BUILDING CLINICAL ENGAGEMENT WITH COSTING

HOW NHS TEAMS ARE ADDRESSING KEY CHALLENGES
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EXECUTIVE SUMMARY

This study, based on interviews with costing practitioners and clinicians from fifteen NHS and Foundation Trusts in England in the summer of 2013, shortly after the Health and Social Care Act 2012 came into effect, explores the issues around the lack of clinical engagement with costing and identifies the ways in which clinicians engage with costing information.

NHS costing teams are small and often isolated, many different systems and methodologies are in use, and clinical contact time is limited. Barriers to clinical engagement include disagreement over the ownership of costing, the limitations of reporting cycles and an overly granular approach.

Six areas in which clinicians engage with costing information are identified: business cases, ongoing improvement of both costing quality and costing systems, benchmarking, decision-making, and driving efficiency improvements. These are supported by examples drawn from the fifteen Trusts, demonstrating practical approaches to the building of engagement.

However, to ensure the sustainability of this relationship in the longer term, it is important to consider clinical perceptions of ‘finance’ and how best to make use of limited contact time. In addition, the recruitment of ‘clinical champions’, accessible and relevant reporting, and Board-level commitment to the use of costing information in decision support are key enablers.

In order to meet the challenges ahead, costing needs to become an enabling rather than a support function. The clinical and financial professions must work together to drive efficiency and deliver better-quality patient outcomes. In order to achieve this goal, greater clinical ownership of costing information is essential.

ABOUT THIS RESEARCH

This report was written by Rebecca McCaffry MSc ACMA CGMA, Head of public sector research and policy, CIMA.

With thanks to Professor Chris Chapman of Imperial College London, and to the dedicated teams of hard-working NHS staff who participated in this project.

The research behind this report was undertaken while studying towards the Manchester Metropolitan University/ CIMA MSc in Strategic Business Management.

Interview transcripts were analysed to identify the context in which costing teams operate, how costing information is used, and perceived barriers to clinical engagement.

Finally, the ways in which costing practitioners are working with clinicians were explored, and key themes for building engagement identified.

Although the sample is insufficient in size to be fully representative of all Trusts, the study is intended to identify common themes and the ways in which they are being addressed in a cross-section of NHS organisations. The Trusts interviewed face a variety of individual challenges alongside the more pervasive issues of funding constraints and rising demand for services: four are in ‘turnaround’ having found themselves in serious financial difficulties; three have been or are soon to be merged with other Trusts; others have complex geographical issues affecting staff and service availability.
FIGURE 1: TRUSTS INTERVIEWED

<table>
<thead>
<tr>
<th>SIGNIFIER</th>
<th>LOCATION</th>
<th>DESCRIPTION</th>
<th>CATCHMENT CLASSIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust A</td>
<td>North</td>
<td>Community and mental health</td>
<td>Rural/sparse urban</td>
</tr>
<tr>
<td>Trust B</td>
<td>North</td>
<td>Large acute</td>
<td>Urban major conurbation</td>
</tr>
<tr>
<td>Trust C</td>
<td>North</td>
<td>Acute district general hospital</td>
<td>Urban minor conurbation</td>
</tr>
<tr>
<td>Trust D</td>
<td>Midlands</td>
<td>Acute district general hospital</td>
<td>Urban town</td>
</tr>
<tr>
<td>Trust E</td>
<td>South</td>
<td>Acute district general hospital</td>
<td>Urban town/rural</td>
</tr>
<tr>
<td>Trust F</td>
<td>South</td>
<td>Acute teaching and specialist</td>
<td>Urban city</td>
</tr>
<tr>
<td>Trust G</td>
<td>North</td>
<td>Acute specialist</td>
<td>Urban major conurbation</td>
</tr>
<tr>
<td>Trust H</td>
<td>South</td>
<td>Acute and community</td>
<td>Urban town/rural</td>
</tr>
<tr>
<td>Trust I</td>
<td>London</td>
<td>Large acute and specialist</td>
<td>Urban major conurbation</td>
</tr>
<tr>
<td>Trust J</td>
<td>Midlands</td>
<td>Acute specialist</td>
<td>Urban major conurbation</td>
</tr>
<tr>
<td>Trust K</td>
<td>London</td>
<td>Large acute teaching</td>
<td>Urban major conurbation</td>
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<tr>
<td>Trust L</td>
<td>North</td>
<td>Large acute teaching and specialist</td>
<td>Urban major conurbation</td>
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<td>Trust M</td>
<td>South</td>
<td>Large acute</td>
<td>Urban town/rural</td>
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<td>Trust N</td>
<td>South</td>
<td>Large acute teaching and specialist</td>
<td>Urban city</td>
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<tr>
<td>Trust O</td>
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<td>Large acute teaching</td>
<td>Urban city</td>
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</tbody>
</table>
The National Health Service (NHS), Europe’s largest employer with over 1.7 million employees\(^2\), has seen many policy and structural changes since its establishment in 1948.

Yet the implications of the Health and Social Care Act 2012, which came into effect in April 2013, have brought more dramatic change than ever before, with increased emphasis upon patients, quality and outcomes\(^3\). At the same time, an overall savings target of £20 billion over four years means that each NHS organisation must deliver on-going ‘efficiencies’ each year without impacting upon service quality: essentially delivering more for less.

The increasing financial pressure is taking its toll, with an increase from 21 to 40 foundation trusts in deficit during 2013/14 and a combined gross deficit of £307m\(^4\). With all NHS Trusts now expected to be financially viable, a more business-like approach is crucial. Yet at the same time, quality patient care must be paramount, as evidenced by the systemic failure of the Mid-Staffordshire NHS Foundation Trust, where a number of issues including the under-resourcing of staff as a result of Board focus on achieving immediate financial savings through cost cutting led to disastrous failures of patient care. The ensuing public inquiry found that the serious failings of the Trust were caused by a “culture focused on doing the system’s business - not that of the patients”\(^5\).

