The Road to Renewal

So… what next?

July 2021

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Housekeeping

- The presentation usually lasts 60 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 the chat box or raise your ‘hand’
- All slides will be on our web site – link at the end
- If you’re using someone else's invite, send us your email address if you would like a copy of the slides or to be sent details of further courses

So what next… “money for stuff”?

As we move away from activity x price and towards a form of risk share… what will we measure and how will we pay for it?

Mapping service pathways

- Shared understanding of the services required
- Simple charts & maps
- Getting the right people in the room
- Some practical tips

Commissioning for patient outcomes

- Distinguishing outcomes from inputs and outputs
- Why commission for outcomes?
- Measuring outcomes using KPIs

Costing and benchmarking

- Why look at provider costs?
- How does provider costing work?
- National guidance
- Benchmarking efficient costs

Mapping Pathways

Agreeing the services required

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Why do we need to map pathways?

- Sets out a common understanding of what is to be delivered within the payment mechanism… and how
- Developing/revising a pathway supports other reviews – cost, quality, CIP/QIPP, etc.
- Sets out part of the wider plan – showing the context in which services sit
- Promotes consideration of the whole pathway and links to other services (eg AEC/ED)
- Good for patients and clinicians – clear about what is possible/not possible
- Clarity of services = good commissioning

How would you map a service?

Whatever sets out the way services should be provided and sets out the expectations for all parties…

It could be:

- a service specification/description, or a detailed policy or procedure
- a description of a process or a simple map of a pathway

And may be:

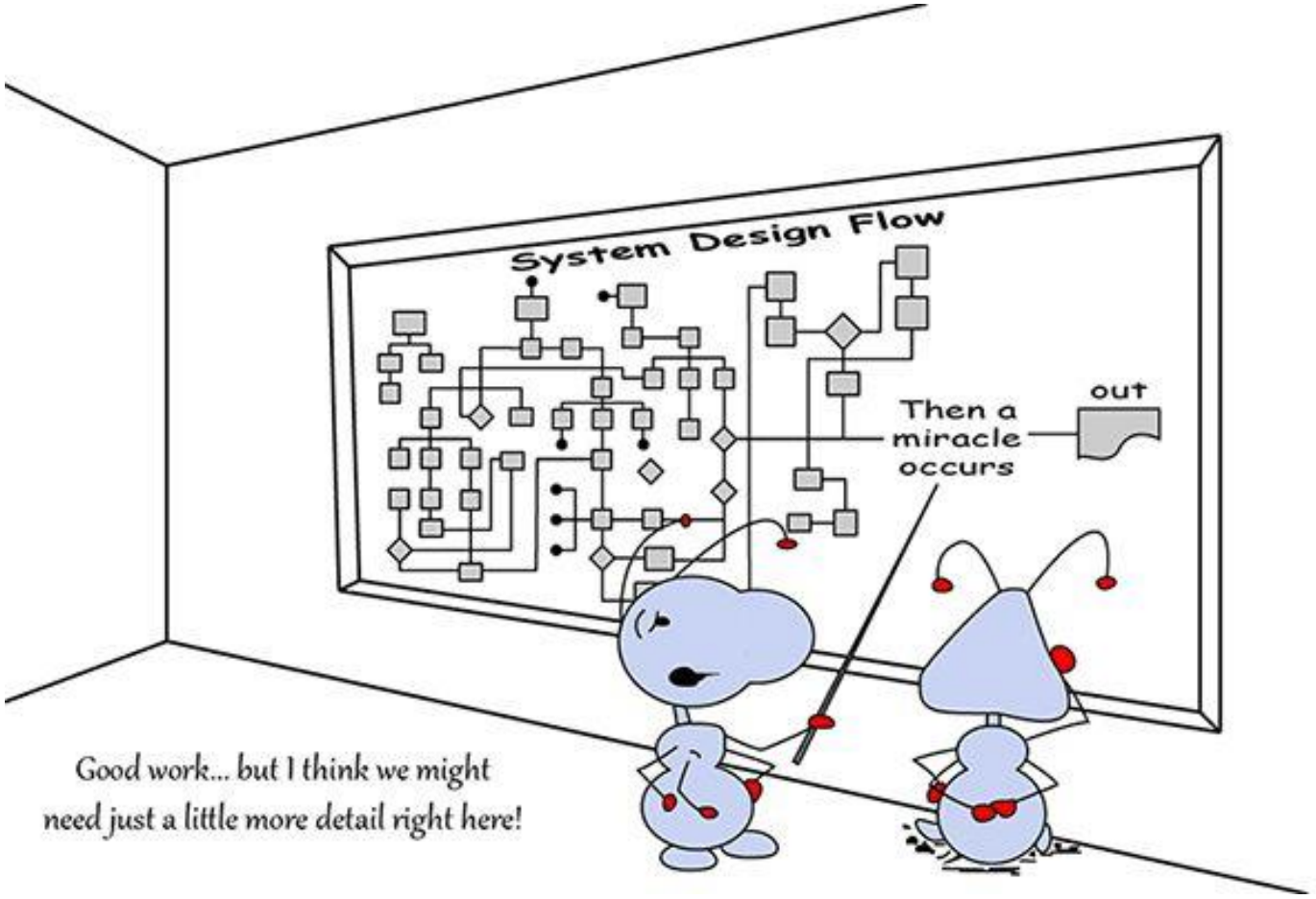
- condition specific - eg MH for young people
- pathway specific - eg emergency access

How would you map a service?

