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Assurance of cost data

Costing extension (formerly CP6)

Version 1, March 2022

Assurance of cost data (formerly CP6)

Purpose: To ensure providers develop and maintain high quality assurance for costing and collection purposes.

Objective

1. To provide assurance that:
   - providers have implemented the standards and collections guidance properly using the costing principles
   - providers are maintaining a clear audit trail
   - processes are adequate to validate the accuracy of submitted data in line with the Approved Costing Guidance (ACG)
   - information governance protocols are followed
   - patient pathways and cost data have been clinically reviewed.[1]

Scope

2. This document relates to all costing processes and outputs produced by the provider.

[1] Later versions of the standards will require clinical review but having taken feedback we recognise that for now developing these review processes should be the goal.

Overview

3. There are many ways to provide assurance on the costing and collection process, including:
    - formal audit of process and submission by the provider's internal and external auditors
    - evidence demonstrating:
        - compliance with the ACG
        - process management using the integrated costing assurance log (ICAL)
        - users' review of cost data
        - minutes of regular user/working group meetings
        - use of the cost information to support decision-making.[2]

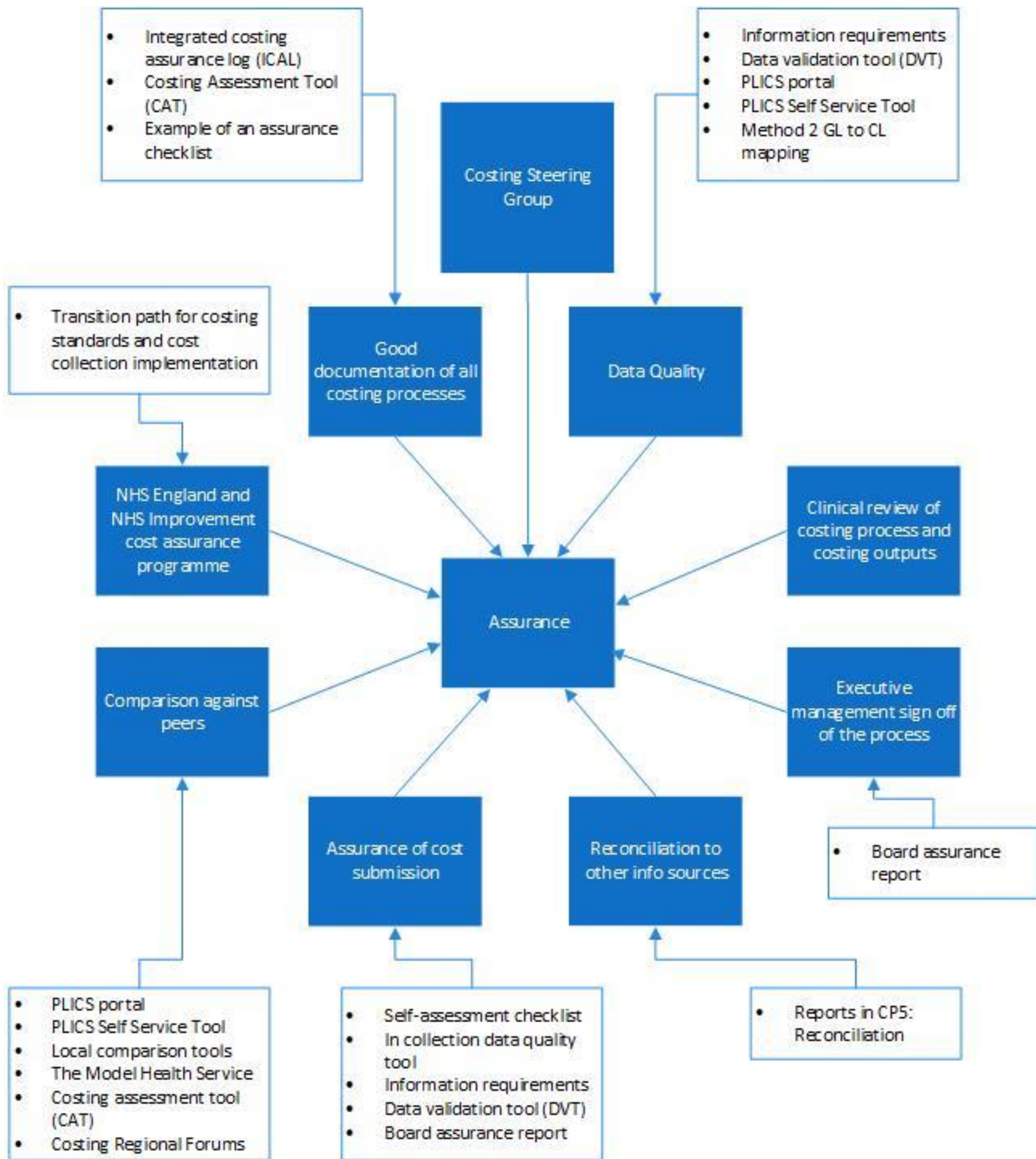
4. The assurance process should be an integral part of producing cost information. Producing an audit trail, covering assumptions, decisions, and reviews will enable your organisation to show both internal and external users that it has adequate processes for ensuring the quality of cost information.

