

## GUIDANCE TO NHS TRUSTS ON COSTING FOR SIFT CONTRACTS

**HSG(95)60**

### Executive Summary

24 November 1995

1. Trusts who support undergraduate medical teaching should identify the costs of doing so, over and above the costs of patient care, following the principles in this guidance. Cost information should be presented to Regional Offices (or health authorities with delegated responsibility for SIFT) by end May 1996, and will be used to inform SIFT contracts for 1997/98. This guidance should be read together with HSG(95)59 which explains SIFT accountability, planning and contracting.

### Addressees

**For action:**  
Regional Offices  
District Health Authorities  
NHS Trusts and Directly Managed Units  
Universities with Medical and Dental Schools

### Action

**For information:**  
Family Health Service Authorities

2. Trusts should:
  - decide whether undergraduate medical teaching adds significantly to their health care costs, and if so inform their Regional Office (or health authority with delegated responsibility for SIFT) of their interest and agree a precise timetable for action (dates below are indicative and may be varied by ROs);
  - plan costing work to be completed by end May 1996, following the principles of this guidance, and agree their approach with the RO or HA by end of January 1996;
  - ensure cost assessments for SIFT contracts are consistent with figures supplied for the research and development provider declaration (EL(95) 100 and EL(95)127);
  - work closely with university medical schools to identify costs of supporting undergraduate medical education
  - \* give their RO or HA an interim assessment of costs by 18 March 1996;
  - \* give their RO or HA by 31 May 1996 an assessment of costs of providing clinical placements for undergraduate medical students and (separately, if applicable) of providing facilities to support undergraduate medical education, following the principles in this guidance;

**From:**  
Health Care Directorate  
NHS Executive HQ  
Room 2W51  
Quarry House  
Quarry Hill  
Tel 01132545956

Further copies of this document are available from:

Department of Health  
PO Box 410  
Wetherby  
LS23 7LL  
Tel 01937840250  
Fax 01937845381

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- review and update cost assessments in subsequent years, agreeing with the RO or HA the timetable and any developments or refinements in the approach to identifying costs.

**3. ROS and HAs with delegated responsibility for SIFT should:**

- agree a clear timetable with interested Trusts for submission of costing information, and for agreement on technical approach and resolution of queries;
- \* assist Trusts in interpretation of the guidance, with the aim of ensuring comparability between cost assessments in different Trusts, seeking in particular to resolve any problems of cost allocation between teaching and R&D;
- \* use the cost information to inform SIFT contracts for 1997/98 and later years (see HSG(95)59);
- \* agree, year by year, with Trusts where cost assessments need to be refined in order to improve accountability or ensure comparability between Trusts.

**Note**

Trusts may seek SIFT contracts for 1997/98, on the basis of demonstrated costs, whether or not they are current recipients of SIFTR.

This guidance does not apply to dental SIFT - i.e. funds to support teaching of clinical dentistry to dental students. It does apply to the costs of teaching medicine and surgery to undergraduate dental students.

# GUIDANCE TO NHS TRUSTS ON COSTING FOR SIFT CONTRACTS

## 1. INTRODUCTION

This guidance has been prepared to assist NHS Trusts with the identification of the costs of supporting undergraduate medical education, for the purpose of agreeing Service Increment for Teaching (SIFT) contracts from 1997-98. It should be read in the context of guidance in HSG(95)59 about the purpose of SIFT, accountability, and the approach to planning and contracting.

## 2. HOW TO USE THIS GUIDANCE

Links to R&D Provider Declaration

- 2.1 Trusts who are also involved in the research & development (R&D) provider activity and cost declaration should complete work on identification of SIFT costs at the same time (i.e. by May 1996). Trusts are required to declare R&D activity and costs to the NHS Executive; for SIFT, the requirement is to make available the same sort of information as a basis for contracting. Costing needs to be sound enough to inform contracts for 97-98, but there are no current plans to use costings from the initial SIFT contracting round to re-base the SIFT levy, as will be done for R&D.
- 2.2 This guidance has been prepared in conjunction with R&D costing guidance to assist in consistent and fair attribution of costs between these funding streams, and others. Thereafter, SIFT costing will need to be updated annually as part of the main costing and pricing round to ensure consistency with costing for other contracts. In essence, there should be one costing and pricing methodology to support SIFT along with other forms of contracting.