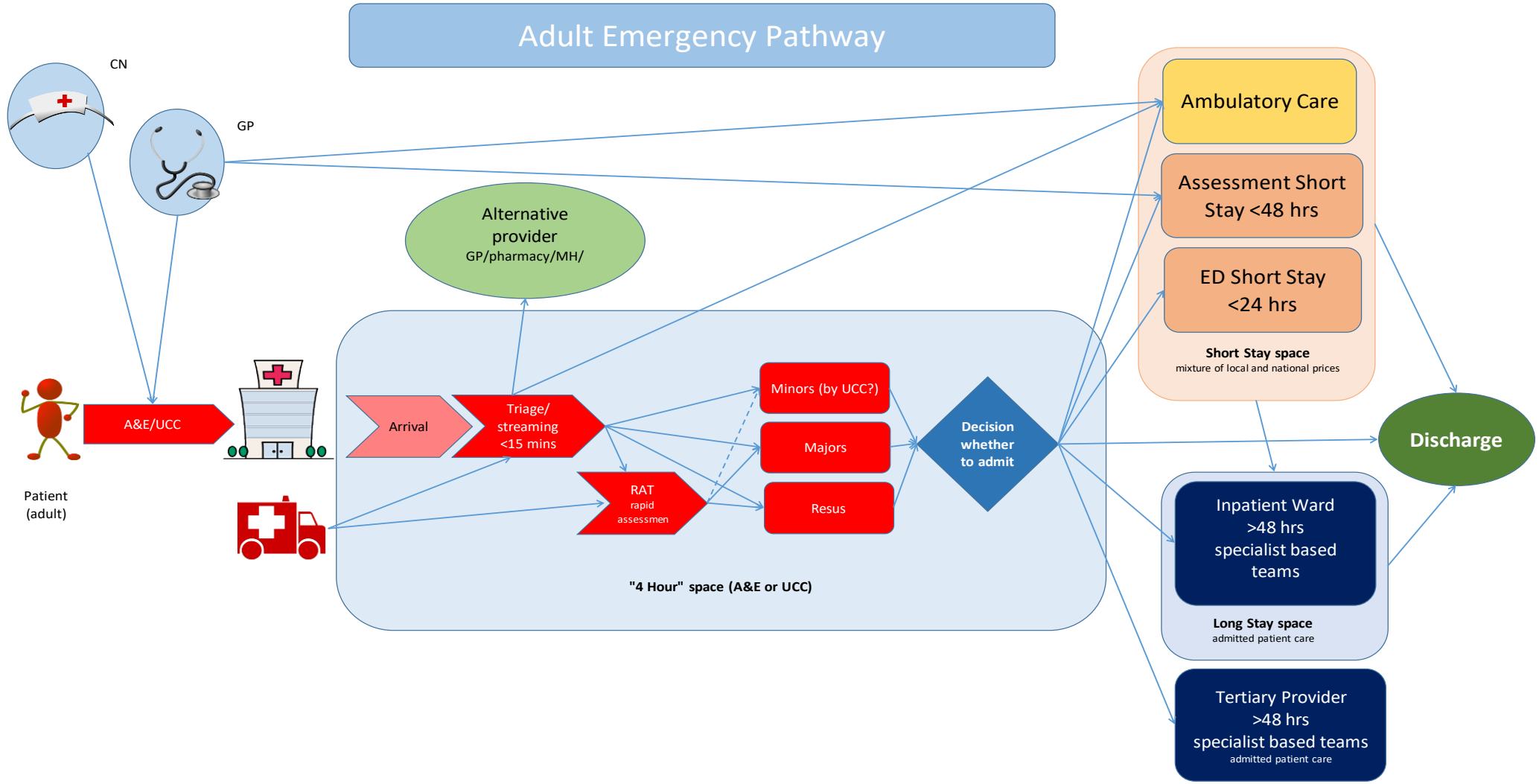
Initially - not in great detail… use a simple map or process chart, showing:

- entry/referral points to the service - how patients will get **IN** to the service
- what happens once they are in – what **PROCESSES** and **STEPS** are required
- what happens at the end of the pathway - how **DISCHARGED** from the service
- protocols or criteria that need to be specified, e.g. eligibility, age, referral route

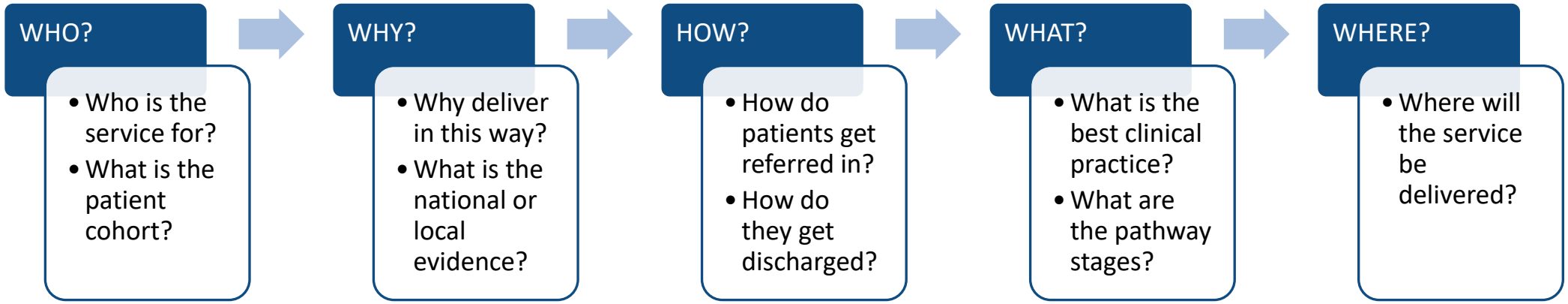
Example of a simple pathway map?



Example of a simple pathway map



Documenting in a service specification



You might need to set this out in a service spec or in other policies, e.g. referral policies, prior approval schemes, etc

Understanding the operational reality

- A vital step when looking at more complex services is to physically walk the patient pathway with the clinician(s) involved in providing the service
- Don’t be tempted to skip this step – a “desktop” exercise will not give you a full understanding of the operational reality of the service!
- For example, you may need to understand the restrictions that estates impose – no point specifying elements of a service must be co-located if the estate will not allow this (although this could be addressed in longer term plans)

The wider patient pathway

Understand where the service sits in the wider patient pathway and requirements, gathering info from:

- local intelligence – GP groups, clinical networks, user groups
- provider intelligence… from multiple providers, links to related services
- current research, evidence, policy docs and audits
- consultation events?
- partner agencies

Tips… some “dos and don’ts”

Get the right people in the room…

- Best specs have **strong clinical involvement** – not a desktop exercise
- Development of ICS means that **providers and commissioners should work together**
- **It’s a team effort** – commissioning, contracts, quality, finance, BI need to work together to produce a rounded spec. Talk to clinical colleagues with one voice. Don’t work in isolation!
- Process and resources required depend on the **value/complexity/risk associated with service**
- **May require consultation and scrutiny** and number of drafts before it before it can be agreed, ensuring it reflects the views of stakeholders and is ready to be used by the provider
- **Get buy in** – spec won’t happen if the clinicians, finance or service managers don’t want it to… it will work best as a joint effort, so make sure everyone is involved

Tips… some “dos and don’ts”

- **Keep it as brief as possible** – consider whether you actually need a spec, and if you do…

  TG 36.8: *“A specification should not be a detailed operational policy for a service; specifications that are no longer than **4-5 pages may be sufficient** ☺, especially if they focus on the outcomes required from the service rather than the inputs.”*