5. Many stakeholders require assurance that the PLICS data is appropriate, so they can place reliance on the decisions taken using the cost information. They include:
    - Your local executive team for its strategic decision-making
    - Your clinicians/healthcare professionals and operational managers when analysing activities and clinical procedures
    - External stakeholders, including the users of the National Cost Collection, who may make varied uses of the information.

6. We provide tools to help you develop and maintain an assurance process that will promote continued improvement. Figure CP6.1 shows examples of these.

[2] See Costing extension IR3: Use of patient-level information.

Figure CP6.1: Assurance tools



7. Once you have implemented patient-level costing, you should frequently assess quality of your costing processes and data using the costing assessment tool (CAT). Submission of this tool will be a mandated part of the National Cost Collection in 2025 (for the 2024/25 financial year)

8. When changing a process or updating data in the costing system, the working version of the CAT can be updated, showing the change to the quality of

processes and output data created. This information can be used to inform your local governance processes for the ongoing improvement. You should record these changes on the ICAL worksheet 18: Decision audit trail, showing why processes have been changed and the level of authorisation given.

9. The level of evidence of a change should correspond with the significance of the change made to the quality or completeness of the cost information. We do not wish you to create additional burden by recording immaterial changes.

10. The CAT and the ICAL tools will support the assurance process for the board when submitting the costing submission. They will also help to identify areas where costing needs to be improved.

Approach

Documenting costing processes

11. You should use our tools to document your organisation's costing processes.[3] In particular:

    - The **ICAL** helps document compliance with the standards. You can use it to record where you have made local adjustments and the reasons for them. It will also ensure your organisation retains costing knowledge and expertise when costing practitioners change.
    - The **CAT** helps providers understand and record their progress in implementing the standards. It will help you focus your attention on areas to develop and improve based on their materiality.
    - **Spreadsheet: Transition path** describes a time-based plan for implementing the standards.

12. The benefits of documentation are:

    - being able to show the assumptions and source data to end users, which improves output(s) credibility and increased confidence in usefulness
    - facilitation of reconciliation, assurance, and evidence generation of the management of the overall process
    - understandable assumptions that can more easily be challenged, leading to improvements in the costing process.

[3] Tools can be found on our website

Assurance on the quality of costing processes and outputs

13. We expect providers to ensure costing is included in internal and external audits as it will provide assurance on the accuracy of cost data for internal and external users.

14. National reviews of the quality of the data submitted will be scheduled periodically – this is known as the Costing Assurance Programme.

15. Cost information must be linked to the organisation’s ongoing management, so it continues to accurately reflect the services being delivered.

16. To do this, cost information should be owned by senior managers and clinicians. The finance function needs engagement from across the organisation if it is to provide meaningful support.

17. The more services use cost information, the more they will understand the cost data, how it has been calculated and be able to contribute to improvements.

18. In doing so, confidence in the cost information for their service will increase and enable its use for operational decisions and the transformation of care.

Local costing steering group[4]

19. To assure the information held within and extracted from PLICS, the organisation should form a ‘costing steering group’ with executive and clinical membership, and a PLICS lead from the informatics department. Ideally, the chair will be a clinician.

20. Such a group’s overall purpose is to provide assurance of the quality of cost information and support improvement where necessary. The group can:

    - provide assurance to the trust board of the process and data quality levels in the cost data
    - provide ideas for, encourage, and evaluate the use and understanding of costing information in the organisation,

[4] During the implementation phase, you may wish to focus on specific topics with members of the group rotating into the meeting dependant on the topic in focus. You would then create a more diverse agenda once you have completed your transition to PLICS and it is embedded in your organisation as business as usual.

- and escalate challenges to accurate/complete costing and information challenges for resolution by the relevant department.[5]

21. It can achieve this by:
    - reviewing cost information and the cost submission
    - reviewing the quality and coverage of the underlying data
    - reviewing existing costing processes
    - agreeing priorities for reviewing and developing the system
    - reviewing feedback from the Costing Assurance Programme, and other audit functions.

