Mental health clinical costing standards

2016/17
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Foreword

Costing has a major role to play in supporting the delivery of sustainable services across the NHS. There is recognition that the service needs to develop new models of care to meet the challenges posed by a growing and ageing population and the prevalence of long-term conditions. But these new models cannot be developed without an understanding of the existing costs of meeting these demands and how these costs might change with a revised pathway.

Good cost data can also help health economies to understand variations in costs and treatment between different patients or in services provided by different organisations, helping to optimise service delivery. Robust cost information is also vital for informing payment systems, whether forming the basis of national tariffs or local contract prices.

But to realise its full potential in these roles, cost data needs to be as accurate as possible. And it needs to be collected using a consistent methodology and at a granular enough level to support detailed analysis.

Monitor’s Costing Transformation Programme is targeting these aims, moving towards national, patient- or service user-level cost collection using a prescribed, detailed process. However, the development of this guidance and its implementation across the NHS will take a number of years.

The HFMA has championed improvements in costing for several years. It continues to do this through the work of its costing practitioner groups and the Healthcare Costing for Value Institute, promoting both the production of robust cost information and its use in value-based decision-making.

As part of this championing role, the association has developed clinical costing standards since 2010 in conjunction with, and with support from, both the Department of Health and Monitor. These standards have aimed to guide NHS providers to improve their costing processes and, in particular, build up costs from the service user or patient level.

The standards – and the materiality and quality score described within them – continue to have an important role in the drive to improve costing. The Acute clinical costing standards and the Mental health clinical costing standards, together with the two guidance papers Understanding the general ledger for costing and Improving the quality of source data for costing form part of Monitor’s Approved costing guidance for 2016/17.

Organisations following the standards will be best placed to implement Monitor’s proposed new approach once guidance has been finalised. They provide a good way to understand what data feeds and allocation methods are needed to assign costs to patients and service users to reflect actual resource usage.

The costing standards have been developed from the outset with the full involvement of costing practitioners and have benefited significantly from this – improving ownership of the standards by the profession. The HFMA will continue to work with these practitioners as the service continues to improve costing and implement Monitor’s transformation programme.

John Graham, chair, HFMA Mental Health Costing Practitioner Group
The HFMA Mental Health Costing Practitioner Group has undertaken a major refresh of the costing allocation methodologies for mental health services. The new materiality and quality score (MAQS) template supports costing practitioners to more accurately cost the delivery of care to individual service users.

Introduction

These clinical costing standards set out best practice guidance for deriving cost data in NHS mental health services. They reflect the methodologies and processes used to derive individual service user-level costs. We acknowledge that some organisations may not be doing full service user-level costing, but will have developed robust and detailed cost information. These standards therefore refer to clinical costing rather than just service user-level costing. They aim to provide organisations with best practice guidance to support improvement in the quality of cost information going forward.

Previous approaches to costing in the NHS have followed a top-down process – allocating total costs down to lower levels, such as the total costs incurred by particular services within a care group using occupied bed days, attendances and contacts, or more recently by clusters. These approaches have provided useful information, but can only produce information about high-level costs or average costs based on the costs of the inputs of service user care.

In contrast, robust service user-level cost data enables organisations to drill beneath aggregate costs to understand how costs are built up. This data can help them understand variations in cost and inform the efficient redesign of pathways, elimination of waste and the reduction of costs. Service user-level costs should also provide better information to inform the development of new payment approaches.

Analysing service user-level costs can help organisations understand if cost variations result from differences between service users (greater complexity, say) or between how their care was delivered. A consistent approach to identifying how individual service user costs are built up can also help organisations understand where variations arise within a service user pathway.

Focusing on costs at the service user level can facilitate meaningful discussions between clinicians, managers and support staff, which can underpin improvements in services and value.

Clinical costing builds costs from the bottom up, identifying where possible the specific resources consumed in the treatment of individual service users – for example, the costs of a community psychiatric nurse. This is not always possible. For instance, it may be difficult to assign medical staff time exactly to each service user. However, costs can be allocated with reasonable accuracy using, say, the actual length of stay on a ward.

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

Once accurate service user cost data is derived, it can be aggregated to provide higher level costs – for example, service lines or clusters – for analysis. But users can always drill beneath these high-level figures to understand how the costs were made up by individual service user interactions.

Organisations are required to submit cost information as part of the reference cost collection, and will need to follow the Department of Health’s reference cost collection guidance to do this. Adhering to these clinical costing standards should lead to an overall improvement in the quality of cost data.

Monitor has set out a plan to move to a mandatory patient-level cost data collection for all trusts in its publication Improving the costing of NHS services: proposals for 2015-2021. As part of this vision, the HFMA standards continue to be integrated into Monitor’s Approved costing guidance, updated in February 2016.

A first draft of the clinical costing standards was published in 2009 by the Department of Health, with a separate set subsequently produced for mental health organisations. The HFMA then took over responsibility for developing the standards, initially commissioned by the Department and now Monitor.
The standards reflect best practice and are intended to drive improvement. They may be stretching or aspirational for some organisations. Where this is the case, they should help organisations to understand their current data, systems and costing processes and how they need to develop to support the adoption of the standards and an improvement in data quality.

Guidance papers on understanding the general ledger and improving the quality of source information

The HFMA Acute and Community Costing Practitioner Groups have developed two guidance papers which form part of Monitor’s Approved costing guidance for 2016/17:

- Understanding the general ledger for costing
- Improving the quality of source information for costing in acute and community services.

Although the guidance papers have been produced by the Acute and Community Costing Practitioner Groups, much of the good practice described is just as relevant to mental health services. Extracting accurate costs from the general ledger and accurate activity data from feeder systems is key to deriving robust service user-level costs.

Mental health costing practitioners are strongly recommended to read both guidance papers which can be found on the HFMA website at www.hfma.org.uk/costing/standards.

The executive summaries of the two guidance papers can be found in Appendices F and G.
Standard 1

Classification of direct, indirect and overhead costs

A: STANDARD
All general ledger costs need to be classified as direct, indirect or overhead.

B: PURPOSE
Assigning general ledger costs into direct, indirect and overhead groups improves the ability to analyse information at the organisational and service user level. It provides an understanding of costs that arise directly as a result of service user care and those that are more loosely tied to service user care.

This standard sets out how costs should be classified to ensure a consistent assignment between direct, indirect and overheads across the NHS for costing purposes, which will also facilitate the understanding of benchmarking data between organisations.

C: GUIDELINES
Definition of cost categories
Direct costs relate directly to the delivery of service user care. These costs can be directly linked to the delivery of service user care and costs are caused/arise as a result of individual service user episodes of care. Some costs, such as community staff costs, can usually be linked directly to individual service users because of the information available. For other direct costs, such as medical staffing costs, the data may not be available to link an individual’s time and cost to a specific service user, so the best available data may need to be used.

Indirect costs are indirectly related to the delivery of service user care, but cannot always be specifically identified to individual service users. Indirect costs can usually be allocated on actual usage or across teams or services with a duration cost driver (actual length of stay or actual duration of face-to-face contacts).

