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Approved Costing Guidance 2022: the costing principles

Version 1, March 2022

Overview

1. Three costing principles[1] of materiality, data & information and engagement underpin good costing processes in an organisation to enable high-quality patient-level costing.

2. They aim to improve the accuracy, consistency, and relevance of costing in all NHS organisations in England.

3. They will offer you a solid framework on which to construct your costing data in conjunction with the standards and collection guidance. Where a unique situation arises, applying these principles should ensure you produce a true and fair view of the cost to deliver patient care.[2]

4. The three costing principles have equal weight as part of delivering good costing, as shown in Figure 1.

5. High-quality costing requires all three principles. If one is missing, it may lead to less useful data.

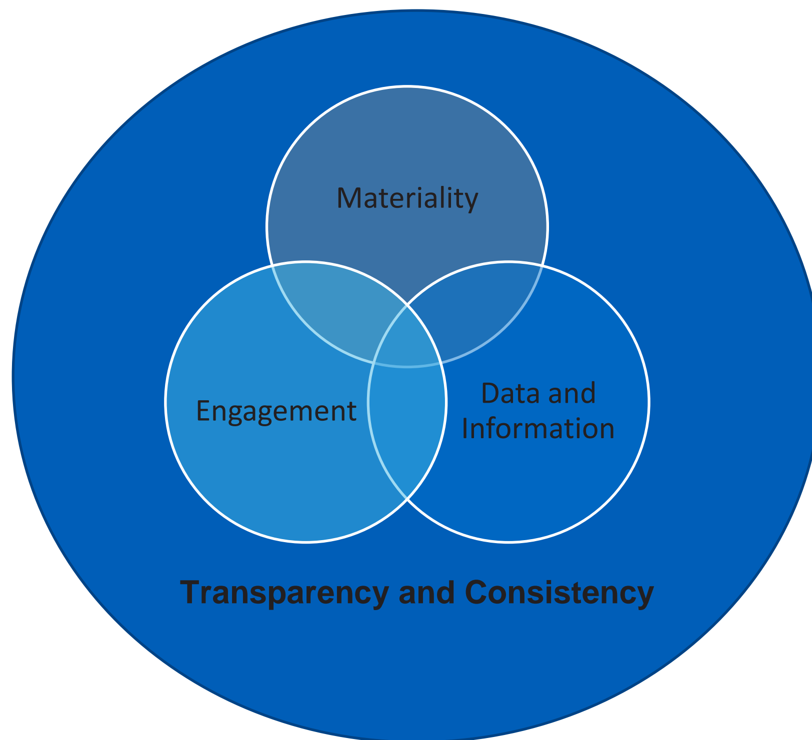
6. The costing principles will help you prioritise where to invest effort in improving costing, and to decide how much time to invest in that improvement. They apply to:

   - all sectors
   - all services delivered by your provider, irrespective of funding source.

7. We also use these principles when planning our implementation support.

[1] In previous versions of the costing principles, seven principles were outlined. This update synthesises those principles into three core concepts which will facilitate practitioners to build forward from a common and simple foundation.
[2] Our collection guidance is available here.

Figure 1: The costing principles



Costing principle 1

Materiality

Those responsible for resources can manage them in patients' best interests only if they understand what drives the larger elements of the cost incurred. Time is a scarce resource. Therefore, to make the most improvement in your cost model, focus on improving the costing for high-value and high-volume services.

Materiality can be subjective

8. In most instances costing practitioners should agree a materiality level[3] appropriate to the service with service leaders. Trusts can set their own materiality level with their costing steering group, and the impact of the decisions will be assessed by the Costing Assurance Programme.

[3] Where this is not possible, or practitioners wish to start with a baseline for a discussion, we would suggest applying a materiality threshold of more than 0.05% of your organisation's expenses, or more than 5% of a specialty's overall costs.

9. When defining the materiality level, consider the threshold above which missing or incorrect information is considered to have an impact on the decision-making of users.

10. Cost and activity which fall below the materiality threshold must still be included in the costing process, but you should focus on high-value or high-volume areas first during your implementation and as part of your cycle of updates.

Costing principle 2

Data and information

To ensure your organisation's costs are a true and fair representation, you must combine high-quality activity information with financial information. In the costing process, you will transform raw and unorganised facts (data) through processing to present something reported in context to make it useful (information). The increased data accuracy improves confidence in the resulting patient-level costs and therefore enables managers to improve patient care.

11. Ensure that costed activity shows the true pathway and clinical interactions of the patient journey. Without such transparency, it is more challenging to get clinicians and managers to accept the numbers are correct or to act on the results.

12. Data accuracy is the responsibility of those supplying and inputting operational data, their managers and informatics leads. Costing practitioners are their internal customers, using the data to produce clear cost information.

13. Costing practitioners may influence the data used, but it is unlikely they can control the quality of data available. They are, however, ideally placed to flag data quality issues and explain the uses of the data for costing and decision-making, ensuring those responsible for it understand their importance in the costing process.

14. In the short term, while an 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.

15. You should keep documentation up to date as the data is checked/cleansed and the costing process is continuously improved. The costing team should use the integrated costing assurance log (ICAL) and the costing assessment tool (CAT)[4] to assure the board about the process undertaken.

[4] CAT for 2022 will be released later in the year.

Costing principle 3

Engagement and use

The costing practitioner, when effectively partnering with services, should be a change agent as well as someone who can provide costing information. Stakeholder engagement is crucial 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.

16. This principle is about creating an active and productive relationship between clinical, management and back-office support teams. Costing patient-level activity does not only include patient-facing costs, and therefore it is important to ensure good stakeholder management with each function of the organisation, not just clinical.

17. Engagement time should be a significant element of the annual costing cycle. Stakeholder management is a key element of partnership building. Understanding what matters most to your stakeholders will enable you to benefit from their knowledge and insights, creating a value-adding relationship.

18. By actively engaging with stakeholders, costing teams can:

    - understand the audience for costing data – who uses it, how they use it and where the effort will achieve the highest impact
    - ensure costing is more accurate, locally relevant and 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 assess how they could be better used.

19. The engagement process is a continuous ongoing endeavour. It will evolve over time and continual improvement will lead to a robust and accurate PLICS position, which in turn will allow data to be used by clinicians for better decision making which will drive improvements to the patient journey.

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