



Community Network response to consultation on mandating patient-level costing for NHS community services

The Community Network is the national voice of NHS community providers. We support trusts and not-for-profit organisations providing NHS community health services to deliver high-quality care by influencing national policy development, sharing good practice, and promoting a vision of integrated care in the community. The Network is hosted by the NHS Confederation and NHS Providers.

Key points:

- We broadly agree with the proposals outlined in the consultation document, which are in line with the wider set of reforms taking place as part of NHS England and Improvement's (NHSE/I) five-year costing transformation programme.
- Moving away from reference costs, and towards patient-level costing, has the potential to bring several benefits to the community sector, including enhanced standardisation across service provision and more accurate data collection – two issues which have historically been a barrier to national investment in, and prioritisation of, the community sector. However, as acknowledged in the consultation, there are some outstanding challenges and risks that must be addressed before moving forward with the proposals as outlined. In particular, the current pressures created by the COVID-19 pandemic, and the ongoing demand increases that community providers will face, mean that NHSE/I must take every possible step to avoid creating any additional burden for providers of community health services.
- Before moving to mandate patient-level costing, NHSE/I should seek to understand the reasons behind the variation in the group of providers already submitting patient-level costing data consistently and support providers to meet the new standards (including the 2% of community trusts who do not have a patient-level information and costing system).
- Additionally, NHSE/I should seek to engage with Community Interest Companies (CICs), who provide a significant proportion of NHS community health services, but are currently excluded from these proposals. We support the extension of patient-level costing to CICs, subject to them being properly resourced and supported to do so.

Introduction:

We welcome the opportunity to give the views of trusts and CICs on NHSE/I's consultation on mandating patient-level costing in NHS community services. Given operational pressures, we have not been able to engage extensively with our membership on these issues. However, our response is informed by engagement with a number of community provider chief executives and trust finance directors.

Given community health providers have historically been overlooked in national prioritisation and investment decisions due to a lack of standardised data collection, we support NHSE/I's efforts to

better understand the granularity underpinning activity and costs in the community sector, while recognising that moving to a new data collection during the COVID-19 pandemic will present challenges that need to be mitigated. In addition, the range of organisational types that make up the community provider landscape necessitates further exploration of unintended consequences.

Given the operational pressures created by COVID-19, our response has been informed by feedback from a small number of Financial Directors at trusts and CICs providing community health services.

The Community Network's response to the four consultation questions

1. To what extent do you agree with mandating patient-level data for community services in line with the methodologies and approaches in the Healthcare Costing Standards for England, from 2021/22?

Overall, we agree with the move to mandate patient-level data for trusts providing community services in line with the methodologies and approaches in the Healthcare Costing Standards for England, from 2021/22, and we welcome the fact that trusts have been involved in drafting and agreeing the costing standards.

We support the aims of this new data collection to provide the following benefits to community services:

- Universal standards allowing consistent comparisons between providers.
- A better understanding of pathways and clinical variation.
- A more detailed understanding of costs, efficiencies, and variations.
- Improved data on patient experience and outcomes.

The need for a higher quality national dataset for community services is a persistent issue for policymakers. While community providers individually hold detailed data into their services, the lack of national standardisation across this data collection has historically been a barrier to national prioritisation and investment, as well as making it difficult to benchmark services. We therefore welcome the collection of patient-level data, which would enhance the quality of information collected on community services at both a local and national level. However, this data must be used to support service improvement rather than enforce compliance.

In addition, community providers are concerned about the lack of transparency around how NHS Long Term Plan investment – ringfenced for primary and community services – is being spent and specifically, the proportion of this funding that is reaching community health



services. More accurate data on spending across the community sector will contribute to a better understanding of how funding flows through the system.

Despite the potential for benefits, we would reiterate concerns outlined in the consultation that the standards are very detailed, and trusts will need full information to progress towards implementation. Alongside this, trusts (and especially the 2% without Patient Level Information and Costing System [PLICS]) will need support from the centre to roll this out. It is encouraging to see support measures outlined in the impact assessment, and we would welcome further details about the support individual trusts can expect to receive from NHSE/I to overcome any barriers to collecting patient-level data. This is especially important considering trusts are expected to begin data collection in April 2021, when the NHS will still be under significant, pandemic-related pressures.

Community health providers are currently facing unprecedented pressures on services, including managing COVID-19 and non-COVID-19 care, responding to the usual winter pressures and playing a key role in the delivery of the Covid vaccination programme. These pressures are expected to continue into 2021, as community services continue to support patients with the long term effects of Covid and support people whose treatment was postponed during the first/third wave.