Overhead costs are the costs of support services that contribute to the effective running of an NHS provider. They are costs, such as the costs of the payroll service, that cannot be traced or easily attributed to service users. Overheads should not be spread equally over all services. Instead an appropriate driver of cost should be used to allocate overheads to services (see Standard 2). Any remaining costs – such as board expenses – can be allocated according to size of service value after all other driver calculations have been completed.

Costs should be classified as accurately as possible, as set out in these guidelines. Wherever possible, new methods and information to support a more accurate allocation of costs should be sought. However, for the purposes of national reporting of costs and benchmarking, it is important to achieve a level of consistency in the way costs are classified. Therefore Standard 1 sets out best practice classifications for the NHS, based on the current information sources available to allocate costs.

It is acknowledged that for local internal reporting, different classifications may be chosen, and clinical costing systems should be able to support this. Some trusts follow Monitor’s service-line reporting guidance, whose hierarchy for the classification of costs is different to the HFMA hierarchy.
Examples of cost centre classifications are shown below. This list is not intended to be comprehensive. However, it reflects a common approach across the NHS.

**Direct costs**
- Diagnostic costs – including MRI scan and CT scans
- Drugs
- Medical, and non-medical, consumable items used in service user contacts
- Medical staff
- Nursing staff
- Out-of-area placements
- Other clinical staff – such as scientific and professional staff
- Psychologists
- Psychotherapists
- Social workers
- Therapists, including:
  - Cognitive behaviour therapists
  - Family therapists
  - Occupational therapists
- Travel costs (related directly to visits to service users – in particular for community services)

**Indirect costs**
- Administrative staff directly linked to service user care/contacts
- Capital charges (depreciation and cost of capital) – equipment that can be allocated to clinical departments
- Clinical safety, quality and audit
- CNST premium
- Consultancy costs for a specific department or service
- Divisional managers and operational managers – for example, service managers and nurse leaders
- Linen
- Medical records
- Pharmacy services – managing and running costs
- Service user catering
- Service user transport

**Comment**

2 The approach to classification of costs is based on best practice in identifying the costs incurred by service users. It is not based on how a particular costing system is set up or how significant the spend is considered to be by finance professionals.
**Overhead costs**

**Estates overhead costs** include:
- Building insurance
- Building maintenance
- Capital charges (depreciation and cost of capital) – buildings
- Capital charges (depreciation and cost of capital) – equipment
- Cleaning
- Consultancy costs for organisation-wide projects
- Energy
- Equipment maintenance
- Rates
- Utilities

**Other overheads** include:
- Administration
- Board costs – trust executives
- Computer licences
- Finance
- Health and safety
- Human resources
- Information management/information technology
- Non-operational units/teams – for example, clinical governance
- Interest payments
- Marketing and public relations
- Organisational development
- Payroll
- PFI payments
- Procurement
- Security
- Service user liaison and complaints
- Strategic planning
- Training
Standard 2

Allocation of costs

A: STANDARD
The costs of resources\(^1\) should be allocated to service users using a method that as closely as possible reflects the actual use of the resource by an individual service user.

B: PURPOSE
To identify the most appropriate mechanisms to allocate costs at service user level. This includes direct, indirect and overhead costs.

C: GUIDELINES
This standard is based on the principle of full absorption costing. For full absorption costing, all costs will be allocated at some point in the costing process. Whenever practical, costs should be allocated on an informed activity basis, using an appropriate driver of the resource use, rather than shared over a number of activity units based on total expenditure.

Organisations should consider the materiality of a resource when considering the amount of effort and/or data collection required to provide information on what drives costs.

Costing practitioners should not establish cost allocation methodologies for their organisation in isolation. It is key that they engage with clinical members of staff and service managers, among others, to determine costing allocation methodologies that reflect the care delivered.

The materiality and quality score (MAQS) template contains a full list of allocation methodologies. It is a useful tool for organisations that have already implemented patient-level information and costing systems (PLICS). It also provides a guide for organisations moving towards implementing PLICS.

The MAQS template has been significantly revised, based on the results of a survey of mental health trusts, site visits, suggestions from Monitor’s costing team and significant debate within the HFMA Mental Health Costing Practitioner Group.

The MAQS lists between one and six allocation options for each resource category. The lowest level is a baseline that should be achievable for organisations with PLICS, and the top level (Gold) is likely to be aspirational for most organisations. A further line is included (‘other’) where organisations can record their allocation methodology if they cannot meet the baseline. Items listed under ‘other’ will be scored zero as they do not meet the minimum requirements for PLICS.

The development of the new costing allocations methodologies for direct costs has been based on the following principles:

- **Top level (Gold)** Cost of specific resource allocated to individual service user who has used that resource
- **Baseline** Cost of team/service allocated to all service users who have used the resource based on a driver such as duration. The cost of the service/team should only be allocated to service users who have actually used the service and costs should never be allocated equally across these service users.

Given the importance of allocating indirect and overhead costs accurately, and the materiality of these costs, the MAQS has three sections: direct, indirect and overhead costs. For the calculation of the MAQS, the quantum of costs in the first stage of the costing process will be required.

A survey of mental health trusts undertaken by the HFMA Mental Health Costing Practitioner Group revealed that about 70% of all costs are direct, 7% are indirect and 23% are overheads.
Pay for nurses and medical staff make up 70% of all direct costs. Focusing on developing costing allocation methodologies for nurses and medical staff, which reflect the care delivered at individual service user level, will significantly improve the quality of costing information in mental health services.

Allocation methods are given a rating to reflect the quality of the allocation achieved. These ratings have an associated weighting that is used within the MAQS calculation to assess the quality of the costing process (see Standard 8).

Research commissioned by the HFMA and Monitor has found that costing systems across Europe use a mixture of top-down and bottom-up costing methodologies. This is primarily because the data is not usually available to allocate many overhead and indirect costs using a bottom-up costing methodology or directly to a service user. Costing outputs also have to reconcile to the final audited accounts, which requires an element of top-down costing. For these reasons all costing systems contain a mix of methodologies. It is for this reason that the MAQS is so important. It highlights the mix of methodologies used by individual organisations and demonstrates how cost allocations could be changed to improve the overall quality of costing.

International approaches to costing can be found at www.hfma.org.uk/costing/standards.

**COSTING METHODOLOGIES**

This section sets out methodologies to allocate costs to service users using activity data obtained from feeder systems or local databases. The methodology an organisation chooses will largely depend on the availability of suitable service user-level data. The aim is to allocate costs in line with the most appropriate cost driver for that particular set of costs. The method chosen should allocate costs to service users on the basis of actual consumption of resources by that service user or provide the best approximation of actual consumption. The methods are broadly set out in a hierarchy, with actual usage providing the preferred option where feasible. If this information is not available, a method that best approximates actual usage should be used.

**1. Actual usage**

Where possible, an actual usage methodology should be employed or one that closely relates to actual usage by individual service users. This may mean allocating resources based on time spent with an individual service user and/or the actual consumption of a resource. Examples of time allocation are:

- **Community clinical staff** The methodology for allocating community clinical staff costs is set out in Standard 2b
- **Medical staff on a ward** The methodology for allocating medical staffing costs on a ward is set out in Standard 2c.

