TRANSFER POLICY

Acute providers have recognised the benefits of understanding their costs at the patient level. Hertfordshire Partnership deputy finance director Paul Ronald explains why the benefits are just as applicable to the mental health sector

HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS Foundation Trust is a mental health and learning disability service provider. By lots of measures, the trust is well-placed and in good financial health. However, there is a recognition by the senior team that it needs further change to meet the NHS-wide challenges ahead. A better understanding of our profitability at service-line level, and of our costs at service user level, is key to this improvement.

The trust was authorised as a foundation trust back in 2007 and operates across a large geographical footprint, providing community based integrated services. It has largely completed an ambitious service transformation programme, which has seen significant investment in its estate and technology.

Financially, the trust is medium-sized with a turnover around £200m, generating a surplus of about 1% and strong cash levels. Commissioner relationships are also very positive and the trust is having success in winning some small tenders.

Despite this positive position, there is a recognition that if the trust simply looks to stand still, it will in fact go backwards. Instead it must seek continual improvement. There is certainly much more we can do, although the challenges we and other providers face will be completely different from those we have faced in the more recent period of funding growth.

Current financial reporting provides a good picture of where the trust is in aggregate, including the broad future projections. But when we look to drill down into different services or different teams, the position is much less clear. We end up making broad assumptions or doing separate analysis.

Our standard analysis is also to report on budget variances, yet we all know that budget variances may be more a reflection of a budget holder's ability to negotiate their budget than how they have managed and used their resources. We do not routinely link spend data with activity information, nor do we produce customer/contract statements.

RAID approach

But the limitations in our reporting have restricted us. We have recently implemented a rapid assessment, implement and discharge (RAID) service, operating within the accident and emergency units of the two local hospitals. Our lead consultant asked for some financial analysis to support a study on the service's effectiveness and we had to advise that this is not easily available as we do not collect or measure information in a way to facilitate this.

As we look to meet the current challenges – summarised at the national level as a need to make £30bn of savings across England by 2021 – these limitations in reporting and analysis will not be acceptable. I believe service-line reporting (SLR) and a patient-level information and costing system (PLICS) will enable the trust to bridge this analysis gap.

There are a number of specific areas where these approaches will support the trust. First, they will provide us with routine profit statements by contract. This will enable us to consider each contract on a standalone basis to support pricing discussions, as well as informing business growth strategies.

Each major contract needs to stand up to close financial scrutiny. This will require an improved understanding of our cost base and the impact of any contract changes on shared cost allocations. A good PLICS system will allow individual costs to be modelled appropriately for any such changes.

Recently the trust was unsuccessful in a contract retender. Although this only accounted for about 3% of total revenue, it had a far greater impact on the financial surplus. Contract-specific financial modelling may have led the trust to approach the tender differently.

By linking cost and activity data and having the ability to drill down to team performance, we will be able to identify and disseminate good practice and spot any areas of relatively poor performance. Given the expected pressure on contract margins, this will be crucial to drive productivity improvements at individual team level.

Of course, team productivity is a result of complex factors, but the SLR/PLICS system will provide far better data to facilitate discussion and review. We recognise there will be data quality issues, at least initially (see box), that hinder confidence in the data and analysis. But we believe the focus on SLR/PLICS will in fact

Green shoots: Hertfordshire Partnership (left) and an artist's impression of the proposed new Kingfisher Court at the trust

provide a lever to improve this data quality.

The ability to benchmark across teams and individual clinicians – provided by SLR/PLICS – is a powerful information tool and highlights areas of variation in clinical practice. I have experience of this working very effectively in Liverpool Heart and Chest Hospital NHS Foundation Trust, where variations in the use of drugs and clinical supplies were highlighted, investigated and removed.

Clinical standardisation reduces risk, improves quality and is more cost-effective. I am confident this will apply equally to mental health provision in areas such as drug use and the type and number of interventions, and should support adopting standard pathways.

The provision of patient-level information will also provide the opportunity to look at the experiences of individual service users. By focusing on the outliers/exceptions, the more granular data should identify areas for improvement in practice that can eliminate inefficiencies – for example, inappropriate interventions, multiple visits and ineffective prescribing.