In light of the current and future pressures created by the pandemic, we agree with the phased approach to implementation proposed, with transition pathways for trusts to move to full submission of patient-level costing data over an agreed number of years. We would welcome more detail about how transition pathways will be agreed, how trusts (especially those who are struggling to make the transition) will be supported along these pathways, and whether there will be any consequences if trusts are unable to overcome barriers in submitting the mandated dataset. It is crucial that NHSE/I recognises that some providers will be better placed than others to make this transition, with some trusts already some way into the process of implementation but others delayed by recent operational pressures. For instance, combined acute and community trusts, who will have experience of collecting this type of data, are likely to be in a better position to collect patient-level costing data in community services than standalone community trusts who have not been involved in the testing phase.

We also note that CICs, who make up a significant proportion of all community service providers, are not mentioned in these proposals to transition to patient-level costing. We believe that the views of, and impacts on, CICs, and indeed other independent providers of community services, should be considered when making this significant change to the costing structure. For CICs, challenges could arise from being excluded from this costing system, for instance, in the commissioning process (as they would be unable to demonstrate their value for money in the same way as trusts), and in collaborative working across the

system (as their data would be an outlier). As such, we believe that NHSE/I should engage with CICs and independent providers on these proposals, and involve them in the technical focus groups discussed in the impact assessment. CICs should then be funded and resourced to implement the patient-level costing data collection.

2. Do you agree with the proposal to cease collection of reference costs for community health activity from 2020/21?

We agree with the proposal to cease collection of reference costs for community health activity from 2021/22 as this would reduce the burden on trusts while they simultaneously move to collecting patient level costing data. This should also ease some of the workload in the annual submission window, which includes reconciliations and resolving errors. This is particularly important considering the Covid-related pressures that all community providers are facing. However, as some trusts are currently using these reference costs for their block contracts, which will not be available after 2020/21, this will need to be a well-managed and supported transition as it could create some significant changes to contract values.

3. Do you have any comments on our assessment of the likely costs?

While the assessment of the likely costs appears robust and reasonable, we have two further questions that are not covered in the consultation:

1. Where will additional costs be funded from?
2. When are estimated benefits expected to be realised?

As the impact assessment highlights, there are five key risks in the assessment of costs:

- Some NHS trusts and commissioners use contracts based on reference costs, which will not be available after 2020/21.
- The level of cost information collected through PLICS is significantly more detailed than reference costs.
- There are upfront costs of setting up a patient-level costing system for the 2% of the trusts that do not yet have the required software.
- It is expected there will also be additional costs for trusts around ensuring the completeness and accuracy of patient-level data, compared to reference costs.
- The impact of the COVID-19 pandemic, particularly around trusts' capacity to implement new data collections at this time.

We agree with these risks identified and ask for further exploration of mitigation options before proceeding.



We would also add that community providers are at different starting points and stages of implementation, and this should be considered when NHSE/I investigates the likely costs of this transition. Combined community and acute trusts are likely to be in a stronger position to move to patient-level cost collection as they will already have experience of this in the acute sector. Therefore, the transition to collecting data on patient-level costing may be more challenging, and indeed more costly, for standalone community trusts. Additionally, if CICs and independent providers were included in these proposals, then they may need extra time and resources to bring them up to speed (as they have, to our knowledge, not been involved).

4. In principle, do you support the move to a quarterly cost collection for the community sector? Please give details of any other risks or issues you feel need to be addressed to support the move towards quarterly collection of PLC data

While we support the principle of moving from an annual to a quarterly cost collection, we would advocate caution in making this collection more frequent at this early stage. We believe that providers should have the opportunity to familiarise themselves with the annual data collection, test the data, and make improvements to its quality/consistency, before considering moving to a quarterly collection. We believe this could be reviewed after a significant period of time (a year or more), and any move towards quarterly collection should be based on a thorough review of how this is working, and based on a mutually agreed timetable with individual providers.

It is also important to recognise that there are risks attached to the quarterly collection of patient-level costing in community services. Submitting data on a quarterly (rather than annual) basis could potentially divert resources away from analysing and utilising the information produced from PLICS, which would reduce its potential to drive improvements across community health services.

Conclusion

We welcome the overall approach outlined in the document and support the phased transition to patient-level cost collection, as set out by NHSE/I. However, in the context of the COVID-19 pandemic, we would reiterate that NHSE/I must mitigate any additional burden or costs on providers which would be inappropriate and untimely considering the significant pressures that providers of community services are facing. We would also encourage NHSE/I colleagues to consider the timing around the introduction of any new ways of working given the pressure, and change burden, currently facing the service.

We would welcome further detail on the package of support for providers, and how the timeframes for transitioning to patient-level cost collection will be agreed with providers. As



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some providers are still grappling with challenges in submitting data to the Community Services Data Set, it is also important that NHSE/I do everything they can to support providers to overcome any similar challenges with submitting data on patient-level costing. Additionally, we know that some providers will be able to make faster progress on implementation than others, and NHSE/I must give appropriate support to community providers who are at different stages in this process.