Mental health clinical costing support guide

February 2014

Shaping healthcare finance

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Contents

Foreword

There has been growing recognition of the importance of costing data in recent years. Good-quality cost data helps finance staff to engage more effectively with clinicians and others about opportunities to improve service quality and efficiency.

This is even more the case if cost data is compiled at the patient or service user level and looked at alongside specific outcomes and service user experience.

But costing practice in the mental health sector has developed at a slower pace than in acute organisations. This is largely due to data collection systems not being very well developed and also there being less demand for more sophisticated costing systems while there were mainly block contracts in place. The preparation for and implementation of a new mental health currency – the care cluster – is driving improvements in data quality, and accurate costing of clusters is vital both to inform local cluster pricing and decision-making.

The adoption of clusters is already driving a greater understanding of care pathways and the packages of care delivered to service users. A good understanding of the costs – based on robust and consistent allocation methodologies – will complement this work and help mental health organisations gain a comprehensive insight into the services they provide.

This publication discusses the importance of costing mental health services and also provides an implementation guide for adopting and using patient-level information and costing systems (PLICS) in mental health organisations. This provides practical advice on what organisations need to do before and during system procurement and then in the implementation phase.

The guide should be read in conjunction with the HFMA's mental health clinical costing standards, which are also summarised in this guide. These standards, developed and refined under the guidance of costing practitioners, describe a consistent approach to the allocation of costs to service users in mental health organisations. They also provide a method for assessing the quality of these costs.

The HFMA firmly believes that better costing practices in the NHS are already starting to drive improvements in service delivery. Spreading these improvements across the NHS will provide a significant tool for providers to transform service delivery to provide higher quality services in a sustainable way. We hope this guide will help provider organisations realise these benefits within the mental health sector.

John Graham
Chair HFMA Costing Practitioner Groups

Executive summary

Mental health costing needs to improve. Financial pressures and changes in commissioning mean mental health organisations must have a better understanding of the relationship between activity, costs, quality and outcomes. Trust boards need to be confident that they are maximising the use of their resources for the benefit of service users. Commissioners and trusts must ensure that local prices for mental health services are fit for purpose.

NHS commissioners spend more than £11bn on mental health[1], which represents 12% of their overall expenditure. Currently most mental health contracts are in the form of block contracts, with few providers having local cluster prices with their commissioners. The likely move away from block contracts towards cost and volume contracts from 2014/15 means it is essential that there is a better understanding of the true cost of mental health services at individual service user level to support the development of both costing and pricing.

Mental health organisations need to adopt national costing guidance so that they can produce accurate and comparable cost data at service user level. Progress in implementing patient-level information and costing systems (PLICS) in mental health is at an early stage. While most mental health organisations can demonstrate they meet some of the HFMA clinical costing standards, it will be more difficult to fully comply with the standards without implementing PLICS.

Stakeholder engagement is fundamental in ensuring that costing data is accurate, relevant and meaningful. Until recently, not all trust boards or senior managers have regarded mental health costing as a priority and the level of clinical engagement has varied. Trust boards need to provide strong leadership to encourage the involvement of staff across the mental health organisation in the costing process.

Data quality is a challenge in many mental health organisations. The lack of investment in information systems means some organisations struggle to collect the clinical activity required for costing care packages. The relatively new process of allocating service users to care clusters means that many organisations are still working to embed these new approaches and improving the accuracy of clustering.

There is a lack of understanding around the variability in costs in mental health services. More research is required to explain the variation in care cluster costs. While some variation may be due to data quality, other reasons may include differences in the care provided, and varying levels of funding and different outcomes.

The HFMA is fully committed to working with and supporting mental health organisations, commissioners and national stakeholders to address these challenges.

Introduction

This guide will help trust boards and finance departments, clinical commissioning groups and national stakeholders have a better understanding of the key challenges in mental health costing, and what needs to be done to address these challenges.

Part 1 of this guide discusses the importance of costing mental health services. It considers the underlying costing principles and the role of clinical costing standards, and the importance of stakeholder engagement. It also identifies some of the key challenges and provides practical examples about how to approach the costing of mental health services. Finally, it looks forward to consider how mental health organisations need to move towards costing at individual service user level.

Part 2 is an implementation guide for patient-level information and costing systems (PLICS)[2] in mental health organisations. It provides practical advice on how to implement PLICS and addresses some of the implementation issues mental health organisations will face.

[2] Traditionally, those receiving mental health services have preferred to be called service users rather than patients, so perhaps this should really be called a service user-level information and costing systems guide, but for clarity the term PLICS already used by the acute sector has continued to be used.

PART ONE: MENTAL HEALTH COSTING

SECTION 1

Why costing is important to mental health services

It is essential that the complex relationship between mental health service costs, activities, quality and outcomes at service user level is better understood and explained. High-quality costing information enables finance staff to engage more effectively with clinicians and managers in making informed decisions about improving both service quality and efficiency.

The development of mental health costing varies across the country and has progressed at a slower pace than the costing of acute services. Mental health costing in many trusts is predominantly based on a top-down approach, which involves apportioning and allocating total costs down to lower levels. This top-down approach can only produce information about average costs, which, while being of some value, does not provide information about the specific costs of caring for a specific service user. Costing is important to mental health services for a number of reasons, including:

Cost reduction and control
The NHS is facing one of the biggest financial challenges ever, which will require significant cost reductions and even tighter cost control. In the four years to 2014/15, the NHS is required to save £20bn and indications are that further significant savings will be required after 2015. By developing and costing appropriate care pathways in mental health, it will be possible to identify where costs can be reduced and efficiency improved while still delivering high-quality care.

Demonstrating cost efficiency
External and internal benchmarking can be used as a tool to help mental health organisations to evaluate the effectiveness and efficiency of their services. The use of costing standards provides a more consistent approach to costing mental health services, which will improve the robustness of benchmarking. Benchmarking enables individual clinicians to better understand the impact of their own clinical practice on resources and outcomes, and how that might differ from other clinicians.

Understanding profitability
It is important that the profitability of service lines is understood in order to ensure the long-term sustainability of mental health organisations. Service line management is used to manage overall financial performance, activity and quality of service lines. It identifies income and costs by operational unit to establish whether the individual units are making a profit or loss. Where income and costs are allocated to individual service users at cluster level, the profitability of each cluster can also be mapped.

Informing future investment
Detailed knowledge about the relationship between costs, activities, quality and outcomes is important

when drafting business cases to support new investment proposals. Such information is also necessary when preparing tenders and quotations to attract new business.

Supporting the pricing of NHS-funded services
Monitor regards accurate and comparable cost data as fundamentally important in supporting their new role in pricing NHS-funded services. NHS England and Monitor propose the introduction of a pricing and payment system for mental health services in 2014/15, with a move from an income guarantee for providers to a cost and volume contract. Contracts would be agreed on a caseload per care cluster. Providers need to be confident in the quality of their care cluster costs.

> **HFMA COMMENT** The HFMA firmly believes that mental health services should be costed at individual service user level. Analysing costs at this level will increase understanding of mental health costs, including the reasons behind any significant variations in the cost of care packages within care clusters. Costs can be aggregated up to cluster level or care group level, but with the ability to drill down to individual service user level. This enables more meaningful discussions to take place between accountants, managers and clinicians, and better decisions to be made based on facts rather than feelings.

SECTION 2

Costing principles and the role of the clinical costing standards

National costing guidance allows organisations to prepare data to consistent standards and improve the quality of costs produced. The main areas of guidance for mental health organisations are:
● Monitor's six principles of NHS costing
● The activity-based costing approach
● The HFMA clinical costing standards

Costing principles
Monitor has developed six universal costing principles[3] which should be applied to all NHS costing exercises (Figure 1).

FIGURE 1: PRINCIPLES OF NHS COSTING
Principle 1: Stakeholder engagement Effective costing requires input from a wide range of stakeholders, including non-finance staff.
Principle 2: Consistency For some costing purposes, a consistent approach is required across or within organisations.
Principle 3: Data accuracy Accurate costing relies on the quality of the underlying input data.
Principle 4: Materiality Costing effort should be focused on material costs and activities.
Principle 5: Causality and objectivity Costing should be based on an understanding of causality to minimise its subjectivity.
Principle 6: Transparency Costing should be transparent and auditable.

Monitor recommends that NHS organisations apply the six costing principles, using an activity-based (ABC) costing approach (Figure 2). ABC requires an organisation to identify the activities it performs and then assign costs to these activities based on causal relationship analysis.

FIGURE 2: ACTIVITY-BASED COSTING
Step 1 Define the cost object
Step 2 Identify the activities
Step 3 Establish the relevant costs
Step 4 Analyse costs
Step 5 Assign costs
Step 6 Validate the outputs

Clinical costing standards

Clinical costing standards provide organisations with a common framework for costing at patient or service user level. They support a consistency of approach that allows a better understanding of costs within organisations and cost comparisons across organisations.

Over recent years, the Department of Health and the HFMA have established clinical costing standards. The HFMA is working with its mental health costing practitioner group to develop these costing standards for mental health services. The 2014/15 Mental Health Clinical Costing Standards[4] set out best practice guidance for deriving cost data and are intended to drive improvement, recognising that some of the standards may be stretching or aspirational for some organisations. They aim to help organisations understand their current data, systems and costing processes, and to identify where current practices need to improve.

Appendix A provides a summary of the relationship between the costing process and the clinical costing standards.

Most mental health organisations already meet some standards, such as Standard 1 - Classification of direct, indirect and overhead costs. Other standards, such as Standard 9 - Quality assessment and measurement, will be a new and bigger challenge for many mental health organisations.

Appendix B maps the inter-relationships between activity-based costing, the six costing principles and the clinical costing standards.

> **HFMA COMMENT** Progress in implementing PLICS in mental health is at an early stage. PLICS supports compliance with the HFMA clinical costing standards. Part 2 of this guide provides practical advice on how to implement PLICS.

SECTION 3

Stakeholder engagement

Costing is not just a finance exercise: it needs the involvement of staff across the mental health organisation to ensure that data is accurate, relevant and meaningful. It is essential that a wide range of all the relevant staff groups are involved in both implementing and reporting on costing. Monitor lists the key NHS stakeholders that should be involved in the costing process:

● Clinical staff (eg consultants, other clinicians, nursing staff)
● Non-clinical staff involved in service delivery (eg operational managers)
● Staff from the informatics division
● End users (eg senior management of providers, regulators).

In order to encourage stakeholder engagement, it is important to have strong leadership and support at board level. As well as the finance director, the chief executive, chief operating officer, medical and nursing director must all be seen to be fully involved and supportive with each having specific leadership roles.

Clinical leads and champions at different levels of the organisation should be identified and involved in costing. Clinicians will be more willing to become involved if the focus remains on the benefits that costing will bring to them and their service users. The training and coaching of lead managers and staff requires considerable time, explaining how the costs link to clinical practice, and to ensure continuing strong levels of engagement.

Clinicians need to be involved in three key stages of engagement:

System design At this early stage of development, it is a good idea to identify a few senior clinicians with management responsibilities who will be supportive and act as clinical champions as well as a few operational managers. In this way, important decisions about the level of detail and integration with other clinical systems can be made.

Validation Once costing reports are available, it is important to engage with clinicians to validate the underlying data and how it has been used to produce the end result. This will also help clinicians to become involved and to consider how their own practice links to the costs.

Using information Costing information and reports can be used at different levels of the organisation in a number of different ways, involving different groups of managers and clinicians. Time will need to be invested to discuss the reports and to encourage feedback.