Finally, I believe that SLR/PLICS draws more attention to overhead allocations and will lead quite quickly to a determination to reduce these costs within clinical teams. This will provide some real challenge to corporate services to justify their value. And while this may be uncomfortable for us in finance, no services can be immune from the search for improved value.

Rounded view

PLICS should also support us to take a more rounded view of services – including quality and patient experience.

The NHS has always had a focus on quality. However, events such as the Francis inquiry and the Winterbourne review have required organisations to check the balance between financial stability and good patient care.

For me, the effect has been quite profound. In particular, it has led me to prioritise the development of an integrated reporting system combining financial performance with clinical performance and patient experience data to give a rounded view of how we are doing as a trust.

Let me give you an example. Until recently, when I reviewed the monthly management accounts, I would view any underspend on pay costs as a positive (indeed we describe this as a favourable variance). However, now I would be far more cautious and want to understand its cause and impact in more detail.

Where the budget underspend is the result of vacant posts and the posts are seen as required to deliver services effectively, what are the implications? Clearly, most obviously there could be implications for service users. But there could also be financial impacts if CQUIN or performance-related metrics are impacted.

SLR/PLICS will support a more holistic view of performance. By triangulating activity, revenue and cost data, we'll get better analysis and improved debate. Equally, because the data is at the service user level, it can be related to specific treatments and outcomes.

PLICS enables the nuances of care delivery to be captured, so that clinicians will recognise that the costs more closely reflect the care they've delivered to individual patients. This can only help to improve clinical engagement and broaden the discussion beyond a narrow focus on financial numbers.

Again, Liverpool Heart and Chest, among a number of other acute trusts (see page 15), is now capturing patient acuity data to improve the allocation of nursing costs. Mental health has exactly the same issues, where some patients consume greater resource than others. We hope that we too can develop appropriate measures to match cost allocations as accurately as possible to the care and support delivered.

I also think that SLR/PLICS will have a role to play in supporting collaborative working across organisations – now widely seen as fundamental to the future of the NHS.

If PLICS is used in a consistent way across whole health economies, it should support decisions about the best place to deliver services and enable whole pathways of care to be viewed and costed from end to end.

We do not underestimate the challenges that will be faced and there is much to consider in developing and delivering our plans. However, we know that if we stick with the status quo, the limitations and gaps within our current systems and knowledge will become more limiting.

We recognise there are genuine questions over how far this is applicable to mental health services where the treatment is over a longer period, consisting of a series of discrete interventions, and where the cost profile is very different. However, we are convinced there is enough evidence to show that SLR/PLICS can provide sufficient benefits to be part of our response to the challenges faced. ■

MENTAL HEALTH PLICS CHALLENGES

Patient costing is almost certainly easier in an acute setting because so much acute treatment is in discrete episodes of care. But the same principles apply in mental health. We want to identify the costs associated with the care and support we provide to individuals.

Clustering and developing the care packages that support each cluster have helped mental health trusts to get a better understanding of the breadth of care they provide and the variation in care – some appropriate, some less so – across all their service users and across England. If we can accurately get costs down to the service user level, I think we will expand this understanding and find more ways to enhance care quality and value.

Even if we are to get basic recording systems in place that don't inhibit care delivery, there are issues we need to address. For example, how do we capture support given to one service user over the phone while travelling to see another client out in the community?

On the face of it, inpatient mental health services should be as easy to capture and cost as inpatient acute activity. However, some therapy sessions for inpatients are open access and some patients may not attend. How should these costs be allocated – across just the attendees or the whole group of patients?

Other issues include dealing with travelling time, personal budgets and the whole issue of DNAs (did not attends), which are far more prevalent in mental health. But getting to grips with variation is a big benefit.

There are clear challenges both with the data currently collected and the culture among staff used to working in particular ways. We need better data and to collect it in ways that put a minimum burden on our staff.

But this shouldn't stop us moving towards a more granular breakdown of costs. By starting on the process, we will much more clearly see exactly where we need better data and feeder systems to help us allocate costs robustly.

We may not achieve these benefits instantly, but we need to start the journey now.

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Paul Ronald is deputy finance director of Hertfordshire Partnership University NHS Foundation Trust and HFMA Deputy Finance Director of the Year 2013