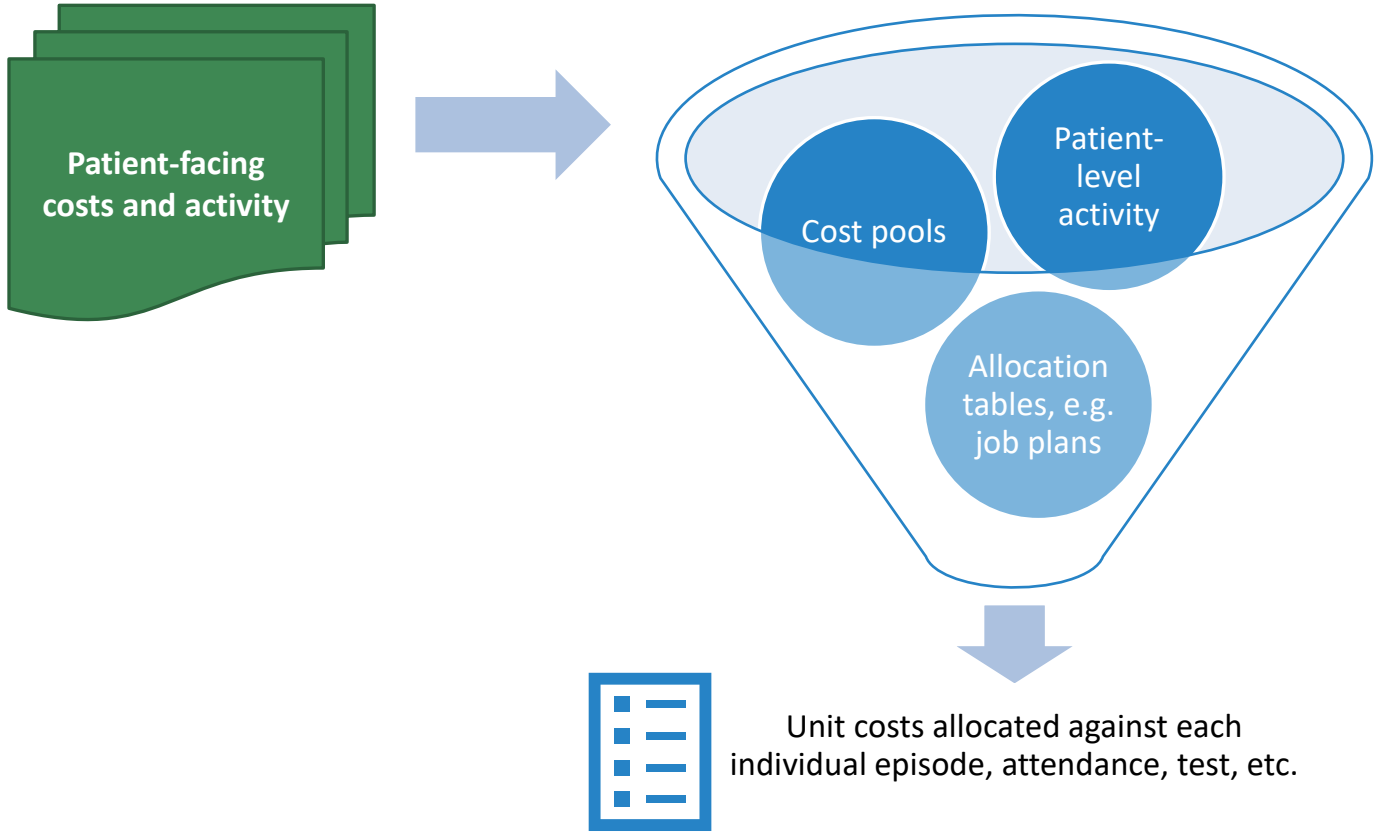
How do provider costing systems work? Bottom-up processing



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Approved Costing Guidance (ACG)

- All NHS providers must follow the ACG
- From 2020, patient-level costing (PLICS) mandated for all acute, MH and ambulance Trusts
- 7 high-level costing principles
- Supported by detailed costing standards
- Plus even more detailed standards for acute/MH/ambulance individually!

https://improvement.nhs.uk/resources/approved-costing-guidance/

ACG Costing Principles

Good costing should…

- be based on high quality data that supports confidence in the results
- include all costs for an organisation and produce reliable and comparable results
- show the relationship between activities and resources consumed
- involve transparent processes that allow detailed analysis
- focus on materiality
- be consistent across services, enabling cost comparison within and across organisations
- engage clinical and non-clinical stakeholders and encourage use of costing information

https://improvement.nhs.uk/documents/2358/The_costing_principles.pdf

National Cost Collection (NCC)

- ACG requires all NHS providers to submit their costs to the NCC (formerly known as Reference Costs) annually each summer
- 2020 submission timetable likely to be extended due to COVID
- NHSI publishes all provider data each year (latest available is 18/19)
- Although some small-value data is now deleted thanks to NHS Digital!
- But still best source of NHS cost benchmarking available
- Other sources like PLICS portal look promising but only have 16/17 data?!

https://improvement.nhs.uk/resources/national-cost-collection/

How to use the NCC

- Data is broken down into the main activity types – inpatients, outpatients, community, mental health, etc.
- Easier if provider records activity in line with ACG definitions in the first place!
- For cost comparisons, look at creating a meaningful peer group for the provider, rather than just taking national average
- Data is as submitted by each provider, so need to deflate for MFF to make fair comparison – obviously London will be more expensive than Yorkshire
- Published data file too large for Excel – need an analyst with database skills!