Dr Mahmood Adil, national QIPP adviser for clinical and financial engagement, defines four levels of clinical engagement in costing (Figure 3 overleaf). Mental health organisations can use this framework to assess how engaged their clinicians are in the costing process and consider areas for improvement.

Practical examples of how costing departments in mental health organisations have successfully engaged other staff groups in the costing process are shown in Figure 4 overleaf.

> **HFMA COMMENT** Stakeholder engagement is fundamental in ensuring mental health costing data is accurate, relevant and meaningful. The next section describes the challenges in making this happen, with suggestions of how to improve engagement with trust boards and clinicians.

FIGURE 3: LEVELS OF CLINICAL ENGAGEMENT IN COSTING

Level	Definition
Level 1	Engagement is only at board/strategic level. For example, dialogue takes place between medical director and finance director, but there is no real joined-up, collaborative work between the wider clinical and finance teams.
Level 2	There is some joined-up, collaborative work between clinical and finance teams but only on an ad hoc basis when required – for example, for a specific CQUIN (Commissioning for Quality and Innovation) project.
Level 3	Joined-up collaborative working between clinical and finance teams is the norm in at least one clinical specialty/directorate. For example, a finance manager works as an integral part of a clinically led quality improvement team. There is also a plan to roll this out across other directorates.
Level 4	Joined-up collaborative working between clinical and finance teams is the norm across all clinical specialties/departments. Finance managers routinely work as integral members of clinically led quality improvement teams and both professional groups share cost and quality data to improve outcomes.

FIGURE 4: EXAMPLES OF STAKEHOLDER ENGAGEMENT IN THE COSTING PROCESS[5]

● **We have developed a dashboard showing full costing analysis that will be provided as part of monthly operational budget information. This is in the process of being rolled out to support the development of costing, but also promote a greater ownership of service line reporting and greater engagement in the development of pricing. Through developing the dashboard we have had a greater engagement with senior staff and are hopeful this will significantly increase once the dashboard is available to all budget holders.**

● **We have run workshops around the implications of non-recording activity and clustering in the PAS system. Our project team meets monthly with representatives from all relevant services. As a result, clustering percentages have increased along with activity recording.**

● **In order to split medical costs across service lines, an annual consultant survey for all trust senior medical staff is conducted. An electronic questionnaire is sent to all individuals by email asking them to divide their time over the categories. Any queries are dealt by phone or email. This is backed up by attending one of the monthly consultants' meetings to explain the importance and purpose of the exercise, and dealing with any further queries. The results are sent back to the consultants and clinical business units via workshops. This process has the additional benefit of engaging and informing the medical staff about the whole process.**

● **We engage with nurses through a Foundation in Management programme to improve understanding of service line reporting (SLR), pricing and reference costs.**

● **We hold quarterly meetings with operational managers to improve understanding of SLR and highlight areas for improvement.**

● **Regular meetings are held with psychologists to develop pathway costings and to consider actual costs and differences.**

● **The reference cost exercise involves engaging several clinical and professional leads to gain assurance on cluster activity and the weighting applied.**

● **Network accountants are engaged/involved in setting apportionment methods with network managers.**

● **Clinical leads are involved in analysing clustering data and explaining variances.**

● **Clinical managers are involved in apportioning medical staff time and recording medical staff activities.**

● **The trust has formed a cost allocation group for both medical staff and psychologists and has completed a 10-day survey of activity.**

SECTION 4

Challenges around costing mental health services

Mental health organisations face a number of challenges regarding the costing of mental health services:
- Inadequate stakeholder engagement
- Lack of investment in information systems
- Poor data quality, in particular around costing care clusters
- Lack of understanding around variability in costs/prices
- Use of benchmarking.

Inadequate stakeholder engagement
Not all trust boards or senior managers regard mental health costing as a priority, and the level of clinical engagement varies. Mental health costing information requirements have often been seen as a lower priority by external stakeholders such as commissioners, due to predominantly block contracts being in place and the absence of a national tariff.

> **HFMA COMMENT** From the HFMA's *Mental Health Costing Survey 2013*: "More than half of trust costing departments have engaged with consultants, nurses, psychologists, operational managers and other finance staff as part of the costing process. Just under half have engaged with therapists, and a few have engaged with junior medical staff and chief executives.

High-quality costing is not possible without senior support and clinical engagement. There must be clear board-level accountability for all aspects of improving costing accuracy, including data quality, and the trust board must understand the implications of poor data quality and be kept informed of developments.

Service user level costs should be fed back to clinicians, as this is most relevant to them and they are in the best position to identify any errors that may have crept in. They can also explain the reasons behind variances which may relate to differences in clinical practice. Information needs to be reported in a format that is clear and easy to understand. Involving clinicians on a regular basis helps data quality to improve in an iterative way (Figure 5).

Commissioners are becoming increasingly interested in mental health costing, and how it can be used to develop local prices, support service redesign and deliver high quality care more efficiently. Commissioners and mental health organisations need to build mature relationships, where costing information can be openly shared and discussed. It is important that commissioners understand that mental health costs are at a developmental stage and may change over time, as costing methodologies become more sophisticated and data quality improves.

FIGURE 5: CLINICAL ENGAGEMENT IN COSTING

Regular feedback to clinicians is often found to be interesting and helpful. Analysis can include answers to the following questions:
- **How much variation is there within and between clusters?**
- **Is my budget set appropriately?**
- **How does my practice appear to differ from that of my colleagues within the same cluster?**
- **How complex is my caseload?**
- **Does my team have the right clinical skills and training to effectively manage our caseload?**
- **How can I determine the needs profile of specific groups of service users?**
- **How can we use this information to plan and reorganise services to make them more efficient?**
- **What is the most cost effective way of producing the best outcomes for our service users?**

Lack of investment in information systems

For decades there have been relatively small amounts of money invested in mental health service information systems compared with acute systems. Until relatively recently there was no uniform patient classification system in England to describe and use as a basis to cost mental health services. This has led to some reluctance in mental health organisations to invest time and money on new information systems until the position around implementing pricing in mental health was clearer.

There has been concern expressed about potentially wasting money if investment was made locally in a system that was different from what was eventually recommended nationally. For the same reason, fewer firms have an established track record of providing purpose built mental health costing systems.

Progress in PLICS in mental health is at an early stage. Part 2 of this guide is a practical guide to organisations who are considering or about to embark on a move to PLICS.

Poor data quality

Data quality is recognised as a challenge in many mental health organisations. Robust mental health costing data at care cluster level is fundamental to trusts' financial viability with the proposed move to cost and volume contracts in 2014/15[6]. Trusts face challenges around accurate clustering and capturing activity at service user level.

Accurate clustering

Most mental health organisations are investing in training clinicians how to cluster. The focus has been on improving the accuracy and timeliness of clustering, taking into account the transition protocols. Typically the training is likely to include:

- The assessment approach and when to assess
- Clusters and cluster allocation
- The local method for capturing the data
- How the data will be fed back to clinicians

The Care Pathways and Packages Project found that in-depth training provided to a small number of individuals with the skilled trainers then passing on their learning to the rest of the organisation worked best. The relative newness of the process means that many mental health organisations are still encountering problems with the accurate allocation of service users to clusters:

- Accurate scoring or rating of scales in Mental Health Clustering Tool
- Consistency in clustering across an organisation
- Validity of algorithms introduced to assist clustering
- Application of the appropriate review periods
- Appropriate transfer between clusters

Capturing activity

Some trusts do not have adequate IT systems to collect the necessary clinical activity for costing care clusters. Where only limited clinical data is being collected electronically, this will inevitably impede the ability to cost at individual service user level. Care pathways are still being developed by many mental health organisations and there may be issues where care packages are not recorded on a clinical information system. Solutions to problems encountered in collecting data from "mobile" staff working in the community are still being worked on in some trusts.

The case study overleaf shows how clinical information was captured using a time and motion study, as the data was not routinely captured. But this did not prevent detailed costing work from being undertaken.

Lack of understanding around variability in costs

More research needs to be done to understand why there appears to be so much variability in mental health service costs. Unfortunately there is less transferable learning about mental health costing from other countries to draw on. HFMA's recent report[7] notes that few countries have detailed costing guidance for mental health services, the two exceptions being England and Germany. Currently, cluster unit costs

vary significantly between trusts. For example, using the 2012/13 national reference cost publication, the national average unit cost for cluster 14 (Psychotic crisis) is £103, but the trust unit costs range thirtyfold from £10 to £350 (Figure 6). The national average unit cost for cluster 5 (Non-psychotic disorders – very severe) is £22 with trust unit costs ranging from £7 to £46, excluding major outliers (Figure 7).

CASE STUDY: USING CLINICAL ACTIVITY TO REFINE INPATIENT COSTS

Greater Manchester West Mental Health NHS FT needed detailed costing information for its RADAR service. The costing challenge was to produce patient-level costing data for the service so that they could compare this to the cost of providing the service in the traditional acute setting, and to understand what savings could be generated to the overall healthcare economy as a whole by the implementation of the pilot.

Historically the costing team would produce an average bed night cost by taking the direct costs, indirect costs and overheads allocated to the ward and divide by the total occupied bed nights. In an attempt to understand the differing complexity of patients presenting on the unit, they embarked on a mini task and finish project working with senior clinicians and nursing staff. A list of interventions was agreed and these were set up on the patient administration system. Business Intelligence colleagues extracted the data at a patient-level detail, with lists of dates, clinical provider, intervention carried out and actual durations.

Costing staff then imported this data extract into their costing software, recalculated the costing project. They succeeded in obtaining different costs for admitted care for each inpatient episode for each patient, and were able to demonstrate savings to the health economy.