Significant developments over the last decade have been the rise of service line management (SLM) and service line reporting (SLR), together with the introduction of Payment by Results (PbR), a fixed-price tariff approach to cost reimbursement for healthcare providers based on Trust level average cost data.
Following the 2012 Act, Monitor, the sector regulator for NHS health services in England, and NHS England, who are responsible for the functioning of the commissioning system, hold joint responsibility for price setting, with Monitor focusing on methodology and NHS England specifying the pricing structure.

Alongside its use as a pricing mechanism, the PbR tariff can also be used as a performance incentive to drive specific behaviours, an example being the ‘best practice’ tariff, which rewards performance complying with clinical characteristics of best practice. The 2012 Act introduced greater numbers of best practice tariffs ‘so that providers are paid according to the costs of excellent care rather than average price’, reflecting both the limitations of average costing and the patient-centred, outcomes-based approach of the contemporary NHS.

SERVICE LINE REPORTING AND PATIENT-LEVEL COSTING

The theory behind SLM is that each service line (examples being orthopaedics, endocrinology or paediatrics), is managed as a separate business unit, typically led by a clinician. SLR supports this by presenting data from a range of clinical and financial sources to improve cost transparency, highlight the profitability of specific service lines and allow effective performance management.

Patient-level costing, as its name suggests, is a more granular approach which seeks to calculate the cost of patient activity at episode or spell level, recording, for example, the cost of minutes an individual patient spent in an operating theatre. This enables greater understanding of the cost of providing patient care to the individual, and is broadly consistent with the way in which reference costs are calculated. Although complex to implement, patient-level information and costing systems (PLICS) are becoming more widespread, and have been implemented in almost half (49.6%) of all trusts. In addition, 116 of the 121 trusts that have implemented PLICS used them to inform some or all of their 2012-13 reference costs return.

This increase in the use of PLICS, which emphasises ‘information’ as well as cost, has been encouraged (though not yet mandated) by the Department of Health, who recognise that better costing locally will inform and improve pricing at the national level. In addition, Monitor are exploring ways in which PLICS data can be used to increase the sophistication of the price-setting process. During 2013 and 2014, a voluntary patient-level cost collection exercise was piloted among acute trusts in order to assess how PLICS data might be used to inform pricing, and to identify areas where data quality needs improvement.

In terms of costing methodology, Monitor recommend an activity-based approach over traditional ‘top-down’ general ledger cost allocation. This view is generally accepted by academics whose conclusions are that an activity-based costing (ABC) approach to healthcare is essential, despite the practice being complex to implement and requiring significant input from both clinical and financial functions.

To enable effective reporting and recording of costs at both patient and service level a wide variety of information systems have been developed; commonly known as ‘clinical costing systems’ these are essentially management information systems for hospitals. To operate efficiently, these systems require input from both clinical and financial staff. Yet hospital-focused case studies highlight the fact that the accountant/clinician relationship can be problematic, finding a disconnect and lack of mutual understanding between the roles of clinicians and accountants in hospital settings.

One explanation for this is that the two professions have preconceptions of each other’s social role and conduct, based on their own ‘meaning’ within the organisation. Hospitals have always been about doctors, therefore a doctor knows that he or she has importance, meaning and purpose within the hospital context. It can of course be argued that accountancy is an equally noble profession; but accountants generally cannot fix broken legs, and therefore have less ‘meaning’ within the hospital setting.

Accountants know this, and clinicians know this, which may shed some light on why the relationship has founndered. Yet given the increasing importance of a ‘business-like’ approach to the NHS, ‘business’ being strongly linked to the meaning of the accountancy profession, and management accounting in particular, it may well be time for these social roles to be both redefined and reinterpreted.

Clinicians disengage from accountants to focus on the day job of clinical care. Yet quality of care cannot be sustained in the long term without financial engagement – without improved understanding of costs and outcomes the inevitable rising costs and demand for services mean patient care will suffer. Equally, if accountants disengage from clinicians to focus solely on the (perceived) day job of number-crunching without fully understanding the nature of the service that is being provided, no efficiency savings will be delivered – and patient care will suffer.
Healthcare costing and clinical engagement have been popular topics for academics and policy-makers over recent years. Patient-level costing has failed to reach its full potential, there is little consistency in costing methodology, and clinical-financial engagement, while recognised by both parties as essential, remains limited.

**FAILURE OF PLICS TO ACHIEVE ITS POTENTIAL**

Blunt and Bardsey’s 2012 study\(^9\) found that, despite its potential for cross-functional engagement, PLICS did not yet appear to have had significant influence on clinical behaviour: given Monitor’s interest in using PLICS data to improve price setting and the rise in the use of PLICS in acute trusts in recent years, this seems a missed opportunity. Yet it is important to recognise that PLICS was still in relative infancy at this stage, a time of major upheaval which will have distracted attention away from developing new ways of working. And as with all information systems, implementation is only one part of the story; effective use, on-going management and continuous improvement are key to success.

While the value of PLICS as a provider of useful information has been recognised by the finance function, an important issue is how this information is used more widely within the organisation. This is a critical area to explore: investment in potentially resource-heavy costing systems should ultimately drive efficiency and value across the organisation, particularly in an era of on-going budget cuts and the ensuing cost constraints. In times of financial pressure, it is essential to understand how activity drives resource consumption. A study by Chapman and Kern\(^1\) examining the use of SLR and PLICS as vehicles for improving cost transparency found that costing systems are too often treated as a box-ticking exercise.
by disengaged clinicians. They identify what could be considered a major risk of allowing accountants full ownership of the costing system, a focus on minutely detailed cost allocation at the expense of good, quality analysis. Effective patient-level costing which enables greater understanding of costs and their drivers relies upon accurate operational input at all levels, from reception staff through to consultants.