- **Avoid generic statements such as** *“we constantly need to review our population against how care is delivered for similar populations to ensure we are effective in our use of clinical and patient time for the whole population”…* save the generic stuff for strategic documents etc
- **Make it a standalone doc** – TG 36.10 says don’t duplicate info from other parts of the contract, but we recommend you do where necessary, so it can be shared. Watch version control!
- **Obviously** – don’t contradict the national terms (General Conditions or Service Conditions)

Tips… some “dos and don’ts”

- **Get it agreed** – before the service/contract starts preferably!
- **Respect the experts** – read the document as if you were one of the clinicians involved. Is it necessary to say “respect the service user” or how many band 5s are needed?
- **Remember this will be a working document for clinicians** – don’t treat it like a desktop exercise to secure financial benefits
- **Don’t fixate on bricks and mortar –** the “where” is less important than the pathway e.g. Ambulatory Care is an ethos, doesn’t matter where it is delivered. Operational matters should be provider responsibility wherever possible.
- **Or clinic hours –** ambulatory care can/should be 24 hours…

Tips… some “dos and don’ts”

- **Limited number of robust metrics** – Make sure the information required is clearly stated in the spec. A few well-targeted metrics will tell you more than a long list that no-one looks at
- **Beware of unintended consequences** – e.g. unmet demand, (un)affordability…
- **Allow time to circulate draft specifications** for comment, amending and re-circulating
- **Use a “guinea pig”** – helpful to get someone who knows nothing about the service to read it
- **Be clear** – readers should be able to understand what it is you expect to be delivered, so avoid using jargon or local shorthand to describe the service.

This is not a quick process!

In summary…

- It’s not just about contract documentation…
- Start with a simple pathway map of existing/desired services – walk the pathway to understand the operational reality and where service sits in wider pathway
- A clear agreement about the desired pathway will help shift system focus away from activity volumes/inputs and towards **key outcomes** for patients
- An understanding the service supports the understanding of system costs
- Not a quick process and success requires a multi-disciplinary approach

Commissioning for Outcomes

Putting the patient at the centre

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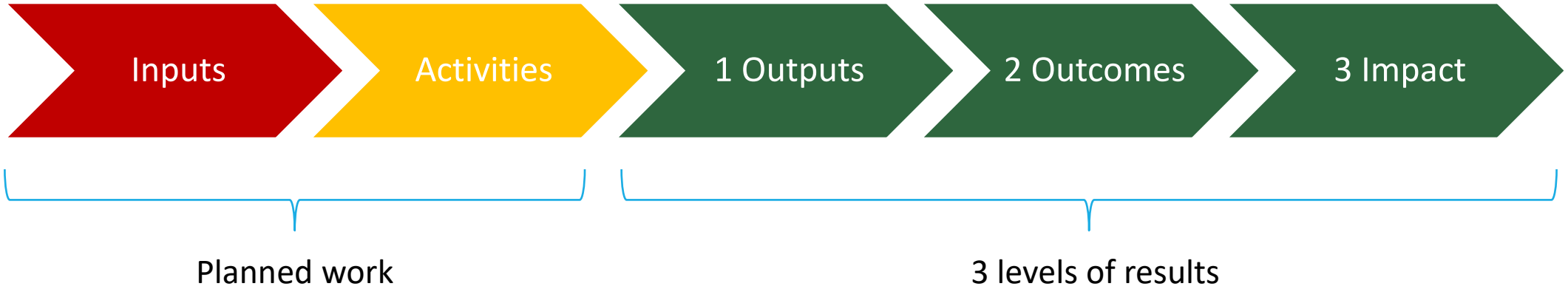
What we will cover…

- What do we need to measure? The 5 elements: inputs, activities, outputs, outcomes & impacts
- Why commission for outcomes?
- Starting from the top – the national NHS Outcomes Framework domains & indicators
- Measuring progress towards achieving the desired outcomes - KPIs
- Designing effective KPIs – some dos and don'ts

What do we need to measure?

5 things we could measure…



In more detail…

Inputs	What is used to deliver the service, e.g. funding, staff, equipment. Often confused with activities. Inputs ensure it is possible to deliver the intended service. *e.g. 3 WTE Smoking Cessation advisors*
Activities	Actions associated with delivering the service. In other words, what staff do in order to achieve the aims of the service. *e.g. organise support group meetings*
Outputs	First level of results – what the project has achieved in the short term. Outputs quantify the project activities that have a *direct link* on the desired outcomes and impact. *e.g. 50% patients attending meetings have quit smoking for >6 months*
Outcomes	Second level of results – what we wish to achieve. An outcome is an effect the service produces on the people or issues you need to address. *e.g. reduce mortality rate from respiratory and cardiovascular disease by 10% by 2024*
Impact	Third level of results – long-term consequence of a programme *e.g. NHSOF Domain 1: preventing people from dying prematurely*

More about…

- Short-term results – actions or products that were created or delivered, the number of people served and the activities or services provided.
- Usually describe outputs with numbers… *after attending the course 50% of smokers were still smoke free after 6 months*
- Outputs are measurable and readily determined – tempting to stop with outputs because they are easy to produce… you just count. *How many people had quit smoking? How many Outpatient attendances were delivered?*

BUT need to assess achievement of the next level… outcomes and impact

More about…

1 Outputs | **2 Outcomes** | 3 Impact

- Outcomes refer to the medium-term – the effect of the service on the people or issues you wish to address
- What do we want to achieve? Health changes for the cohort of patients for which the service is intended – usually defined in terms of expected improvement in condition, behaviour or health status
- Outcomes should be measured as they link directly to the efforts of the ICS and serve as a basis for joint accountability

Inputs vs outputs vs outcomes

Important to define measurable outcomes as precisely as possible

some is not a number… *soon* is not a time

Improve life expectancy?

OR

Reduce premature mortality by 3 years by 2024?

Inputs are NOT outcomes

Outputs are NOT outcomes

What are the desired outcomes?

Choose a school…

School A	employs 150 staff
School B	delivered 55,000 lessons last year
School C	85% of students achieved A-C at GCSE

What are the desired outcomes?

Now choose a hospital…

Trust A	employs 3,200 staff
Trust B	delivered 105,000 A&E attendances last year
Trust C	was in the lowest 10% nationally for emergency readmissions last year

Outputs vs outcomes: choosing a hamburger…

McDonald's sells approximately 33 million hamburgers a day

Five Guys sells approximately 350,000 burgers a day

- Based on this information, who makes the better burger?
- Counting hamburger sales is obvious (output) but does it show effectiveness or impact?
- Whereas an outcome shows success against the objectives required
- Depending on what goals you have, outcomes here might be **which burger tasted the best** or **which burger had the highest nutritional value**?

