HFMA discussion paper on costing NHS community services (April 2014)

1. Purpose of this discussion paper

The HFMA has taken a strong lead in supporting and developing costing in the acute and mental health sectors over the past four years. The association is aware that there is a great desire in the community sector to improve and raise the profile of costing and it remains committed to supporting the sector to achieve this.

However, this work needs to be approached carefully and time has been taken to consult key stakeholders to understand more about costing community services. The findings are set out in this paper and are used to consider options on how the HFMA can best support the work going forward.

The options set out in this paper will be discussed at HFMA's Strategic Costing Group in April 2014 in order to ensure that any work is fully integrated and supported in HFMA's costing work programme. This paper will also be published on the HFMA website to provide transparency in this area of work.

It is worth noting that at the same time that this paper has been researched and written, Monitor has commissioned Deloitte to undertake a study evaluating the current costing of community and mental healthcare services. HFMA has been working closely with Deloitte and both workstreams are seen as complementary to one another.

2. Introduction

With a total yearly investment of nearly £10 billion[1], community services make up 10 per cent of the NHS budget. This area is likely to grow in significance over the next few years as commissioners try to reduce costs by moving care out of acute hospitals.

[1] Department of Health annual report 2012/13

Many community service organisations have undergone significant changes over recent years as former PCTs divested themselves of their provider arms. This reconfiguration has led to community services being provided by four main different types of organisation:

- NHS community services trusts
- NHS combined acute and community services trusts
- NHS combined mental health and community services trusts
- Private sector organisations (This includes social enterprises of community interest companies and other organisations such as Virgin Care which won a £500m contract to run community health services in Surrey for five years and Serco which won a bid to manage Suffolk Community Healthcare).

This paper incorporates information from a wide range of sources, including:

- A costing survey, undertaken by the HFMA was sent to all reference cost leads submitting information on community services in August 2013. Twelve trusts with community services completed the survey and, although the relatively small sample size means the results should be treated with caution, they provide useful insight into the issues involved with costing in community services. The findings of the survey are included in Appendix B and the key points are summarised within the sections below.
- Discussion from a meeting held on 19 September 2013, to which HFMA invited those community costing leads who had completed the survey and those who had contacted HFMA directly. In total six trusts were represented at this meeting.
- Department of Health reference cost team
- NHS England
- Foundation Trust Network
- Monitor
- Department of Health's community tariff working group
- Interviews with individual organisations and key stakeholders identified above

As a result of discussions with these stakeholders, some key issues have been identified that have prevented costing practices in community services from progressing and developing as quickly as costing in the acute and mental health sectors. These are discussed further in section 3 below.

3. The context for costing community services

3.1 Core issues

The key issues identified that have prevented community services from improving the quality of costing more rapidly are:

- absence of either a national currency or tariff
- historic lack of a standard minimum data set (now introduced) and detailed service descriptions

- limited electronic information systems
- data quality issues
- data capture issues, for example the capture of non face-to-face time including telephone calls and travelling time
- lower priority given to community services costing by commissioners
- distractions created by the merger/acquisition of community services in recent years.

3.2 Other issues

The meeting of costing practitioners in September also identified the following issues as impacting on costing in community services:

- ***Variation in types of trust, types of service, how services are delivered and what activity data is collected***

  In newly formed trusts that combine several former community services organisations, there can be variation in service delivery and what activity data is collected. More long standing trusts have had the chance to establish more consistent services across their organisations.

  There is also a new challenge relating to the increase in the number of commissioners where individual clinical commissioning groups (CCGs) have different requirements? The types of community services provided vary quite widely between trusts. For example, some have hospital inpatients, others don't. The development of community costing standards needs to acknowledge and take account of the different delivery methods of community services and the different stages of development of trusts.

- ***Integration***

  Integration of services does make costing more complex because of different sources of information and the need to track patients across multiple care settings. However, it also makes costing community services even more important. For example, traditionally the community sector has not had 'intermediate' services like radiology and theatres where the real drive for PLICS has come from in the acute sector. However, integrated care turns the traditional community service lines into 'indirect' or 'intermediate' services. For example district nursing becomes an indirect element of a long term conditional package of care. The need to understand the drivers of cost for complex cases moving to the community from the acute sector is critical. Granular patient level costing will drive service transformation and help commissioners understand that discharging more complex patients earlier from hospital may save on acute costs but it does not come without additional costs in the community.

- ***Service line reporting***

  Community trusts appear define their service lines in many different ways such as geographical area, management structure, reference cost categories, specialities or contract

specification. Some trusts feel that geographical area is the best way to manage services, especially with the fragmentation of commissioners. Using localities as service lines (rather than defining service lines in terms of specialities) supports moves to integrate services around patients' needs.