COMPLEXITY AND INCONSISTENCY OF SYSTEMS
To address what they see as the cost crisis in healthcare, where poor cost measurement prevents links to process improvements, service cross-subsidies distort the supply and efficiency of care, and efficiency itself carries few incentives, Kaplan and Porter advocate a time-driven activity-based costing (TDABC) method which measures costs and outcomes relative to the patient, seeking to increase transparency and eliminate fixed costs. This approach, while recognised by Monitor, can be complex, time-consuming and resource-heavy to implement, requiring significant input from clinicians alongside the finance resource. Where there is poor engagement between the clinical and finance functions, effective implementation is virtually impossible.

Clinical costing systems have traditionally been the preserve of the finance function; however, the rise of PLICS, with a wider focus on information of clinical interest as well as costs, can encourage cross-functional working on the development, implementation or improvement of such systems. This is ultimately of benefit to both parties in understanding service efficiency and, by improving cost transparency, the organisation as a whole. As such, collaborative working would appear to be a useful way in which to develop a system of which clinicians take greater ownership.

THE NEED FOR COLLABORATIVE, PRODUCTIVE WORKING
An effective patient-level information and costing system relies upon accurate clinical input to ensure data quality. This requires clinicians and finance staff to work together in order to develop robust data input processes. However, the relationship between clinicians and healthcare management is often distant; as previously mentioned this is potentially due to lack of mutual understanding and shared purpose.

This distance is not, perhaps, surprising considering that separation may be physical as well as conceptual: clinicians spend most of their time in theatres, wards and clinics, while ‘management’ are often to be found in a separate office building in a far corner of the hospital site.

Recent surveys of clinical-financial engagement from both sides found that 96% of finance directors and 98% of senior clinicians believed that the provision of high quality, affordable services will only be achievable through strong clinical-financial engagement. When asked to select measures to improve engagement, 73% of clinicians wanted to see more use of patient-level costing data. While finance directors agreed that this was important, most (87%) felt that the single most effective measure to improve engagement would be to introduce clear consequences or incentives for the achievement or non-delivery of quality and cost improvement. This raises the issue of ownership and accountability for costing: should it lie with the finance staff who produce the numbers, or the clinical staff who drive the resource use and provide the data inputs?
In order to better understand the context in which the survey sample operates, the research first investigated the costing teams, the technology they use, and the areas in which they interact with clinicians. Teams are small and often isolated, many different systems are in use, and clinical contact time is limited. Unless stated otherwise, all quotes are from costing practitioner interviews.

CHARACTERISTICS OF COSTING TEAMS
Within the sample, costing teams were small, even in the larger Trusts, with an average of three full time staff working on costing; in the smaller Trusts, the teams often have additional responsibility for income and contracting. Despite being part of the finance department, many interviewees reported a sense of isolation from the wider finance function. The technical nature of costing work, requiring a detailed focus on rules and processes, combined with the need to work closely with other departments on a regular basis is a possible explanation of this. All Trusts operated service line reporting to some extent, with eleven using and a twelfth rolling out PLICS. This represents 80% of the sample, in comparison to the national level of 63% of all Trusts.

CHARACTERISTICS OF CLINICAL COSTING SYSTEMS
The Trusts interviewed used a wide variety of clinical costing systems to support service line reporting and, in most cases, patient-level costing. Nine different clinical costing systems were in evidence, ranging in complexity from Excel spreadsheets at a small community and mental health trust to a newly developed ‘integrated service line reporting’ (iSLR) system at a large teaching hospital, based on an internal trading model which feeds to and from the general ledger, delivering month end results within one working day. A similar number of general ledger systems were in use across the fifteen Trusts.

Most Trusts also used some form of business intelligence (BI) package to present a ‘dashboard’ of costing and other relevant information. By far the most commonly used was a simple and intuitive platform which allows users to drill down to the patient level. In theory, this allows clinicians to access the data at their convenience: in practice there is limited engagement, several Trusts reporting that there was little use of the system outside the finance function.
“We’ve sat with them and shown them [the BI] and then observed that it’s then little used when it’s not prompted, so it’s sitting on the desktop but it’s not something that they are actively engaged in. Either they don’t fully understand it, or they’re not sure about the results.”

(Trust D)

With the exception of iSLR, which is integrated with the general ledger, all costing systems operate in a similar way, as standalone systems to which feeds from Trust databases are uploaded manually. Feeds might include the general ledger and the patient record management system or electronic patient record (EPR) system, together with patient activity data from around the hospital. This may include, for example, pharmacy, pathology, radiology, wards and theatres, or feeds yet to be discovered.

“...there is a constant review... we’re constantly looking for new data feeds from the Trust, what information’s available. Because sometimes you find activities available that you didn’t know about before, or someone’s producing something where you can get the data and use it.”

(Trust H)

Yet while multiple feeds can provide a rich body of data, it is important to bear in mind that the end users of the information may not appreciate such richness. Over-complicated reports carry the risk of turning engaged end users into disengaged recipients.

CLINICIANS AND THE FINANCE FUNCTION

The study then investigated the main areas in which costing information is used and how costing practitioners interact with clinicians in these areas (Figure 2), further discussed later in this report. On a generic ‘finance’ basis, the majority of contact between clinicians and the finance function is via divisional finance managers or business partners, who work with the various clinical divisions, but have a professional reporting line to the Director of Finance. This contact, however, tends to be mainly around monthly meetings focused on setting budgets and controlling expenditure; any resulting perception of the finance function as ‘the bad guys’ would partly explain clinical reluctance to engage on more complex issues such as costing.

