TAKING COSTING SERIOUSLY

An audit of NHS costing has found some significant inaccuracies in a sample of 50 trusts. The biggest problem is lack of organisational support and a failure to actively use the data. It's time to take costing seriously, says CHKS's Howard Davis (pictured)

MOST NHS TRUSTS are not using their cost information to run their business. This means they are not getting the benefits this granular information can bring. But the failure to use this data in a meaningful way also means it doesn't get the scrutiny needed to improve its quality. And, given that this cost data is also used as the basis for national payment tariffs, this has much wider and more serious implications.

In 2013/14, CHKS audited the costing arrangements at 50 acute trusts as part of the payment by results data assurance framework that we deliver on behalf of the Department of Health. To support local improvement, we selected 30 trusts identified as being 'at risk' of having poor cost information.

We then selected 10 'low risk' trusts to understand what constitutes good practice and 10 trusts were selected at random. A briefing, entitled *Improving the quality of costing in the NHS: findings from the audit of cost information 2013/14*, sets out the key findings from these audits and will be published shortly.

We found that improvements are needed in the quality of cost information at the majority of trusts we looked at. Reference cost submissions at one third of the audited trusts were materially inaccurate, with 'at risk' trusts in particular struggling to cost accurately.

While we tested the accuracy of the reference costs submission – as this is currently the only national return that informs pricing – we also reviewed the approach to costing across the whole organisation, including patient-level costing (using patient-level costing and information systems or PLICS) where it had been implemented.

Our audit methodology also examined the support to costing across the whole organisation, from the board downwards.

In most cases, we found that errors occurred not because of mistakes by individual costing accountants, but because of inadequate support to the costing process within the organisation. Trusts with poor costing arrangements and inaccurate cost submissions frequently had poor processes across their organisations. And there was often a lack of understanding outside of the finance department of the importance and benefit of costing. There were also many trusts where the quality of costing was incorrectly perceived to be poor by clinical staff, and sometimes by finance as well.

Improving the quality of cost information is secondary to the benefit that comes from sharing cost information with clinical leaders.

ERROR FILE

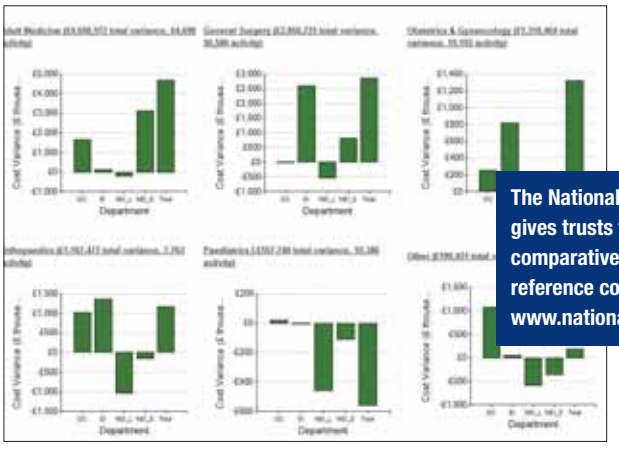
Material errors leading to incorrect reference cost submissions included:

- A complete failure of arrangements to produce accurate cost information, including no board assurance process
- Costing systems failure
- Inadequate checking of cost outputs
- Inaccurate activity data used in many areas of the submission
- A poor approach to costing, leading to errors in allocations
- Use of out-of-date information, such as job plans and floor area
- Incorrect financial treatments, such as income from donated assets not being excluded and impairments being double-counted
- Exclusions of services not authorised by the Department of Health.

But actively using cost information will improve its quality, as issues with data quality are identified and resolved and costing methodologies are refined. Cost information will not accurately reflect the services delivered until it is linked to the ongoing management of the trust. Yet many trusts were reticent to share costs with clinicians until they were 'perfect', not realising that this was what was holding back the improvements that could be made.

The best trusts we visited routinely used cost information as part of their day-to-day business, using costing to inform contract negotiations and set local prices, assess service performance and profitability, and to identify anomalies and efficiencies in delivery.

