Consultation on mandating patient-level costing for NHS community services

December 2020

Contents

About this document

1. This consultation document proposes changes to the requirements on NHS foundation trusts and NHS trusts (referred to collectively throughout as “NHS Trusts”) who provide community services[1] to record and report the costs of community activity. We propose that from 2021/22 the costs should be recorded and reported at a patient level, in line with the methodologies and approaches in the Healthcare Costing Standards for England (“the Standards”). The changes would apply from the 2021/22 financial year, with the first mandated collection in 2022.

2. Since 1 April 2016, Monitor and the NHS Trust Development Authority have operated as a single organisation known as NHS Improvement (NHS England and NHS Improvement since April 2019). This document is issued in accordance with the duty to consult imposed on Monitor by section 69(7) of the Health and Social Care Act 2012[2] (the 2012 Act). In this document ‘NHS England and NHS Improvement’ means Monitor, unless the context requires otherwise.

3. The document covers:

   - what we propose to change
   - options reviewed
   - how we engaged with the sector in developing these proposals.

4. It should be read with the annexes and the supporting documents, especially the impact assessment[3].

[1] See Annex 2 for the current list of relevant trusts.
[2] The duty to consult applies where section 69 requires Monitor to carry out an impact assessment of proposals which are, among other things, likely to have a significant impact on providers of NHS services.
[3] https://www.england.nhs.uk/approved-costing-guidance/

Scope of the consultation

5. This is a statutory consultation in relation to the following proposal:

   - For the financial year 2021/22 and onwards, it would be mandatory for NHS trusts providing community services to record and report patient-level costs (PLC) in line with the costing standards.
   - There would be no dual running of reference costs, with reference costs ceasing to be collected after the financial year 2020/21.

6. The PLC data submission would cover all of the services currently collected under reference costs[4]. The submission of PLC will be subject to an impact assessment and consultation of service-specific mandation proposals, and approval by NHS Improvement. For details of when the mandation would apply, see Annex 7 of the impact assessment.

7. Collecting PLC data is key to achieving the vision in the Five Year Forward View (5YFV) and the NHS Long Term Plan, on improving patient outcomes and allowing commissioners and providers to better understand costs and activity flows, so enabling them to "maximise the use of taxpayers investments".

8. We described the role of costing in supporting these wider objectives in our 2016 report, Patient-level costing: case for change.[5] The plan for the transition to costing at a patient level was set out in Improving the costing of NHS services: proposals for 2015 to 2021.[6] As part of this process, from 2018/19 the submission of PLC data has been mandated in the acute sector and from 2019/20 mandated for mental health and ambulance 999 activity.

9. Engagement with NHS Trusts providing community services has been good. The number of trusts involved has increased from 3, in 2017/18 to 42 in 2019/20. Their feedback, and that from the Community Technical Focus Group, has been invaluable in supporting the implementation of the Costing Transformation Programme (CTP) and we thank all the trusts that helped draft and hone the costing standards. At the time of publication of the impact

[4] Annex 10 of the impact assessment
[5] https://improvement.nhs.uk/resources/plics-case-change/
[6] https://www.gov.uk/government/consultations/improving-the-costing-of-nhs-services-proposals-for-2015-to-2021

assessment, there are only 2% of trusts providing community services that do not have a Patient Level Information and Costing System (PLICS).

10. Our impact assessment[7] indicates that mandating recording and submission of PLC data using the Standards would have an impact (costs) but also have benefits to trusts, commissioners and other users of the data.

11. We have estimated there would be additional costs to trusts in implementing PLC, over and above the cost of producing reference costs. On average we have estimated the average cost to a trust of producing reference costs for all services is £169,589, compared to £172,659 for PLC – however we believe this will reduce over time for PLC as it becomes more automated and with costing becoming more embedded in the day-to-day operation of trusts, as found in many acute trusts. Though PLC is not yet embedded in the community sector, some trusts are already identifying benefits, including improving the quality and completeness of data being submitted. Other benefits the sector expects to achieve include:

    - improving the quality of underlying data and ensuring consistency of approach to counting and costing
    - enabling NHS Trusts providing community services to compare patient pathways and costs with peers, helping them reduce unwarranted variation
    - improving understanding of patient pathways between NHS Trusts providing community services and the rest of the sector, facilitating new care models
    - producing more accurate cost data that will improve the accuracy of the local prices, helping to strengthen efficiency incentives and improve sustainability across the service in the longer term.