More about…

- Long-term consequence of a service/programme – what we ultimately hope to achieve in the great scheme of things
- The result of all outcomes of all services – difficult to ascertain exclusive impact of a services since other projects/services can contribute to same impact
- Impacts are hard to measure since they may or may not happen
- For instance, graduating from a training program may eventually lead to a better quality of life for the individual. But how do you know? What are the indicators of a better quality of life? How long will it take to see the impact?

Summary

Using the smoking cessation service example:

Input	Successfully recruited 3 WTE smoking cessation advisers
Activity	Organise support group meetings 5 times per week
Output	Increase the number of patients successfully quitting smoking by 15% compared to last year
Outcome	Reduce the county's mortality rate from respiratory and cardiovascular disease to below the average for England
Impact	NHSOF Domain 1: Prevent People From Dying Prematurely

Why commission for outcomes?

Understanding commissioning for outcomes in 10 seconds…

Do outcomes matter?

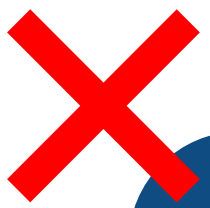
The key principle behind commissioning for outcomes is a clear **focus on the actual results being achieved** for the individual and for populations and putting in place commissioning models and/or pathways of care to achieve those results

Why commission for outcomes?

- Huge opportunity to get different parts of local health systems working together, to deliver patient benefit - unlikely that any single provider of care can deliver any given outcome in isolation from other providers
- Understand how resources are used, what health gain outcomes are delivered and how these can be measured – redesign use of resources to maximise health gains
- To expand the skills capabilities and expertise across the system so this approach becomes “business as usual”
- Inputs, activities & outputs still matter – but we want better patient outcomes…

AND btw… commissioning for outcomes is NOT a savings programme…

Joint accountability for outcomes/costs



Internal market

- No one provider is accountable for/has visibility of whole cycle of care
- Results in a lack of ownership of the overall/continuing health of the patient
- Focus tends to be on reactive treatment, rather than proactive intervention and preventative action
- Clashing organisational objectives as each provider delivers care for their part of the patient pathway…

Integrated system

- Different providers deliver the specified outcomes across the full care pathway for a group of people with similar needs
- Key objective… how to deliver outcome together
- System incentivises collaboration towards delivering those outcomes
- Where waste or 'inefficient cost' is identified, this is a system issue not an organisational issue
- Need to agree outcomes across provider organisations and the full pathway

Specifying the outcomes

- Start from the top (National Domains & Indicators) and expand on these
- If outcomes aren't linked to the 5 national domains, check… is this really a priority?
- Add any relevant additional local indicators if necessary
- What do you actually want/need to happen? Probably the same as the service users…

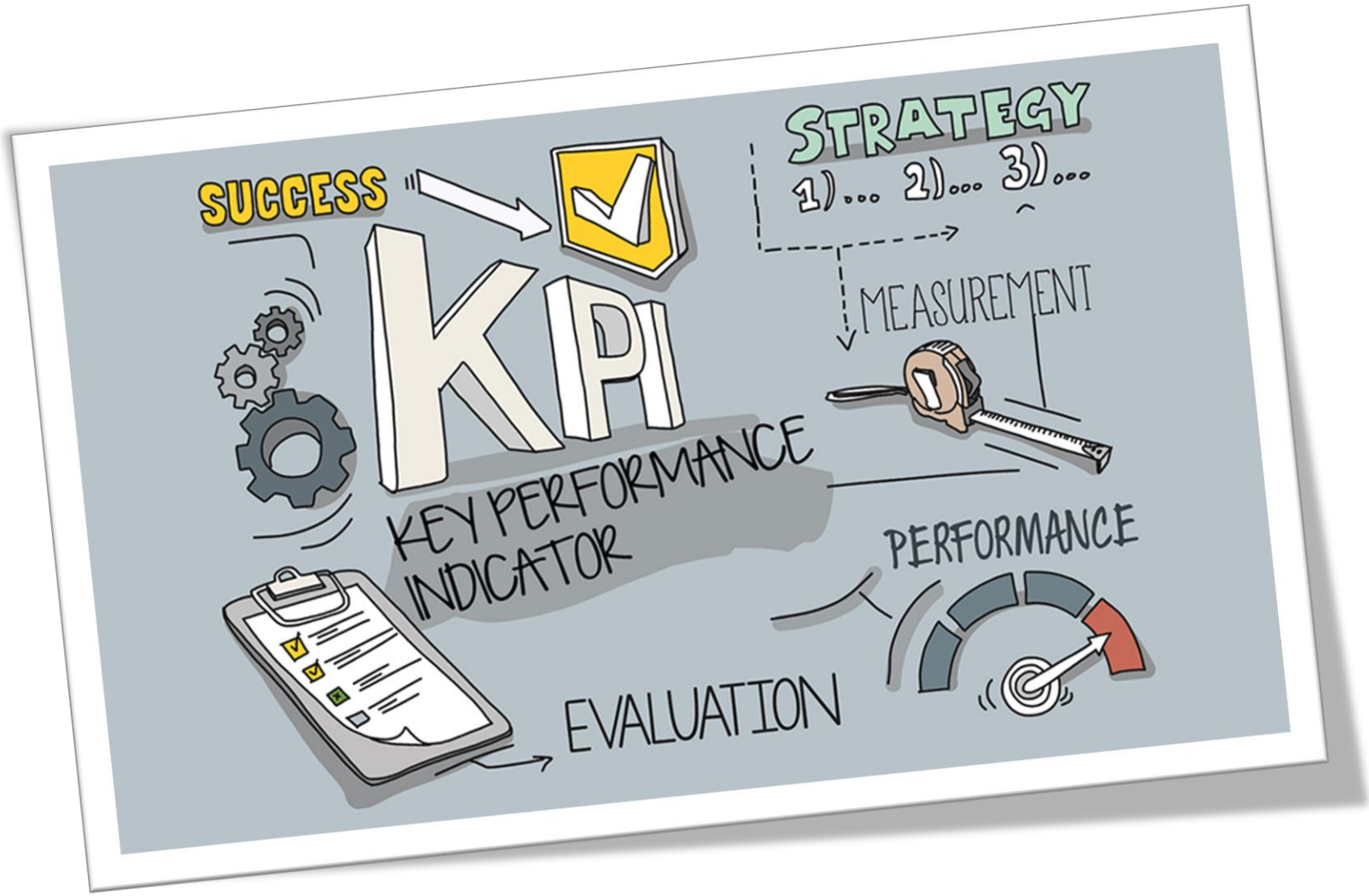
NHS Outcomes Framework Domains & Indicators

Sets out high-level national key outcomes:

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill-health or following injury
Domain 4	Ensuring people have a positive experience of care
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework

How do we measure outcomes?