FIGURE 6: UNIT COST PER DAY FOR CLUSTER 14   2012/13 Department of Health reference cost publication
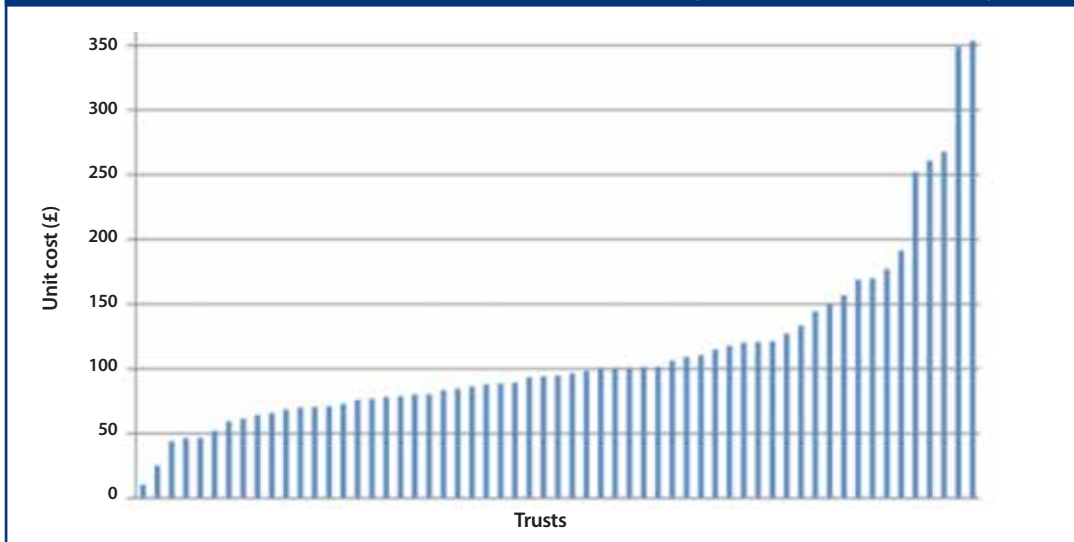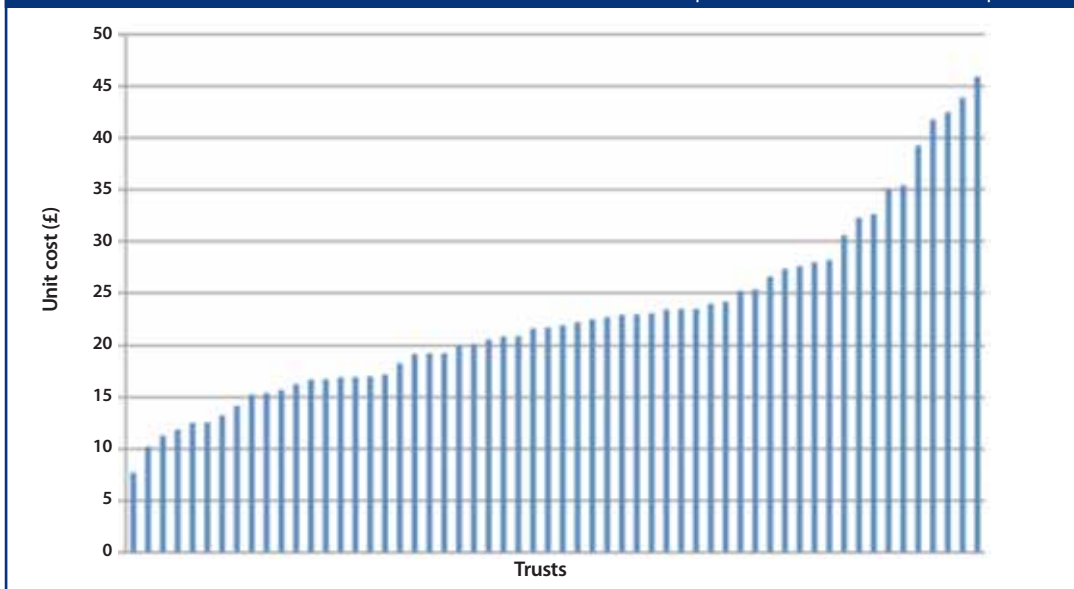

FIGURE 7: UNIT COST PER DAY FOR CLUSTER 15   2012/13 Department of Health reference cost publication

As clustering is relatively new, some of the variation in cluster costs may be due to data quality issues around the accuracy of recording clusters and capturing activity data. It is envisaged that data quality will improve over time. Other reasons for variability in costs may be due to differences in care packages provided, the resources available and quality and outcomes (Figure 8).

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FIGURE 8: POSSIBLE REASONS FOR VARIATION IN CLUSTER COSTS

Accuracy of recording clusters
- Lack of consistency of the scoring / rating of scales in Mental Health Clustering Tool
- Accuracy in attributing service users to cluster
- Different review periods being used
- Variability in assessment processes

Capturing activity data
- Inadequate IT systems
- Community activity data
- Matching activity costs to individual service users

Variation in care packages provided within a cluster
- Differing levels of need of individual service users within the same cluster
- Service user co-morbidities
- Different care packages for service users within the same cluster
- Differences in clinical practices
- Complexities, for example where English is not the service user's first language

Resources available
- Variation in NHS funding levels
- Different levels of local social care provision
- Availability of beds

Quality and outcomes
- Different levels of quality standards between organisations
- Variation in outcomes between organisations

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Use of benchmarking

Benchmarking mental health costs between organisations is not that well established. In the past reference costs have been benchmarked, for example cost per inpatient bed day or community mental health team contact. While these unit costs allow trusts to compare their relative efficiency in the use of specific resources, they do not provide the whole picture. For example, a trust could have a relatively low unit cost per inpatient day, but if admission rates and/or lengths of stay were greater than average, the overall cost of caring for a particular cohort of service users could be higher than at another trust, where the use of inpatients is lower.

In future, benchmarking the costs of care clusters could be a more powerful way of understanding variations in the cost of care. This would allow trusts to identify variances at cluster level as well as individual service user level, and explore the main reasons behind them.

The case study overleaf describes how benchmarking costs has led to transformational changes in clinical practice.

Linking costs to outcomes

It is essential in developing a new currency model that the focus is on ensuring that robust indicators of quality and outcomes are at the heart of the approach.

The current plan is to have a number of quality indicators, a clinician rated outcome measure (CROM), a patient rated outcome measure (PROM) and a measure of patient experience (PREM) as integral parts of the currency model. Some of these measures will start to become available for use via the HSCIC

CASE STUDY: CARE PATHWAYS AND PACKAGES BENCHMARKING

The Care Pathways and Packages Project (CPPP) is a consortium of organisations in the North East and Yorkshire regions who are working together to develop national currencies and local tariffs for mental health services.

Their work has also provided a unique benchmarking opportunity that each trust in the consortium has found invaluable. An example can be seen at Northumberland Tyne & Wear NHS Foundation Trust (NTW).

Each trust in CPPP shared their development information around the unit costs per community day and the costs per inpatient day by care cluster. NTW's individual results for community and inpatients were consistent with the other trusts within the consortium. However, once the costing information was aggregated to produce a combined unit cost for each care cluster, the benchmarking showed NTW to be a significant outlier across several of the clusters.

Benchmarking the combined unit cost across the clusters prompted NTW to undertake several 'deep dives' to review the components of the costs for the clusters in question. These showed that while NTW was indeed consistent on the unit cost for a community day and inpatient day with other local mental health trusts, their level of inpatient use for the provision of the pathway was far greater than the level of inpatients used in other organisations. Clinical engagement in this process was also far easier as the benchmarking is based on the operational MHCT data rather than a generic externally co-ordinated benchmarking exercise.

In one instance, for a particular care cluster, NTW was using more than five times the inpatient bed days to deliver the pathway, compared with another trust in the consortium. On average, 61% of the resource used to provide the care clusters by NTW was based within inpatient units, compared with an average of 46% across other members in the consortium.

To deliver a financially sustainable organisation going forward, NTW developed its Transforming Services Programme to radically change service provision and deliver improved services while delivering the required financial efficiencies. The programmes to deliver Transforming Services have been developed based on a host of service reviews and information, including the CPPP benchmarking. The initial CPPP combined unit cost work led to further benchmarking on bed numbers per 100,000 of population. This also evidenced the high bed use at NTW.

Looking forward, one of the key components of the trust's Transforming Services Programme relies on delivering more of the trust's services through highly skilled and developed community teams and placing less reliance on inpatient units. This will reduce the cost of the pathway. The CPPP benchmarking proves this is deliverable for NTW, as it is consistent with how other organisations provide these pathways already.

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during 2014 and others will continue to be developed. It is envisaged that they will be used and reported on a cluster basis.

Current currency guidance requires commissioners and providers to use a number of indicators, a CROM and a PROM within contracts in 2014/15 and review their use throughout the contract year.
The publication of experimental data for the results of a number of quality indicators will commence in July 2014 and will be accompanied by guidance on their use and interpretation.
The use of CROMs, PROMs and PREMs is also being developed and further guidance and information regarding this can be found on the CPPP website www.cppconsortium.nhs.uk.

SECTION 5

Future direction of costing

The Health and Social Care Act (2012) gave Monitor and NHS England joint responsibility for pricing NHS services. Monitor is responsible for developing how prices are calculated, setting prices and publishing the national tariff. NHS England is responsible for defining which services the tariff will cover and how services will be paid for (currencies). Understanding the underlying costs of mental healthcare is essential in order to determine and set appropriate prices. This becomes even more vital with the likely move away from mental health block contracts to cost and volume contracts linked to outcomes in the near future.

In *Costing Patient Care* (November 2012), Monitor set out its approach to costing and cost collection for price-setting. It stated its intention to support the development of improved activity and costing data in the mental health and community sectors. It was also clear its direction of travel will be based on costing treatments at individual service user level. It set the following six general costing objectives:

● Improve data quality by aligning regulatory cost collections with the costs used by providers to manage their organisations.
● Increase comparability and consistency of data, which will make provider benchmarking exercises even more meaningful.
● Improve transparency of price setting by collecting more granular data, which will enable providers to explore the more detailed cost information supporting it.
● Develop the potential for new pricing mechanisms, possibly moving away from prices used for payment by activity based on average costs towards – for example, potential year of care tariffs for patients with long-term conditions.
● Proportionate regulatory cost by ensuring the benefits of enhanced cost collection outweigh the costs – for example, by aligning regulatory cost collections with patient-level costs, already reported for provider management purposes.
● Improve the use of cost data by managers and clinicians by involving them appropriately to drive up the quality and accuracy of their costing.

The Department of Health's latest survey of trusts show acute trusts have made more progress than mental health trusts in implementing PLICS (Figure 9 below). But the number of mental health trusts that reported having implemented or were implementing PLICS has risen from 13 in 2011/12 to 18 in 2012/13.

FIGURE 9: 2012-13 SURVEY ON THE UPTAKE OF PLICS
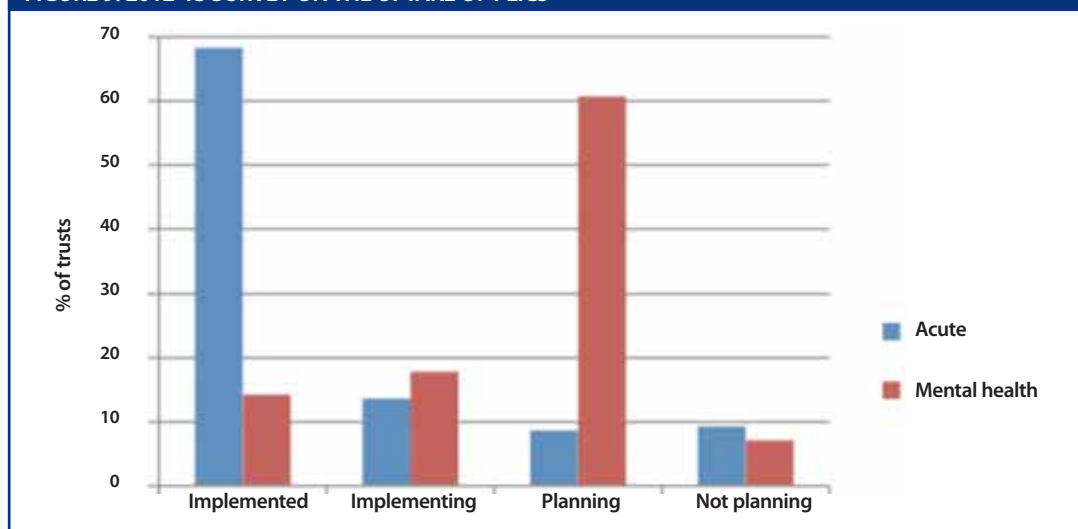
SECTION 6

Next steps for the HFMA

The HFMA fully supports the need for a greater focus on mental health costing. To support trusts and commissioners it is:

● Working with HFMA's mental health costing practitioner group to develop the current clinical costing standards for mental health services.

● Supporting Monitor, with their work on costing and pricing mental health services.

● Working with other national groups such as the HFMA mental health faculty and the mental health payment by results finance sub group to support the dissemination of best practice and integrate workstreams effectively.

● Working with relevant national bodies to support developments in the capture and quality of clinical information in mental health services.