12. This consultation invites you to feed back on the proposal to make PLC mandatory for community services from 2020/21. We plan to publish our response to the issues you raise and expect to make a final decision on the proposal in January 2021. We will publish our decision on our website[8]

[7] https://www.england.nhs.uk/approved-costing-guidance/
[8] https://www.england.nhs.uk/approved-costing-guidance/

13. If you want to keep up to date with this work, please see the mandation page on our website at https://www.england.nhs.uk/approved-costing-guidance/

Responding to this consultation

14. The proposal for the mandatory submission of PLC for community activity from 2021/22 is subject to a statutory impact assessment and consultation process, as required by Section 69 of the 2012 Act. These processes offer stakeholders the opportunity to be informed of the likely impact of the proposals and to tell NHS Improvement what they think about them.

15. The consultation period begins on Thursday 17 December 2020 and ends on Friday 29 January 2021.

16. We welcome feedback on the proposals and will consider your responses before making a final decision on whether to mandate PLC for community activity.

17. Please submit your feedback via email to costing@improvement.nhs.uk.

What are we proposing?

Mandation

We propose that, for the financial year 2021/22 onwards, it will be mandatory for NHS Trusts providing community services to record and report costs at a patient level for community activity in line with the Healthcare Costing Standards for England. The mandation of reference costs will cease, with final year of collection being 2020/21.

18. NHS Trusts currently submitting reference costs using the datasets would be required to record and report costs at a patient level. The methods and basis for costing would follow the rules set out in the Standards published as part of the Approved Costing Guidance[9] . Data would be submitted to NHS England and NHS Improvement after the end of the financial year.

19. This data would be recorded and reported by the relevant NHS Trusts (currently those noted in Annex 2) from the financial year 2021/22. The annual collection would take place after the end of the financial year – the first currently planned for summer 2021, in relation to 2021/22 activity.

20. Currently cost data for community services is collected on an average basis as part of reference costs, and the methods for calculating costs[10] have been on a comply-or-explain[11] basis rather than required. This has led to issues and differences in how costs are calculated, reducing the benefits for users from benchmarking their costs and pathways. Inconsistencies and poor methods of apportionment caused about half the inaccurate costing audit results over the last five years – affecting all services at providers, including community.

21. The result is that this data, using average costs and differing methods of apportionment, cannot easily be linked to an individual patient and can often hide errors in how resources are allocated. Because of this, the data does not allow community providers to review and benchmark pathways internally or with

[9] https://www.england.nhs.uk/approved-costing-guidance/
[10] Previously the Healthcare Financial Management Association Costing Standards, recently the Healthcare Standards for England.
[11] A regulatory approach used in the UK and other countries in corporate governance and financial supervision. Rather than setting out binding laws, regulators set out a code, which listed companies may either comply with, or if they do not comply, explain publicly why they do not.

other providers. In addition, costing processes vary across organisations, meaning there is no consistency in costing processes or methodologies, impacting on the usefulness of data for comparison, both between trusts and within organisations.

22. Our impact assessment indicates that, based on various types of trusts that have already implemented PLC, more accurate costing would bring a range of benefits, including the following:

- **Supporting the provision of care in the best environment for patients, as envisaged in the Five Year Forward View and NHS Long Term Plan**. PLC would allow providers and commissioners to use anonymised activity to identify patient pathways across all types of providers – from ambulance to community settings. This could support plans for integrated care across providers and contribute to a more joined-up and preventive approach across NHS and other service providers.
- **Improving comparison between peers – internally and with other providers**. Production of consistently costed activity will allow more accurate benchmarking internally and with other providers which will allow identification of cost variations across providers.
- **Leading to better engagement with clinicians and clinical staff**. Because PLC is at a patient level and can be regularly produced, providers can share patient pathway and cost data with staff outside of finance departments. This will not only improve the accuracy of the data but will also allow community trusts to work with other providers to improve treatment options.
- **Allowing providers and sustainability and transformation partnerships to assess the impact of changes in service provision**. Many NHS Trusts have started to use patient-level data to understand the profitability of services. One trust has found issues with the accuracy of activity data by comparing costs and activity across services and is using initial PLC data to ensure all activity is being correctly recorded, improving the information available for planning services. The ability to link across providers is also seen as a major benefit, supporting the move to system-wide planning and service provision.
- **Improve the quality and granularity of information at a trust and across a system area.** Patient level data, with costing, coding and pathway information, will allow trusts, clinicians and stakeholders to better target interventions to support people to manage conditions within the community.