How much detailed work on costing?

- 2.3 All Trusts with significant involvement in undergraduate medical education should work to identify costs in time for the 1997/98 contracting round. The detail of the guidance is permissive rather than obligatory in that the process of identifying costs may legitimately be done in different ways, and timescales, in different circumstances. The cost of work to identify resources used to support undergraduate medical education should be kept as low as possible, bearing in mind the large sums involved and the value to the NHS of better understanding of costs and better attribution of funding. For some Trusts, large sums are involved in facilities to support undergraduate medical teaching, accounting for a significant proportion of Trust income and expenditure. It is therefore appropriate to go to some trouble to identify the costs accurately, within constraints on NHS funding and respecting concerns about management costs. Other Trusts may find that simpler methods are sufficient. As a minimum, Trusts should aim to apply the "top down" analysis detailed in the "Costing for Contracting" manual.
- 2.4 In most cases the Trusts which incur significant costs on facilities to support undergraduate education will also have extensive R&D programmed and are required under EL(95) 100 "Supporting Research & Development in the NHS: A Declaration of NHS Activity Costs Associated with Research and Development: Initial Guidance" to identify all R&D costs by 31 May 1996. It will be important for those Trusts also to identify SIFT costs by the same timescale, in order to confirm the accuracy of apportionment of R&D costs. But refinement of the division between SIFT and patient

care costs may take place in later years, if Trusts and ROS agree that it is sensible to spread more detailed costing work over a longer timescale.

- 2.5 All Trusts should ensure that the approach they intend to take to the identification of costs is acceptable to their SIFT purchasers: normally the Regional Office (lead health authorities in conjunction with the RO in Trent) working closely with the university medical school. SIFT purchasers will expect Trusts to justify any significant variation from the suggestions in this guidance, and will generally look for a uniform approach so that the results are comparable at least between Trusts in the same university area.

- 2.6 Each RO (or HA in Trent) will agree a local timetable for SIFT costing work with Trusts. Subject to local agreement, the 1995-96 timetable is likely to include:

Trusts who aim to retain, or gain, SIFT contracts to explain planned costing methodology to RO or HA by end January 1996;

Trusts who also have significant R&D costs to show ROs/HAs "first cut" SIFT costs by 18 March - at the same time as the "first cut" R&D costs;

Trusts who also have significant R&D costs to provide ROS or HAs with delegated responsibility for SIFT with SIFT costs by the end of May, at the same time as their R&D declarations.

ROS may ask other Trusts with SIFT costs to work to the end May deadline, or may agree a slightly longer period.

- 2.7 Trusts should collaborate closely with the local medical schools in the identification of activity to support medical undergraduate education and the resources used, and in the approach to costing.
- 2.8 Tables A and B identify the main NHS resources which contribute to support for undergraduate medical teaching and suggest ways of identifying the "extra costs" for each example. Trusts may use different methods if they are more compatible with their normal approach to costing for contracts, making use of information which is already available or which can be gathered at an affordable cost. In some cases Trusts and SIFT purchasers may agree to use one approach to costing initially, but to develop a more accurate approach by an agreed time - particularly where SIFT purchasers wish to ensure reasonable consistency in the way costs are attributed, and funded, in different Trusts. Trusts should plan to integrate such changes into their current plans to develop costing for contracting.
- 2.9 Using the Costing for Contracting guidance, Trusts should aim to identify a fully absorbed cost for SIFT for each relevant specialty. The fully absorbed cost for each specialty, used for health care contracts, will include the impact of teaching on that specialty unless "teaching" costs are explicitly identified and treated separately. Identification of costs for SIFT therefore involves consideration of each of the main direct and indirect costs which contribute to the specialty cost, to identify the areas where teaching is likely to affect the use of resources. The impact of teaching should also be considered in identifying and apportioning overhead costs.
- 2.10 Costing work in the spring of 1996 should be based on 1995-96 budgets (original or updated, whichever is easier for reconciliation) and not on forecast outturn. Trusts may also wish to explain planned or predicted changes in activity and resources used to support teaching in the 1997-98 financial year: these should be identified separately. In general, costing for SIFT contracts should use the same price base as other costing for contracts.

costs (e.g. extra pathology tests, longer length of stay) may be charged to the clinical placement budget. Other expensive aspects of teaching hospitals (e.g. sophisticated medical equipment) may properly be shared between the budgets for health care, SIFT (facilities) and R&D, where needed for these activities.