Where clinical engagement was fully embedded, we found clinicians who accessed their own PLICS data using online tools. Information provided at the most granular level encouraged clinicians to review their own behaviour – and that of their colleagues – to identify inefficient use of resources and differences in clinical practice within their own teams. Sustained engagement occurred when divisional managers had responsibility for the quality of cost information, supported by the costing lead, leading the engagement with services.



The National Benchmarker service gives trusts free access to comparative analysis of previous reference costs submissions www.nationalbenchmarker.co.uk

The accuracy of costs is only as good as the activity information it is based on. Yet data quality continues to challenge the NHS. No matter how detailed and accurate costing methodologies are, if the activity data is incorrect, then so will be the unit costs. There was lack of ownership of the data used in costing, and this is causing problems, not just for costing, but for running a trust as a whole.

At most trusts, the informatics team oversaw routine patient administration system data, covering admitted patient care, outpatients and A&E. However, there was often very poor communication between information and finance departments. Data for other services, such as radiotherapy and community services, often came direct from the service itself. It was extracted or collected by administrative staff not supported by the informatics teams.

Taking ownership

Ownership of clinical data by non-informatics staff increases the risk of error in data reporting. The costing process relies heavily on data, and as such should be a joint project between finance, information and other departments.

Costing also uses other information beyond activity data. Again, the quality of this data was inconsistent, and always fell outside the purview of any data quality policies. Job plans that formed the basis for allocating medical staff costs were often out of date – and often by more than four years. When they were up-to-date, clinicians felt they did not accurately reflect the actual care they delivered. The quality of floor area data used to inform costing was similarly variable. These are key pieces of information.

A previous review of 2008/09 reference costs by the Audit Commission found that more than half of a sample of trusts were not undertaking basic checks on costs. This has improved, but the quality of these checks is not consistent. High-performing organisations treated costing as an ongoing process and checked data as much as possible throughout the year, instead of leaving it to the last minute once they had produced their draft reference costs submission.

It is also important to check all available guidance, not just the latest changes. Some trusts with otherwise good-quality costing made simple mistakes.

Benchmarking continues to be an effective tool for refining costing methodologies, yet many trusts rely on year-on-year comparisons when checking outputs, which is dependent on the accuracy of previous costing methodologies and activity data.

Trusts with good-quality costing shared benchmarking information alongside their cost data throughout the organisation. Previous reference costs submissions are available in the National Benchmarker service, which is freely available to the NHS.

Many trusts also reported issues with their costing systems. Costing methodologies are becoming increasingly complex – reviewing your cost system on an annual basis to ensure it is fit-for-purpose, and that the appropriate IT support is in place, will stop problems occurring during business critical periods.

It may also be self-evident, but it's worth reiterating that the accuracy of costing and the quality of individual unit costs were more reliable at organisations in which basic project management principles were adhered to – a project plan in place, detailed project documentation and senior management scrutiny at key stages.

> "It is also important to check all available guidance, not just the latest changes. Some trusts with otherwise good-quality costing made simple mistakes"

The introduction of PLICS has improved the quality of costing in the NHS. However, patient-level costing is still in its infancy. While many trusts have implemented PLICS, only a small number of trusts had patient-level inputs for all material cost components. Even high-performing organisations struggled with some patient-level data, such as prostheses information.

Despite improved guidance on costing, there is still much variability in how costing methodologies are implemented, and this inconsistency becomes much more marked for trusts with PLICS. And how a general ledger is mapped to a trust's costing system can lead to variation in unit costs across separate organisations.

These issues of inconsistency will impact on national cost collections, both reference costs and the voluntary PLICS submission. Not only are Monitor and other organisations unable to obtain a consistent picture of cost drivers at individual organisations, but unit costs for use in the tariff-setting process will be based on various methodologies irrespective of the relative accuracy of the costing approach identified through our audits.

Costing data has rightly been identified as a key tool in helping to understand variation and support transformation as the NHS collectively looks to close the estimated £30bn efficiency gap by 2020. It is also an integral part of value judgements as we look to base decisions using information about quality and costs together.

But there are significant opportunities for improvement. And the first step is to give costing the right profile within organisations – take the data seriously, provide the costing team with the right support and make sure the data is used to inform decision-making and drive change. ■

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