“There is still the perception in some parts of the organisation and the medical staff particularly that we are a partly supporting function that does things like payments and buying things, and also there is still the perception that we are the people that cut their budget.”

(Trust F)

FIGURE 2: NUMBER OF TRUST COSTING TEAMS REPORTING CLINICAL ENGAGEMENT IN KEY AREAS

<table>
<thead>
<tr>
<th>Area</th>
<th>Costing team involvement</th>
<th>Clinical engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business cases</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Improving costing quality</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Benchmarking systems</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Improving systems</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Decision support*</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Driving efficiency*</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

*excluding business cases
The research identified three general barriers to clinical engagement with costing, as identified by costing practitioners - disagreement over the ownership of costing, reporting cycle limitations, and granularity of focus - together with the ways in which they are actively being addressed.

**BARRIERS TO ENGAGEMENT**

**PERCEIVED OWNERSHIP OF COSTING**

The concept of distance between clinicians and finance staff has already been identified: physical or perceived distance between any two parties will never be conducive to engagement, but in this case it is quite possible that the problem has been created by the system itself.

“...we have continually divorced clinicians from the process of paying for the NHS and therefore they are not desperately interested in how we do it. They weren’t interested when it was block contracts, they weren’t interested when it went to capitation of district health authorities, they’re not interested in HRGs and by the time you have explained how you define an HRG – they’re more interested in car parking.”

(Trust M)

Given this distance, it is unsurprising that an overwhelming majority of costing teams reported that costing was owned by the finance function. Significantly, the three Trusts reporting the highest levels of clinical and Board-level engagement with costing were those where the ownership of costing lay with clinical specialties.

“Part of the challenge the costing team face is that we have to work with the information as we receive it. We are not in a position to change or amend it... good quality information lies with the
specialties, but costing teams can provide valuable insight when clinicians identify areas where costing information is not accurate, by helping the specialties focus on areas where documentation processes can be strengthened. This in turn will naturally lead to improvements in the quality of the costing information.”

(Trust J)

This returns to the issue of data quality, a challenge exacerbated by what Kaplan and Porter describe as an idiosyncratic patient care system: two patients presenting the same symptoms may not follow the same care pathway. This is thought to stem from the freedom traditionally given to clinicians to do things their own way, a practice somewhat at odds with efficiency targets, standardisation of processes and the consistent cost of service provision assumed by the PbR system.

Costing teams, as controllers of costing methodology, are ultimately accountable for the costing data output. Not all errors can be blamed on the quality of inputs: an incorrect rule within the system can result in costs being coded to the wrong speciality, consultant or patient. Without input from the relevant clinicians, such errors may easily go unnoticed, and under the Payment by Results system the impact on income can be significant, whatever the source of the error.

“When they make errors or they put things in with the wrong admission method, that actually means that somewhere down the line we’re reporting that as a non-elective when it should be an elective. That costs us 70% of the tariff we would have earned, and that means also that when we report it in reference costs it’s wrong.”

(Trust C)

It is clear from the above that the key to quality data inputs and accurate costing is for costing teams and clinicians to work closely together, identifying and rectifying errors and areas where data input quality is at risk. This is in the interests of both accountants and clinicians, yet in many cases engagement around costing remains limited.

FINANCIAL BARRIERS

A second barrier is one in which the finance function are potentially complicit: the timing of the reporting cycle and a focus on budget control.

Ten of the Trusts interviewed produced their service line reports quarterly, with a further two reporting operational difficulties around the production of monthly reports. As a result, clinical exposure to ‘new’ costing information is infrequent. One Trust, in an attempt to address this issue, had gone so far as to abolish monthly reporting altogether, training clinical leads to use the BI dashboard systems in order to access ‘live’ data independently.

Such an approach is not without its challenges. Another Trust found that, although clinicians were happy to sit with a finance person in front of their dashboards to discuss costing, independent use of the system itself was extremely limited.

This presents a significant risk that the information will be ignored: this lack of engagement could be explained by clinicians having a very clear understanding of their role, of which they do not view costing as an element. This theory was explicitly supported by most costing practitioners.

“...it’s my job to treat patients, it’s your job to do finance, why are you coming to me?” - you get a lot of that...

(Trust I)

“...traditionally they just see themselves as a provider of patient care first and that is their priority, so to sort of get them into the business world and understanding that they’ve got to be viable is really difficult...”

(Trust C)

Despite lingering evidence of traditionalist viewpoints, Figure 3 demonstrates that clinicians, whether or not they feel it appropriate, have begun to take a more business-focused approach and engage with the finance function in several key areas. However, as previously mentioned, the main interaction is around budget control. This is
understandable; budget over- or under-spends are by their very nature simpler concepts to understand than the more complex allocation processes used by costing teams, and confusion around cost allocations was highlighted as an issue by all Trusts. Indeed, one of the main barriers to engagement with service line reporting appears to be confusion caused by the dissimilarity between reported budget and SLR positions.

In order to overcome this problem, the finance function needs to demonstrate a more joined-up approach in which the value and purpose of costing information as an enabler to service efficiency and development is clearly communicated. Kaplan and Porter see a clear link between the improvement of costing and service improvement: ‘Accurate costing allows the impact of process improvements to be readily calculated, validated and compared.’

This ‘outcomes’ focus sits well with the new NHS and its increased focus on patients, quality and outcomes, as well as helping minimise the risks inherent in the development of new or existing services.

‘MICRO’ FOCUS
The combination of limited clinical exposure to costing and access to information at the patient level carries the risk that clinicians will become engaged at a very ‘micro’ level, ignoring the bigger picture focus. As a result of this tendency one Trust had chosen not to fully implement PLICS, feeling that it provided too granular a level of detail.