The ability to review at pathways across providers is a key benefit of PLC and will support the move to system provision of services.

- **Providing more accurate data for agreeing local prices and local variations to national prices**. In the past, prices have often been based on a provider's average costs. However, detailed costs at a patient level, which have been validated by clinicians and commissioners, would give a more accurate basis for agreeing prices.

23. We have estimated the costs of implementing and running PLC systems as part of our impact assessment[12]. Unlike the acute sector, as PLC is only just being implemented in community, most of the benefits are expected rather than being realised. Benefits those implementing PLC expect to achieve include:

    - Being able to cost across all services in a consistent manner (even where the service is a commercially let contract and cost information is not collected). This will reduce time spent on business cases and bidding for contracts as cost information will be readily available.
    - Producing more accurate information to identify cost or savings improvements, or business cases for service changes.
    - Consistency on counting and costing, which will enable providers to benchmark more accurately both internally and externally.

24. By mandating the methods and approaches for costing according to the Standards we can ensure consistent costing, which would support benchmarking of costs and job cycles.

How would PLC recording and reporting be made mandatory?

25. The standard conditions of the NHS provider licence[13] contain provisions relating to pricing, including requirements on recording and reporting information about costs – see conditions P1 and P2. These licence conditions apply to NHS foundation trusts; NHS trusts are required to comply with equivalent conditions, including the requirements relating to pricing and costs[14].

26. The conditions require licence holders to:

[12] https://www.england.nhs.uk/approved-costing-guidance/
[13] https://www.gov.uk/government/publications/the-nhs-provider-licence
[14] The pricing licence conditions also apply to independent providers, but we have decided not to make the recording and reporting of PLICS mandatory for them at this time.

- record cost information in accordance with cost allocation methodologies published by NHS England and NHS Improvement in its Approved Costing Guidance (condition P1)
- provide such information, documents and reports relating to costs as NHS Improvement may require for its pricing functions (condition P2).

27. These requirements apply if the relevant providers are notified in writing – we notify providers by publishing the relevant requirements in our costing guidance.

28. The proposal to mandate NHS Trusts to carry out PLC recording and reporting would be implemented by including the applicable requirements, methodology and standards in guidance published by NHS Improvement in advance of the financial year 2021/22 (likely to be early 2021).

29. This would mean that NHS Trusts would have duties to record and report costs in accordance with the Standards. Failure to comply with those duties would be a breach of the relevant licence conditions (or, in the case of NHS trusts, conditions equivalent to the relevant licence conditions), which might result in regulatory action by NHS Improvement, including, in appropriate cases, use of its statutory enforcement powers.

Issues and risks of the proposal

30. This proposal is a significant change in how costs are recorded and reported across NHS Trusts. Implementing PLC raises several issues. Table 1 summarises these issues and sets out the mitigation or rationale for our decision.

Table 1: Obstacles to implementing PLC

Issue	Mitigation or rationale
The new standards are very detailed, and some trusts are concerned they do not currently have all the expected information to fully implement the new approaches.	For 2019/20 we have 42 trusts planning to submit voluntary PLC data in January 2021 (delayed due to the pandemic). If mandated from 2021/22, we expect this to increase to 80 NHS trusts (or 47%). We will continue to work with the Community Technical Focus Group (TFG) and Community Early Implementer Groups to identify trusts that need additional support and identify whether a transition pathway, similar to that for acute, is required for those trusts who are not as advanced as others. We will also consider, with the TFG, the creation of an implementation timetable to support trusts implementing PLC.
The accuracy of underlying data has not been verified, and the cost of introducing PLC may not lead to sufficient benefits to recoup the costs.	We believe that PLC will improve the accuracy of data collected by providers and will allow trusts to compare productivity and patient pathways, both internally and externally, to identify where processes can be improved. It will also allow community providers to link in and be part of conversations on future plans for providing health services across areas.
The impact of COVID-19 on costing submissions for 2021/22 (collected in 2022) is unknown and some concerns have already been raised.	Various processes have and will be out in place, including • A transition pathway to allow trusts to move to full implementation of the costing standards over a number of years (consistent with other sectors) • Providing support and guidance for all trusts (including community providers) on costing on the pandemic, with creation of a working group and Costing Advisory Group to provide detailed help • Extending the Costing Assurance programme to identify those trusts that need additional support and help NHS Improvement to target additional support.

