NHS Improvement

The costing principles

collaboration trust respect innovation courage compassion

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

The costing principles

The seven costing principles support the costing process described in the *Healthcare costing standards for England* (the standards)[1] and describe what good costing looks like. Their aim is to improve the accuracy, consistency and relevance of costing in an organisation when used in conjunction with the standards and collection guidance.[2]

Figure 1: The costing principles

[1] https://improvement.nhs.uk/resources/approved-costing-guidance-2019
[2] Collection guidance is available from https://improvement.nhs.uk/resources/approved-costing-guidance-2019

The costing principles

By applying the costing principles to the costing and collection processes you will ensure a true and fair view of what it costs to deliver patient care in your organisation.

The costing principles provide a sense check to help you prioritise where to invest effort in improving costing and decide how much time to invest in that improvement.

The costing principles apply to the costing of NHS services.

This document describes each of the principles and how they fit with the costing process described in the standards.

Principle 1

Good costing should be based on high quality data that supports confidence in the results.

Increased data accuracy improves confidence in the resulting patient-level costs. However, as providers are generally organised into functional units, it is easy for those responsible for recording data in a timely and accurate manner to lose sight of the data's purpose and not pay enough attention to its accuracy, especially if resources are stretched.

Responsibility for data accuracy: This sits firmly with those charged with inputting operational data and their managers. Costing practitioners are their internal customers.

Fixing poor data quality: While a user may be tempted to fix a quality problem on finding it, this fails to address the cause of the error and does not establish a 'feedback' loop from which the organisation can learn. Where a data error is identified, good practice is to report it to those responsible for that data, and for them to fix it and establish routines that prevent it recurring.

However, costing practitioners are ideally placed to flag data quality issues within their organisations.

In the short term, while the organisation is working to improve its data quality generally, it is reasonable for costing practitioners to perform some data cleansing so the resultant cost data can continue to be used in a meaningful way. Any data cleansing should be documented in the costing manual.

Measuring accuracy: Management is responsible for data accuracy. It should be routinely measured and reported to management. Improvement programmes should be set up where necessary and progress tracked.

Data definitions: Inconsistent classification affects the accuracy of data underpinning cost collections. These inconsistencies can be avoided by ensuring that activity data from the NHS minimum datasets is recorded according to the *NHS Data Dictionary*.[3]

[3] www.datadictionary.nhs.uk

Principle 2

Good costing should include all costs for an organisation and produce reliable and comparable results.

Cost quantum: This is the total cost an organisation's cost model should reconcile to its audited accounts. All expenditure purposes should be traceable to the activities it has been allocated to and then traceable to the patient episode, contact or attendance the cost activity has been matched to. Any costs that cannot be allocated to an activity should be reported under 'cost and activity reconciliation items'. This totality ensures a consistent baseline for each organisation.

Netting off income: As a general rule, income should **not** be netted off against costs. Show all costs as gross, and show any related income against the relevant cost units. However, there are exceptions to this rule in paragraph 21 of Standard CP2: Clearly identifiable costs.[4] Also, operating income is to be netted off against cost for collecting purposes (see paragraph 114 in Standard CP2). This is to aid the transition from reference costs to a patient-level cost collection. It will be reviewed for 2020.

Full-period costing: Include all activity and all costs in a period, not just those for completed patient episodes, as this will make the calculated incomplete patients events position more accurate. This in turn allows you to assess more accurately the costs of the activity undertaken in the period. It also removes ambiguity in approach and comparison. However, please note that incomplete episodes are excluded from the national cost collection as part of the transition approach for moving from reference costs to a patient-level cost collection.

Activity quantum: Reconcile all activity included in the costing output to the source activity inputs and to the organisation's reporting position. A key element of patient-level costing is the reconciliation to Secondary Uses Service and Hospital Episode Statistics datasets, which are nationally reported activity by providers.

[4] This refers to the integrated version of the costing process standards, available from https://improvement.nhs.uk/resources/approved-costing-guidance-2019

Principle 3

Good costing should show the relationship between activities and resources consumed.

How costs are incurred should be traced through the system:

- How much cost was incurred – as recorded in the general ledger?
- Why was the cost incurred – what resources were purchased with this cost, such as staff, space, consumables?
- Where were these resources used and for what purpose – the activity of admitting patients would be classified into the activity group of wards?
- What drove the need for this activity?
- Who incurred these costs?