“Another issue that we have with patient-level costing, is that when you start giving information to consultants on a particular patient they will want to know which patient it was and then find 101 reasons why they were an atypical patient – ‘ah well, that was Mrs so-and-so and she had this, this, this and this and we had to do this and there was this and there was that and the other.’ Which is why we think to a certain extent patient-level costing can become counter-productive.”

(Trust L)

In all Trusts similar issues exist around allocations: engagement on costing frequently revolves around how costs, particularly overheads, are allocated to specialties. This can occasionally cause conflict.

“...we get a lot of arguments about the £10 they get from some estates and facilities costs that they don’t think they ever use and so it does become difficult.”

(Trust N)

“If this department is losing money they will argue until the cows come home that they’re not, but what they’ll do, in my experience, is to argue about the direct allocations rather than arguing about the direct costs.”

(Trust D)

The challenge is to focus thinking upon how things are done, and how they could be done more efficiently; arguing over allocations serves only to move costs from one department to another while retaining the overall financial impact of any inefficiencies. One Trust has addressed this problem by focusing upon helping clinicians digest the costing information, re-presenting it in a new format; this is further explored later in the report.
### FIGURE 3: AREAS IN WHICH CLINICIANS ARE ENGAGING WITH COSTING INFORMATION

<table>
<thead>
<tr>
<th></th>
<th>BARRIERS/CHALLENGES TO EFFECTIVE CLINICAL ENGAGEMENT</th>
<th>ENABLERS OF CLINICAL ENGAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Business cases</strong></td>
<td>Emphasis on business cases can come at the expense of other areas</td>
<td>Clear and obvious benefit to clinicians</td>
</tr>
<tr>
<td><strong>Improving costing quality</strong></td>
<td>Undermining effect of 'average' reference cost calculations</td>
<td>Provision of relevant and useful information</td>
</tr>
<tr>
<td><strong>Benchmarking</strong></td>
<td>Limited value of reference cost index benchmarking</td>
<td>Leveraging clinical competitiveness</td>
</tr>
<tr>
<td><strong>Improving systems</strong></td>
<td>Fear of new systems being used to cut services.</td>
<td>Highlighting the role of information in service improvement</td>
</tr>
<tr>
<td><strong>Decision support</strong></td>
<td>Focus on getting costs 'right' over actual use of the information</td>
<td>Costs don't have to be 100% correct to be useful</td>
</tr>
<tr>
<td><strong>Driving efficiency</strong></td>
<td>Little understanding of department interdependencies</td>
<td>Faster, more efficient systems which highlight interdependencies</td>
</tr>
</tbody>
</table>
HOW COSTING PRACTITIONERS ARE WORKING WITH CLINICIANS

BUSINESS CASES

All Trusts interviewed used costing information to support business cases or tendering processes for the development of new services and resources. This is a key area in which all Trusts agreed that clinicians and costing staff are working effectively as business partners.

“...we do have a sort of commercial business case process, which is pretty well defined, and for us, we’re lucky, we have very enthusiastic clinicians here. They’re always coming to either myself or finance, to say ‘I want to do this, I understand that I’ve got to make sure that I understand the cost and income, so can you help me with that?’ And we do, so we’ll sit down and we will do, depending on the service, probably time-based activity-based costing, and we’ll do a bottom-up costing for this project. This isn’t the costs for everything though, this’ll be very much on an individual project basis. So we will do that kind of detail for those projects, because it’s manageable.”

(Trust E)

Business cases, as well as their role as a vehicle for informed decision making, serve the additional purpose of helping clinicians engage with the costs generated by their service lines and choice of clinical practice. However, one downside of the business case approach occurs when clinicians choose to ignore the more ‘inconvenient’ costs.

“...we’ve got much better at tying business cases up, so having at least my team’s approval for the costs that are used. They’re not usually the full costs because they’ll be looking at ‘if we shut X beds here and move Y beds there and re-employ 64% of the staff we had before would it be legitimate to say that our
costs would be 30% lower than what they were? ‘Well, that’s legitimate but we’ve still got the same estate costs, the same heating and lighting and capital charges costs - where are these in your business case?’ – ‘Oh that doesn’t matter for this decision.’” (Trust M)

Although clinicians are understandably happy to engage when they see the opportunity for an expanded service, their engagement on and understanding of costing needs to be far wider if the NHS is to meet its efficiency targets. There is a risk that piecemeal approaches will lead to poor decision-making and ultimately a misguided lack of faith in the value of cost information for decision support, leading to further disengagement.

**IMPROVING COSTING QUALITY**

The majority of Trusts reported some clinical engagement in working to improve the quality of costing information, although some relationships are more successful than others. A lack of common understanding from both parties was mentioned by several Trusts as a key challenge.

“…there’s a level of understanding that both of us have to get to both groups – the finance and clinical to be able to talk with meaning about things. So it is quite hard to improve their understanding of the costs, to improve their understanding of how data flows through all the clinical systems into what we see. It’s also quite difficult for them to spend time explaining what they’re telling me, that probably is a frustration for them.” (Trust N)

One reason frequently given by costing practitioners for clinicians not wanting to become involved in the improvement and development of costing information was a perceived lack of direct benefit. The way in which the reference costs are currently calculated, based on average costs incurred across many Trusts, does little to disprove this.

“And our issue is that they could feed into their reference costs for example and then one of the issues then becomes about, ‘well I’ve helped you develop these costs specific to [Trust I] but then the national average is coming out, it doesn’t reflect it so I’ve done all this work and it hasn’t really benefited the organisation.’ So they have to see a benefit to what they’ve done.” (Trust I)

This feeling is not unfamiliar: as management accountants worldwide are only too aware, an inordinate amount of time can be spent producing information which is rarely used by its intended audience. Providing relevant information is key to successful engagement with improving costing quality.