**2. Outsourced service**

If goods or services are provided by an external agency and billed to the service, these costs should be allocated to a service based on the price charged by the external agency. This is similar to the ‘actual usage method’ and forms another version of the Gold standard.

**3. Duration of activity**

Where there is a service user resource that has no associated feeder system to provide service user-level data, such as ward stock drugs, it may be appropriate to use ‘surrogate’ or ‘proxy’ service user resource information as a costing methodology – actual length of stay in days, say.

**4. Overhead – based on total expenditure**

This methodology allocates costs based on the size of the expenditure pot after all other allocations have been made. It is not acceptable for direct costs but may be appropriate or necessary (due to lack of better information) for overhead costs, but more sensitive resource drivers should be used to allocate costs if available.
Standard 2a

Allocating ward nursing staff costs

The HFMA has been working with the Mental Health Costing Practitioner Group to understand how organisations currently allocate ward nursing staff costs. Most organisations allocate nursing costs to service users based on the actual length of stay in days. However, this approach does not reflect the actual nursing input required to treat and care for individual service users, and this view is reflected in the MAQS.

The most accurate method would be to allocate nursing costs using the actual time each nurse spends with a service user. However, this would place a considerable burden on nurses to collect this information, and potentially require significant IT investment.

Understanding acuity and the resulting nurse dependency is clearly key to ensuring wards have the right nursing staff in place to meet the needs of service users. Different service users need different levels of nursing care and support.

The staffing tools for mental health services developed in the West Midlands indicate that the level of nursing resource consumed by service users varies quite significantly, depending on their dependency levels. Data collected from 120 acute wards shows that about a third of patients on a ward require at least 50% more nurse resource than the other two thirds, with 5% requiring five times as much resource. A key factor is the level of one-to-one observations required.

The Mental Health Costing Practitioner Group has decided that the gold standard for allocating nursing costs should only be awarded where the actual interventions received are recorded.

There are now three allocation methodologies for ward nursing staff:

- **Gold** Nursing costs of individual ward allocated to service users based on the actual length of stay (days) weighted by actual interventions received
- **2nd level** Nursing costs of individual ward allocated to service users based on the actual length of stay (days) weighted by actual observation level
- **Baseline** Nursing costs of individual ward allocated to service users based on the actual length of stay (days).
Mental health clinical costing standards

Comment

Mental health services tend to have more granular activity data for community services than for inpatients, allowing for more sophisticated costing allocation methodologies.

Standard 2b

Allocating community clinical staff costs

The HFMA has been working with the Mental Health Costing Practitioner Group to understand how organisations currently allocate the costs of community clinical staff – for example, nurses, psychologists, psychotherapists and other therapists.

In community services, many organisations can link the actual care delivered by a specific member of staff to a service user. Some organisations capture data on the duration of some or all the activities undertaken to support a service user. A few organisations can directly link service user activity to the cost of the staff delivering the care.

We have updated the costing allocation methodologies to clarify what Gold standard is and have included additional scoring levels to take account of the different stages at which organisations are with their feeder systems.

The six new levels are:

- **Gold** Cost of individual member of staff allocated to actual care delivered to a service user, based on duration of all activities undertaken to support a service user – for example, face-to-face contacts, travel, telephone calls, liaison, clinical administration
- **2nd level** Cost of individual member of staff allocated to actual care delivered to a service user, based on duration of face-to-face contacts
- **3rd level** Costs per band of staff type allocated to actual care delivered to a service user, based on duration of all activities undertaken to support a service user – for example, face-to-face contacts, travel, telephone calls, liaison, clinical administration
- **4th level** Costs per band of staff type allocated to actual care delivered to a service user, based on duration of face-to-face contacts
- **5th level** Costs of team allocated to actual care delivered to a service user, based on duration of all activities undertaken to support a service user – for example, face-to-face contacts, travel, telephone calls, liaison, clinical administration
- **Baseline** Costs of team allocated to actual care delivered to a service user, based on duration of face-to-face contacts.

There has been considerable debate within the Mental Health Costing Practitioner Group about how to establish the cost quantum for community clinical staff. While this is outside the scope of the standards, it is worth noting the issue that will be considered as part of the Costing Transformation Programme.

Some organisations calculate a minute rate for a member of staff by taking the total pay cost in a period and dividing it by the whole time equivalent (WTE) worked. This rate is applied to the minutes the staff member has recorded against a service user to allocate the cost to the service user. The remainder of the pay is then allocated across all service users, based on the level of weighted activity recorded by the team.

An alternative method is to divide the total pay cost in a period by the total number of minutes the clinician records as service user activity time. The cost of a service user contact is calculated by multiplying the duration of the activity by the cost per minute of the individual clinician who delivered the care.
Standard 2c

Allocating medical staffing costs

The HFMA has been working with the Mental Health Costing Practitioner Group to understand how organisations currently allocate medical staffing costs.

Most organisations have limited information on how medical staff spend their time in inpatients, but have good information about activity delivered within the community, including review clinics. In community services, many organisations can link the actual care delivered by a specific member of medical staff to a service user. Some organisations capture data on the duration of some or all the activities undertaken to support a service user. A few organisations can directly link service user activity to the cost of the mental health professional delivering the care.

The MAQS template provides different costing allocation methodologies for inpatient and community activity undertaken by medical staff, to take account of the differences in activity information available for inpatients and community.

Unlike in previous years, the 2016/17 MAQS template provides separate costing allocation methodologies for consultant medical staff, career grade doctors and doctors in training.

Before applying a costing allocation methodology, it is necessary to get the quantum of costs right. Organisations with medical staff who work across both the inpatient and community setting need to split the costs of medical staff between inpatient and community in the costing system. Job plans may provide some help, although they should be treated with caution as they do not always accurately reflect how a member of staff spends their time.

CONSULTANT MEDICAL STAFF

Consultant medical staff – inpatient activity

The new levels are:
- **Gold** Cost of individual consultant allocated to the service user, based on actual time spent with that service user
- **Baseline** Cost of consultant team allocated to the service user, based on actual length of stay (days).

Consultant medical staff – community activity

The new levels are:
- **Gold** Cost of individual member of staff allocated to actual care delivered to a service user based on duration of all activities undertaken to support a service user – for example, face-to-face contacts, travel, telephone calls, liaison, clinical admin
- **2nd level** Cost of individual member of staff allocated to actual care delivered to a service user, based on duration of face-to-face contacts
- **3rd level** Costs per band of staff allocated to actual care delivered to a service user, based on duration of all activities undertaken to support a service user – for example, face-to-face contacts, travel, telephone calls, liaison, clinical administration
- **4th level** Costs per band of staff allocated to actual care delivered to a service user, based on duration of face-to-face contacts
- **5th level** Costs of all consultants in the multi-disciplinary team allocated to actual care delivered to a service user, based on duration of all activities undertaken to support a service user – for example, face-to-face contacts, travel, telephone calls, liaison, clinical administration
- **Baseline** Costs of all consultants in the multi-disciplinary team allocated to actual care delivered to a service user, based on duration of face-to-face contacts.

Comment

The revised MAQS template provides different costing allocation methodologies for consultants and junior doctors.
JUNIOR DOCTORS

Junior doctors – career grade
This group of staff includes staff grades, specialty doctors, associate specialists, clinical assistants. These members of staff have their own clinical caseload.