What are KPIs designed to do?

- Evidence of progress towards achieving a desired outcome
- Track performance change over time and whether on track
- Reduce the complex nature of organisational performance to a small, manageable number of key indicators
- Help inform better decision making
- Ultimately, help improve performance!

KPIs to measure outputs

Use KPIs for inputs **rarely**, outcomes **always** and outputs **occasionally**…

For example:

- Outcomes can also be secured by ensuring key pathway steps are followed:

  e.g. ED: % of patients streamed within 15 minutes, and seen by senior decision-maker within one hour

- What are the key KPIs/metrics that show the service is being delivered as agreed so that the outcomes are as required?

  e.g. AEC – 90% of patients with suspected DVT to be treated as non-admitted care

Selecting the right KPIs

- Decision makers need information on the key measurements of performance
- For example, instead of measuring random things, a doctor would focus on key health measures – blood pressure, cholesterol levels, heart rate and BMI, as key indicators of health
- KPIs relate to joint system objectives and provide clarity on the important issues for the local health system
- Less is more… before you add a KPI, check do you really need this information?

How to Develop Effective KPIs

- ✓ Start with ICS objectives in the service spec
- ✓ Define the **key** questions you need answers to
- ✓ Identify what supporting data you need to answer the questions
- ✓ Evaluate all existing data to see how it can be made available
- ✓ Determine the best measurement, methodology and frequency
- ✓ Allocate responsibility for delivery of the KPIs
- ✓ Ensure KPIs are understood by those who will be using them
- ✓ Regularly review KPIs to ensure they support improved performance

Remember to be SMART about KPIs!

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Example of outcomes with KPIs: 1) Adult Cystic Fibrosis (national spec)

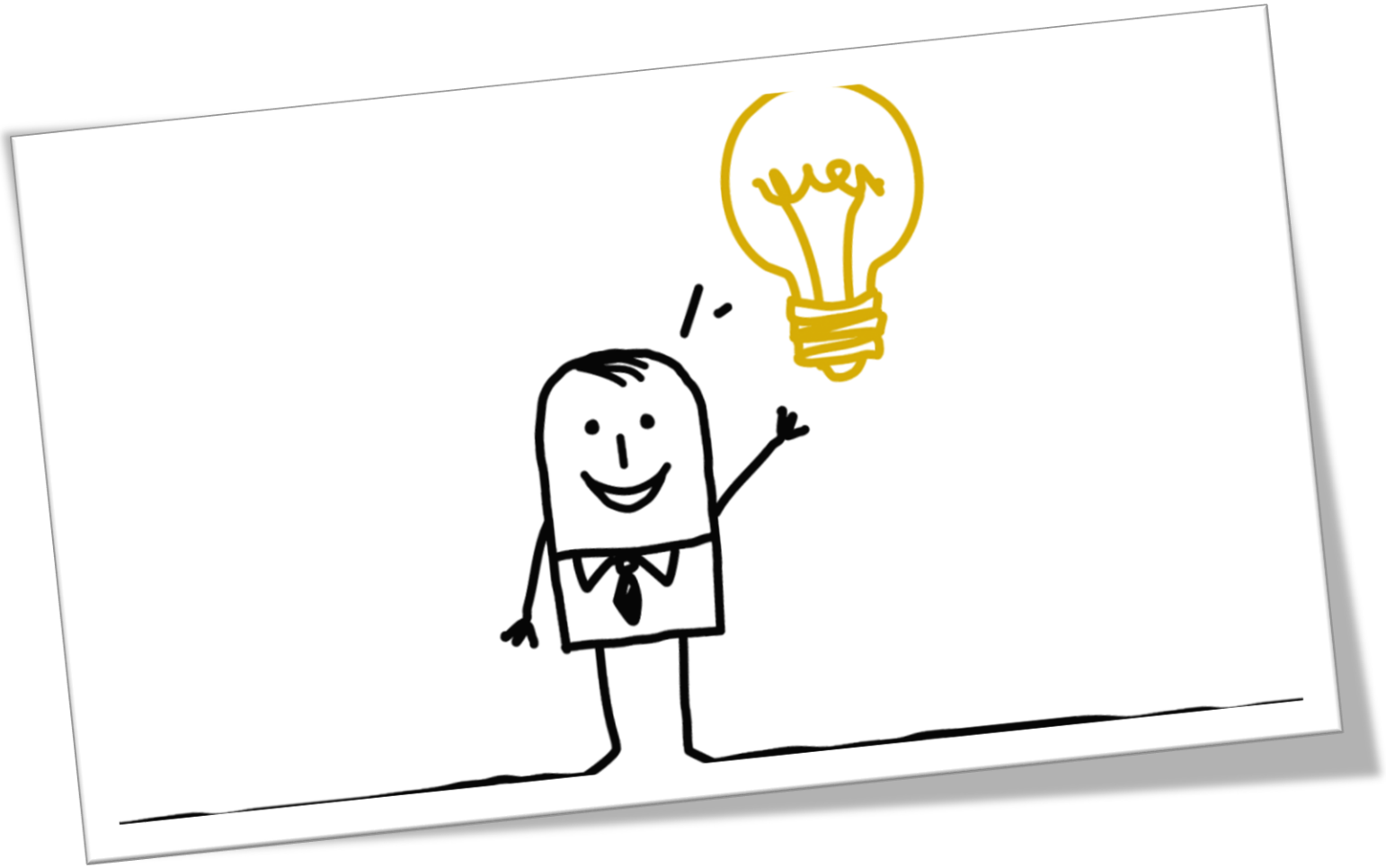
Domain 1	**Preventing people from dying prematurely**
Forced Expiratory Volume in 1 second (FEV1)	Number of patients and % with FEV1 >65% by age group and sex
BMI	Median BMI of centre cohort
Median Survival of National population	UK CF registry data
Domain 2	**Enhancing quality of life for people with long-term conditions**
Annual review and feedback	Number and % of patients who have had a post-annual review management plan with discussion
Accessibility of psychological support	Number and % of patients who have seen a psychologist within the past 12 months
Domain 3	**Helping people to recover from episodes of ill-health or following injury**
Timely initiation of treatment for exacerbation	% patients breaching standards of care for timing of admission.
Mucociliary clearance therapies	Number and % of adults receiving mucociliary clearance therapies
Domain 4	**Ensuring people have a positive experience of care**
Admission to specialist unit/ward	% of patients admitted to a ward with specialist CF staff
Systematically measure patient experience and satisfaction at a frequency driven by patient need	Systematic engagement and feedback on actions taken
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**
Chronic Pseudomonas Aeruginosa infection (3+ isolates between two annual data sets)	% adults with chronic pseudomonas infection
Pseudomonas (PA) Chronic PA is 3+ isolates between two annual data sets	Number and % of patients with Chronic PA infection on inhaled antibiotics
Data	Number of complete annual data sets taken from verified data set expressed as a % of actual patient numbers