“If data coming from the stock management system is not right they are taking steps to correct it because they want the information… There’s a small shift between saying ‘you’re giving me wrong information so I won’t trust it’…{to}…‘well, this information seems to be wrong, how can we improve it, what can I do to improve it?’” (Trust C)

**BENCHMARKING**

External benchmarking in terms of reference costs already exists in the form of the NHS Reference Cost Index (RCI), which ranks the costs reported by each service provider against the average cost of providing each service. However, the way in which reference costs are calculated using averages limits the value of the RCI as a benchmarking tool or measure of relative efficiency, and, as previously mentioned, clinicians may lack faith in the reference cost calculation. A further disadvantage of using the RCI for benchmarking is that it is based on all reference cost submissions, regardless of the quality or methodology of their calculation. As a response to this issue, seven of the Trusts interviewed have begun to use an alternative patient cost benchmarking tool, which aims to provide better comparability between Trusts through the use of consistent cost definitions.

“…using [the patient cost benchmarking tool] rather than the reference costs tool, you are able to understand for a cohort of patients, what their cost is and how that compares with your chosen peer group… And you can then drill into that within that cost base, at a cost pool level, and ask the question; ‘where do I appear to be expensive within the chosen HRG compared with my peer group?’ You can then focus management attention in that area.” (Trust K)

Another use of benchmarking revolves around the clinicians themselves: a competitive nature was identified as being a common characteristic which can be used as an enabler for engagement with costing information.

“What I’ve found is, what engages the clinicians, you could say, particularly if you’ve got two or three in the room [with the clinical costing system] is that they start comparing and contrasting each other. Because you know, you can go down to consultant level, patient level, whatever. So they sort of have a bit of fun with it, but behind the fun there’s this kind of competitive element…” (Trust O)
During the system design process, significantly higher levels of clinical involvement will be needed, with a focus on system inputs and outputs. Most crucially, clinicians have a role to play in setting up the internal rules of the system.

“They need to help us understand what the key cost drivers are – we assume key cost drivers are length of stay, theatre time, but that’s not always the case in certain specialties, especially specialties with high cost devices in cardiology, vascular surgery, and we ourselves don’t know.”

(Trust L)

PLICS outputs, with their clear emphasis on the patient, provide a gateway to costing which clinicians can easily understand, and, most importantly, are interested in.

**DECISION SUPPORT**

Accurate costing information has huge potential here, and the fact that clinical training favours an evidence-based approach indicates high potential for clinical involvement. Yet the use of costing information for decision making currently appears to be on an ad hoc basis, and mainly focused around business cases for the development or discontinuation of services. This could be a result of an over-zealous focus in the past upon getting the costs correct rather than actually making productive use of the costing information.

“Our job is to deliver something that the consultants can use to improve service. If we’re not doing that then we’re not doing our job correctly. And therefore, their involvement in telling us what they want out of the system is one of the key things in producing a system that works.”

(Trust D)
team that the clinicians are looking at the costing information and feeding back areas of weakness so we can continuously improve our costing methodologies - but that's only 20% of the challenge. The other 80% is building confidence within the organisation to use the costing information as part of the decision-making process to benefit patient care. Part of that challenge is resisting the temptation to want to get everything perfect in the costing system before we include the information. It's about getting the balance between understanding what's happening on the patient floor so we can get the costing rules correct, and working with clinicians to provide answers to such questions as: ‘what is the costing information telling us? How can we use costing information to support improvements in patient care and to help specialties identify ways to become more efficient?’ That's the challenge.”

(Trust J)

A more integrated approach to costing, which embeds costing information into decision support, would help move towards the required change. Producing information that can be used and acted upon is perhaps a more valuable use of time than the minutiae of allocations – one Trust reporting very engaged clinicians found that they were not actually interested in fully accurate costs.

“They don't want to have a 100% reliable system. They want 95% reliability. If you can keep the mistakes within 5%, or the difficulties within 5% then people will accept it.”

(Trust G)

**DRIVING EFFICIENCY**

The potential for using costing information to identify and drive efficiency savings was recognised, with a clear understanding of the value that can be added by, and for, clinicians.

“...the real purpose of PLICS is to highlight and identify the variations in clinical practice in order to standardise them. If that is your goal, towards that you require clinicians to engage, understand, accept, validate and use the figures. That’s the most important thing. So clinical engagement is a broad term comprising all these things.”

(Trust G)

Although the use of costing information to help identify and drive efficiency savings was limited in scope, one Trust was finding new ways to improve efficiency in the costing process, an example being the treatment of theatre stock.

“...they are looking at introducing stock modules to the theatre system so that hopefully that will be useful, for all the kit, the consumables which, at the moment we have to do on an average procedure basis, based on some really, really time consuming costing exercises that we have done in the theatres that can become obsolete very quickly due to changing practices, changing prices-suddenly something might have come out of patent so becomes cheaper.”

(Trust B)

With limited time available to engage with clinicians, increasing the speed at which costs can be calculated and freeing up resource to work on other areas can only be a good thing. The use of iSLR demonstrates an approach to indirect cost transfer which shares accountability between departments and encourages a focus on efficiency.

“...the way in which we transfer the (indirect) costs... is based on a standard cost basis rather than on a total absorption basis. So what that means is if I’m in a front line service and I demand one more x-ray then I know I’m going to have to pay the standard price for that one more x-ray and if I order one less, then I will save that price – and that price doesn’t vary all year... And that's the key to this...it’s that we separate out the efficiency variance and leave that with the people responsible for delivering an efficient service, from the volume and mix variance that sits with those responsible for demand.”