Inpatients
The view of the HFMA Mental Health Costing Practitioner Group is that it would be good to map career grade activity to specific service users, but currently systems do not collect such information for inpatients. It is hoped that in future, systems may allow the costing allocation methodologies for this group to be the same as for consultant medical staff. The costing allocation methodology for 2016/17 is therefore:

- **Gold** Cost of career grade junior doctor team allocated to the service user based on actual length of stay (days).

Community
Some trusts are able to map the activity of career grade junior doctors to specific service users. The costing allocation methodologies for career grades in the community are therefore the same as for consultant medical staff in the community.

Junior doctors – doctors in training
This group of staff includes F1, F2 and specialty registrars. These members of staff do not have their own clinical caseload and it is not possible to map their activity to specific service users.

The costing allocation methodologies for this group are:

Inpatients
- **Gold** Total costs of junior doctors in training on individual ward allocated across all service users, based on actual length of stay (days)
- **Baseline** Total costs of junior doctors in training in team allocated across all service users, based on actual length of stay (days).

Community
- **Gold** Total costs of junior doctors in training in team allocated across all consultants in the team.

Comment
The revised MAQS provides different costing allocation methodologies for career grades and doctors in training to reflect the differences in their responsibilities.
Standard 3

Classification of costs into fixed, semi-fixed and variable categories

A: STANDARD
All costs are to be classified as fixed, semi-fixed or variable.

B: PURPOSE
Understanding the variability of costs will facilitate better analysis of costs around incremental changes in activity (upwards and downwards) but also inform decision-making when considering growing or divesting of services. When an organisation has knowledge of its fixed cost base and the thresholds where blocks of cost are added or removed, the financial impacts of service development can be more accurately anticipated.

C: GUIDELINES
As a general rule, fixed costs are those that would not be affected by in-year changes in activity. It is accepted that, in the long term, all costs are variable because all resources can be removed. However, using a 12-month period to judge how costs vary with activity enables the consistent classification of costs from organisation to organisation.

- **Fixed costs** Fixed costs will not change as activity changes over a 12-month period. Fixed costs are absorbed across the service users treated in a period and therefore the amount absorbed per service user will change as volumes of service users flex through the year. Fixed costs may also change if a contracted service is removed or added – therefore fixed costs are not just time-defined

- **Semi-fixed costs** Semi-fixed costs do not move with activity changes on a small scale, but jump or step up when a certain threshold is reached. Defining the threshold, and the materiality of the step change, is at the discretion of individual organisations

- **Variable costs** Variable costs will be directly affected by the number of service users treated or seen. They are an incremental or marginal cost. One more unit of activity will generate an extra cost. It is important to note that the very nature of service user-level costing means that this cost may differ from service user to service user, but the nature of the cost is that it is triggered by the quantity of service users.

A mapping of account codes to fixed, semi-fixed and variable classifications is provided in Appendix B. This mapping has been reviewed by the HFMA Mental Health Costing Practitioner Group. While the list intends to be as comprehensive as possible, if an organisation uses an account code that is not listed, similar account codes can be found to classify the costs according to the principles developed by this standard.
Standard 4

Work in progress

This standard on work in progress has been included for information only. Mental health trusts that have implemented service user-level costing are able to allocate each period’s costs over the activity that occurred in that period, so that at any point in time they know the costs of the resources consumed so far by individual service users.

Work in progress is likely to become relevant for some trusts when costing completed episodes of care, once organisations start to consider the new payment approaches for mental health services proposed by NHS England and Monitor.

The Mental Health Costing Practitioner Group will continue to review the applicability of the standard to mental health organisations.
Standard 5

Treatment of income

A: STANDARD
Income should be clearly identifiable for internal reporting without being ‘netted off’ from cost.¹

Two classifications apply:

• All income should be classified as core or other
  
  **Core income** Commissioning income for core NHS service users (including overseas visitors covered by reciprocal arrangements)²

  **Other income** Including income from private service users or overseas visitors (not covered by reciprocal arrangements), service provision to other providers (for example, payroll or pathology) or provision of goods and services to non-NHS entities. Research and development income and education and training levy income (see Standard 6) are also ‘other’ income.³

• All income should be classified as direct, indirect or corporate.

B: PURPOSE
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. Additionally, the standard supports a consistent approach to the treatment of income to support the understanding of profitability at service user and service line level.

This standard is aspirational as categorisation of income in this way is relatively new compared with the corresponding categorisation of cost. This standard forms best practice and is closely linked to the improvement of service line reporting and benchmarking with other organisations.

C: GUIDELINES
The treatment of income relates to costing in two ways. First, the costs of activities generating income that is unconnected to service user care – for example, delivery of a payroll service to a local trust or social care to a local authority – should not be assigned to service user costs. Instead, the specific costs should be identified, matched with the relevant income and stripped out of service costs before any profit/surplus element is allocated down to service users and shown as income.

Second, it is acknowledged that income is also vital for comparing with cost data to understand profitability at service user or service line level. Income therefore needs to be handled consistently to ensure accuracy and comparability. With the development of payment systems for mental health, the transparency of income sources will increase and this standard will become easier to implement in practice.

Comments

¹ These standards cover approaches to costing, not income. However, it is recognised that inconsistent approaches to income, and the costs associated with that income, can significantly influence the unit cost of the service user’s care.

² Core income is broadly income from service user-related activities not including private service user income. This is equivalent to income from mandatory services for foundation trusts.

³ The category of ‘other’ income should align to the Department of Health reference costs guidance for ‘allowable income’.
Core income is defined as income received from clinical commissioning groups (CCGs) and NHS England (NHSE) for main clinical services:

- Service activity and block contracts with CCGs/NHSE for core care
- Non-contract activity with CCGs/NHSE
- Contracts with the NHSE for specialised services
- Local authority contracts.

Other income is all other income streams that do not relate to the core NHS activity commissioned by CCGs or NHSE, including:

- Provider-to-provider service contracts
- Social care provided to a local authority
- Contracts with non-NHS parties
- Private service users and overseas visitors.

DIRECT, INDIRECT AND CORPORATE INCOME

All appropriate income must be classified as direct, indirect or corporate. However, it is acknowledged that information may not be available to place all income streams into these categories with confidence. 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 shown separately as an income stream. The reasons for this are as follows:

- After netting off, the residual value may not truly represent the cost of service user treatment as there may be an element of profit or loss that would be absorbed incorrectly into the cost of service user care. For example, a small surplus achieved on the provision of catering services should be shown as exactly that. If instead the full income were netted off from the quantum of costs, this would result in service user costs that were artificially low
- Expenditure or resources that attract non-service user care-related income should not be included in the costs of service user treatment to start with – for example, rented-out floor space
- Where a trust receives income other than that received for service user care, it is usually associated with a defined business unit that could make up or be part of a separate service line – for example, clinical training or social care income.

While the general rule is that income should not be netted off from gross costs, there will be exceptions. For example, if the relevant information is not available to split costs accurately between service user and non-service user-related services, netting off income received and applying the remaining cost to service user services may be the most reliable alternative approach. The approach will depend on materiality, quality of information and the accuracy obtained in matching income and costs.
Standards for the treatment of income types are described below:

**Direct income**
Direct income is income that can be directly attributed to service user care and should not be deducted from gross cost. It should be reported as service user-related income.