Question				
To what extent do you agree with mandating patient-level data for community services in line with the methodologies and approaches in the Healthcare Costing Standards for England, from 2021/22?				
Strongly agree	***Agree***	***Neither agree or disagree***	***Disagree***	***Strongly disagree***
What is the reason for your answer?				

Ceasing the collection of reference costs

To support the implementation of PLC, we propose ceasing the collection of reference costs, with the last year being 2020/21.

31. We believe that ceasing the collection of average reference cost data will not only reduce the burden on the small costing teams in community health trusts but will also hasten the implementation and use of PLC as the single version of cost data by providers, commissioners and other data users.

32. We believe that having a single consistent method of recording activity (and associated costs) will be extremely beneficial, as it will focus on PLC becoming the only source of costing data. We are also confident that, should it be required, we would be able to recreate reference cost data from PLC.

33. There are a number of risks and issues with this proposal. We have included these, and the mitigation or rationale for our decision, in Table 2:

Table 2: Dual collection issues

Issue	Mitigation or rationale
Reference cost data is used as the basis for local prices and moving to PLC may impact on agreeing prices with commissioners. This was noted during the impact assessment work. Those	We will also work with NHS England and the Community Technical Focus Group to support the move away from reference costs for pricing and contracting purposes, including providing guidance to commissioners on how to use the aggregated PLC data published. Moving to PLC will support the aims and approaches identified

trusts not on block contracts have been using various costing processes to calculate and agree local prices.	under the blended payment approach for contracting.
The accuracy of underlying data may impact on contracting arrangements.	As noted above, we believe the accuracy of data will be improved by moving to PLC. We will continue to work with trusts and other users of the data to refine and improve costing, using the PLICS portal (Add link) and the costing assurance programme to improve the accuracy of data.
Information for contracted-out (outsourced patient activity) work has previously been included in reference costs but has been excluded since 2017/18.	Outsourced activity remains excluded as this is not currently available at a patient level. We are asking trusts to start working with their providers to obtain this at the required level. We will continue to work with the sector as part of the costing transformation programme, with the aim to reduce exclusions from the quantum.

Question	
Do you agree with the proposal to cease collection of reference costs for community health activity from 2020/21?	
Yes	**No**
If you disagree, why do you disagree?	
Is there an alternative? Please provide details of what you propose.	

34. Because of how each organisation has structured its internal finance process, we have only included an estimated cost of producing the required cost return - whether this is reference costs or PLC. For example, some providers include the cost of producing service line reporting and other cost data as part of their costing function and others exclude this. Therefore, we have estimated the cost of producing a costing return (including collecting the relevant data, calculating and verifying costs and senior review and sign off) based on information collected from previous reference costs surveys and on-site visits and data provided by trusts and excluded the costs of internal financial functions.

Do you have any comments on our assessment of the likely costs?

Frequency of PLC data collection

35. Though we are not currently recommending collection of PLC data more frequently than annually, we would like to use this opportunity to invite comments from trusts and other users of reference cost data.

36. Currently, costing data is collected annually. In trusts, financial data is often produced more frequently – often quarterly. Producing and collecting cost data on a more regular basis would, initially, increase the burden on trusts. However, this would be spread over the year and we believe the overall increase would be limited.

37. Feedback from the previous PLC consultations[15] indicated that this would be beneficial, but that certain issues and processes would need to be addressed prior to rolling this out.

38. We believe collecting PLC data more frequently would benefit all providers and other users. For all trusts these benefits include:

    - identifying issues with costing during the year rather than after the year-end, allowing correction and more accurate costs to be submitted
    - supporting the financial management process as cost and activity information is available more frequently; this data will enable trusts to identify and address issues on a more timely basis.