(Trust K)

This approach underlines the interdependencies between departments, which can often be ignored when clinicians consider their costs. This is potentially a result of the way in which clinicians work: a surgeon, for example, can work almost exclusively with his or her surgical team and rarely see, let alone engage with, staff from other specialties. Yet with an increased focus on efficiency savings across the NHS, clinical teams from different specialties must work together to maintain care levels while reducing costs.
The examples we have seen above demonstrate some practical approaches to building clinical engagement. To ensure the sustainability of this relationship in the longer term, it is important to consider clinical perceptions of ‘finance’ and how best to make use of limited contact time. In addition, the recruitment of ‘clinical champions’, accessible reporting, and Board-level commitment are key enablers.

PERCEPTIONS OF FINANCE

In order to build engagement with clinicians, it is important to understand how they view their finance colleagues.

As described earlier in this report, the research took the position that clinicians have a specific preconceived view of both their role and the role of the accountant. When costing practitioners were asked how they felt clinicians viewed the finance function, there were mixed views, with one comment calling the self-identity of the accountant as business partner into question.

“...there’s also a difficulty of the embedding of that model on individuals in the finance team, some of us are happier going to see clinicians, and talking about their issues and others are happier manipulating the ledger producing an answer... The business partner model does rely on those personal relationships and they’re not always going to line up and we have to recognise that at the outset.”

(Trust M)
Although there are well defined areas in which finance professionals are considered to be business partners, these generally revolve around the role of the divisional finance managers, which are to all intents and purposes built into the divisions (in four Trusts these roles are actually referred to as ‘business partner’ or ‘business manager’), rather than the role of the costing team. There is an overall sense that costing remains a support function, although one Trust strongly supported the view that the costing role is defined by the way in which you perceive it. In part, this includes being the controlling ‘bad guy’, but the overall picture is positive: there is a more strategic role for costing, and for costing practitioners as business partners in the new NHS.

“…there will always be an element of healthy challenge between finance and the specialties… we are a control function, and that is part of our role... However, we are also a business partner – the challenges facing the NHS are enormous. The structure has fundamentally changed, the funding envelope is decreasing, patient expectation is much higher, social funding has been dramatically cut and significant savings need to be achieved. All these factors contribute to the pressures NHS organisations are experiencing and it highlights the importance of costing teams supporting specialties and clinicians as they continue to meet these challenges. We have to be a business partner.”

(Trust J)

This is encouraging news: regular collaborative working between clinical and finance teams scores highly on the Department of Health clinical engagement scale. Yet in order to develop these collaborative working practices in the first place, ongoing clinical engagement is essential.

MAXIMISING AVAILABLE TIME

The onus is upon finance staff to ensure that the ‘rules’ of costing are clearly understood in the limited contact time available. All costing practitioners highlighted the lack of access to clinical staff as an issue, with limited clinical availability and interaction with the finance department tending to focus upon budget control cited as significant factors. Yet some have developed innovative ways to maximise use of clinician downtime, with costing practitioners from two Trusts reporting that they had donned scrubs to meet clinicians in their surgical rest-rooms between operations.

“My role was to help them set prices. But it was quite interesting because I got to work quite closely with quite a lot of them, they’d call me down into their rest-room between operations... if you want to catch three or four of them together, you’ve got to.”

(Trust O)

Whatever the logistical circumstance of the meeting, it is essential that clinicians and costing practitioners learn to understand each other’s business. Some Trusts have sought to address the time issue through building costing into consultant job plans, which cover ten four-hour programmed activity (PA) sessions per standard week; of these, there is generally only one ‘management’ session.

“So you’ve got four hours of their time on a weekly basis about leading their service, developing a strategy, and implementing and making financial decisions, and managing the rest of the team.”

(Trust D)

One Trust board, wanting a more central focus on costing, has built in one PA per week during which consultants are to focus on the improvement of costing and coding. In addition, an Associate Chief Medical Officer role for costing and coding has recently been created, the aim being to get more co-operation from senior clinicians by promoting the ‘bigger picture’ aspect of costing using a peer to peer approach. The recruitment of these ‘clinical champions’ was, unanimously, considered to be an essential enabler for engagement.

CLINICAL CHAMPIONS

A British Medical Journal article from 2003 identified the ‘highly codified tribal dialects’ of managers and doctors to be a significant barrier to engagement. This study found the message to be equally as applicable today. If clinicians speak a different language to other Trust employees it therefore makes sense to identify clinical champions, sympathetic to and recognisant of the value of costing, who can spread the word among their peers. But how to identify these champions? One Trust favoured the psychological approach, identifying clinicians with ‘techie’, ‘forerunner’ and ‘follower’ personalities.
“The first thing we found that was helpful was to identify which personality groups they fell into, because if you can identify from among the first two personality groups those who will be your clinical champions and invest in working with them, once the success stories start to be collected you’re then able to bring along the third personality type because you can demonstrate the practical value of good quality costing information.”

(Trust J)

Other Trusts were less optimistic, feeling that the role would need to be appointed from above, rather than self-made.

“It’s really difficult because someone else would have to designate them as the champion or say ‘this is part of your role’ – as a Clinical Director, for example, you are responsible for financial control to some extent, so this is part of your role.”

(Trust E)

A reluctantly designated ‘champion’ will, at best, only solve part of the engagement problem: costing practitioners may have to find additional ways of improving engagement with their clinical colleagues.

RELEVANT, ACCESSIBLE REPORTING

One tried and tested approach to building engagement is to focus more upon what clinicians want to see. Communication is the key: sometimes a change of layout can be all that is required to improve engagement. One Trust, recognising that their clinicians needed extra help understanding the system outputs, chose to re-present them in a more user-friendly format.