- ***Benchmarking***
  There is significant interest in benchmaking data for community services. However, much greater consistency is needed in defining services and incorporating the complexity of patients into classifications. A standard approach to costing – setting out a consistent approach to cost pool groups and allocation methodology – was seen as helpful to moving this agenda forward.

4. The current status of costing at a national level

We have undertaken discussions with key national bodies to understand what work is currently underway on costing community services. It is worth noting that most of this work relates specifically to pricing, and future tariff development. However, we have included all key groups / workstreams below, as any work on pricing is likely to impact on costing work at some point in the future.

4.1 Department of Health – Community Tariff Working Group

In August 2012 a community tariff working group was created to support and influence the development of a robust, system-enhancing pricing model. The membership was drawn from Department of Health, the former National Commissioning Board, Monitor, NHS Trusts, NHS Information Centre, NHS Confederation and FTN. Its objective was to provide a practical forum for commissioners, regulators and providers to positively influence the community tariff agenda, and test options / proposals. It was agreed that it would meet quarterly with information sharing and informal communication in between meetings. The group is chaired by Gary Andrews, (director of finance from Liverpool Community Health NHS Trust).

The Community Tariff Working Group has developed terms of reference with the following objectives:

- Level playing field for payment
- Payments that link to outcomes
- Payments that drive/incentivise better system behaviours
- To share the risk between commissioner and provider
- To use existing models and information wherever possible.

4.2 Department of Health Reference Cost Community Services Group

Six trusts that provide community services were represented at a meeting to discuss reference costs for community services in September 2013. The issues discussed were:

- currency
- exclusions
- definitions

There are issues in ensuring comparability of community services reference costs for services that have less clearly defined boundaries. For some services, this can result in the same staff delivering services in ward settings in acute hospitals and in the community to provide continuity of care to patients. As these services are delivered in a range of settings, input from other health professionals, such as GP practice nurses will occur. All relevant costs have to be included to ensure comparability and the key issue is the cost of services and not the funding stream. However, it will also be important to ensure that we don't have double counting of costs by acute, mental health and community providers and that (for SLR) cost are matched against appropriate income / funding streams.

4.3. Monitor and NHS England

NHS England and Monitor have taken on responsibility for the NHS payment system from the Department of Health, under rules set out in the Health and Social Care Act 2012.

As part of this role, Monitor published a research paper titled ***Local price setting and contracting practices for NHS services without a nationally mandated price*** in September 2013. For this study they undertook more than thirty interviews with organisations across England. They spoke to local commissioners, mainly CCGs and some commissioning support units (CSUs), and providers covering ambulance, acute, mental health, and specialist and community services. Monitor found that most local contracts are block contracts, particularly for community and mental health services. They noted that, where activity-based prices have been agreed, many have been based on poor quality data and do not reflect the true cost of provision. The findings from this research have helped inform the rules and guidance proposed for the *2014/15 national tariff payment system* on local payments for services without a nationally mandated price. The findings will also help to inform the regulator's future programme of work.

Monitor's current costing programme includes plans to develop costing for mental health and community services. The aim of the work is to ensure that the money flowing from CCGs to trusts reflects the activity as accurately as possible. Monitor has commissioned a study to evaluate the current costing practices of community health and mental health services. This study, being taken forward by consultancy Deloitte, will consider whether there is a case for change in the costing strategies for these services, and will put forward recommendations and proposed timelines for improvement.

As part of this project, the community health services work stream is aiming to:

- understand the limitations of the current approach to costing of community health services

- identify the source of these limitations, for example – incentives to record activity and costs, lack of common service definition, limited use of technology
- develop and test a range of hypotheses with key community health stakeholders
- design and test recommendations (both short and long term) to address the main issues identified, including provisional timelines and milestones

5. Other relevant NHS initiatives involving community services

5.1 Year of care tariff for long term conditions (LTCs)

The nationally driven year of care tariff for LTCs provides examples of currencies that have been developed at a local level for various community services. The LTC tariff uses a funding model to facilitate the delivery of integrated, needs-based health and social care for people with LTCs. The financial model is based on an annual risk-adjusted capitation budget that reflects different levels of need. The model aims to improve outcomes and deliver a more effective use of resources by shifting from episodic, activity driven funding flows towards person-centred care, irrespective of organisational boundaries. To develop the financial model, it will be important to understand the level of resources required to meet the needs of people with LTCs delivered in both community and acute settings.