#### **Junior Doctors**

- 3.6** Comments on “SIFT into the Future” suggest there is some uncertainty on whether SIFT should cover service costs of postgraduate medical education. This has never been the intention. Postgraduate medical education costs will continue to be met on the same basis as now through the medical and dental education levy. The levy will fund 50% of full time junior doctors’ basic salary and 100% of salary for flexible trainees and non pay costs for all junior doctors. The levy will also fund other specific costs attributable to medical and dental education (e.g. postgraduate medical centres). The remaining employment costs, including those of NHS teaching staff, are met by Trusts, and are balanced by the service contribution made by junior doctors. Trusts should not attribute any general “excess costs” of junior doctors to SIFT. They may, though, take account of the time which junior doctors contribute directly to undergraduate teaching (without double counting any salary costs reimbursed from the medical and dental education levy).

#### **Merit Awards**

- 3.7** The new arrangements whereby B, A and A + distinction awards are funded through a separate national levy (EL(95)93) relieve individual Trusts of the cost of rewarding senior consultants for their achievements in professional leadership, including the NHS costs of consultants employed by universities. The costs of distinction awards should not therefore feature in SIFT contracts. As an interim measure in 1996/97, some Trusts which previously received explicit funding for some distinction awards from SIFTR will continue to have the costs met from SIFT or the R&D levy. Details have been agreed with ROS. This does not alter the principle that distinction awards should be charged only to the new national levy. Costing for SIFT contracts from 1997/98 onwards should in all cases exclude the costs of distinction awards.
- 3.8** The former “C” awards have been replaced by locally decided discretionary points, payable in addition to the maximum of the consultant salary scale. These are part of the Trust’s salary costs, a proportion of which may be a legitimate charge to SIFT.

#### **Dental Students**

- 3.9** This guidance does not apply to the identification of costs of teaching dental students in dental hospitals. But it should be used when considering the costs of providing medical and surgical teaching to dental students. There will generally be no need to identify these costs separately from those of medical students, e.g. the cost of a clinical placement for a medical student studying surgery should be regarded as the placement cost for a dental student in the same circumstances. Dental students studying medicine or surgery should be included in any relevant exercises to gather information on the use of resources to support teaching.

#### **Shared Resources**

- 3.10** In apportioning costs, Trusts will need to make judgments about resources which serve a number of purposes. For example, a library may be shared by:

uses	budget
medical undergraduate education	SIFT (facilities)
research	R&D levy
junior doctors (postgraduate education)	medical and dental education levy (if specifically agreed in current funding arrangements)
other purposes	health care budgets

University funds may also be involved.

- 3.11 The best information which is to hand, or can reasonably be gathered in the time available, should be used to apportion costs fairly between different sources of funding. For a library, some possible options are:

survey of readers/users over a representative time period

examination of costs of new acquisitions and journal subscriptions to consider the main target readership and split the overall budget accordingly

pro rata to numbers of staff/students/trainees entitled to make use of the facility

The views of the managers responsible for the resource (e.g. the librarian) and any established “user committees” will be an important guide to a fair and practical method of apportionment.

- 3.12 The Trust has discretion on whether to calculate relatively small sums of money for minor uses of a shared facility, but decisions on the source of funding should not be used in later years to deny access to a “facility” to legitimate minor users on the grounds that they are not paying for it.

#### Documenting Decisions

- 3.13 The method of costing, including the apportionment of costs, and the reasons for choosing it, should be documented in a way which can be shown to be fair to SIFT purchasers, health care purchasers and (as appropriate) R&D purchasers and to medical schools. Trusts are encouraged to be open with each other about their costing methods and actual costs for SIFT contracts.

