The costing principles

March 2021

The Costing Principles

Overview

1. The three costing principles[1] underpin good costing processes in an organisation to enable high-quality patient-level costing.

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

3. The three principles will enable you to have a solid framework to construct your costing data in conjunction with the standards and collection guidance; but where a unique situation arises the application of these principles should ensure that 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 an element of all of these in the process, the absence of one principle in a costing process may lead to a reduction in the usefulness of the data produced.

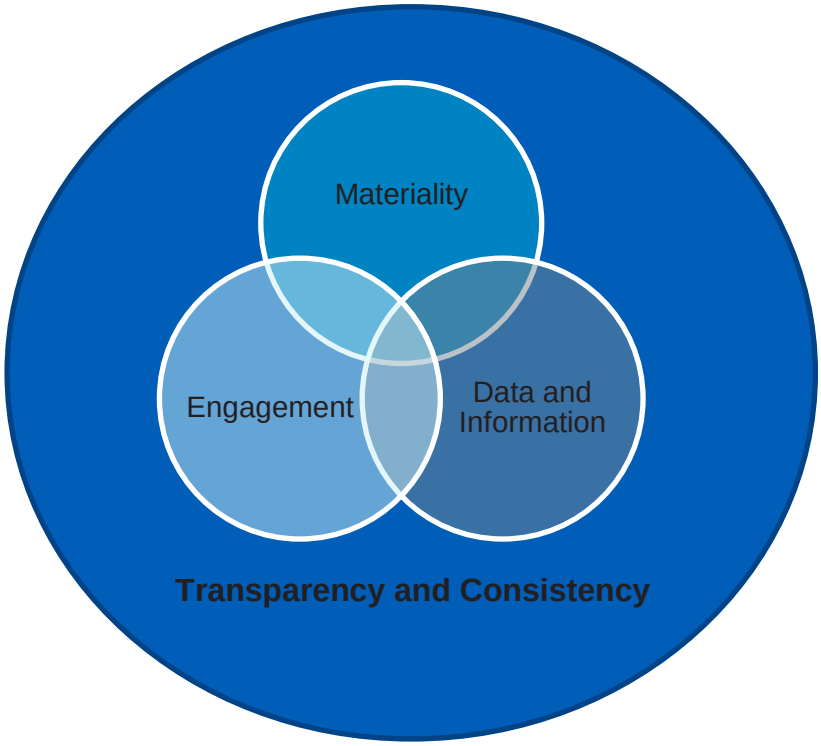
6. The costing principles provide a sense check to help you prioritise where to invest effort in improving costing, and to decide how much time to invest in that improvement. The costing principles apply to:

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

7. NHS England and NHS Improvement also uses 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] Collection guidance is available from https://www.england.nhs.uk/approved-costing-guidance/.

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 and therefore, to make the most improvement in your cost model, you should 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 are able to set their own materiality level with their Costing Steering Group, and the impact of the

[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.

decisions made will be assessed by the Costing Assurance Programme (CAP).

9. When defining the materiality level, you should 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 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 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 each 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. You should 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 that the numbers are correct or to act on the results.

12. Data accuracy is the responsibility of those charged with 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 level of data quality available. Costing practitioners are ideally placed to flag data quality issues within their organisations. They can 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 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.

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) to assure the board about the process undertaken.

Costing Principle 3

Engagement and Usage

The costing practitioner, when truly partnering with services, should be a change agent as well as someone who can provide 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.

16. This principle is about creating a real and active relationship between clinical, management and back-office support teams. Costing patient-level activity does not only include patient-facing costs, and therefore you should 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. You should understand what matters most to them to enable you to benefit from their knowledge and insights and therefore 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 assesses how they could be better used.

19. The engagement process is a continuous ongoing endeavour. It evolves 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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