Example of outcomes with KPIs: 2) Cardiac rehabilitation nursing service

Domain 1: Preventing people from dying prematurely						
Outcome	**Ref**	**Quality Requirement/KPI**	**Threshold**	**Method of Measurement**	**Consequence of breach**	**Timing of measure ment**
National Indicator/improvement area						
Reducing premature mortality rate from cardiovascular disease	1.1	Under 75 mortality rate from cardiovascular disease	70.8 per 100,000 (national av)	NHSOF annual indicator	GC9 process followed	Annually
Local outcomes & indicators						
Reduced Admissions – reduction in readmissions for another cardiac event	L1.1	Readmission rate	10% reduction	SUS monthly extracts	GC9 process followed	Quarterly

Tips for selecting effective KPIs…

some “dos and don’ts”



Tips… some “dos and don’ts”

- **Have a limited number of robust metrics** – a few well-targeted metrics will tell you more than a long list that no-one looks at. Don’t throw in every KPI you can think of – less is more!

  Avoid:

  - Measuring everything that is easy to measure – just because you **can** measure it, doesn’t mean you **should**
  - Measuring everything that moves – **too much** information is as bad as **too little**

Tips… some “dos and don’ts”

- **Copy-cat KPIs –** don’t include KPIs just because someone else includes them or you have seen them in an article

  Is it relevant? Is it key? If not, move on…

- **Make sure you can see the “wood for the trees”** – don’t bury the key measures in pages of information. Separate vital KPIs from other data
- **Use it or lose it –** only collect and publish data that will be used... use the KPIs to gain insight by relevant and useful presentation, deciphering what the results mean for the system objectives

Tips… some “dos and don’ts”

- **“We always do it this way”**… avoid publishing KPIs as a “tick box” exercise – it should be a timely measure that supports the delivery of better outcomes
- **Link KPIs to the ICS objectives** – they are only useful if they inform strategic decision making and link back to agreed service descriptions
- **Use KPIs as a compass, not a target** – KPIs should be used to evaluate the achievement of goals, not penalise part of the system. A focus on financial incentives may lead to data manipulation – use payment mechanisms judiciously

Tips… some “dos and don’ts”

- **Design KPIs by multi-disciplinary approach** – avoid a lack of ownership so everyone understands the connection with system objectives, KPIs and what KPIs will be used to measure
- **Keep up to date** – as strategies and objectives change, review/update the KPIs

In summary…

- Commissioning for outcomes encourages the health system to collaborate to maximise patient gain within the resources available
- Distinguish outcomes from inputs, activities and outputs
- Start with the national NHSOF domains and indicators – don't reinvent the wheel
- Properly designed KPIs provide objective evidence of progress towards achieving your ICS objectives… use them sparingly and wisely

Costing in the NHS

How it happens and why it matters

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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
- The Price is Right… good benchmarking principles

The 2021 financial context

- National Tariff originally payment by volume at a fixed national price
- Effectively suspended under COVID-19 guidance since April 2020
- But even before COVID, NHS gradually moving away from payment by volume towards **aligned incentive contracts** and/or **blended payments**
- MH, community, ambulance, etc never part of national tariff anyway!
- ICS working collaboratively on real change… where national tariff rules often hinder more than help

What will all this mean?

- Health and Care Bill proposes ‘NHS Payment Scheme’ rather than NT
- NHSE must consult on and publish pricing rules each year – which may or may not include national prices
- Each ICS uses the national rules to incentivise its locally agreed priorities
- To use them effectively, you need to understand how provider costs behave as patient activity changes
- (PS obviously you were doing this for non-acute providers all along ☺)

Firstly, some technical costing terms…

Cost Type

- **Direct** – incurred directly (in this dept) as a result of patient activity
- **Indirect** – incurred indirectly (in another dept) as a result of patient activity
- **Overhead** – not incurred as a result of patient activity

direct & indirect costs simply called **Patient-Facing Costs** in 2021 NHSE guidance

Cost Behaviour

- **Variable** – change in proportion to activity
- **Semi-fixed** – change with activity but in 'steps' as activity passes thresholds
- **Fixed** – do not change as activity changes

Costing Concepts

- **Cost driver** – event that causes a cost to be incurred & used to attribute cost to an activity
- **Cost pool** – aggregation of costs into a logical structure, e.g. *Memory Clinic* or *Ortho DC*

Examples of different cost types

Cost Type	Tend to be…	Examples
Variable costs 	Patient-facing (direct) costs	Consumables, e.g. drugs Bed linen Patient meals
Semi-fixed costs 	Patient-facing (direct or indirect) costs	Staff costs (clinical) Cleaning Utilities, e.g. electricity
Fixed costs 	Overhead costs	Staff costs (corporate) Capital charges on estate CQC registration

How does activity drive cost?

Accountants would say ‘it all depends’… Consider these 2 issues:

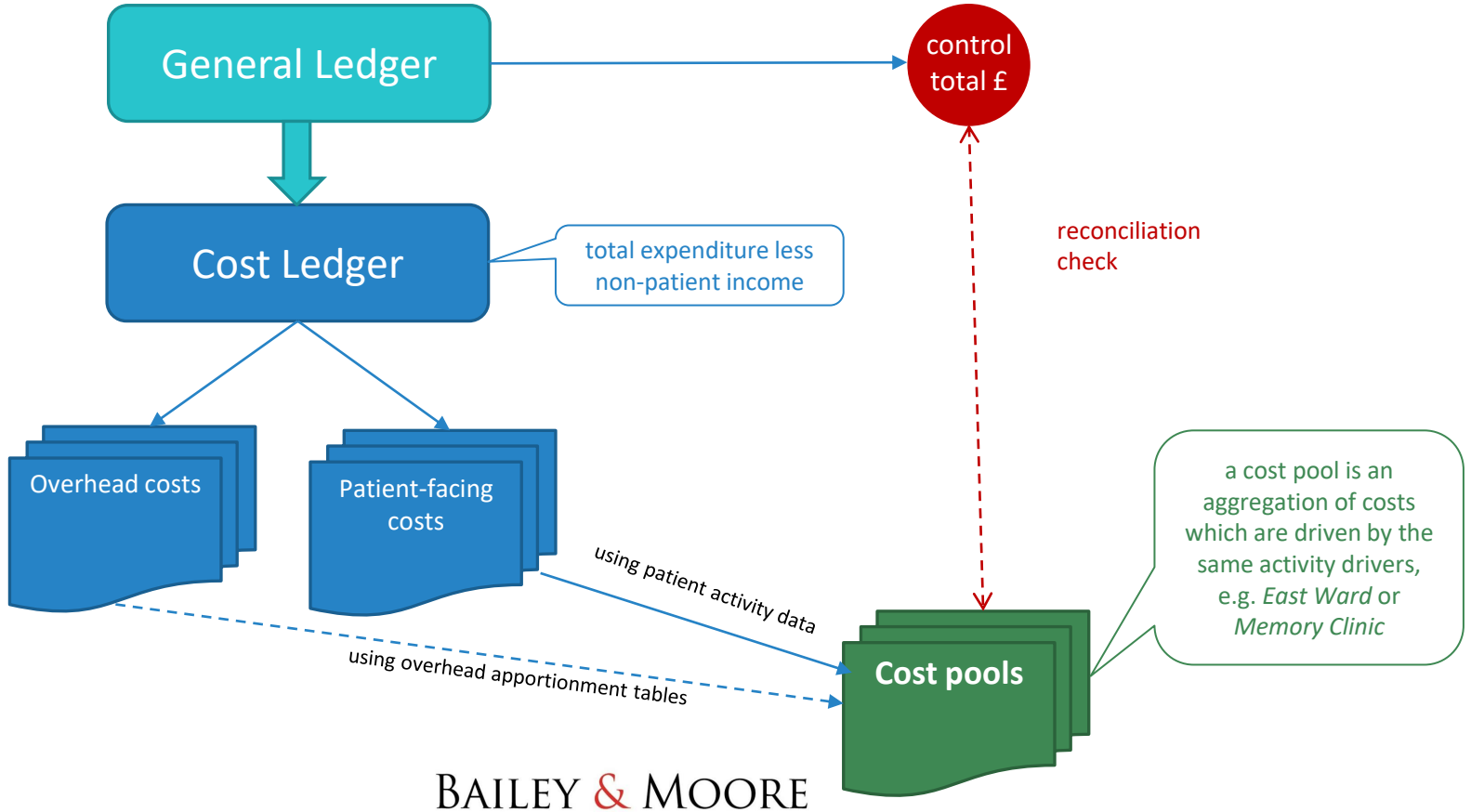
Which activity drives the cost?

- 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 costs are fixed v variable?

- 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!

How do provider costing systems work? Top-down control totals



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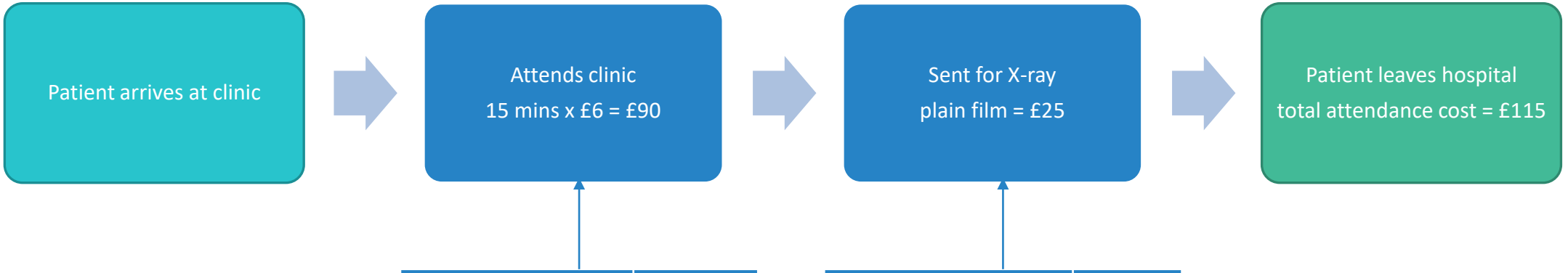
Example: an extract from a mental health inpatient ward cost pool

Cost Pool	Record Type	Allocation Key	Expense Code	Description	Total
EAW10	Expenditures		B1010	Consultants	£103,587
EAW10	Expenditures		B1800	Specialty Registrar	£131,249
EAW10	Expenditures		B7500	Medical - On-Call Payments	£2,960
EAW10	Expenditures		D9A40	Bank Nurse - Band 6	£9,603
EAW10	Expenditures		D9A50	Bank Nurse - Band 5	£88,951
EAW10	Expenditures		D9E70	Bank Clinical Support Worker - Band 3	£157,505
EAW10	Expenditures		D9E80	Bank Clinical Support Worker - Band 2	£1,318
EAW10	Expenditures		DXA30	Nurse - Band 7	£10,754
EAW10	Expenditures		DXA40	Nurse - Band 6	£130,330
EAW10	Expenditures		DXA50	Nurse - Band 5	£381,687
EAW10	Expenditures		R2000	Drugs	£11,760
EAW10	Expenditures		R4000	Dressings	£997
				Patient-Facing Costs (Direct)	**£1,030,699**
EAW10	Allocated From	CC_TPHARSLA	CMQ56	Pharmacy SLA	£12,980
EAW10	Allocated From	CC_MEDEQUIP	EEE43	Medical Devices Maintenance	£458
				Patient-Facing Costs (Indirect)	**£13,438**
EAW10	Allocated From	CC_CAPCH	CEEZZ	Trust Capital Charges	£126,792
EAW10	Allocated From	CC_TEXP	CMF10	Finance	£17,786
EAW10	Allocated From	CC_TINVOICE	CMF14	Accounts Payable	£1,145
				Overheads	**£18,931**
				Total XX Ward Cost Pool	**£1,189,860**

How do provider costing systems work? Assigning costs to outpatient activities



T&O OP clinic cost pool	Costs
Direct costs	£535k
Indirect costs	£121k
Overheads	£237k
Total cost pool	**£893k**
Operational hours	2,480
Cost per minute	**£6**

Radiology x-ray cost pool	Costs
Direct costs	£279k
Indirect costs	£20k
Overheads	£98k
Total cost pool	**£397k**
Total volume	15,931
Cost per exam	**£25**