## 4. COSTING FOR CLINICAL PLACEMENT CONTRACTS

- 4.1 Clinical placement contracts will be placed by the Regional Office (or health authority where RO has delegated responsibility) on the advice of the Medical School Dean. The total sum available is based on a standard sum per student-year, but this does not imply that each contract will use the same rate of payment per student; there may be variation according to, for example, specialty educational requirements relative to the stage of the curriculum, or factors affecting the Trust’s costs.

- 2.11** Tables A and B are not offered as a prescriptive costing manual. They offer practical assistance in a common sense, professional approach to meeting the objective of costing for SIFT contracts, i.e:

recognise the NHS resources which are used to support undergraduate medical teaching;

identify the extent to which the use of those resources exceeds what would be required for contracted health care;

cost the additional resources in a way which is consistent with costing for health care contracts;

ensure that all the Trust's costs are fairly apportioned across the relevant funding streams (patient care, SIFT, R&D, and any other specific sources of funding), and that the basis of costing can be demonstrated to SIFT purchasers, health care purchasers and the auditors;

identify costs in a way which allows fair comparison between Trusts.

**Basing contracts on demonstrated costs**

- 2.12** If work to identify the costs of supporting undergraduate medical education suggests that the actual costs are higher, or lower, than current SIFT funding, the pace of change in SIFT contracts should be discussed with the regional office in order to avoid unnecessary turbulence or financial instability. See also HSG(95)59.

**GP costs**

- 2.13** This guidance is not directly applicable to GP practices engaged in teaching undergraduate medical students. Further guidance on costs of GP support to teaching will be prepared, following some pilot work in the West Midlands.

### **3. GENERAL PRINCIPLES: BOUNDARIES**

#### **NHS and University Costs**

- 3.1** SIFT funds the additional costs to the NHS associated with student teaching. This is not the same as the full cost of teaching students in a clinical setting, since the cost of “teaching” as such will be met from university funds. Nor is it the cost of all resources used while students are present (e.g. costs of consultant salaries pro rata to the number of sessions used for teaching) since clinical teaching often happens at the same time as the delivery of patient care. The question is the extra resources used because of teaching. For example, if a consultant arranges to see fewer than usual patients for a “teaching” ward round or clinic, what is the extra cost of providing the patient care for which NHS purchasers have contracted, compared with the cost if no teaching was involved?
- 3.2** SIFT contracts should reimburse actual extra costs incurred by the NHS. These may include specific arrangements for financial support for joint appointments with a medical school. There is no requirement, for the purposes of SIFT, to identify costs incurred by universities in teaching undergraduates within an NHS environment, or to calculate the “knock for knock” value of services exchanged. However, as the identification of costs becomes more sophisticated, Trusts and universities may find they need to understand these arrangements better.
- 3.3** SIFT contracts should be based on costs in the existing pattern of teaching to allow a baseline for planning for later years. The prime aim is to fund appropriately the costs which the NHS is already bearing, separately from steps to change funding to reflect agreed changes in support for undergraduate medical education. Over time, university medical schools will look for changes in the pattern of undergraduate teaching, for example more teaching in community settings, which may increase or decrease costs, with corresponding financial changes. Neither universities nor Trusts should assume that SIFT will be available to fund the costs of changed patterns of teaching without prior discussion and agreement with the RO (or HA with delegated responsibility for SIFT).

#### **Clinical Placements and Facilities**

- 3.4** SIFT funding is divided into two budgets: for clinical placements and for facilities to support undergraduate medical teaching. Further definitions and examples are given in sections 4 and 5. In identifying costs, Trusts may be clear that resources are used to support teaching, but be uncertain whether they are more appropriately charged to clinical placements or to facilities. This should be discussed with the university medical school Dean and the Regional Office (or health authority with delegated responsibility for SIFT), bearing in mind the relative size of the budgets and pressures on them.