5.2 NHS England – integrated care pioneers

In November 2013, NHS England announced fourteen areas in England that have been selected as integrated care pioneers to help lead the way in delivering better joined-up care. The aim is for health and social care services to work together to provide better support at home, and earlier treatment in the community, to prevent people needing emergency care in hospital or care homes. A list of integrated care pioneer sites is contained in Appendix A. Although this is not solely a community services costing project, it will contribute to understanding of the complex relationship between the new integrated care pathways and the resources needed to support them.

5.3 Foundation Trust Network (FTN) – Community Services Group

The Foundation Trust Network (FTN) is a membership organisation for NHS public provider trusts, representing large acute and specialist hospitals through to community, ambulance and mental health trusts. The FTN has both a Community Services Group and a Finance Directors Group.

The Community Services Group is attended by chairs and chief executives or their nominated representative. It provides a network, and also provides a forum for discussing current issues, sharing learning and good practice and supporting and influencing the development of policy relevant to community services. The recent themes for discussion have included the community tariff.

Over the next two years, the FTN will be developing community services performance indicators for benchmarking. Dr Christina Walters has been appointed as national programme director to develop the suite of indicators. It is anticipated that these indicators could be used to inform the development of a currency linked to a tariff payment system. However it is recognised this would take some length of time.

6. Recommendations on how HFMA can take community services costing forward

As a result of the research carried out in this paper, three recommendations are made for how the HFMA can develop work on costing community services.

6.1 Recommendation 1: develop community costing standards

It is recommended that the HFMA works with community services trusts to develop costing standards and to provide a network of support. The HFMA will need to consider whether these standards are developed as a separate set of standards for community services, or whether they are integrated into the acute or mental health standards (or indeed whether it is an appropriate time to integrate the standards for all sectors).

However, using experience from the mental health sector it will be important to sell the vision for costing first and to agree the future direction of travel. PLICS does lend itself well as a costing methodology to community services, because the key cost driver is clinical time but the benefits of PLICS will need to be identified and communicated first, if improvements in costing are to progressed relatively quickly.

6.2 Recommendation 2: establish a community costing practitioner group

It is recommended that the HFMA establishes a new community costing practitioner group. There are a number of considerations that will need to be taken into account in establishing such a group:

- **expand an existing group or create a new group?** The group could either be combined with the existing Department of Health Community Services Reference Cost Group (subject to the agreement of the Department of Health) or a separate HFMA Costing Group could be established. The Department of Health Community Services Reference Cost Group has indicated it would be happy to meet on a single day to contribute to developing the costing standards and progress the work on reference costs. Consideration would need to be given as to how to ensure continuity with the work of other existing HFMA costing groups, especially where the care pathway spans acute and community or mental health and

community settings. However, there was overwhelming support at the meeting in September to establish a community services-specific costing group, to provide time to explore many of the issues that are specific to community services.

- **Venue:** The preference indicated was to alternate meetings between a venue in Leeds and a venue in London.

- **Membership:** Membership of the group would need to include a mixture of both combined trusts and standalone community trusts. However, consideration would need to be given to the mix of these providers on the group to maximise learning opportunities from the different provider models and ensure all voices are heard. Those attending the workshop felt that at this stage, private sector providers should be excluded. Consideration will also need to be given to the services that may be covered by the group members to ensure representative coverage. For example should the group cover learning disabilities? Finally consideration should also be given to inviting an organisation from the integrated pioneer project at NHS England to ensure learning from this project can be incorporated into the development of costing guidance for community services. As with the acute and mental health costing groups, members from the following organisations should be invited to join
    - Monitor
    - NHS England
    - NHS Trust Development Authority
    - Capita
    - Health and Social Care Information Centre– given the specific focus on data in costing community services

  Consideration will also be required regarding the chair of this group, and whether a chair of one of the existing costing groups is proposed or whether a chair could be selected who is currently a Director of Finance at a community provider.

- **Frequency of meetings:** The preference would be to meet quarterly, which is consistent with HFMA's current costing groups. The next HFMA costing conference will take place on 1 May. It is suggested that the community workstream is launched at this conference. At present a separate workshop has been devoted to community costing that will be led by Helen Strain and Steve Wilson.

- ***Costing system suppliers***

  It is important to keep costing system suppliers informed of what community services need. The suggestion was made that a future meeting could include a presentation from a supplier on how they could support costing community services. Suppliers may also be able to identify areas of best practice in costing community services, amongst their client base.
- ***Reference costs***

There is great variation between trusts concerning how much of their costs are included in reference costs. For example, one community trust had only 50% of its costs included in reference costs, as they provide learning disability services. Some practitioners saw value in reintroducing 'family groups' of statistically similar community trusts to facilitate greater comparability.