39. For other users, we believe:

    - it would further the work of, for example, the Model Health System and as part of Use of Resources Assessment work, as metrics could be run more frequently, allowing them to support providers in a more timely manner
    - it may reduce information collected by NHS Improvement – for instance, data on costs and activity could reduce the information trusts must collect as

[15] See links at https://webarchive.nationalarchives.gov.uk/20200501110529/https://improvement.nhs.uk/resources/transforming-patient-level-costing/

part of quarterly reporting, and it would help in agreeing financial targets and cost improvement plans.

Issues and risks of the proposal

40. As with our other proposals, we have identified issues and risks. Table 3 summarises these and explains the mitigation or rationale for the proposal.

Table 3: Frequency of collection issues

Issue	Mitigation or rationale
Moving to quarterly collection would increase the burden on providers' costing and finance staff and reduce the time available to investigate and review PLC within trusts.	The burden would increase initially, but much of the validation and investigation that happens at the year-end would be spread throughout the year. We also believe that: • more frequent collection of cost data would link better with trusts' internal reporting arrangements and therefore better support internal financial monitoring • the data can be used to support commissioning and reduce time spent investigating queries • it will help identify cost saving plans – and costs that differ from expectations – more quickly.
What would quarterly data be used for?	We could regularly publish data validation reports and outlier information, to help trusts improve the accuracy of their data during the year. It could also be used to assess the impact of casemix changes during the year.

Question				
In principle, do you support the move to a quarterly cost collection for the community health sector.				
Strongly support	***Support***	***Neither support or oppose***	***Oppose***	***Strongly oppose***
What is the reason for your answer?				

If you agree, when would it be realistic to make this a requirement?

2022/23	***2023/24***	***2024/25 or later***

Please give details of any other risks or issues you feel need to be addressed to support the move towards quarterly collection of PLC data

Do you have any other views or comments to make on the proposals?

How we developed our proposal

History

41. Cost data is recorded and reported by NHS Trusts under the requirements of the NHS provider licence issued by NHS England and NHS Improvement (Monitor) and conditions equivalent to it as specified by NHS Improvement (NHS Trust Development Authority) as applicable to NHS trusts. This information has a variety of users – for example:

    - trusts and commissioners use reference costs to manage their costs, agree local contracts and prices, and plan future services
    - NHS England and NHS Improvement uses reference cost as the basis for pricing, including the national tariff
    - cost data supports a wide variety of cross-sectoral work to improve clinical outcomes and efficiency, including the work on operational productivity led by Lord Carter and benchmarking trusts to identify unwarranted cost variation.

42. The processes for submitting reference costs – and their accuracy – vary considerably between NHS Trusts. Previous reviews of accuracy of reference cost data undertaken as part of the Costing Assurance Programme (focusing on acute providers who also provide community services) found the level of information available for these services was poor. There were a large number of examples where data for services not included in the mandated commissioning data sets (collected and submitted to NHS Digital) was found to be estimated or incomplete - based on information collected for a few weeks or months and extrapolated for the full year.

43. We published several documents to support our plans: *Patient-level costing: case for change*[16] and *Improving the costing of NHS services: proposals for*

[16] https://improvement.nhs.uk/resources/plics-case-change/

2015 to 2021.[17] The latter introduced the CTP. By 2022 the CTP aims to address inconsistency and improve costing across the NHS.

44. In preparation for a proposed move to PLC, many trusts have already been involved in piloting PLC through voluntary collections. Currently only 4 (2%) of trusts do not have a costing system capable of producing PLC and we would expect all trusts to have a system in place to produce a return for 2021/22.

45. The work undertaken for other sectors confirms that mandating PLC and ceasing to collect reference cost data is likely to have a significant impact on NHS Trusts. Therefore, we are required by the 2012 Act[18] to undertake an impact assessment of the changes, looking at the costs and benefits of various options. The next section summarises the impact assessment, which is available (ADD LINK).

Impact assessment summary

46. Initially we identified eight options for mandating PLC (see impact assessment document for more information), and investigated three in detail:

- Option 1 (business as usual): reference costs remain the mandated costing return, but we continue with a voluntary PLC submission; the standards remain on a comply-or-explain basis
- Option 2: mandating PLC for community health activity from 2021/22, with up to a two-year dual running of reference costs; mandating standards for costing for both PLC and reference costs from 2019/20
- Option 3: as Option 2 above but ceasing collections of reference costs after the 2020/21 financial year.