Good benchmarking principles

- Brainstorm different ways of selecting a peer group, e.g.
  - Volume – similar levels of activity
  - Cost base – similar overall size in financial terms
  - Service mix – similar range of services
  - Geography – similar location, e.g. urban v suburban v rural
  - Catchment area – similar types of patient, e.g. age, ethnicity, deprivation
- Suggested overall principles:
  - Size of peer group – ideally needs to be >10 members
  - Demonstrable comparability to your provider – e.g. using the examples above
  - Objectivity – use transparent data rather than anecdote or gut feel

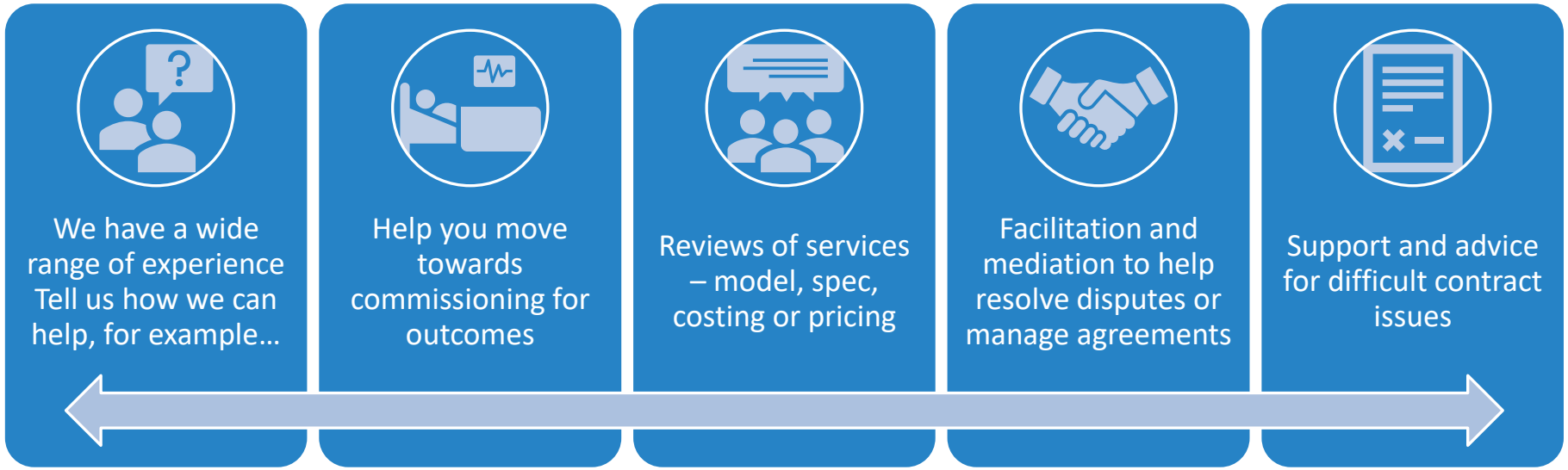
Drawing the right conclusions…

- Spend some time selecting best peer group, so results are seen to be fair
- Understand the cost drivers – what factors cause costs to go up or down
- Costs only ever tell part of the story
- Get to know your services really well – no point in suggesting costs are taken out where it's not feasible, e.g. estate reconfiguration. Be pragmatic!
- Cost reviews are best done as part of a multi-disciplinary team, covering the service spec, quality reqs, reporting reqs at the same time. Work as a team!

In summary…

- System costs must be jointly managed if they are to be reduced… and Provider costs ARE the system costs
- Moving away from payment by volume, understand how activity drives costs (or not!)
- Open book approach to costing will support agreement - work alongside providers to understand the outputs of their costing system and how it works
- Benchmarking/National Tariff should be used to understand efficient costs

Can we help?



We have almost 30 years' experience at senior level within the NHS and can provide practical support across a wide range of issues

Email us at info@baileyandmoore.com to discuss how we could help

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Other courses we offer include

- *Step by step guide to writing a service specification*
- *Outcomes-based commissioning – developing KPIs and metrics*
- *A 'how to' guide – local pricing and costing reviews*
- *The future of ICS – moving to aligned incentives*

If you are interested in these or other topics, email us at training@baileyandmoore.com and we can discuss your requirements

Thanks for listening!

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Email us with any comments or requests for training courses at:
training@baileyandmoore.com

Slides available at:
http://baileyandmoore.com/resources/training-slides/