Examples include:

- **NHS clinical income with activity-related payment (price and volume)** This is a common currency for specialist services such as low and medium secure mental health contracts.

- **NHS block contract income where this relates to a particular group of service users** In order to implement the requirements of this standard, trusts must be able to identify their income streams to service lines. This requires the disaggregation of block arrangements. The most successful way to achieve this is to identify the full cost of the services provided from within the block contract, break these down at the lowest level possible and divide the income in line with these costs.

- **Non-NHS clinical income** – private service user and overseas visitor income – should be reported in the same way as NHS clinical income, at the service user level, and not deducted from NHS service user costs. If the timing of this income does not allow it to be linked directly to a service user episode, this income can be reported at a higher level. Private service user income is relatively rare in mental health settings.

**Indirect income**
Indirect income relates to service user care services but not directly to the care of the organisation’s own service users. It should not be deducted from the gross cost of providing a service if it is material and the costs relating to how the income is generated can be isolated.

Consider a mental health trust providing psychiatric liaison services to an acute provider. If this service is provided through a service-level agreement with the acute trust, the full costs of the services (including overheads) should be identified separately and reported against the relevant service line, with activity (or measure of time) being used to support the performance management of the agreement. Where this is a separately commissioned service, it should be managed as a service to the commissioner and identified separately at full cost against commissioner income.

Similarly, a mental health trust may sell a number of beds to other parts of the country, including the devolved nations. The income and costs of the service should be separately identified, and not have an impact on the cost of the services provided to the own organisation’s service users.

Where there is insufficient information to isolate the costs, or the income stream is not material to the service line, income should be netted off against the associated relevant costs.

For example:

- Income from low-value or non-regular staff recharges – deducting this from the gross cost of the member of staff gives the cost of providing the service. The level of detail to pursue should be reflected in the materiality of the impact on the costs of the results.

- Clinical excellence award income – the actual cost to the service is the subsidised cost of the member of staff receiving the award. This cost should be held against the service the post is supporting.
Corporate income

Corporate income should be reported separately from the costs associated with the business unit that is receiving this income. This income should not be deducted from gross cost, but can be allocated in service line reporting processes to provide information about the fully absorbed income for a service line. Using an appropriate activity-based driver may be possible.

Examples include:

- Commercial income from rental of the organisation's facilities – for example, retail outlets or consulting rooms rented to psychologists working privately
- Provider-to-provider arrangements – where a service is provided for another organisation, such as payroll, the income and associated costs should not be included when calculating the cost of providing a service to the organisation's own service users
- Interest receivable from investment of cash
- Technical adjustments from NHS England
- Service-level agreement income for services provided to other organisations.

A significant amount of work may be required in order to ascertain the costs associated with corporate income – for example, the element of facilities costs associated with retail space. However, this standard sets out a higher standard than is currently in operation and it is recommended that organisations aim for these classifications over time.

Surplus (an excess of income over expenditure) should be treated as income, and kept separate from the costs of running the service. For service line reporting, the organisation may wish to show surplus separately from the income covering costs, but this is not a part of this standard. In general for service line reporting, it is recommended that the surplus, like the income, is matched to the service that generated it, or that it is shared across a range of (or all) services.

Training income and research and development funding should be treated as corporate income and reported separately, together with their associated costs. This income should not be deducted from gross cost. In service line reporting processes, it should be matched against the relevant service line.
Standard 6

Treatment of costs of non-service user care activities\(^1\)

A: STANDARD

The costs of clinical training and education, 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.

B: PURPOSE

To provide a consistent methodology to determine the cost of non-service user care activities to ensure that these costs are not included in service user care costs. This treatment will also show the surplus or deficit of providing services, to enable information for reimbursement discussions.

C: GUIDELINES

Training and education and research and development have historically been funded separately from healthcare. In costing terms, these activities have generally been treated as cost-neutral in terms of the costs of service user care activities. In practice, the income received for these activities has been deducted from an organisation’s overall quantum of cost before these costs are allocated down to service user care activities.

However, using income received as a proxy for the costs of delivering training/research may not reflect the actual costs incurred. This may result in costs for service user care that are higher or lower than the real costs of care delivered.

The NHS reference costs team indicated in their 2013/14 cost collection guidance that the Department of Health is working towards a position where, in future years, trusts will exclude from reference costs the cost of, rather than the income from, education and training.

Work is currently under way to develop and test a proposed approach to integrating the reference costs and education and training collections to enable providers to net off the costs rather than the income.

It is recognised that for some other activities, identifying costs may be difficult and may require a great deal of effort for a perceived small amount of benefit. For non-service user care activities other than education and training, if the costs involved are judged to be not material, then the costs may be left with the service user (rather than separated out and matched with the relevant income).

Equally, where new commercial ventures are material in cost terms, they should only be undertaken if the cost of providing the service can be validated against the income. Therefore, the costs should be identified. For non-material commercial ventures, costs may be left with those of running the healthcare services. The costing lead of the organisation should agree the treatment of these areas with the director of finance.

Comment

\(^1\) Non-service user care activities are any clinical and non-clinical activities where the organisation’s service users are not the primary reason for the activity. This includes clinical training, education and research and other non-service user-related or commercial activities such as rental of space or catering.
Training and education

The Department of Health introduced transitional tariffs for non-medical placements and undergraduate medical placements in secondary care from 1 April 2013. A similar tariff for postgraduate/medical trainees came into effect on 1 April 2014.

The cost collection does not cover all types of training programmes that take place within NHS trusts. In broad terms, the training programmes that are included are those that lead to a professional registration. For the purposes of costing, these training programmes have been categorised as non-salaried and salaried training.

An interim guidance document was released in early November 2015 to support the 2015/16 collection. The guidance encourages early engagement within trusts and aims to increase awareness of the in-year processes that can be implemented in advance of year-end for the collection of activity and cost data.

The final guidance and collection templates to support the 2015/16 collection exercise are dependent on the outcomes of the integrated pilot exercise and are expected to be released in early 2016.

Research and development

Research costs can be generated in one of three ways:

- Research that is funded by an external third party, such as Cancer UK
- As part of a funded trial, such as by a drug company
- Through internal NHS research.

Organisations should identify the full cost of research activities, regardless of the funding stream, in order to separate them from the costs associated with service user care.

Robust methods will be required to ensure that appropriate time, space and activity drivers are agreed and identified. While it is likely that consultant job plans will identify research and development time, this is only a starting point. The involvement of junior medical staff, nursing time and support service staff time must also be identified.

For example, there may be instances when the research is funded by the supply of specific drugs without charge. These will still need to be registered, recorded, checked, measured, assessed, stored and dispensed by pharmacists.

Organisations will also need to identify the space used by research activities and, therefore, ensure appropriate allocation of capital charges and estate-related overheads.

In developing robust methodologies for research, there must be a clear involvement with each specialty to ensure the best drivers can be identified relating to activity and that these in turn link accurately to costs.