47. As part of the impact assessment we engaged with trusts by:

- undertaking two surveys (one in 2019 and one in 2020) collecting data on:
  - expected costs and costs incurred for updating or purchasing a costing system for community services
  - the expected resources to include community services at a patient level

[17] https://www.gov.uk/government/consultations/improving-the-costing-of-nhs-services-proposals-for-2015-to-2021
[18] See section 69(4) of the Health and Social Care Act 2012

  - areas of concern, risks and benefits of implementing PLC for community services

- discussions with 8 trusts – either through on-site meetings or telephone conference, all at different stages of their PLC journeys to discuss the risk, benefits and costs of implementing PLC
- collecting feedback from the Community Health Technical Focus Group (TFG) and the Community Early Implementer Groups to identify any areas we have not covered
- meeting other key users of reference cost data to understand the impact of the proposed change on their work and identifying the risks and benefits of various options.

48. We used our findings to assess what we consider to be the best option for our proposals and identify its potential benefits. Feedback from trusts implementing PLC identified many benefits – some of which they were already achieving, and others expected. These include:

- more granular information, which will enable trusts to review unwarranted clinical variation by patient, which, in turn, will allow better benchmarking, both internally and across the sector, to identify innovative ways of providing services
- improving the completeness and accuracy of activity data by providing more granular information which can be verified on a regular basis with service managers and clinical staff
- more detailed information on clinical pathways, which can be used to improve how services are delivered, not just in individual trusts but also, in the future, across systems as part of Integrated Care Systems
- future planned links to clinical outcomes will support service redesign by identifying where patients could have been more appropriately treated.
- Ceasing the collection of reference costs will allow community providers to focus on producing a single return for all their services. Feedback from acute providers has been that this burden, running two versions of a costing system and having to reconcile across two submissions, is a significant burden. Clearer and more consistent apportionment of overheads and better understanding of cost drivers across the trust.

49. For each of the options, we used data collected through on-site discussions and from trusts to calculate the average cost of running patient-level costing and information systems, updated for the most recent information available in the summer of 2020 – see Table 4. Considering this, along with the benefits and risks, we found that Option 3 was the preferred option.

Table 4: Summary of estimated cost for each option

Year	Option 1	Option 2	Option 3
2020/21	£164,688	£178,767	£178,767
2021/22	£152,585	£180,445	£142,382
2022/23	£154,588	£180,748	£140,938
2023/24	£156,090	£156,772	£156,772
2024/25	£158,370	£164,124	£164,124
2025/26	£165,741	£171,821	£171,821
2026/27	£173,458	£179,882	£179,882
2027/28	£181,536	£188,323	£188,323
2028/29	£189,992	£197,161	£197,161
2029/30	£198,844	£206,417	£206,417
Total	**£1,695,892**	**£1,804,461**	**£1,726,587**

50. Though the costs of Options 1 and 3 are broadly similar (1.8% difference over 10 years), feedback from most community health providers and other users of data, such as Getting It Right First Time (GIRFT), Model Health System and other regulators, indicate that the benefits of Option 3 much outweigh those for Option 1 (business as usual).

51. As well as generating the benefits noted above, we believe there would be additional cost savings from reducing time spent producing bids for commercial tenders for activities which are often let commercially by commissioners. We also believe that other regulators and other national bodies (such as the National Audit Office) would, subject to information governance arrangements, be able to use the activity data as the single version of the truth on performance, which would reduce information requests in the future.

52. More information on the detailed assumptions and benefits can be found in the impact assessment (ADD LINK).

Annex 1: Patient-level costing consultation: glossary

Term	Description
2012 Act	The Health and Social Care Act 2012.
Costing transformation programme (CTP)	Aims to improve the quality and use of costing information in the NHS, with patient-level costing and a single, national annual cost collection.
Healthcare Costing Standards for England (the Standards)	The approved approaches and methodologies for calculating costs, published in the Approved Costing Guidance: https://www.england.nhs.uk/approved-costing-guidance/
Patient-level costing (PLC)	Calculating and collecting data at an individual patient level.
Patient-level information and costing system (PLICS)	The system used to record and report costs at a patient level.
Reference costs	The average unit cost to the NHS of providing health care to NHS patients.

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This publication can be made available in a number of other formats on request.

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