CASE STUDY: FOCUS ON THE DATA

Service user costing at Kent and Medway NHS and Social Care Partnership Trust is about much more than developing local prices for cluster-based contracts and supporting funding flows. It is about meshing finance and activity information and understanding the cause and effect of the use of resources.

'Finance is an important consideration in patient and service user care,' says Ada Foreman, the trust's deputy director of finance. 'It is not the lead consideration, but you can't ignore the money. We are working from a finite pot of money and if you want to put the patient first, the costs and how you use your money have to be a consideration.'

The trust is keen to refresh its PLICS reports to ensure they deliver information to clinicians that will inform better, more cost-effective care. 'The focus needs to be on the outcome, but we need to highlight potential efficiency opportunities that don't impact on the outcomes – information that helps them to target their efforts,' she adds.

Over time Mrs Foreman hopes the system will be able to show the volumes of intervention associated with each pathway along with the resource consumption and highlight how much of this pathway/cost is common to all users on the pathway. The aim will be to understand the case mix within each cluster, both to inform service development and contract discussions with commissioners.

The move to using clusters in mental health is driving a much greater understanding of services provided for service users, providing an opportunity to identify variation and standardise pathways as appropriate. Credible patient-level costing provides an important part of this understanding, enabling trusts to understand not only the range of interventions and services provided, but the associated costs too. And while there are some significant challenges for mental health trusts – particularly in establishing robust data – Mrs Foreman says the end goal is well worth the effort.

This case study is described in more detail in part 2 of this report.

PART TWO: PLICS IMPLEMENTATION SUPPORT GUIDE FOR MENTAL HEALTH SERVICES

Part 2 is a practical guide for organisations who are considering or about to embark on a move to PLICS.

PLICS is a costing methodology that builds costs from the bottom up. It involves identifying, wherever possible, the specific resources consumed in the treatment of individual services users – for example, the costs of a drug or the specific resources consumed by an individual service user during their stay on a ward.

This methodology therefore allows organisations to produce costs at a more detailed and accurate level than is possible with more traditional methods of costing.

It will not always be possible to assign costs and resources directly to individual service users. For instance, it is difficult to assign medical and nursing staff time exactly to each service user. Nevertheless, costs can be allocated with reasonable accuracy using – for example, the number of ward round visits to a service user or the time spent on a ward, with adjustments made for the intensity of the nursing support needed by an individual service user.

Indirect or overhead costs – such as the costs of payroll, the human resources department or the finance team – can also be divided among all service users based on appropriate allocation and apportionment methods.

Research commissioned by the HFMA and Monitor, carried out by Imperial College London, concluded that across 10 European countries, all of the so-called bottom-up costing systems, involve a mixture of top-down (averaging) and bottom-up costing because no country has the information systems to allocate every single cost specifically to the patients or service users generating them[8]. However, organisations should aim to allocate a large proportion of their direct costs down to this level.

PLICS can bring huge benefits to organisations as well as policymakers and regulators. These benefits are discussed in Section 1 overleaf.

SECTION 1

The benefits of PLICS

In order to deliver better care for service users in a time of financial constraint, organisations need detailed information about the current delivery and models of care for individual service users. PLICS has numerous benefits for the whole organisation in terms of financial and clinical transparency and, most importantly, can drive and inform decisions about service improvement.

Change is often seen as threatening. Explaining the need for change and the consequent benefits are a prerequisite to ensuring a successful implementation. Responsibility for explaining the need for change should be assigned to an individual or a group, who should regularly report back to the PLICS Project Board. This person or group must make sure that the relevant audience understands the benefits of PLICS.

This section discusses the benefits of PLICS, which can be used when setting out the case for changing an organisation's approach to costing through the implementation of PLICS.

Aggregation of costs
Costing at service user level provides organisations with the flexibility to group costs in a number of different ways – for example, by:

● Cluster
● Service line
● Clinician
● Department
● Across pathways of care.

This flexibility of reporting means the costing outputs can easily adapt – for example, if the design of a cluster were to change. PLICS provides very useful information for understanding casemix and the costs of individual clusters, because costing at the individual service user level allows organisations to identify easily the distribution and composition of costs.

Service line reporting
PLICS can support service line reporting (SLR) and therefore assist organisations in understanding the profitability of service lines. The benefit of deriving SLR from PLICS is that clinicians and managers can drill down through their service line reports to individual service users to gain a better understanding of what is driving their costs and profitability.

If PLICS is used to generate SLR reports, income needs to be brought into the costing system. Consideration will need to be given as to how to allocate this income to individual service users or services.

Transparency and ownership
Many members of the HFMA Mental Health Costing Practitioners Group report that PLICS greatly assists the ability of finance professionals to engage with clinical staff. This is because costing leads can discuss the costs of individual services users rather than average costs across a service – the component costs of service user care become more transparent. If clinicians are involved in the decisions on how to allocate costs and can review the outputs at this granular level, ownership and understanding of costing can greatly improve.

Cost management / investment
PLICS is being increasingly used by acute trusts as a tool to distribute efficiency savings across services. In addition, PLICS is being used as the basis for financial analysis within business cases and the costs

produced used to inform investment / disinvestment decisions. The HFMA *Clinical costing implementation guide* summarises these benefits:

- Providing a more robust basis for building business cases
- Demonstrating the profitability and sustainability of a service
- Enabling more robust decision-making
- Using PLICS to help inform CIP targets
- Helping clinicians provide invaluable input into tariff design and national price setting.

Improving data capture and data quality
Experience of implementing PLICS in acute trusts has shown that as cost information is shared across organisations, the quality of the data used to build these costs is improved. This is often because it raises the profile of information that may not be reported elsewhere in the organisation. This in turn can improve data capture. For example, a service may see that by capturing information, such as the time spent with a service user, the quality of the cost information produced can be significantly improved, and at the same time the information collected is clinically meaningful and can be used to support the performance and development of a service.

CASE STUDY: CLINICIANS CLICK WITH COSTING

Patient or service user-level cost data provides a real opportunity to bring finance and clinical staff together to deliver benefits to patients. It can provide a window on current practice and highlight variation that can help improve services and reduce costs. Accurate data that clinicians trust is vital. But just as important is what data is actually shown and how it is presented.

The solution at North Essex Partnership NHS Foundation Trust has been to bolt on a dedicated analysis and reporting tool to its patient-level costing system.

The mental health sector faces significant challenges in costing its activities. One key challenge is capturing all the different types of inpatient, outpatient and community interactions and then understanding how support and care is delivered in those sessions so that costs can be allocated correctly.

Alan Doe, costing accountant at the trust, believes the trust is well on the way to having really meaningful cost data. 'We are confident that 85% of our activity data is correct and, with our new patient administration system (which went live at the end of 2013), we can get this even better.'

But robust cost data is only half the battle. This data needs to be communicated to the trust's different service teams in a way that is meaningful to them. This is where the reporting tool comes in, providing a series of dashboards that bring together finance and activity information in an easy-to-interpret format.

Although full roll-out of the system was not due to start until 2014, early feedback from potential users is good. 'We've been told that the simple display means the data and system is much more likely to be used in local areas,' says Mr Doe. Users also like the ability to change the dashboard layouts and the ability to find information across a range of indicators.

The dashboards can show cost and activity information broken down by cluster. 'You can look at patient level or by GP practice or you can look at performance at the area team level,' says Mr Doe. 'So if you want to look at the cost per community mental health team per cluster, you can,' he says. Once local cluster prices have been agreed with commissioners, these will also be loaded onto the system so that users can compare average and specific service user costs with both national cluster averages and local prices.

One service manager believes the system will make it easy to see the service types that are most cost-effective, and those that might benefit from review, and to make easy comparisons across service areas. Mr Doe says the aim is to update the service user cost data on a monthly basis. With separate reports produced previously for inpatients, outpatients, day cases and psychological areas – among others – the new system will cut out a significant amount of paperwork. But it will also provide a much more powerful way into the data, enabling users to click and drill down to pursue different lines of enquiry.

Future pricing role

Monitor, in its new role of economic regulator, is reviewing the costing of mental health services. This will inform its strategy and approach to developing a national pricing framework for mental health services. Monitor is supporting PLICS in the development of costing acute services. Last September, the first voluntary national collection of PLICS data was undertaken, with 70 acute organisations submitting patient-level costs. Monitor regards PLICS as a potentially useful tool for costing mental health services and developing prices.

In summary, PLICS can improve the quality of the financial information produced and used within organisations. It can drive improvements in data quality as cost information is more actively interrogated and reviewed. PLICS enables a much better understanding of the costs and resources used for the treatment and care of individual service users and how these interact and change over time. This provides the opportunity for more effective benchmarking between services and across organisations, and can support the development of more robust local tariffs. The greater transparency of financial information allows clinicians to be more involved in discussions on how resources are used and how their use varies.

There is the potential for PLICS in mental health to lead to more robust strategic and operational planning and decision-making, as cost information becomes more robust. All of these benefits will improve knowledge about the financial performance of an organisation and how resources are utilised, thus supporting real improvements in the quality of care given to service users.

SECTION 2

Engaging with key stakeholders

PLICS should be seen as naturally belonging to the whole organisation, not just to finance or information departments. Senior managers, especially board members, should ensure all key stakeholders are involved in the initial implementation and ongoing development of PLICS.

It is strongly recommended that a PLICS project board is set up to oversee implementation. The project board should include senior clinical personnel, the director of finance and the trust information lead. This board will be primarily responsible for meeting milestones and final delivery, as well as identifying key stakeholders, usually medical directors, clinical leads, general managers and financial managers. The project board will identify how the stakeholders will be involved and their requirements for training. They will also identify their performance information needs. This should be documented. It is recommended that the project board appoint an individual who is responsible for ensuring the ongoing involvement of stakeholders.

The project board should determine and choose the specific dedicated resource that will be used in the project and ensure that the dedicated lead is included in all project board meetings. The project lead should be someone who is numerically literate, who is capable of liaising with clinical staff in a manner which inspires trust, and has a record of resilience and accomplishment.

Clinical personnel and other information providers may well require additional remunerated time to fulfil their role in setting up and implementing raw data collection systems.

It is recommended that a brief status report be provided to the trust board each month detailing the project's progress against the pre-agreed time frames, outlining any variances, the reason for them and how they should be resolved. Such an approach reinforces the overall corporate nature of this activity.

SECTION 3

Procuring a PLIC System

A specialised PLIC System will normally consist of a data warehouse that can import data extracts and integrate them, a costing engine and a front end reporting and analysis tool.

The process of selecting the right solution and supplier for an organisation should ideally be led by the project board to ensure the requirements of the whole organisation are met and to ensure the solution fits with the overall strategy of the organisation.

It is strongly suggested that before any procurement process begins, the project board should consider the following issues fully. Answers to these questions are likely to impact on the system and supplier selected:

- What are the timescales for producing clinical cost information?
- What resources will be committed by the organisation to the implementation?
- What are the outputs required from the system for internal and external use?
- What information do the board, clinicians, managers and finance teams want to see?
- How will the information produced be used by the organisation?
- What information is available to support the implementation of clinical costing and what, if any, key information requirements are missing?

The procurement process
The right supplier can be a key resource in a timely and effective implementation. The objective is to supply accurate, timely, credible information and the extent to which a supplier is able to work internally with the trust to ensure this is achieved can be a vital determinate in the right choice of supplier. For this reason, as well as to eliminate any possible reformatting of raw data, it is highly recommended that the trust choose a supplier early in the process. This does not mean the PLICS process cannot begin until a supplier is chosen. Forethought and understanding of what the trust really needs, and where information shortfalls exist, should be a precursor to supplier selection.