Other non-service user care activities (including commercial activities)

These activities should be costed using the same principles as service user care costs (as in Standards 1 and 2) but without the service user care context. The key objectives are to provide transparent costs, using appropriate methodology. This will ensure that costs are available for pricing and contract discussions.
Standard 7

Ensuring high-quality source data is used in the costing process

A: STANDARD

Organisations should assess and ensure the integrity of all of the source data used in the costing process.

B: PURPOSE

To ensure that the data used to underpin or inform clinical costing is a complete and accurate reflection of the treatment delivered within an organisation, therefore ensuring that costing outputs reflect as closely as possible the actual cost of the treatment and care provided for each service user.

In order to do this:
- Data should be managed and maintained centrally by an informatics team, which provides direct and ongoing support to the costing process
- There should be adequate processes to ensure that data is accurate, and these processes should cover all services delivered by the trust, and all data used within costing.

The HFMA guidance paper Improving the quality of source information for costing in acute and community services, published as part of the 2016/17 HFMA clinical costing standards and supporting guidance, provides further information on how costing practitioners can work with others in their trust to improve the quality of source data. Although acute and community costing practitioners have contributed to the guidance paper, much of the good practice described is relevant to mental health too. Appendix G includes the executive summary.

C: GUIDELINES

Data management

No matter how detailed and accurate costing methodologies are, if the activity data used to inform them is inaccurate, then so will be the unit costs produced. Costing leads should work with informatics and IT to ensure that the data used for costing is in line with national guidance and has already undergone routine checks.

The data used for costing should be the same data that is used elsewhere in the organisation, and the same data that is submitted in national returns. Costing leads should not have to amend data to fit national requirements when loading into the system.

Activity data for costing should be provided by the informatics team. Costing leads should not have to go directly to the service for activity data. The role of the informatics team should be clearly outlined in the costing plan, and signed up to by senior managers responsible for data management and data quality.

At a minimum level, all data within an organisation should be managed and overseen by a central team. If this is not currently in place, this issue should be escalated through the costing development plan, and plans should be put in place to move to a more adequate structure and management arrangement. Where services have their own data staff managing standalone systems, at the very least the central informatics team should maintain professional responsibility for the data in those systems, ensuring the quality of that data and managing the use of that data within the trust and for national returns.
Comment

Good-quality source data is fundamental to recording accurate information for service users and ensuring the costs allocated reflect the resources consumed. Monitor’s report on the 2014/15 audit of acute reference costs in October 2015 – Reference cost assurance programme: Findings from the 2014/15 audit – identified a number of management arrangements that have an impact on the quality of source data including:

- Clear and recognised senior accountability for data quality
- Informatics team has ownership of all data and provides all information for costing.

Ideally, a trust will have a data warehouse that contains all data from all systems within the trust, covering all services provided. There will be routine automatic checks run on the data to ensure it is consistent and that all fields are completed, such as the NHS number.

It is vital to involve IT and information staff. Costing leads should ensure that the informatics team understand the ultimate use of the data provided and feed back any issues identified when using the data. The informatics team should ensure that the data is in line with national guidelines and that it accurately reflects the care delivered within the trust.

Where a data warehouse is not in place, informatics should lead on supplying the data for costing to ensure that it is consistent with data used elsewhere in the organisation and that information standards are maintained. This will provide assurance over who will provide the data and to what timeline, the format of the data and what data quality checks will be undertaken prior to the data being sent to the costing team.

When setting up service user-level activity records with informatics, care should be taken to consider all of the fields available in the patient administration system (PAS) extract. For example, it may be helpful to bring demographic and commissioning information for service users into the costing system to support analysis at the end of the process.

Data quality

The key to improving data quality is engaging with clinical staff, and recognising them as significant users of the costing information. Experience of implementing PLICS has shown that as cost information is shared across the organisation, 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 data, such as the time spent with a patient, the quality of the cost information produced can significantly be improved, and at the same time the information collected is clinically meaningful and can support the performance and development of the service.

All trusts should have a data quality policy that covers data from all services within the trust, not just data from the PAS. This data quality policy should be signed off by a senior manager and it should be monitored by a senior committee. Staff within the trust should be aware of the data quality policy and their responsibilities. Ideally, data quality will be a standard objective for all staff involved in the capture and management of information, including clinicians.

Trusts should have processes in place to review the care recorded, or treatment delivered, in activity data against source documentation to ensure that it is an accurate reflection of the treatment delivered.
**National data sets**

Data quality programmes should be designed to validate local submission of national datasets – the mental health services data set (MHSDS) and hospital episode statistics (HES). Audits should be focused using local intelligence and national comparisons and should be proportionate to the volumes of activity within the services audited.

**Costing inputs such as medical staffing, therapy data, drugs and similar**

Where activity or service user-level data is used to drive cost allocation, that information should also be subject to review and assurance processes.

The HFMA guidance paper *Improving the quality of source information for costing in acute and community services* emphasises in Section 2 how the informatics team should be responsible for checking the quality of source data used for costing. The accuracy of source data should be checked on a regular basis and the trust’s systems should help them achieve this.

A number of trusts have developed lists of data checks that are undertaken either ‘manually’ or automatically by costing systems or feeder systems. These checks are typically based on a trust’s experience of common data errors and omissions, and good practice is that the list is generated through joint work between a trust’s costing team and data quality leads.

**Information used in the allocation of indirect and overhead costs**

Information used to allocate indirect and overhead costs is set out in the MAQS template. This information includes floor plans, headcount and other financial and non-financial information. It is important that all of these allocation statistics are included within the costing team’s information policy and should be subject to the same data quality checks and rigour. Floor area in particular is often owned by the estates department and is used to allocate significant volumes of cost.

There are several principles that should be used to ensure completeness and accuracy of this information:

- Ensure it is updated/reviewed on an annual basis
- Ensure it is checked/tested by a member of the costing team or relevant member of the finance team. In the case of floor area, this may involve walking the floors to check the usage of rooms and allocate them to the correct team/service or department.
Standard 7a

Matching data from feeder systems to service users

A: STANDARD

This standard provides guidance on the importance of matching resources captured in feeder systems to individual service users and the factors to consider to ensure that this process is undertaken as accurately as possible.

B: PURPOSE

The successful matching of feeder systems to service user interventions is important for the costing process for the following reasons:

- It provides the basis of attributing costs to specific service users based on the actual resources they consume
- Low levels of matching or incorrect matching will significantly distort individual service user costs and therefore undermine the validity of service user-level cost data
- Unmatched activity will distort service user-level costs through:
  - Unmatched service users not having the full cost of care attributed to them
  - Service users that did not necessarily receive the care attributed to them may receive the cost of this unmatched activity. This will result in significantly inflated costs if the unmatched activity is treated as an overhead to matched activity.

In an ideal world, every resource allocated using a feeder system would be matched perfectly to a service user episode of care or contact. However, in the absence of fully integrated information systems, we know that in reality discrepancies will arise for the following reasons:

- Poor data quality of feeder systems
- Time spent with service users not recorded on patient administration systems
- Tests ordered or delivered outside of the dates of a contact or episode
- Observations not recorded.

The quality of the underlying data is a significant issue and we encourage costing professionals to liaise with clinical and information colleagues to understand the issues and resolve them as an organisation-wide issue. If significant, they should also be placed on the costing risk register.