- **Purpose:** It is proposed that the purpose of the community services costing group is to:
    - provide a focus for costing discussions including the future direction of travel
    - develop community services clinical costing standards and agree the principles that the group will use to develop costing guidance
    - help improve the quality and accuracy of costing
    - have a focus on specific themes at each meeting *(e.g. Community Information Data Set project)*

6.3 Recommendation 3 – collaborate with other national workstreams / groups

It is recommended that the HFMA works collaboratively with the following organisations / groups, and ideally a representative from these organisations / groups would be invited to join a future HFMA community services costing group.

- Monitor/NHS England
- FTN Community Services Group
- The Department of Health Community Tariff Working Group

Appendix A – Integrated Care Pioneer Sites (source NHS England)

- Barnsley
- Cheshire
- Cornwall and Isles of Scilly
- Greenwich
- Islington
- Leeds
- Kent
- North West London
- North Staffordshire
- Southend
- South Devon and Torbay
- South Tyneside
- Waltham Forest and East London and City
- Worcestershire

APPENDIX B ***HFMA community services costing survey 2013 – analysis of results***

HEADLINE MESSAGES

- 12 trusts with community services completed the survey. The small sample size means that the results should be treated with caution, but they provide a useful indication of the issues relating to costing in community services.
- There is recognition that the costing of community services is different from costing other clinical services, for example there are more problems with data capture, data quality is often poor, and there is a lack of a national currency/payment mechanism similar to the payment by results framework (now national tariff) for acute organisations.
- Trusts would welcome help from the HFMA with costing community services. A community services benchmarking service and a community services forum are the most popular suggestions.
- Most trusts produce reference costs and service line reporting. A small number of trusts produce patient level costing or costing using the new community information data set.
- The majority of trusts think that current reference costs are not very good for informing decision making to support commissioning and transformational change.
- Two out of the 12 trusts have implemented patient level information and costing systems (PLICS) for community services, and it is likely that another four trusts will have implemented PLICS within the next 2 years.
- The majority of trusts are interested in working with the HFMA to develop costing standards specifically for community services. There is an appetite for more detailed costing guidance on cost classifications and cost pools, as well as examples of best practice.
- The majority of trusts support the introduction of a national payment system for community services, but there are concerns about the current poor quality of data and the inconsistent recording of data. Most trusts feel that community services tariffs cannot be implemented in the short term.

Extracts from the survey are provided below.

INTRODUCTION

Twelve trusts with community services completed the survey in August 2013. Although the survey related to community services costing only, it is possible that some combined trusts have answered some questions for all their services, rather than purely community services.

The survey provides information on:

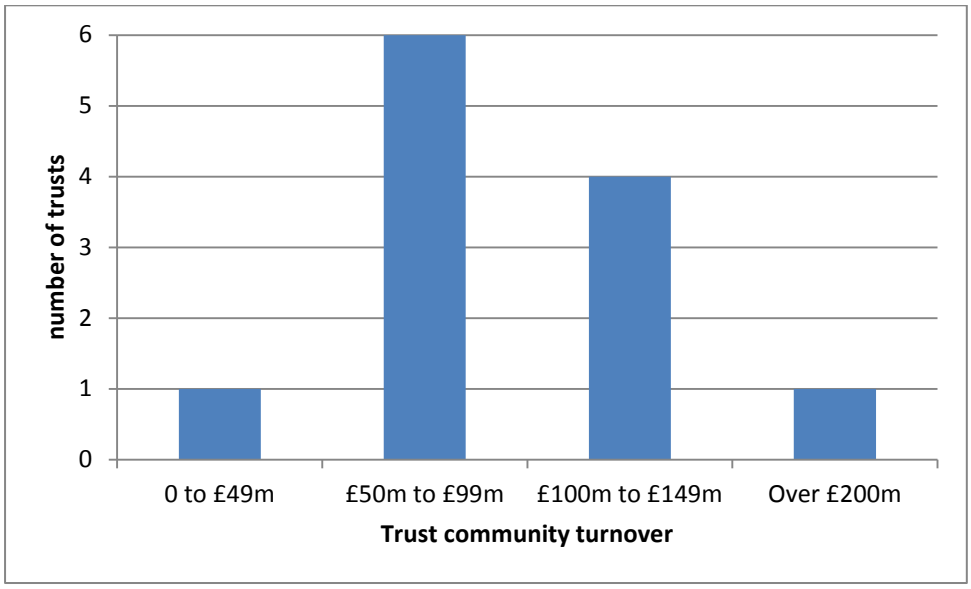
- Current state of costing in community services
- Patient level information and costing systems (PLICS)
- Costing guidance

The types of trust included within the survey are as follows:

	Number of trusts
Combined acute and community	5
Combined mental health and community	3
Community only	4
Total	12

Community services turnover for the twelve trusts ranges from less than £50mto over £200m (figure 1). Most trusts are within the range of £50mto £149m.