A sample list of questions that organisations may wish to use in their discussions with suppliers is provided in Appendix C. The questions are intended to provide insight into the areas that should be discussed and considered before a decision is made. There may also be other questions or considerations that organisations may have when assessing suppliers, such as integration with existing IT systems.

Organisations should go through the standard commercial procedures in evaluating prospective suppliers, basing any decision on the normal parameters of value for money, experience, reliability, quality of product, back-up and service. References should be sourced and, if possible, site visits undertaken to see systems in action and learn more about the operation of a system from those who are using it.

It is important to set out an appropriate evaluation period to adequately review all of the shortlisted products. Given the complexities involved, it is not possible to make an informed decision about a system's suitability in a demonstration that is less than an hour long. It is suggested that an agenda is forwarded to suppliers in advance of a meeting to outline all the topics the demonstration should cover.

To further evaluate the capabilities of systems and companies shortlisted from the demonstration process, it is worth arranging a half-day workshop with a supplier so that a more detailed review of the system can be provided and tested. Methodologies and time frames can be discussed in more detail.

Any implementation of clinical costing will be an iterative process. For example, information gaps or

problems with the quality of data will only become obvious when data is requested and reviewed. It is therefore important to set clear expectations and deliverables for both the organisation and the chosen supplier. In most cases, the implementation of clinical costing will be an iterative process, rather than one final definitive roll-out. It is therefore important to define the scope of deliverables within the project plan and contract to ensure that momentum for the project is maintained and tangible benefits are delivered quickly. This will ensure continued visibility and support to the project.

Minimum Requirements
The minimum requirements for a specialised PLIC System/supplier should include the following:

● The PLIC System must be capable of reporting both cost and resource consumption data on a daily basis. The resource data produced must be clearly identifiable (for example, the ward name, community mental health team name, drug name, consultant name or code).

The ability to produce service user level cost and activity data on a daily basis is necessary to ensure maximum clinical engagement with the data. It enables clinicians to understand where there may be areas for efficiency savings and monitor adherence to or variance from established clinical protocols. It will also allow costs to be aggregated across a pathway of care.

● A PLIC System must be capable of reporting on the underlying clinical information associated with service users. This may include HoNOS scores, for example.

Considering how a system will be used
It is worth spending significant time determining what information clinicians and other stakeholders will find most meaningful, as well as identifying current data gaps, before holding discussions with potential suppliers. The greater the effort, thought and discussion about how the system will be used, the greater the likelihood of choosing the best supplier as a result of a robust selection process.

Resource implications for operating the PLICS software
Post implementation, ownership of the processes involved in generating PLICS data on an ongoing basis should ideally reside within the trust, and the trust must be capable of making any changes to the cost (or income) model(s) and the underlying methodologies that have been applied to the construction of the PLICS data. The PLICS supplier must be able to provide evidence of how ownership and knowledge is transferred to trusts to allow them to effectively run PLICS independently. It is also important that the data inputs are easily changeable to meet any revisions to national costing and cost collection guidelines.

PLIC System providers can play an important role in assisting an organisation in project implementation. Most organisations will benefit from the experience that PLICS suppliers can provide, and the purchase should be seen as more than just a supply of software. It is suggested that potential suppliers should be exhaustively questioned regarding the support they could provide in ensuring their software works as a business intelligence solution rather than merely technical IT support for software and/or software support.

PLICS suppliers
There are a range of suppliers with clients in the NHS. The list below sets out PLICS suppliers operating in the acute sector in England that are known to the HFMA. They may therefore not all be currently providing services to mental health clients, however the full list has been provided for information.

● Allocate
● Ardentia
● Assista
● Bellis-Jones Hill
● CACI
● Civica
● Clearcost
● Healthcost
● Power Health.

SECTION 4

Being clear about what you want to get from your costing

It is important that expectations and deliverables are clearly defined. Implementing PLICS will be an iterative process with information gaps only becoming obvious when data is requested. It is important to define deliverables that can be achieved within a period of time which is not so long that the project loses its momentum but is long enough to demonstrate some beneficial results. This ensures visibility and encourages support.

One of the key lessons that the HFMA's acute costing practitioner group has shared is the need to be clear at the beginning of the process about how you want to use your costing system. The choice of system and how it is set up will determine how it can be used. Any changes post implementation may take considerable time and have significant cost implications. In particular, organisations should consider whether they wish to use their PLIC System to do the following:

● Comply with the HFMA's clinical costing standards
● Produce service line reports
● Produce the national reference cost return
● Undertake analysis at cluster level
● Review the costs and resources consumed across pathways of care
● Report costs and resources by day.

CASE STUDY: PLICS IMPLEMENTATION QUESTIONS

North East London NHS Foundation Trust has provided a list of questions that are helpful to consider before implementing PLICS:

● **Is the general ledger hierarchy set up as you would want to see your service lines? This is not an absolute, but will be very helpful and would save time.**

● **Is ESR data up to date, with staff correctly allocated to the correct cost centres. If allocated by a journal in the general ledger, the SLR system will not be able to pick up as staff data comes from ESR feed.**

● **Is activity data robust? Can the activity codes be directly matched to team cost centres, and how often is this information available?**

● **Are staff recording all activity? Do we need to start changing anything now? Is activity outside of direct patient care recorded – for example, travel. If not recorded, can we apportion? How?**

● **What are your cost drivers? Is this how activity is now recorded?**

● **If you have a tariff, is it the same as how reference costs are allocated?**

● **How would you allocate your block income to the service lines?**

● **Are you involving the performance team early on in the process?**

● **How will the data feed into the system? (Spreadsheets are used for the ESR and GL data, but we have an automatic feed from Informatics for activity)**

SECTION 5

Implementation plan

The amount of time required to implement PLICS depends on the organisation's starting point in terms of data quality, IT infrastructure, clinical leadership and so on. Typically the initial implementation phase will take three to six months, assuming that all the basic data required is readily available. This phase includes:

- Gathering and inputting activity data
- Gathering and inputting base financial data
- Gathering and inputting activity and financial information to be used to allocate costs
- Producing data quality reports
- Writing costing scripts
- Creating costing model
- Producing costing output/reports
- Reviewing and refining the system
- Training and sign-off of the system.

Figure 10 provides an example of an outline implementation plan for PLICS.

FIGURE 10: EXAMPLE OF AN IMPLEMENTATION PLAN FOR PLICS	
Key actions	**Target dates**
Decision to implement PLICS – paper to board outlining PLICS process	April 2014
Launch event with key stakeholders	April 2014
Stakeholder engagement to identify key issues	April-May 2014
Establish project board to establish timeframes, priorities and workstreams	June 2014
Proposal to trust board	August 2014
Stakeholder involvement and consultation	September-October 2014
Draw up and agree specification for proposed PLICS data collection, cost allocation and reporting structure	November-December 2014
Research what PLICS are available and do cost benefit analysis	December 2014
Shortlist system suppliers	January 2015
Decision on system supplier and award contract	February 2015
Initial system implementation and data input	March-May 2015
Implement agreed reporting and management structure	May-July 2015
Produce first cut reports and review	August 2015
Monthly service user level costing reports	November 2015
Refinement and development of reports	Ongoing

Once the initial costing output has been produced there is usually a further six to 12 months' settling down period to further refine the reporting and review the outputs.

We will discuss the steps outlined above and the key steps that form part of a PLICS implementation:

Gathering and inputting activity data
The first step is to agree what your base activity dataset is going to be. This is essentially the record of the care and treatment provided to service users.

Some mental health organisations use the same extract they use for commissioning and NCA contracting. This ensures the activity being costed is the same activity being reported to commissioners for payment purposes. For mental health services, care should be to taken to ensure the activity extract includes hospital and community activity.

In addition, the extract will need to include information regarding each service user contact or episode of care in order to provide characteristics with which to group service users. Figure 11 provides a suggestion of the fields you may wish to include in your activity extract.

It is important to agree these fields in advance with your supplier. Post implementation, this base activity extract will need to be provided in the same format and with each field in the same format each time the costing system is updated.

Gathering and inputting finance data

FIGURE 11: SUGGESTED FIELDS TO INCLUDE IN ACTIVITY EXTRACT
Clinic code
Clinic name
Cluster
Cluster description
Commissioning CCG
Consultant code
Contact method
Contact reason
Contact type (eg community contact, occupied bed day)
Contact duration in minutes
Episode end date/time
Episode start date/time
First assessment (yes or no)
First contact (yes or no)
Locality
Occupied beds
Outcome (eg attended, DNAs)
Patient ID
Episode ID
Professional carer type
Professional name
Source data type (name of PAS system)
Specialty code (eg 710 = adult)
Staff assignment no
Staff team code ID (prod code – PAS system) for community contacts
Staff team name
Ward code (prod code – PAS system) for inpatient contacts
Ward days
Ward description
Ward name

Gathering and inputting financial data
The second step is to agree what your base record of income and expenditure is going to be. The HFMA mental health costing practitioner group recommends that a ledger extract is used as the record of financial expenditure and income.

Again, it is important to agree the format of this extract with your supplier and with the financial accounts team. The extract must be produced in the same way, each time the costing system is updated. Ideally the same extract should be used that is the basis for all internal financial reporting so that the costing output produced can be reconciled to the final accounts or internal board report.

As a minimum the ledger extract should include:
● Cost centre
● Cost centre description
● Account code
● Account code description
● Amount.

As part of the ledger upload process, each cost centre and account code combination will need to be classified in order to comply with the clinical costing standards. This therefore requires three classifications:
● Direct, indirect or overhead
● Fixed, semi-fixed or variable
● Cost pool and cost pool group.

Care should be given to the treatment of income. Standards 6 (Treatment of income) and 7 (Treatment of non-service user care activities) provide further information on this. If the PLIC System is to be used to produce service line reports and report on profitability of services, then the income received for a service will need to be included within the base financial extract. If PLICS is to be used purely as a costing system, then income from service user activities can effectively be ignored.

The aim of PLICS is to ascribe the actual cost of clinical activity to individual service users. This means non-service user activities carried out by trusts need to be identified and both their income and cost measured accurately and excluded from those related to service user care. The major non-service user care activities are: research and development; education and training; and other commercial activities.

Gathering and inputting activity and financial information to be used to allocate costs
Standard 3 Allocating Costs provides information on the allocation of overhead, indirect and direct costs.

PLICS aims to record meaningful clinical interactions, processes and events, which take place during a service user's episode of care or treatment and to ascribe the actual costs of those interventions to them. The quality of how costs are allocated to individual service users is a significant determinate of how good the costing data produced is. Ensuring that the costing model allocates costs with relevant granularity, without becoming lost in the unimportant minutiae, is a pivotal judgement for each organisation.

The HFMA has developed a materiality and quality score (MAQS). This score allows organisations to rate their allocation methodology for each cost type. This rating is multiplied by the financial value reported for that cost type to produce a weighted score. The MAQS is a significant step forward in providing transparency of approach in costing and showing organisations alternative allocation methods that would result in more accurate cost data being produced. Because the MAQS calculates a weighted score, it focuses on the materiality of each cost and is therefore an important tool that can assist organisations in targeting resources to achieve the greatest impact on quality.