22. To assist with this, the group should be supported by members from:
    - IT (technical services)
    - informatics (information services)[6]
    - clinical coding (if relevant)
    - finance
    - service managers
    - other care providers including senior nursing
    - E&T lead
    - a clinical champion (any discipline).

23. The costing steering group review should be part of a rolling programme rather than a one-off as part of a national mandated collection.

24. The group may be required to report to existing trust groups, to fit local arrangements. For example, the costing steering group may be required to report on the National Cost Collection to the audit and assurance committee.

Regular assurance processes

25. You should have an annual plan for reviewing the costing processes and outputs to provide assurance that the costing information is sufficiently accurate for its intended use.[7]

[5] See also Costing extension IR3: Use of patient-level information.
[6] IT technical services and information services may form one department or be separate. Regardless, both should be appropriately represented as they are critical to PLICS.
[7] Applying costing principle of materiality to focus efforts.

26. You should work with clinicians, other healthcare providers and service managers so you can:
    - understand the resources and activities involved in delivering patient care
    - understand the information sources available to support costing
    - identify the expected costs associated with that care
    - ensure all information is reflected in the costing processes within your costing system.

27. Effective engagement between an organisation's board and its costing team is a prerequisite for improving and making better use of patient-level cost information. Boards have an important role in securing greater engagement between clinical and costing staff.

Assurance on information governance

28. You should ensure local and national information governance protocols are followed for patient-level data within PLICS data feeds, processing, and outputs. Work with the trust information governance lead and informatics to gain sign off from both, to provide assurance to the costing user group.

Assurance on the quality of the cost submission[8]

29. We provide tools to help you with the quality of your cost submission. These include the following.
    - **The self-assessment checklist** ensures providers are reviewing their data quality and including executive review and sign-off, and minimum expected quality checks.
    - **The PLICS data quality tool** (Tableau) is accessed via NHS England and NHS Improvement's single sign-in website. It reviews the submitted cost data, quickly identifying quality issues, and informs providers if resubmission is required. Providers will receive a quality/index report to help inform their costing and data investigation. It also enables providers to review their costs with peers.
    - **The data validation tool (DVT)** - as part of the National Cost Collection - comprises mandatory validations as part of the collection process that

[8] Information on these tools and where to find them is given in the Approved Costing Guidance or by emailing costing@england.nhs.uk

indicate whether the submission will fail based on the field and values formatting requirements for uploading the data.

Comparison with peers

30. Acute and mental health providers that have submitted National Cost Collection data at patient level can access the national PLICS portal via NHS England and NHS Improvement's single sign-on website. Ambulance providers can use this portal to view incident level data.

31. The PLICS portal enables review of submitted data, anonymously comparing outputs with those of peers. In this way a provider can identify and focus on its outlying areas of cost and activity. The PLICS portal also identifies potential productivity opportunities and other metrics such as the weighted average unit.

32. The DVT provides assurance that the successfully submitted data is appropriate to be loaded into the national PLICS dataset. It also provides warnings that highlights area where data may need review. The work to understand and correct (if necessary) the warnings gives additional assurance that providers understand their data and confirm it appropriately fits the expected costs of the submission and those of their peers.

33. The CAT provides a dashboard that allows comparison of CAT scores against those of your peers.

34. You should also have a programme of local exercises to regularly compare your organisation's costs with those of your peers within your assurance plan.

Costing Assurance Programme[9]

35. The aim of the assurance process is to provide evidence of the work undertaken and the reasoning behind the decisions made. The audit trail, evidence of data flows, discussions and meetings, discussions with clinicians, etc should be maintained but not be an end in itself. The ICAL should be populated as a central location for evidence, or for signposting to where the evidence is stored.

[9] Details of the Costing Assurance Programme can be found here

36. Providing evidence for an external assurance audit should not be the main purpose of collecting this information.

37. The evidence provided should also be in harmony with the costing principles.[10]

38. As part of the Costing Assurance Project we recommend your organisation has a clear and robust plan for costing, so priorities and achievements can be easily communicated.[11]

39. The CAP will report its findings to the local trust board or audit and assurance committee (if delegation is authorised). The findings should form part of the development plan for the forthcoming costing period.

[10] See *The costing principles:* https://www.england.nhs.uk/approved-costing-guidance/
[11] Example project plans and an assurance checklist are available on the Open Learning Platform at https://www.openlearning.com/nhs/courses/costing-improvement/homepage/

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