Figure 1: Community services turnover



Six of the twelve trusts cover areas described as mixed urban and rural. Three are mainly urban and three are mainly rural.

COSTING BACKGROUND

Costing system supplier

Eleven out of the twelve trusts provided the name of their costing system supplier (Figure 2).

Figure 2: Costing system suppliers

Costing system supplier	*Number of trusts*
Ardentia	1
Bellis-Jones Hill	1
CACI	4
Civica	2
Healthcost	1
Microsoft Excel	1
Powerhealth	1

Costing information currently produced

Trusts were asked what types of costing information they produce, and how useful the different types of information are in informing decision making in their organisation.

Most trusts produce reference costs and service line reporting, and half generate programme budgeting data (figure 3). Only two trusts produce patient level costing data, while a different two trusts produce costing using the new community information data set (CIDS)

Most trusts find reference costs and service line reporting helpful to a certain extent in informing their decision making, but programme budgeting is not considered helpful. The small number of trusts producing patient level costing find it helpful (Figure 4).

Trusts commented:

'Reference costs are a useful start point in understanding service expenditure and cost drivers. This can aid in directing attention to the right areas but are open to misinterpretation when viewed in isolation.'

'For community services, the current reference costing guidance is insufficiently clear, excludes too many services and the measures do not always allow the service cost to be fairly represented. Because community services are delivered through many different mechanisms, it is very difficult to map services to the reference cost categories and be confident that this is consistent with how other organisations have mapped their services. There is a lack of confidence in the quality of the data, national as well as local, although as a trust we have been working very hard to improve the completeness and accuracy of our data quality and costing.'

'*Around 50% of our activity is included in reference costs'*

'Improvements in data quality will increase the value of reference costs in decision making'

'Currencies used for reference costs for community services are different to the ones used for contracts and the service, so are not meaningful when it comes to commissioning'

Using reference costs for other purposes

Ten out of twelve trusts said that reference costs are used for other purposes. Examples include:

- Business planning
- Contract pricing
- Baseline review of contracts
- Proxy for tariff while splitting block contact into new commissioners on a shadow basis
- Long term financial model
- Service redesign costing
- Benchmarking
- Inform CIP target setting
- Decision rights

Definition of service lines

Those trusts producing service line reporting data were asked how they define their service lines. Trusts analyse by geographical area, management structure, reference cost categories, specialities or contract specification. Sepcific comments include:

- *Currently at total community for the two distinct geographical areas covered, but planning to segregate further based on managerial hierarchy*
- *By management structure*
- *By reference costs categories but this year moving to reflect commissioning specifications. They will also take into account the changes in CIDS*

- *Similar to reference costs categories but using our own structure by localities*
- *In line with the special service we provide, which has its own funding stream, activity and expenditure*
- *In the process of developing Service Line Reporting across the organisation - currently information is limited to specialty surplus/ deficit on total absorption costing basis. Costing information has been used to inform CIP target setting but is limited as a result of lack of confidence in national average reference cost information for community services and lack of clarity of guidance.*
- *By specialty or community location*
- *Defined by the community specifications in the contract with CCGs*

Examples of more accurate, detailed costing of community services

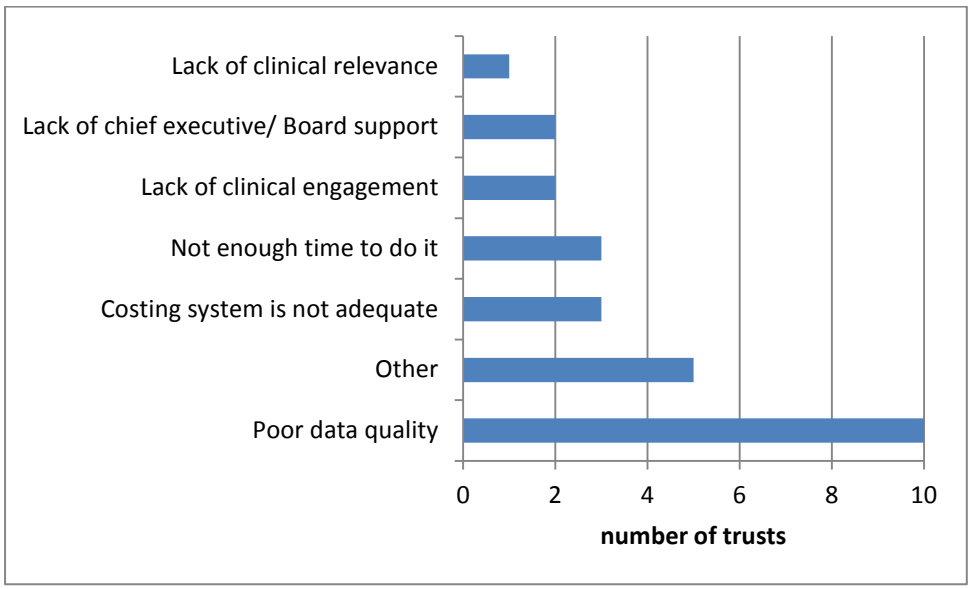
Six trusts provided examples of where they have carried out more accurate, detailed costing of community services:

- Community dentistry
- Rheumatology services
- Community Care Teams
- Sexual health services
- Neurology tariff development
- Specialist Paediatric Nursing
- Specialist rehabilitation (Acquired Brain Injury)

Main barriers to improving the quality of costing

Trusts regard poor data quality as the most significant barrier to improving the quality of costing (Figure 6).

Figure 6: What are the main barriers to improving the quality of costing?



As well as the pre-defined list in the survey, trusts cited other problems:

- Lack of clear definitions
- Cost allocations
- Lack of consistency in how the data is recorded
- Some data sources are manual inputs
- No costing system, all done on Excel model

What are the key cost drivers for costing community services?

The three trusts that answered this question listed the key cost drivers as:

- Face-to-face contacts
- Non face-to-face contacts
- Group contacts
- Attendances
- Staff time per contact

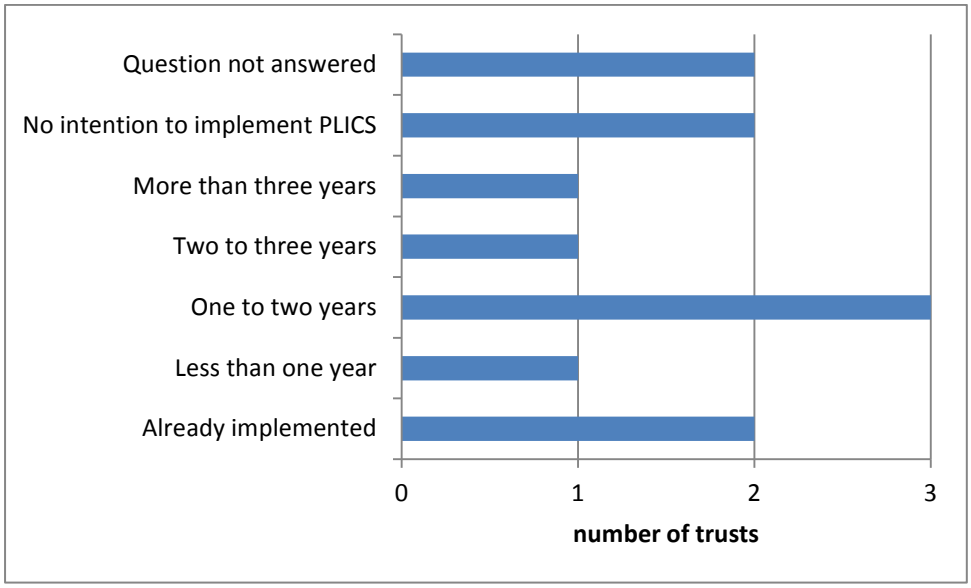
PATIENT LEVEL INFORMATION AND COSTING SYSTEMS (PLICS)

Eight out of twelve trusts have costing systems that are capable of supporting the allocation of costs down to individual patient level. Two trusts have implemented PLICS for community services. One trust has been operating PLICS between two to three years, and the other for more than three years.

When do trusts intend to implement PLICS?

Six out of the ten trusts that answered this question should have implemented PLICS within two years (Figure 7).

Figure 7: When do you intend to implement PLICS?