In order to undertake PLICS, service user level data feeds will be required to allocate material direct costs. Possible information sources (and the specific data fields that may be required) are:
● Community contacts
● Outpatient attendances/telephone contacts (patient ID, contact provider, duration, case number, NHS number, unique contact ID)
● Inpatient activity (patient ID, case number, ward name, admission date, discharge date)

- Pharmacy (patient ID, NHS number, drug name, drug code, unit cost, quantity)
- Pathology (patient ID, NHS number, test name, test code, unit cost, quantity)
- Radiology (patient ID, NHS number, test name, test code, unit cost, quantity)

In many mental health organisations, radiology and pathology may be a subcontracted service. In this case, it is likely that a fee is paid per case and therefore the service user level data required is provided through the invoicing process. If it is not, organisations should investigate whether this level of detail can be provided.

Part 1 of this guide describes how data quality is a key challenge in costing mental health services. The HFMA Mental Health Costing Practitioner Group regards data quality as one of the key challenges to PLICS implementation, in particular with regard to the data fields above.

If it is known that data is missing from these data fields because data capture is not complete, or there are known issues with the accuracy of the information reported, these need to be fully documented and understood by the costing team. However, they should not prevent PLICS from being implemented or shared with the organisation.

It is often only when clinical staff understand how the data will be used and the importance of collecting it in an accurate and complete manner that data quality can improve. Standard 8 provides further guidance on the role of information in PLICS.

It is suggested that the costing team meet with the owners of information feeds, such as pharmacy, to discuss drugs information. The rationale for data collection should always be fully explained to information providers. It is important that an action plan and timetable is agreed to bridge any gaps between existing and required data.

It is also important to ensure that these data fields can be provided in the same format and produced in the same way, each time an update is required. If extracts are not in the same format, they will usually fail in the upload process.

Data quality reports, writing costing scripts, creating costing model
Once all of the input data has been collected, an organisation will need to work with their chosen supplier to integrate these data sources. This will involve the process of writing a series of 'scripts' or 'rules' to integrate the data and to link it together.

It is important that an organisation takes time to understand this process as it will greatly impact on the accuracy of the cost information produced.

Reviewing and refining the system, training and sign-off
These are the final two stages in the implementation process. Sections 8 and 9 provide more information on sharing initital outpatients and the ongoing development required to refine costing outputs.

SECTION 6

The role of the mental health clinical costing standards

The role of the clinical costing standards and costing principles addressed earlier in this document need to be fully understood when they are used in designing and setting up clinical costing systems.

The HFMA clinical costing standards set out best practice guidance to support clinical costing. The aim of clinical costing is to identify the actual costs of treating service users. This means that other activities carried out by an organisation will need to be identified and excluded from those costs that relate directly to service users care.

The diagram in Appendix A shows how the clinical costing process works and its relationship with each of the costing standards. For easy reference, the section below includes a brief summary of many of the key costing standards involved. These extracts are taken from the HFMA *Mental Health clinical costing standards*, where you will also find a lot more detailed information.

Standard 2: creation of cost pools/cost pool groups
All service costs need to be grouped into associated cost pool groups. Cost pool groups are 'types' of costs, forming a set of component costs. Cost pool groups are distinct from service lines or points of delivery. The aim of establishing cost pool groups is to provide sensible component costs for service user care to enable possible benchmarking and comparison.

In implementing PLICS it is important to try and get the structure right from the beginning, as it may be costly and time consuming to change it. Acute trusts have made relatively more progress with PLICS than mental health organisations and there is a greater degree of consensus on the use of cost pool groups to facilitate meaningful comparison. This consensus is still developing in the mental health community. The suggested cost pool groups below have been updated for the 2014/15 version of the mental health clinical costing standards following feedback from costing practitioners.

Mental health organisations have freedom to choose cost pools (within cost pool groups) to suit local circumstances. However, best practice dictates that these pools should map to the cost pool groups in the standards to enable like-for-like comparison. The recommended cost pool groups are:
● Clinical support functions (including radiology, pathology and other diagnostics)
● Drugs and pharmacy
● Medical staff
● Non-inpatient services/teams
● Non-service user care activities (including education and training – see Standard 7)
● Other clinical services (including day care)
● Special procedure suites (including ECT)
● Secondary commissioning costs
● Therapies
● Wards

Standard 6: treatment of income
Income should be clearly identifiable for internal reporting without being netted off from cost. This is done to ensure consistent treatment of different sources of income so that service user level costs reflect the real cost of treating service users and do not include costs associated with non-core income. It also ensures a consistent approach to the treatment of income to support the understanding of profitability at service user and service line level.
● All income should be classified as 'core' or 'other'. Core income relates to commissioning income for core NHS care given to service users, while other income includes service provision to other providers (for

example, rent or social care) or research and development income and education and training levy income (see Standard 7).

● All income should be classified as direct, indirect or corporate. The guiding principle is whether the income relates to direct service user care (direct) or service user care for other organisations (indirect) or non-service user services/goods (corporate). As a general principle, income should not be netted off from gross costs, but rather shown separately as an income stream.

Standard 7: separating patient care from other activities
The costs of clinical education and training, and research and development should be separately identified from the costs of providing service user care.

The costs incurred in other clinical and non-clinical activities, where the organisation's service users are not the primary reason for the activity, should not be allocated to service users but separately identified. This is to provide a consistent methodology to ensure these costs are not included in clinical costs. This treatment will also show the surplus or deficit of providing services, to enable information for reimbursement discussions.

Education and training and research and development have historically been funded separately from healthcare. A costing methodology and guidance to support the national cost collection of training and education costs has been developed by the Department of Health and Health Education England and has now been published for the NHS.[11]

Standard 8: data integrity
This standard provides guidance on how organisations can assess and ensure the integrity of the service user level information used in the costing process.

This standard has been addressed in much more detail earlier in this document, as it is a key issue for many mental health organisations. Data quality issues will need to be addressed at the earliest possible stage in implementing a clinical costing system. Ideally, issues should be identified before data is imported into a costing system, as this will speed up the implementation and reporting process. Data quality is a key issue in the implementation of clinical costing and its importance must be recognised throughout the organisation – from the owners of the data right up to board level.

This standard aims to ensure high-quality data in two areas: the service user data set and linking service user records to resource usage. A service user data set provides the record of each service user episode/contact. The quality of these service user records (the mental health clustering tool score outputs and associated clusters) will be vital in ensuring that robust service user level costs can be produced. Processes should be periodically reviewed and tested by internal audit.

Standard 9: costing standards quality assessment
Organisations should document and measure the materiality and quality of their costing process. The materiality and quality score (MAQS) has been designed to assess an organisation's ability to provide robust, reliable data for internal and (potentially) external assurance by using a template.

This is a relatively new area under development for mental health services. It will help organisations that are implementing clinical costing to assess and monitor improvements in data quality. It will also help those organisations that may not yet be fully implementing service user level costing, highlighting opportunities to improve quality in the costing process.

SECTION 7

Sharing initial outputs

PLICS is a journey. There will always be tension between those in an organisation who wish to share and start using outputs and those who feel that further work is required to improve their accuracy. This is a healthy tension.

It is suggested that initial reports for review and feedback should be made available within three to six months. There should be no expectation that these initial draft reports will be perfect but will rather be a learning exercise to expose gaps in raw data, business terminologies, object coding and allocation methodologies. It is important to be realistic about time frames and early results and to ensure that where there are gaps in data, or known issues with some of the input data that these are clearly communicated.

Most organisations should be able to produce meaningful and fruitful data within nine to 12 months as an output from the initial implementation project. It is suggested that results are shared with the project board in the first instance and then shared more widely with the board and across services. Keeping the board up to date with the progress of the project and sharing early results enables them to see what information will be made available to them and therefore discuss how this information may be used in the future once acceptance is reached over its quality. The timetable for results should also be clear.

SECTION 8

Ongoing development

It is important to realise that the installation of a PLIC System is not a one-off quick fix exercise. This will be a start in the improvement and development of meaningful information to be used by clinicians and management in achieving the organisation's strategic, clinical and financial goals. For this reason, it is essential that the ongoing development and improvement of the system is managed in the same manner as the implementation – with a challenging but achievable project plan, status reports and board reviews.

Improvements may include the upgrading or inclusion of additional feeder systems, the refinement of acuity allocations or enhancement of cost allocation statistics. If an organisation fails to recognise this phase, it is likely that the benefits attainable through the full potential of clinical costing will be reduced.

The MAQS template provides useful information regarding where improvements in costing may be made. It also has the facility for organisations to input a target MAQS and see where resources could best be targeted to obtain the MAQ score.

The case study overleaf, from Kent and Medway NHS and Social Care Partnership Trust, highlights that PLICS is a journey and that the rewards can be significant, if costing is allowed to develop and evolve.

See Standard 9 of the Mental health clinical costing standards 2014/15 *for further guidance on the MAQS*

CASE STUDY: FOCUS ON THE DATA

Service user costing at Kent and Medway NHS and Social Care Partnership Trust is about much more than developing local prices for cluster-based contracts and supporting funding flows. It is about meshing finance and activity information and understanding the cause and effect of the use of resources.

'Finance is an important consideration in patient and service user care,' says Ada Foreman, the trust's deputy director of finance. 'It is not the lead consideration, but you can't ignore the money. We are working from a finite pot of money and if you want to put the patient first, the costs and how you use your money have to be a consideration.'

Kent and Medway has been pursuing a bottom-up costing strategy for some years. Its patient-level information and costing system (PLICS) was in place in December 2011, with a plan of checking the quality of the output before using it as a performance tool from 2012. However, data issues – compounded by a switch to a new patient administration system (RIO) – meant these ambitious plans had to be delayed.

Instead, the trust spent 2012/13 doing some major data cleansing and sorting out some of the activity data flows. Mrs Foreman says that budget holder and clinician trust in the data was fundamental to getting service user cost data used to inform decision-making. 'It was vital that the data from different sources – from their activity systems and the cost reports – told the same story,' she says.

The context for costing was also changing – with the mental health sector moving to the use of new clusters as the basis for contracting and payment – adding to the complexity and dictating the trust's focus. However, Mrs Foreman says the time has been 'useful and necessary' in ensuring the system is fit for purpose.

She believes the system is already giving useful data. 'We are able to get to cost pools and get some very basic intervention-level costing, but we still need to improve on attaching these to clusters,' she says.

The focus in 2013/14 has been on two areas. First, Mrs Foreman has met each service line management team to help them understand and sign off on the cost calculation and apportionment methodologies. 'This has helped them to understand that the costs of an intervention are about far more than just their direct costs and to see how we've matched activity,' she says. 'But it has also helped us to highlight how the system will work and the information that they will be able to get from it. That has been really useful.'

The second issue has been reconciling activity data extracted from RIO. It can take several days to run a full suite of reports and timing differences between when data is input (and the period it is allocated to) for the different reports can create difficulties.

Other challenges await. 'RIO captures only basic information about interventions – differentiating between an occupied bed day and a contact, for example,' says Mrs Foreman. 'But with the move to clustering, we want to distinguish between, say, a psychologist intervention or an occupational therapy intervention. We might know a pathway has a set of likely interventions, but we can't see what interventions are being made.'

The trust is keen to refresh its PLICS reports to ensure they deliver information to clinicians that will inform better, more cost-effective care. 'The focus needs to be on outcomes, but we need to highlight efficiency opportunities that don't impact on the outcomes,' she adds.

Over time, Mrs Foreman hopes the system will be able to show the volumes of intervention associated with each pathway along with the resource consumption and highlight how much of this pathway/cost is common to all users on the pathway. The aim will be to understand the case mix within each cluster, both to inform service development and contract discussions with commissioners.

