WHY EVERY NHS DOF SHOULD BE VERY INTERESTED IN REFERENCE COSTS

Reference costs have been collected by the DH since the 1997/98 financial year. Since then many refinements have been made to the collection process and over the years the quality of the data produced has significantly improved, but still they've ended up the Cinderella of NHS finance departments, unloved and undervalued. All that, however, is now beginning to change.

Three Important Factors

Whether they realise it or not Trusts and FTs currently face a perfect storm, meaning **no one will ever underestimate reference costs again** – NHS Improvement's forthcoming mandating of PLICS returns, PWC's audit of 2014/15 reference costs returns and the imposition of Lord Carter's ATC metric.

These three factors will drag NHS costing kicking and screaming out of the dark and into the glare of the NHS spotlight.

Going back in time the main purpose of reference costs was to help set prices for NHS-funded services in England, but they were also intended to support the DH's commitment to data transparency, thus benefiting patients.

What started the new focus on costing was when the 2012 Health and Social Care Act transferred responsibility for the National Tariff Payment System in England from the DH to Monitor and NHS England. The DH continue to collect reference costs, but Monitor is now accountable for them.

Clearly it's common sense that accurate costing should underpin everyday decision making in the NHS, but it also underpins Monitor's ability to set efficient prices. This is reflected in Monitor's provider license. Both trusts and FTs must submit reference cost returns that adhere to Monitor's costing guidance. This falls into 3 main areas:

1. adherence to Monitor's six principles of costing,
2. compliance with the Department of Health's reference costs guidance,
3. compliance with the Healthcare Financial Management Association (HFMA) costing standards, on a 'comply or explain' basis.

Enter Capita

Building on their increased focus on reference costs Monitor engaged Capita to audit the 2013/14 reference cost submissions of 75 acute trusts in July 2014. These organisations equated to £23 billion of NHS expenditure. However, a somewhat mixed picture emerged with **49% of the trusts audited being found to have materially inaccurate reference cost submissions.**

Building on this initial work by Capita, PWC will shortly be reporting on the 2014/15 Reference Costs Assurance Programme. It will be interesting to see if any further headway on accuracy has been made in the interim.

Not ones to ever rest on their laurels Monitor also set up the Costing Transformation Programme (CTP) with the objective of improving the quality of costing within the NHS and to move towards having a more detailed cost collection, at patient level, rather than the traditional 'top down' approach to costing used in reference costs.

P.T.O.

The CTP will take several years to come into full effect across acute, community, mental health and ambulance services in England, but it's worth noting that 128 NHS organisations used patient level costing in their 2014-15 reference costs returns. **On the face of it an impressive step in the right direction.**

The latest CTP timetable indicates the first year of collection by the new method will be 2018/19 for acute and ambulance service providers, 2019/20 for mental health providers and 2020/21 for community service providers.

88% said 'yes'...

Given our experience 'on the ground' this sounds like a big ask, but when Monitor consulted trusts on this last year 88% of respondents said this pace of change was achievable. **Time will tell.**

The final piece of the jigsaw is Lord Carter and his Adjusted Treatment Cost (ATC) metric – a new productivity and efficiency measure.

The idea here is that the ATC highlights to trusts how they vary in their costs against other trusts for a variety of outputs. The hope is that as the ATC is developed it will be used to identify both the most efficient practices and also where the greatest efficiency opportunities lie. But the ATC is based on reference costs and only 51% of trusts have got materially accurate returns. So whilst it's a good idea in principle it's going to take a lot of work in NHS finance departments across the country to get the underlying data right.

Hopefully then, given the factors above, there is a virtuous circle starting to form around costing in the NHS – greater accuracy at patient level, an engaged regulator and a high profile secondary user of the base information.

David Ginola

All well and good, but this needs to be set in the context of the everyday reality. A bit like David Ginola at Newcastle United too often costing has been **the luxury player** in NHS finance departments. Whilst there are undoubtedly some shining beacons out there many trusts have just a single costing practitioner, sometimes even less. This is not enough resource for the task in hand.

The present economic outlook and political sentiment points towards a continued focus on efficiency and therefore costing, but if the potential gains are going to be achieved more investment in this vital area needs to be made sooner rather than later.

Done the right way reference costs can have a massive beneficial impact on the performance of NHS finance departments. If you'd like help improving yours, do get in touch. We'd be delighted to help.

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