C: GUIDELINES

In allocating costs to service users, resources need to be costed and allocated to specific service users and specific episodes of care. The costing allocation methodologies for all resource categories have been substantially revised in the 2016/17 standards. Once mental health trusts have had the opportunity to try out the new MAQS template that lists all the costing allocation methodologies, further work will be carried out within the Mental Health Costing Practitioner Group to develop guidelines on data matching for specific resources – for example, time spent with service user.

The guidelines on the following page provide some generic advice on data matching. The HFMA acute clinical cost standards provide further guidance on drugs and radiology examinations.
We recommend the following information is completed for each feeder system to document, understand and monitor the quality of feeder systems and how they are used in costing systems:

- Type of feeder system – name, owner and version being used
- Currency and fields of data – for example, time or test and the details of the cost weights to be applied
- Total transaction count
- Cost allocated by feeder system
- Percentage linked
- Percentage allocated to inpatients and community contacts.

One of the key risks identified relates to the quality of matching. Organisations could report excellent matching scores but actually the resources may not be allocated against the correct service user episode or attendance. This not only affects the quality of the cost data produced, it will also be detrimental to obtaining the buy-in of clinical staff – if they see that the costs include resources the service user has not actually consumed, or not consumed as part of that particular episode of care. Several fundamental rules should be applied:

- Resources must be linked to the correct service user type. As a minimum, resources should match to the service user type using date and a service user identifier. Further accuracy can be obtained using additional variables, including speciality code, consultant and a location code – for example, ward or department code
- Where there are multiple possibilities for a service user as to which episode or attendance to link to, then a consistent set of rules should apply
- Where the attendance is out of the date scope, some flexibility may be required, such as extending the parameters of the date to which it is matched
- Unmatched activity needs to be costed up to prevent the matched activity from attracting higher costs.

There is some key information organisations must understand and document:

- How the matching rules set up in their costing system work
- The percentage matching for each resource dataset used – the percentage is based on activity count and not the cost value. This should be broken down by service user type
- Ideally, this should be broken down by cost driver to fully understand data quality
- The data quality issues relating to the underlying feeder system – data quality should be monitored with each costing update
- Where the attendance is out of the date scope, some flexibility may be required – such as extending the parameters of the date to which it is matched.

**Treatment of unmatched activity**

Unmatched activity will distort service user level costs through:

- Unmatched service users not having the full cost of care attributed to them
- Service users that did not necessarily receive the care attributed to them may receive the cost of this unmatched activity. This will result in significantly inflated costs if the unmatched activity is treated as an overhead to matched activity.

Unmatched activity should not be treated as an overhead to matched activity. This will result in significant distortions in cost to those service users, whose activity and resources utilised can be matched. Unmatched activity should be costed and reported separately.
Standard 8

Assessing the quality of the costing process

A: STANDARD
Organisations should document and measure the materiality and quality of their costing process. This should be evidenced by a materiality and quality score (MAQS), which is calculated using the supporting template. The score structure is as follows:

- **Gold** 75% - 100%
- **Silver** 60% - 74.9%
- **Bronze** 45% - 59.9%
- **Baseline below 45%**

The MAQS template for 2016/17 has been substantially revised to support costing practitioners more accurately cost the delivery of care to individual service users. Once a significant number of trusts have completed the template, further work may be required on refining the scoring system.

B: PURPOSE
This standard provides a consistent methodology for organisations to assess and improve the quality of their costing process and data. In particular it looks to:

- Provide internal awareness of data quality issues that have an impact on the quality of costing data
- Provide a tangible method to assess improvements in the quality of costing over time – for example, to demonstrate improvements to an organisation’s board or audit committee
- Inform development plans by focusing attention on areas that will create maximum improvement to cost information
- Provide transparency on the approaches taken to produce cost data
- Provide a consistent approach to comparing data quality across NHS organisations.

Clinical costing is intended to be a practical management tool that helps to drive best care/best value. Robust and transparent cost information is essential for the engagement of clinicians and managers, to improve the management of resources and clinical care. The MAQS has been designed to assess an organisation’s ability to provide robust, reliable data for internal and (potentially) external assurance.

The MAQS will help organisations that are implementing service user-level 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.

For most organisations, the main driver for undertaking clinical costing is to deliver high-quality internal business information. Understanding the robustness or the limitations of the information presented to senior management is very important if decisions are to be taken on the back of this information.

Comment
1 The scores produced by the MAQS process are intended to provide a guide only – helping organisations to understand the current quality of their costing data in assessing its reliability to inform decision-making. The scores should also help organisations to target their improvement efforts for costing systems and processes.
C: GUIDELINES

The MAQS template can be downloaded from the HFMA website at www.hfma.org.uk/costing/standards. The template and all supporting documentation should be completed and saved for future reference.

Procedure for calculating the MAQS

The MAQS template is designed to allow the calculation of a MAQ score for the allocation of direct, indirect and overhead costs separately.

The MAQS worksheet is the main data input sheet. The cells where input is required are coloured in yellow.

The reconciliation statement allows organisations to reconcile the financial values input in the MAQS worksheet to the output from a costing system.

Costing allocation methodologies

• The MAQs template has been automated so that, for each resource category, the template provides a dropdown box with a selection of allocation methodologies. For each resource category, you will need to select the allocation methodology used in your organisation. Each methodology has an associated quality rating.

• It is possible to duplicate a resource category row where there are multiple allocation methods, allowing better reflection of the costing approach adopted. To achieve this use the [+ ] button, which then duplicates the row below. If an organisation uses several different allocation methodologies for one resource category (for example, different community teams), the costs associated with each allocation option can be entered accordingly.

• An additional costing allocation methodology option (‘other’) has been included, for use where trusts are unable to meet the baseline. Any costs allocated to this line will be included in the quantum but will be zero-scored when contributing to the overall MAQ score.

• Standard 2 provides information on costing allocation methodologies.

• A table listing all of the mental health MAQS allocation methodologies can be found on the HFMA website.

Costs

• Having selected an allocation methodology for a resource category, you should then input the actual costs.

Template outputs

• The template weights the costs used by each resource category to take account of the quality of the allocation methodology used.

• The weighted financial amount for each resource category is divided by the total unweighted financial amount for all resource categories to give that resource category’s contribution to the MAQ score.

• An overall MAQ score is calculated by adding up all the contributions from all the different resource categories.

• The tab ‘Resource MAQS’ provides a breakdown of the overall MAQS by resource category. This enables organisations to identify areas for improvement.

If you have any comments or suggestions regarding the MAQS template, please contact costing@hfma.org.uk
Standard 9

Review and audit of cost information

A: STANDARD
Costing information and processes should be reviewed regularly to ensure that:
- The allocation methods used in costing are appropriate
- The data that informs costing is correct
- Costing outputs are materially accurate
- The clinical costing standards have been followed
- Processes exist to ensure that cost data is robust.

B: PURPOSE
Evidence suggests that conducting audits of costing systems, processes and outputs results in improved data quality and procedures. It provides vital information on areas for improvement, supports board and senior sign-off and ensures confidence in the data presented.