#### **Case Mix**

- 3.5** Costing for SIFT contracts should not include the cost of more complex case mix. Patients who require more complex and expensive treatment, or who have multiple pathology, may be referred to “teaching hospitals” because of the concentration of specialised consultants and other facilities. The costs of their treatment fall to their purchaser’s health care budget, since the reason for the patient being in hospital must be their own health and welfare. It is inappropriate to charge to SIFT the costs of complex or specialised patient care, because this suggests that patients are in hospital primarily as an aid to teaching rather than as people receiving the most appropriate NHS care for their needs. However, there may be ways in which their care is more expensive because students are involved in observing their treatment, and those extra



- 4.2 The aim of clinical placement contracts was defined in the report “SIFT into the Future” as covering “variable service costs which depend directly on the presence of students”. This is not strictly limited to “variable costs” as defined in Costing for Contracting (see para 4.3) and so this guidance refers to clinical placement costs. The difference between clinical placement costs and facilities costs is best understood by considering which costs change:
- a when students come and go (e.g. during vacations)
  - b if an extra student firm is added, or taken away
  - c if a significant amount of student teaching were to cease: which costs could change in the first year?
  - d if a significant amount of student teaching were to cease: which costs could change in the longer term but not in the first year?

Elements a, b and c belong to the clinical placements budget. Element d belongs to the facilities budget.

- 4.3 Clinical placement costs include “variable costs” as defined in NHS Costing for Contracting, i.e “those that tend to vary with the level of activity, in such a way that a near proportionate change in cost accompanies a change in activity”. They also include “semi-fixed” costs, including staff time. Staff (medical and non-medical) may alter their use of time significantly when there is a requirement to support undergraduate teaching. Where this results in extra staff costs (e.g. overtime payments or agency staff) they should clearly be attributed to the clinical placements budget. In other cases, particularly for hospitals with a significant, regular involvement in teaching, the use of staff time for teaching may have been built into the normal complement. Nevertheless, the Trust could deliver its contracted level of patient care with fewer staff if it were not involved in teaching. An objective assessment of this use of staff time can legitimately be charged to the clinical placements budget.
- 4.4 Some examples of resources likely to be affected by the presence of students are given in Table A.

**TABLE A: EXAMPLES OF RESOURCES TO BE COSTED FOR  
CLINICAL PLACEMENT CONTRACTS**

Resource	Comments	How to identify resources attributable to clinical placements	How to cost the resources
NHS medical staff (consultants and other)	Time involved in direct contact with students, and/or result of slower throughput of patient services when students are present.	<p>Consultant forward job plans or diaries to identify teaching commitments, checking when time is dedicated to teaching (e.g. seminars and preparation time) and when it also provides patient care (e.g. ward rounds and clinics)</p> <p>Comparisons of patient throughput with similar units without teaching (or same unit at different time of year) to identify impact of students</p> <p>Specific costing of medical time, and other resources below, to support clinical examinations</p>	Pro rata to average salary cost for consultants and each other grade involved
NHS nursing staff and professions supplementary to medicine	Time involved in direct contact with students, and/or result of slower throughput of patient services when students are present.	<p>Staff rotas, diaries etc to identify teaching contacts</p> <p>Comparison of ward costs in similar units with and without undergraduate teaching (or same unit at different time of year) to identify impact of students</p>	Pro rata to salary costs for each grade involved
Unit cost of staff (e.g. through grade mix)	Unlikely to be extra costs directly linked to teaching, but case may be demonstrated locally	Compare numbers and grade of staff with those in similar units without teaching; ensure costs due to specialised case mix are attributed to patient care rather than to SIFT	Excess salary cost

Pathology costs X ray, drugs, therapy services, theatre running costs;  also hotel costs through longer length of stay	Need to demonstrate resources used in teaching, over and above normal patient care.	Compare use of different resources in similar units without teaching (or same unit at different time of year) to identify impact of students. Need some detailed study of <b>how</b> resources are used to distinguish actions by/for the benefit of medical undergraduates from effect of case mix (or other factors such as R&D, other education and training)	Number of excess "units" times average cost; or % addition to cost of health care contract
NHS support and overheads e.g. portering, laundry, catering, medical records	Some direct impact from presence of students	Simple systems to estimate resources per student week e.g. laundry of white coats, subsidised meals and accommodation	Extra units times average cost, or % addition to costs of health care contract

**5. COSTING FOR CONTRACTS FOR FACILITIES TO SUPPORT UNDERGRADUATE MEDICAL TEACHING**

**5.1 The report “SIFT into the Future” explains “facilities to support teaching\*” as follows (para 2.4):**

“Facilities” may include tangible assets (space, libraries, equipment) and human resources (richer skill mix, higher staff to patient ratios, higher pathology costs, medical illustration) within an environment of clinical excellence. The distinction between a “clinical placement” cost and a “facility” cost is that the former would no longer be incurred if student teaching ended - allowing a year or so for practical change. A “facility” cost is more fixed, though this does not rule out the possibility of managed change over the right timescale”.