How do provider costing systems work? Assigning costs to inpatient activities

Time-based
e.g. £ per occupied hour

Event-based
e.g. £ per test

Event-based
e.g. £ per exam

Time-based
e.g. £ per min + signif prosthetics etc

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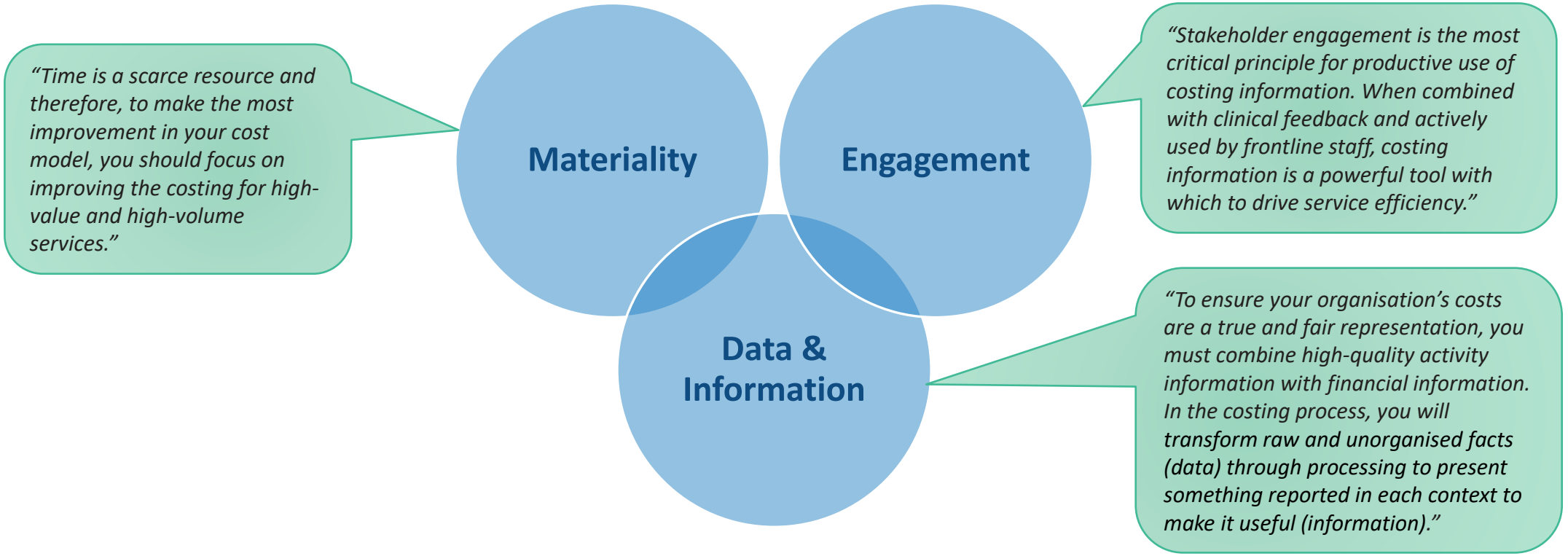
Approved Costing Guidance (ACG)

- All NHS providers must follow national costing principles and standards
- Patient-level costing (PLICS) expected to be mandated for all NHS Trusts from 2022 (including community for 21/22 financial year)
- 3 high-level costing principles
- Supported by detailed costing standards
- Plus even more detailed standards, documents, templates etc for acute, community, MH, ambulance individually!

https://www.england.nhs.uk/approved-costing-guidance/

ACG Costing Principles



https://www.england.nhs.uk/wp-content/uploads/2021/03/Costing-Principles-2021.pdf

National Cost Collection (NCC)

- ACG requires all NHS providers to submit their PLICS to the NCC annually
- Replacing Reference Costs, which were based on average unit costs
- NHSI publishes provider data each year (latest available is 19/20)
- Although some small-value data is now deleted thanks to NHS Digital!
- But still best source of NHS cost benchmarking available
- More detailed comparatives available through PLICS Portal & The Model Hospital

https://www.england.nhs.uk/national-cost-collection/
https://analytics.improvement.nhs.uk/#/views/NationalPLICSPortal/TermsandConditions?:iid=1
https://model.nhs.uk/

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 national 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 files 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

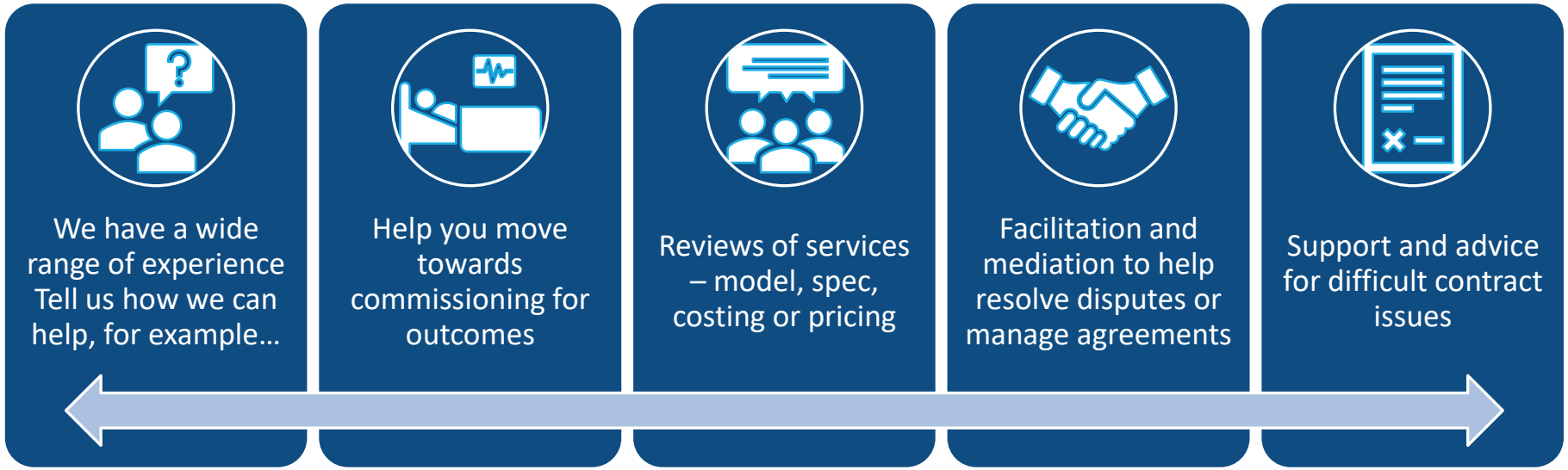
Drawing the right conclusions…

- 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 which activities drive costs
- Open book approach to costing will support agreement – work alongside providers to understand the outputs of their costing system and how it works
- Align currencies in contracts with how events are recorded in their costing system
- Benchmarking should be used to debate efficient costs v reported 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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training@baileyandmoore.com

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