Principle 4

Good costing should involve transparent processes that allow detailed analysis.

At every stage of a costing process it is important that:

- costs are allocated transparently
- costs can be easily traced from one stage to another, or their origin can be identified by working back.

Without such transparency it is more difficult to get clinicians and managers to accept that the numbers are correct or to act on the results.

Transparency also makes it possible to audit a cost model to check that all costs have been accounted for at every stage of the cost allocation, or to ensure that a cost submission is acceptable for use in an annual collection.

If software is to effectively facilitate the transparency required by this principle, it should satisfy the *Minimum software requirements for the costing of NHS services in England*.[5]

It is important to apply transparency at every stage of the costing process. This should make it possible to trace all costs across every stage of the process back to their origin in the general ledger at cost centre and expense level.

Keep documentation up to date as the costing process is continuously improved. The costing team should use the costing manual and the costing assessment tool (CAT) to assure the board about the process undertaken.

Principle 5

Good costing should focus on materiality.

Those responsible for resources can manage them more cost-effectively in patients' interest if they understand what drives the need for the larger elements of cost. As time is a scarce resource, to make the most difference you should focus on improving the costing for high value and high volume services.

Apply a materiality threshold of more than **0.05% of your organisation's expenses**, or **more than 5% of a specialty's overall costs**. Cost and activity which falls below the materiality threshold must still be included in the costing process, but you should focus on high value or high volume areas first.

If the variation in costs is wide, pay particular attention in the costing process to information sources, cost allocation methods and matching rules to understand it, explain it and, if appropriate, rectify it.

[5] https://improvement.nhs.uk/resources/minimum-software-requirements

Principle 6

Good costing should be consistent across services, enabling cost comparison within and across organisations.

Supporting improvement: Consistent cost allocation in an organisation's costing system supports three levels of improvement:

- **Within the organisation:** An organisation's ability to understand and link expenditure to patients and services year to year helps it trace and manage costs and monitor trends in costs against services.
- **Between organisations:** If all organisations allocate costs against the same standard in the same way, each can compare their costs against those of their peers, assess their performance and generate efficiencies in service delivery.
- **Across the service:** Service-wide consistency – where each organisation allocates costs consistently against the same standard – makes it easier for national bodies like NHS England, the Department of Health and Social Care and NHS Improvement to improve the overall system. Consistency supports the creation of more accurate pricing models, specific local variations and better tariffs through better reference costs that drive sector-wide efficiencies.

Quality of costing: More consistent costing and better quality operational data will produce more reliable costs and less unexplained variability in what should be comparable results.

Principle 7

Good costing should engage clinical and non-clinical stakeholders and encourage use of costing information.

Stakeholder engagement is the most critical principle for productive use of costing information. When combined with clinical feedback and actively used by frontline staff, costing information is a powerful tool with which to drive service efficiency.

By actively engaging with stakeholders, costing teams can:

- understand the audience for costing data – who uses it, how they use it and where effort will achieve highest impact
- ensure costing is more accurate, locally relevant and actually used by clinicians to drive improvements
- improve business intelligence by working with those delivering patient care, and so develop an understanding of how resources are consumed and could be better used.

Stakeholders who should typically be involved in costing are:

- **Boards and executives:** executives need to be confident using costing information, both in their own decision-making and throughout the organisation – there should be a governance framework to review and sign off the costing processes used and the collection returns.
- **Clinical staff, including consultants, therapists, nurses and staff from clinical support services:** they can provide information about service delivery that enables accurate allocation of costs to patients.
- **Staff from the informatics and clinical coding departments:** they can help automate the extraction of patient activity information from various systems, speeding up the costing process and supply of accurate activity data.
- **Finance staff, including financial management:** they are crucial for providing the correct financial information from the general ledger and interpreting the ledger coding.

- **Non-clinical staff involved in service delivery, including operational managers, education and training colleagues, and research and development colleagues:** they can ensure costing information is reported to support decision-making.
- **Commissioning and contracting staff**: they can help verify patient activity information and identify income at a more detailed level to assist allocation.

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