**5.2 The report also says (para 2.46)**

“We consider it dangerous to take a narrow interpretation of “facilities to support teaching” which would exclude genuine and desirable costs, where there is no other more appropriate budget from which they could be reimbursed”.

**5.3 Following the principles of Costing for Contracting, all the Trust’s actual costs will be charged to patient care unless there is agreement to meet them from another budget. Trusts will need to agree with their SIFT facilities purchaser (the regional office, or where delegated, as in Trent, the health authority) exactly which “facility” costs can be charged to SIFT. If this shows a significant difference between the costs which are agreed to be appropriate to SIFT, and the historic pattern of SIFT income, ROS will plan for managed change to secure a predictable transition path, avoiding disruptive changes in income.**

**5.4 Table B provides a number of examples of additional resources which may be required to support undergraduate medical education on a “permanent” basis, in addition to those in Table A. It suggests ways of identifying, quantifying and costing the resources appropriate to SIFT. Other resources may be included if Trusts and ROS agree they are required to support undergraduate medical education and are not more appropriate to a different budget, and sound costing information is available. ROS will compare their approaches to ensure they move, in successive contracting rounds, to a consistent basis for assigning costs to SIFT, in order to be fair to all Trusts and their health care purchasers.**

**5.5 Table B includes an example of “clinical leadership” costs which are not strictly associated with teaching but, in the spirit of the quotation from the SIFT report above, may continue for the time being to be funded through SIFT facilities contracts. It is important that such costs are identified separately and discussed explicitly in contracting, so that all ROS can take a fair and consistent approach to similar borderline issues.**

**5.6 “Facilities” are not limited to traditional large teaching hospitals. The test is whether there are demonstrable costs of resources used in maintaining an ability to provide undergraduate medical education which would not be required in providing patient care, but go beyond clinical placement costs.**

**TABLE B: EXAMPLES OF RESOURCES TO BE COSTED FOR CONTRACTS FOR FACILITIES TO SUPPORT UNDERGRADUATE MEDICAL TEACHING**

Resource	Comments	How to identify resources attributable to facilities to support medical undergraduate teaching	How to cost the resources
NHS medical staff (consultants and other)	Most of the medical staff time is likely to be charged to the clinical placements budget, as direct student contact. But there may be other costs, e.g. curriculum development work, advance planning for changes in teaching, time used for "teaching the teachers" which is better funded through facilities. Also, to the extent agreed locally, time spent by some eminent consultants away from the hospital on national professional work where there are demonstrated significant additional costs in providing health care which cannot appropriately be recovered from any other NHS budget.	Consultant forward job plans or diaries to identify appropriate commitments	Pro rata to average salary cost for consultants and each other grade involved
Pathology costs X ray, therapy services, pharmacy, medical illustration, teaching equipment (computers, audio-visual), provision of bleeps and white coats	Some fixed costs of facilities to support undergraduate teaching, e.g. additional equipment and staffing not already charged to the clinical placement budget; includes capital charge equivalents (CCEs) and maintenance costs.	Evidence of use of each resource to show fair basis for apportioning cost between SIFT, health care and any other appropriate budget	Split cost in an agreed proportion

Additional space: specifically for students (residences, locker rooms, teaching and study areas, library) and more generally (e.g. larger consulting rooms in outpatient departments); consider CCEs and other overhead costs such as cleaning, energy costs, portering	Need sound rationale for apportioning costs of shared areas and facilities	Information on actual use of space to identify all areas involved in teaching; need fair but simple basis for apportioning indirect costs	Split costs in an agreed proportion
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