The move to using clusters in mental health is driving a greater understanding of the services provided for service users, giving an opportunity to identify variation and standardise pathways as appropriate. Credible service user level costing is an important part of this, enabling trusts to understand not only the range of interventions and services provided, but the associated costs too. And while there are challenges for mental health trusts – particularly in establishing robust data – Mrs Foreman says the goal is well worth the effort.

SECTION 9

Integration of PLICS

The implementation of PLICS should be seen as an organisation-wide project, led by a project board. However, as the system matures over one to three years, the aim should be to integrate PLICS fully within the trust. PLICS should be an important information source feeding into a range of operational and strategic activities.

The project team should consider how the structure of the costing team may need to change to support the ongoing update and development process, as well as how the integration of the costing outputs within the organisation can be supported.

Consideration should be given to integrating PLICS into the following areas:

Financial reporting
- Updates regularly reported at board level
- Information used as part of regular management meetings between the finance team and services
- Used to identify where efficiencies may be made
- Discussions with commissioners regarding price setting.

Performance management
- Regular performance reviews with services
- Development of business cases
- Performance shown by PLICS may be used as an indication of investment or disinvestment in a service.

National reporting
- Production of the annual reference cost return
- Production of programme budgeting
- Breakdown of cluster costs could be used to support the national development of clusters.

SECTION 10

Conclusions

Here are our top 10 tips for a successful PLICS implementation:

- At the outset, explain the need for change and the consequent benefits of PLICS.
- Gain commitment across the whole organisation.
- Ensure that there is a robust and realistic project plan.
- Identify and address any data quality issues at the earliest possible stage.
- Ensure the project is adequately staffed and resourced at all stages.
- Develop and resource the training/organisational development plan.
- Be realistic about the timescale for achieving benefits.
- Ensure that expectations are managed by regular communications.
- Share information as soon as possible, even if it isn't perfect in order to improve it further.
- Don't forget: clinical costing is an iterative process that will require ongoing development.

Appendix A

Summary of the costing process and relationship with clinical costing standards
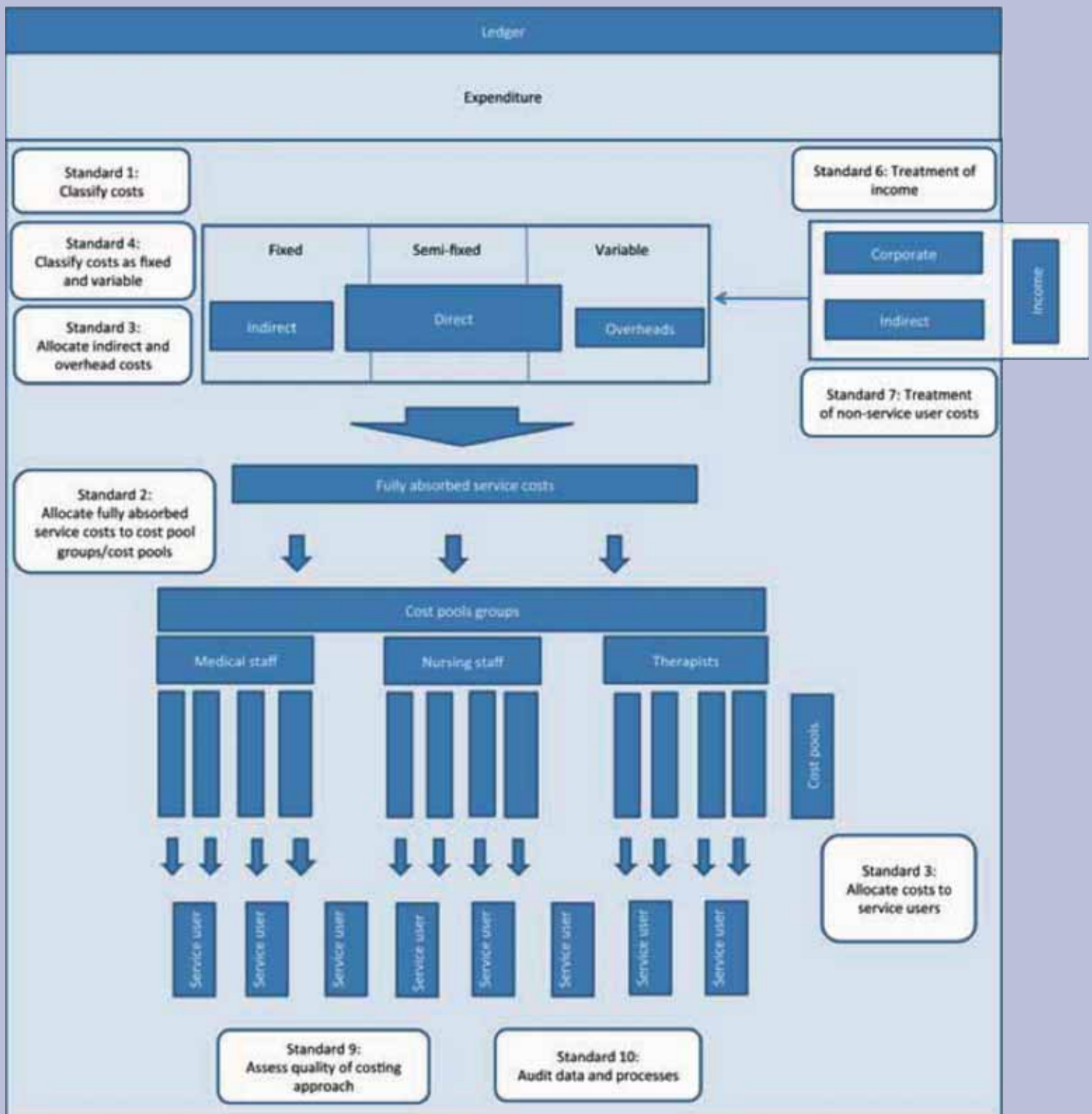
HFMA 2014/15 Mental Health Clinical Costing Standards

APPENDIX B
Links between activity-based costing, costing principles and clinical costing standards

ACTIVITY BASED COSTING	MONITOR'S COSTING PRINCIPLES	HFMA CLINICAL COSTING STANDARDS
Step 1: Define the cost object What needs costing. The cost object in mental health is the care package provided to a service user in a particular cluster. **Step 2: Identify the activities** Activities associated with a cost object must be identified to produce accurate costs. This will help establish the cost causality when allocating costs.	**Principle 3: Data accuracy** Requires good-quality underlying input data. Data quality is still a big issue with many mental health providers as clinicians are getting used to recording the data to report by clusters accurately. **Principle 1: Stakeholder engagement** Involves input from a range of stakeholders, including non-finance staff. This will help ensure activities are correctly identified and ascribed and encourage ownership by clinicians.	**Standard 8: Data integrity** Provides guidance on how organisations can assess/ensure the integrity of service user-level information in the costing process, such as the accuracy of assigning the service user to the right cluster and linking the correct level of resources for the interventions. **Standard 8a: Matching** In allocating costs to service users, resources will need to be costed and allocated to specific service users and specific episodes of care.
Step 3: Establish relevant costs When establishing the relevant costs, you need to consider: ● What period the costing exercise covers ● What source data will be used ● Which costs should be included and the overall cost quantum.	**Principle 4: Materiality** Important when considering both costs and activities by focusing on high cost resources first – such as medical or nursing staff costs.	**Standard 5: Work in progress** Mental health services continue to move towards using a cluster currency for costing and payment purposes. **Standard 6: Treatment of income** Income should be classified 'core' (commissioning income for core NHS service users) or 'other' (including income from overseas visitors and R&D), and classified as direct, indirect or corporate. **Standard 7: Treatment of non-patient care activities** For costs incurred in delivering services but not directly related to the care or treatment of service users, such as R&D, the direct costs of time spent on it and a proportion of indirect/overhead costs must be stripped out to produce accurate costs for the treatment of individual service users.
Step 4: Analyse costs The purpose of this is to a) facilitate the cost causality analysis which supports the cost allocation and also b) to enable the costs to be reported in different ways.	**Principle 5: Causality and objectivity** It is essential to understand the real cost drivers. Engagement with stakeholders will help clinicians and accountants understand the relationship between services, activities and costs. This can also help organisations to deliver more cost-effective services	**Standard 1: Classification of direct, indirect and overhead costs** The first step in clinical costing is to assign cost centres to a direct, indirect or overhead costs category. **Standard 4: Classification of costs into fixed and variable categories** Costs are then classified as fixed or variable. **Standard 6: Treatment of income** (as above)
Step 5: Assign costs To simplify the costing process, resource costs attributable on the same basis to cost objects are often grouped into cost pools groups or cost pools	**Principle 2: Consistency** with a similar approach across or within organisations. This is particularly important for pricing and benchmarking.	**Standard 2: Creation of cost pool groups and cost pools** Once adjustments have been made to establish the quantum of costs, all remaining costs must be assigned to a cost pool group or cost pool. A cost pool is a grouping of associated costs that relate to a product or service that can be assigned to activities with the same cost driver. This will involve identifying the main cost drivers and understand how they behave with changes in activity. **Standard 3: Allocation of costs** Overhead costs must be allocated or apportioned to the direct and indirect cost centres, wherever possible on the basis of actual usage of resources. Different allocation methods will be appropriate for different types of cost. Next, costs in cost pool groups or cost pools need to be allocated or apportioned to individual service users again on the basis of actual usage of resources wherever possible. **Standard 4: Classification of costs into fixed and variable categories** (as above) **Standard 9: Quality assessment and measurement** Organisations should measure the materiality and quality of their costing process using a MAQS score.
Step 6: Validate the outputs Basic checks should be undertaken to ensure the costs are accurate – sense check, comparisons with previous years' data and benchmarking activity and costs.	**Principle 6: Transparency** Necessary to ensure costs are auditable.	**Standard 10: Audit** of both finance and activity data also plays an important part in assuring and developing data accuracy and the robustness of the costing process.

Appendix C

Questions for suppliers

Below are some sample questions. These questions are intended for use in the evaluation of different products and suppliers, and for use in discussions with suppliers as part of the procurement of a patient level information and costing system (PLICS).

A: TECHNICAL
● What is the core database used within the system?
● At what level is data stored in your system – for example, at the service user, department, or service level?
● Is full access provided to the resulting databases for the organisation or only the reporting information? If full access is not provided, what level of access is?
● Can you demonstrate the ease at which system interfaces are created?
● Are there any limitations in the use of your system – for example, the size of the data files that can be integrated?
● What are the server and other IT requirements necessary to operate your system?
● What data quality checks and controls does your system include to monitor and analyse the quality of data being input into the system – for example, will new account codes, or drug names be notified?
● Are users required to learn a new programming language to make changes in how the data warehouse operates, such as the data linkage scripts or make changes to the rules set up in the costing model? If so, what programming language is this?
● Will users be required to 'bolt on' an additional query tool in order to fully integrate and manipulate the data?
● Once the system is fully integrated, who will own the system? Will it reside on the organisations servers or will it be reside with the supplier?

B: ABILITY TO ENGAGE CLINICIANS AND GAIN CLINICAL OWNERSHIP
1. Method
● What demonstrable experience do you have in talking to clinicians and managers and securing engagement in this PLICS implementation?
● Can your system automatically run daily or weekly updates of service user level data in order to support more timely clinical level information?