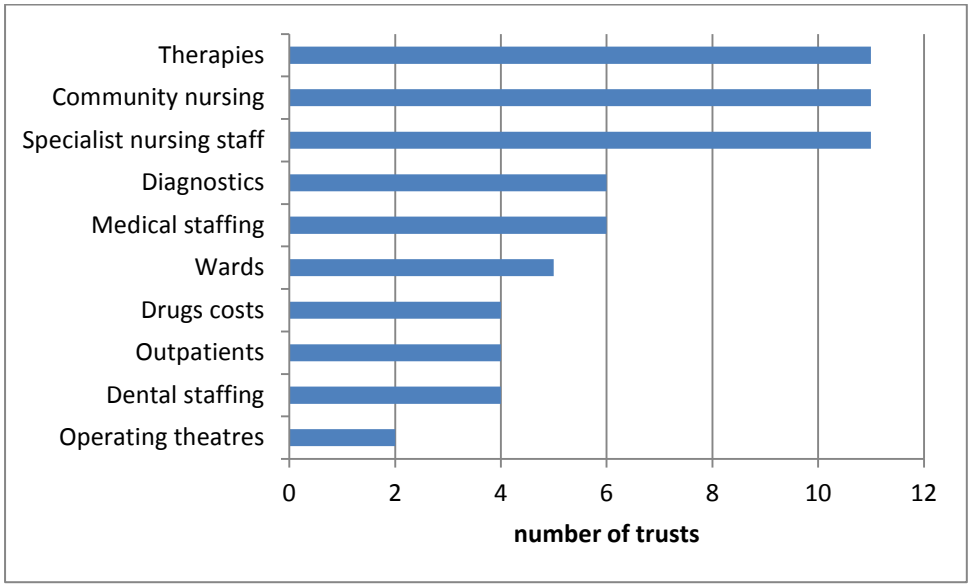


COSTING GUIDANCE

Nine trusts are interested in working with the HFMA and other trusts with community services to develop costing standards specifically for community services.

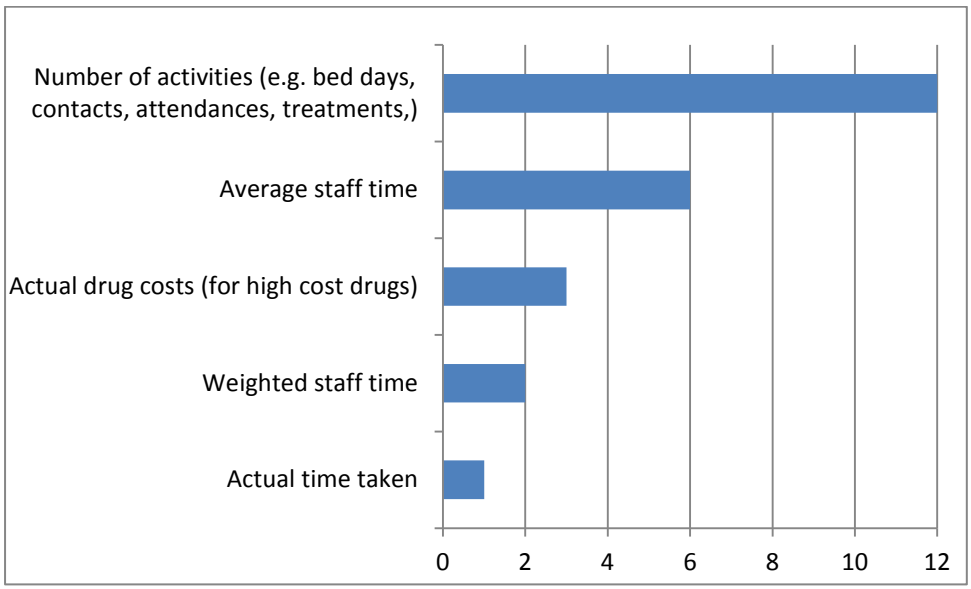
All twelve trusts can analyse their costs over direct, indirect and overheads. Trusts' main cost pool groups are shown in Figure 8.

Figure 8: What are your main cost pool groups?



The units of activity used to allocate costs from the cost pool groups to patients, or groups of patients, are shown in figure 9. The most common unit is the number of activities (bed days, contacts, attendances, treatments).

Figure 9: What units of activity are you currently using to allocate your costs from the cost pool groups to patients, or groups of patients?



Areas where more detailed costing guidance for community services would be useful

The majority of trusts would welcome more detailed costing guidance in the following areas:

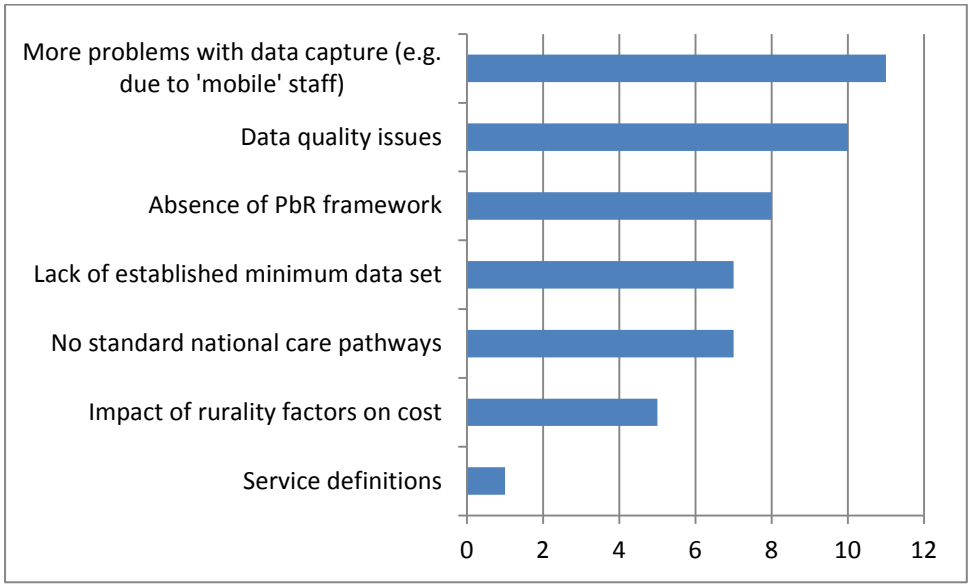
- Examples of best practice in costing
- Cost classifications
- Cost pools

One trust also suggested that activity definitions would be useful as would a materiality and quality score (MAQS) template/methodology for community services.

Key issues that make costing of community services different from costing other clinical services

Two thirds of trusts regard the issues of data capture, data quality and the absence of payment by results –type approach as making the costing of community services different from costing other clinical services (Figure 10).

Figure 10: What are the key issues that make costing of community services different from costing other clinical services?



Trusts commented:

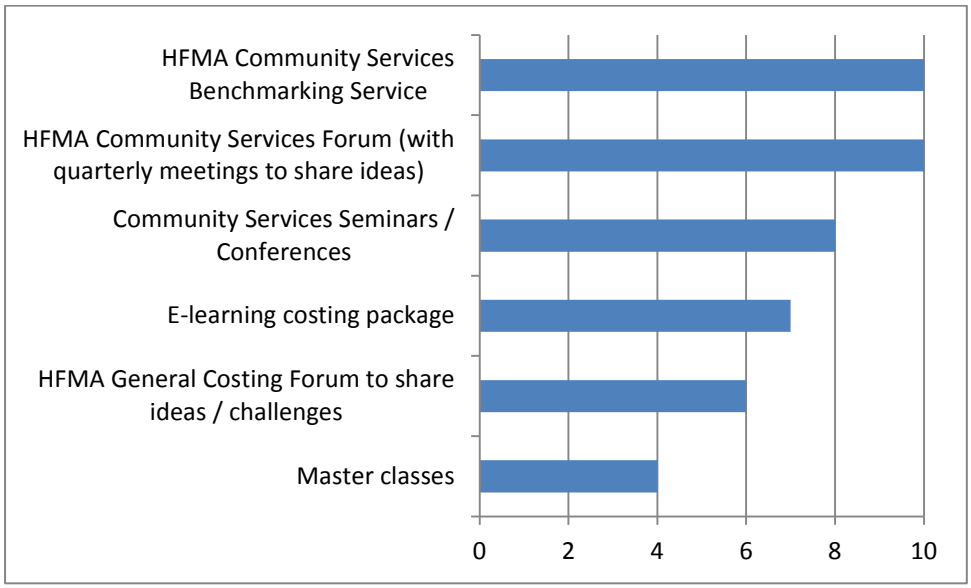
'We have always worked in the spirit of the acute costing standards; however a national structure of units of measurement and tariff for standard care pathways would greatly improve comparability of data.'

'We are always seeking new solutions to connectivity in order to improve our data capture as this can be a barrier.'

How the HFMA can help with costing community services?

Trusts were asked what possible HFMA initiatives would be useful to support them with costing community services (Figure 11). A community services benchmarking service and a community services forum were the most popular suggestions.

Figure 11: What possible HFMA initiatives would be useful to you?



Trusts commented:

'We are always keen to participate in any developments and training opportunities to enhance costing for community services.'

'An E-learning module would be useful for non-finance staff to understand.'

'The HFMA could help with contracting and pricing in the absence of national tariffs, and with improving data quality.'

'Whilst I have said all of these could be useful, I would be wary of introducing too many different mechanisms for risk of overwhelming organisations and adding to the burden. Master classes in the areas of mapping community nursing services to the specialist nursing categories would be helpful.'

Currency for community services

Trusts have a range of views on what currency should be used for community services (Figure 13). The most popular choice is current activity types (bed day, attendance, contact).

Figure 13: What would be the basis for your preferred currency for the payment of tariff? Please tick up to two main ones that apply.