“...some of the stuff that I’ve done is taking the information we’ve got from the costing system and using that PLIC system to take data they’ve really already got access to, but then putting it into a premasticated form where you say – ‘well, here are your conclusions’, really. ‘Are you aware that this particular procedure you are making a massive loss on, or this one is profitable, so by doing a coding change we’re able to get income for this particular procedure, what’s your view on that?’ ”

(Trust D)

Yet although such an approach has an educative element and increases engagement with costing information, it is a labour-intensive solution which ultimately may not enable increased understanding.

LEADING FROM THE TOP

Despite the best efforts of costing teams to engage clinicians with costing information, there will be little progress without Board-level commitment to the use of costing information for decision-making. New organisational structures, procedures and priorities must reflect this emphasis: the drive for efficiency coupled with an increased emphasis upon patients, quality and outcomes is not sustainable without a stronger relationship and mutual understanding between clinicians and accountants. Such a change can only come from above.
A CLINICAL VIEW OF COSTING

The insight provided by clinicians to this study reinforces the evidence from costing practitioners regarding data quality and the importance of taking a ‘bigger picture’ view. It also demonstrates the importance of recognising engagement as a two-way process.

“The major difficulty in costing is due to inadequate records of actual surgical procedures. This can only be improved by increasing senior clinician involvement in recording the accurate procedures or investigations that are performed. Most senior clinicians are constrained by the time they have in their working days, and in prioritising their tasks the patient care always comes first and 100% accuracy in recording gets compromised. My role as the Associate CMO for costing and coding would involve getting more co-operation from senior clinicians by convincing them of the need for accuracy and the bigger picture that is getting distorted due to inadequate costing.”

(Clinician, Trust J)

The evidence-based nature of the clinical profession was reflected in one response, giving a clear justification of the relevance and importance of costing to clinicians. This benefit-focused approach has been previously identified as a key enabler to engagement.

“Bottom line, my number one concern is to deliver the best quality care possible based on the best available evidence. This has to be balanced within the realities of the system. If a service loses money, I risk losing the service so it is not advantageous to not keep track of this.

Case example: I am keen to get some orthopaedic lists done in a pre-existing theatre which is quiet in the afternoons and has most of the kit to deliver the service. Information/strategy tell me there are more than enough patients who could go on such a service, [costing practitioner] tells me it would make money so I’m now trying to convince those who can make the changes happen go for it.”

(Clinician, Trust M)

When asked about ownership of costing, a shared approach was suggested. While this may not be representative of the clinical community as a whole, it highlights the fact that, while clinicians may not understand the subtleties of costing, the same can be said of accountants understanding clinical care: engagement is a two-way process.

“My personal view is all of us [own costing]. There is both false economy and extravagance. The clinicians have a responsibility that the equipment, set-up and service provides safe, effective treatment. The cheapest piece of equipment/set-up may not allow good quality care. Likewise even if I personally like a piece of equipment but I can provide an equally good quality of service with something cheaper, I have a responsibility to be sensible and think selflessly. I cannot expect supplies or finance however to understand the subtlety of why two things designed to do the same thing may be so different in delivery. Sometimes these things only come to light when you use them.”

(Clinician, Trust M)
CONCLUSIONS

Costing needs to become an enabling rather than a support function in order to meet the challenges ahead; the clinical and financial professions must work together to drive efficiency and deliver better-quality patient outcomes. In order to achieve this goal, there must be greater clinical ownership of costing information.

The key issues identified through this study are similar to those identified in prior literature. Firstly, that there remains a distance, both conceptual and physical, between the two functions, often related to the way in which clinicians and finance professionals perceive their own, and each other’s, roles within the hospital setting.

Engagement with costing is particularly challenging as most ‘finance’ contact revolves around budgets. Budgets are simple to understand and it is easy to see what ‘good’ looks like: costing is far more complex and is therefore viewed by clinicians as belonging to the finance function. The reporting of costing information on a quarterly basis (in many cases) results in it being low on the busy clinical agenda. Finally, engagement with costing is often around cost allocation rather than decision making.

Costing is generally viewed by clinicians as a support function, which may partly explain the lack of enthusiasm for deeper engagement. The use of costing information to drive efficiencies and support decision making appears to be on an ad hoc rather than a consistent basis in most Trusts, and in most cases, partnership working between costing teams and clinicians is limited to business case development. However, the increasing sophistication of business intelligence systems for reporting has helped increase both clinical engagement and use of costing information.

The study found little evidence of the use of costing information as a strategic tool, which does not bode well for the billions of pounds of efficiency savings expected over the coming years. This issue could be remedied to some extent by improving clinical ownership of costing information, through involving clinicians in the development lifecycle of information systems.

At present, this is most apparent during the requirements analysis and system design stages of the system development lifecycle, in order to understand user needs and set up the internal rules of the system.

A more strategic, bigger picture view is needed: although some Trusts reported clinical representation on system project boards the view is still very much that clinical costing systems belong to the finance function. One way to build longer-lasting engagement would be for senior management to lead by example: highlighting the role and long-term value of clinical costing systems, and their outputs, in strategic decision-making.

Costing information, and the dedicated, hard-working teams who produce it, have a crucial role to play in supporting the sustainability of the NHS: this must be recognised at the highest levels and built into organisational priorities.

Costing needs to become an enabling rather than a support function; whatever the perception of clinical and financial roles has been in the past, it is clear that both professions must work together to meet the challenge of delivering better-quality patient outcomes at a lower cost.
1. To find out more about this course visit http://mmubs-cimamsc.course-source.co.uk
17. Healthcare Resource Groups (HRGs) are the currency for the bulk of acute patient services in English hospitals. Patient activity is coded and collated into common groupings of events which might require a similar level of NHS resource, to which the relevant costs are attached.
19. Ibid.
Two of the world's most prestigious accounting bodies, AICPA and CIMA, formed a joint venture to establish the CGMA designation to elevate the profession of management accounting.

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