2. Tracking resources to patients
● Explain the ability of your system to accept and report input information at the levels described below, as well as at greater levels of granularity. such as nurse time/cost within ward by service user by day. Relevant variables include:
- Wards
- Community teams
- Pharmacy services and drugs
- Therapies

- ECT
- Diagnostic costs – including MRI scan and CT scans
- Drugs
- Travel costs (related directly to visits to service users)
● Explain how you would help us deal with different levels of service user need.
● Explain how you would help us cope with inadequate /non-existent data feeds.
● Is your system capable of reporting both cost and resource consumption on a daily basis? Resource data means, for example, the drug name, ward name, consultant name or code.
● Is your system capable of reporting on HoNOS scores at individual service user level?

3. Comparability
● Can your systems produce reports on costs at the following levels:
- By service user
- By cluster
- By types of intervention
- By patient age or other demographic
● Can these reports be also produced by clinicians? For example:
- Average time in a cluster by clinician comparison
- By consultant by cluster
- By clinical team by cluster
● What service user level reports have you actually provided to clinicians working in mental health organisations?

C: COSTING STANDARDS
● Can your system meet the reporting standards as categorised in the *Mental health clinical costing standards*, published by the HFMA?
● What is your ability to reconcile back to the general ledger?
● Is your system able to modify the general ledger so that it better supports service user costing activities and enables the clinical costing standards to be met – for example, by offsetting revenue, moving values from one cost centre to another, creating dummy cost centres and account codes?
● What/how complex or fixed – for example, hardwired – are any definitions or algorithms underpinning your costing methodology?
● Are you able to construct and resolve simultaneous equations in the allocation of costs where departments both distribute charges to and receive charges from another department? If not, what do you do?
● Do you or can you attribute overheads and indirect costs to intermediate levels – such as ward costs or therapy sessions – before allocation to service users? Do you have the flexibility to then, if required, disintegrate and report these overheads separately by cost pool group in a service user's final cost bill – for example, ward costs (direct) and ward costs (indirect/overhead)?
● Does your system allow users to easily review the indirect and overhead costs allocated to individual service users?

● Is there a limit to the number of cost components, cost weights etc. that can be defined as part of the costing process? Are you restricted in what you call them?

● Can you allocate direct costs to several different cost pool groups – for example, nursing to ECT and wards? Can this be done directly from individual account codes in the ledger or does information have to be re-assembled?

● How flexible is your system in using differing allocation methodologies for the same expense types within a setting such as a hospital? Some administration costs may be indirect in some circumstances but an overhead in others. Therefore some nursing costs may be allocated using service user numbers and other nursing costs by the minutes service users spend on a ward.

● If updating the service user level data more frequently than monthly, can your system use previously calculated costs to estimate the costs of recent service users, or do you need to wait until the general ledger is closed and then the costing process is carried out again?

● How do you handle work in progress in clusters between years?

D: WILL YOUR SYSTEM ADEQUATELY INFORM THE TARIFF?

● Are you able to group service users by cluster?

● Are you able to produce a report of the cost of individual service users, by cost pool group by cluster?

● Is your system able to cost and attribute care packages to individual service user level?

● Can your system identify care pathways by cluster at individual service user level?

● Does your system support the production of the annual reference cost return?

● Does your system support the production of the annual programme budgeting return?

● Did any of your acute clients use this system to produce Monitor's 2013 voluntary patient level cost data collection?

E: EASE OF USE

● How easy it is to write reports in your system? What skills are required? Is there a need for an external system report writer or specialist IT programmer knowledge?

● Can you demonstrate the ease at which knowledge of the system can be transferred and users can become self-sufficient in operating the system?

● Are the reporting and analysis standards within the system suitable for all levels and job specifications within the organisation – for example, business analysts, high-level managers, clinical consultants?

F: EXPERIENCE

● How long has your product been on the market?

● How many staff do you employ? What is the experience/ background of these staff and what NHS experience do they have?

● How many (i) mental health and (ii) other healthcare organisations have implemented your system and in what countries? If applicable, what extra value can you bring to this organisation as a result of your overseas experience?

● How will you help us access the necessary granular information within our organisation to deliver a successful business solution?

● How many (i) mental health and (ii) other acute organisations have implemented your full PLIC system in England – that is, costing to the patient at a granular level and subsequent reporting? Do not include sites where you have not supplied the costing engine as part of the solution. Provide references of all sites to allow independent verification by random sample

● How long will it take to properly implement your system? What will be the key steps and which will you do and which will we need to do?

G: COMMITMENT TO MARKET/RESOURCES/CAPACITY

● What resources do you intend to commit to this market?

● What are the ongoing system support capabilities of your company?

● What are your ongoing training/knowledge transfer capabilities?

H: GENERAL

● How can we assess your financial stability?

● How much is your solution likely to cost and what are the main variables?

● How much do you anticipate the annual support/maintenance cost to be?

● Why should we choose you?

Appendix D

Glossary

Activities A measurable amount of work performed to convert resources into products or services, used in activity-based costing

Activity-based costing (ABC) Focuses on the identification of activities an organisation performs and then assigns the costs to these activities based on causal relationship analysis

Allocation The process of assigning costs from a high-level pool of costs to an activity, based on an agreed methodology

Assessment In mental health pricing, service users are assessed using the assessment tool based on HoNOS PbR. The results of the detailed assessment of the needs of each service user is used to allocate them to a 'cluster'

Care cluster See Cluster

Care packages The care and interventions given to service users, designed to meet the needs of individuals within the clusters

Care pathways: The care packages an individual receives over a period of time could be described as their care pathway

Clinical costing Patient or intervention-level allocation of an NHS organisation's costs

Clinical costing system (CCS) Software that enables patient or intervention-level allocation of an NHS organisation's costs

Clusters Care clusters form the classification system of mental health pricing. They are a way of grouping service users with service users with similar characteristics such as level of need, and which require similar resources to meet those needs through the provision of packages of care. There are currently 20 clusters in use

Cost driver A factor that causes activities and costs to vary, such as length of stay or HoNOS level of need

Cost object A product or service (such as a mental health cluster episode of patient care or a service line) for which costs are built up

Cost pool A grouping of associated costs that all relate to a specific product or service that can be assigned to activities with the same cost driver

Cost quantum The total costs involved in the costing exercise

Cost weight A weighting to reflect resource usage – staff on a ward can be assigned a cost weight as different types of service user may use different levels of resources in terms of staff time.

Costing The methodologies organisations use to trace and allocate their costs between different services

Currency The unit of healthcare for which a payment is made. Clusters are expected to be the currency for mental health services

Data quality The degree of completeness, consistency, timeliness and accuracy that makes data appropriate for a specific use

Direct costs Costs that directly relate to the delivery of patient care. Examples include medical and nursing staff costs

Feeder system A system that feeds into the costing system – for example, a pharmacy system may provide important data about the drugs used in the treatment of different service users

Fixed costs Costs that are not affected by in-year changes in activity – for example, rent

Healthcare Resource Groups (HRGs) Standard groupings of clinically similar treatments which use similar levels of healthcare resource

Health of the Nation Outcome Scales (HoNOS) An assessment tool used in clustering. It includes the original 12 items of the Health of the Nation Outcome Scales (HoNOS), rated on a current basis and six additional items, mostly rated on an historical basis

Materiality Information is material if its omission or mis-statement could influence a decision taken on the basis of the financial information

Outcome The NHS is collecting a range of outcome measures such as clinican-rated outcome measure (CROM), patient-related outcome meaure (PROM) and a measure of patient experience (PREM)

Overhead costs Costs that are not driven by the level of service user activity and which have to be apportioned to service costs as there is no clear activity-based allocation method – for example, the chief executive's salary

Patient-level costs Costs that are calculated by tracing the actual resource use of individual service users

Patient-level costing The ability to measure the resources consumed by individual service users

Patient-level costing system (PLICS) A method of costing that combines activity, financial and operational data to cost the treatment and care given to individual patients. It can also refer to the IT system itself which brings together the data

Payment and pricing system New terminology likely to be used by Monitor to replace the term payment by results

Points of delivery A term used in the NHS to describe the location or manner of care given to patients and service users. For example, in mental health services a crisis resolution team and an inpatient unit are two different points of delivery

Semi-fixed costs Semi-fixed costs are fixed for a given level of activity but change in steps, when activity levels exceed or fall below these given levels – for example, nursing costs

Service lines Discrete operational/business units that can be reported separately in terms of activity, expenditure and income.

Service line reporting (SLR) A method for reporting cost and income of clinical activities by service lines to improve the understanding of the contribution of each service line to performance

Service users People with mental health problems who use health and social care services, or who are potential users of health and social care services

Standard cost A standard cost is the estimated or predetermined cost of producing a service, under normal conditions. Standard costs can be used as target costs (or as a basis for comparison with the actual costs) or to calculate cost weights. They are often developed from historical data analysis. They are likely to differ from actual costs and may be also different from average costs

Tariff A locally or nationally set price for a given currency

Unbundling A term used in NHS payment systems to refer to the splitting up of a currency into smaller units. A cluster may be unbundled where multiple providers are commissioned to provide care – for example, a main provider offering the majority of care, and then a voluntary body providing input into a peer support group

Variable costs Costs that vary with changes in activity – for example, drugs

Appendix E

Acknowledgements and thanks

The HFMA is grateful to members of the HFMA Mental Health Costing Practitioner Group for their input into this document:

- John Graham, Royal Liverpool and Broadgreen University Hospital NHS Trust (chair)
- Graeme Burgess, South London and Maudsley NHS Foundation Trust
- Steve Carr, Barnet, Enfield and Haringey Mental Health NHS Trust
- Sheelagh Carr, Greater Manchester West Mental Health NHS Foundation Trust
- Chris Cressey, Northumberland, Tyne and Wear NHS Foundation Trust
- Clare Crossland, Coventry and Warwickshire Partnership NHS Trust
- Alan Doe, North Essex Partnership NHS Foundation Trust
- Gordon Folkard, Avon and Wiltshire Mental Health Partnership NHS Trust
- Ada Foreman, Kent and Medway NHS and Social Care Partnership Trust
- Mark Fox, Norfolk and Suffolk NHS Foundation Trust
- Patrick Grubb, Somerset Partnership NHS Foundation Trust
- Clare Jacklin, Humber NHS Foundation Trust
- Lisa Marsh, Central and North West London NHS Foundation Trust
- Luke Robinson, Devon Partnership NHS Trust
- Paul Ronald, Hertfordshire Partnership University NHS Foundation Trust
- Steven Tait, Tees, Esk and Wear Valleys NHS Foundation Trust
- Gideon Vandyke, East London NHS Foundation Trust
- Paul Vincent, Oxford Health NHS Foundation Trust
- Helen Strain, HFMA Costing Lead
- Ben Renshaw, HFMA Committees Manager
- Helen Gott, Department of Health
- Yin Shi, Monitor
- Bevin Manoy, Capita

Special thanks go to:

- Catherine Mitchell, independent consultant
- Letsie Tilley, healthcare management consultant and former NHS mental health services finance director
- Keiley Gardner, North East London Foundation Trust

Appendix F

Contacts

The HFMA will continue to engage with costing practitioners in the development of the mental health clinical costing standards and supporting guidance. Your views and comments on this guidance are welcome by contacting: costing@hfma.org.uk

Further details about the HFMA Mental Health Costing Practitioners Group can be found at: www.hfma.org.uk/costing

If you are interested in joining or finding out more, please contact committees@hfma.org.uk

Any feedback or comments about this document should be emailed to the following address: costing@hfma.org.uk

You can also write to the HFMA at:
111 Victoria Street, Bristol BS1 6AX