Costing leads and other staff involved in the costing process should build regular checks on cost data into the ongoing costing process, and ensure there are adequate checks undertaken on any national cost submissions. They need to work closely with their informatics colleagues, who should be responsible for managing and maintaining the activity data used in the costing process.

C: GUIDELINES

Review of cost information

Monitor’s latest reference cost audit report, Reference cost assurance programme: Findings from the 2014/15 audit, indicated that 49% of trusts audited had made materially inaccurate reference cost submissions. While the scope of the review was acute trusts, many of the good performance examples quoted in the report are relevant to mental health services. Relevant examples are included in Appendix D. Trusts are encouraged to assess their own practice against the good performance examples to identify how they can improve their review of cost information.

Audit of cost information

The costing process covers many areas where assurance can be sought. Audit of costing processes and the activity data underpinning the cost information provides assurance that the trust’s costing is effective.
There are many individual areas where trusts can seek internal or external assurance, such as:

- Assessing the organisation’s internal arrangements for reviewing and self-assessing the key component areas of costing data
- Focused and specific work on any risk areas identified
- Other data collections not covered by routine data quality audits
- Assessing compliance with clinical costing standards
- Reviewing the process for clinical engagement in the trust
- Obtaining executive and board-level sign-off of data.

In addition, working with internal audit will allow organisations to improve the robustness and quality of the information produced. Trusts that are implementing systems should obtain internal assurances over controls, processes and outputs. Assurance should cover all aspects of activity that underpin costs data, including all activity data sets. It should also cover other feeder information used in the costing process, such as pharmacy, staff costs, floor area and therapy contacts.

Once systems are implemented, ongoing and regular internal review and scrutiny of the key information components of financial, activity and service user-level information data should be completed on a quarterly basis and should be reviewed annually as a minimum by internal or external auditors.

The outcomes from other related audit and assurance processes – for example, internal and external audit and inspection reviews, the information governance toolkit and external audits – may provide assurance on wider activity data used for costing.
Appendix A

Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate income</td>
<td>Also known as overhead income, this income does not relate to patient or service user activity.</td>
</tr>
<tr>
<td>Data quality</td>
<td>The degree of completeness, consistency, timeliness and accuracy that makes data appropriate for a specific use.</td>
</tr>
<tr>
<td>Direct costs</td>
<td>Costs that directly relate to the delivery of patient care. Examples are medical and nursing staff costs.</td>
</tr>
<tr>
<td>Direct income</td>
<td>Income relating directly to the organisation’s own patients, including all national and local tariff clinical income as well as private patient income. It can be attributed to individual patients or a defined patient group – for example, block contract income received for a particular service.</td>
</tr>
<tr>
<td>Feeder system</td>
<td>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.</td>
</tr>
<tr>
<td>Fixed costs</td>
<td>Fixed costs are not affected by in-year changes in activity – for example, rent and rates.</td>
</tr>
<tr>
<td>Indirect costs</td>
<td>Costs that are indirectly related to the delivery of patient care.</td>
</tr>
<tr>
<td>Indirect income</td>
<td>This relates to patient care services but not directly to the care of the organisation’s own patients.</td>
</tr>
<tr>
<td>Matched patient</td>
<td>Matched patient records record the proportion of patients whose patient records administration system (PAS) records match to a recorded event such as radiology or drugs issue.</td>
</tr>
<tr>
<td>Materiality</td>
<td>Information is material if its omission or mis-statement could influence the economic decision taken on the basis of the financial information. Materiality depends on the size of the item, judged in the particular circumstances of its omission or mis-statement.</td>
</tr>
<tr>
<td>Overhead costs</td>
<td>Costs that are not driven by the level of patient 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.</td>
</tr>
<tr>
<td>Semi-fixed costs</td>
<td>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. Nursing costs are an example.</td>
</tr>
<tr>
<td>Variable costs</td>
<td>Costs that vary with changes in activity – for example, drugs.</td>
</tr>
</tbody>
</table>
## Appendix B

### Classification of fixed, semi-fixed and variable costs

#### FIXED
- Ambulance car service
- Audit fees: internal
- Audit fees: statutory
- B9 psychology
- B9 senior mgs
- Bad debt expense
- Building contracts
- Building and engineering equipment maintenance
- Chairman
- Chief executive
- CNST contributions
- Comps ex gratia
- Contract: other external
- Contract: premises security
- Contract: refuse and clinical waste
- Debt recovery and credit control
- Defence costs
- Depreciation on owned/leased assets
- Director
- Dividend payment
- Doctors’ fees (BD8s etc)
- Early retirement payments
- Electricity
- Engineering contracts
- Executive director
- External consultancy fees
- Finance lease interest
- Gas
- Grounds and gardens expenses
- Healthcare from local authorities
- Heating oil
- Insurance costs
- Interest receivable
- Laundry equipment
- Legal fees
- Net bank charges

#### SEMI-FIXED
- Non-exec members
- Patent costs
- Performing rights
- Professional fees
- Rates
- Research and development
- Security payments (cash delivery etc)
- Sewerage
- Staff consultancy and support
- Staff location systems/bleeps
- Telephone installation and maintenance
- Telephone rental and call charges
- Training materials
- Vehicle maintenance
- Vehicle running costs: other
- Water

#### B5 maintenance
- B5 occ therapy
- B5 pams other
- B5 pharmacy
- B5 physiotherapy
- B5 prof & technical
- B5 psychology
- B5 qfd bank nurse
- B5 qfd nurse
- B5 speech therapy
- B5 unqfd nurse
- B6 A&C
- B6 dietician
- B6 nurse mg
- B6 other sci & prof
- B6 PAMS other
- B6 pharmacy
- B6 physiotherapy
- B6 prof & technical
- B6 psychology
- B6 qfd nurse
- B6 senior mgs
- B6 social worker
- B6 speech therapy
- B6 unqfd nurse
- B7 A&C
- B7 dietician
- B7 nurse mg
- B7 occ therapy
- B7 other sci & prof
- B7 PAMS other
- B7 physiotherapy
- B7 prof & technical
- B7 psychology
- B7 qfd nurse
- B7 senior mgs
- B7 speech therapy
- B8 psychology
- B8a dietician
- B8a nurse mg
- B8a occ therapy
- B8a other sci & prof
Appendix B

Classification of fixed, semi-fixed and variable costs (continued)

External contracts:
catering
External contracts:
domestics
External contracts:
laundry
External contracts: other
hotel services
External contracts:
window cleaning
External data contracts
FM computer contracts
Furniture and fittings
General losses and
special payments
GP sessions/staff fund
Gross redundancy
payments
Hardware and crockery
Healthcare from
foundation trusts
Hospitality
Information tech security
costs
Interpreting services
Interview expenses
Junior medical training
Laboratory equipment
Laboratory equipment –
maintenance
Lease rents
Leased cars: contract
Leased cars: private
deductions
Lecture fees
Local authority staff
Locum clinical asst
Locum consultant
Med surg eqpt hire
Med surg eqpt mtce
contracts
Med surg eqpt repairs
Microfilming and dit
Miscellaneous
expenditure
Mobile phones
National QC and
accreditation fees
Non-healthcare services
from foundation trusts
Office equipment and
materials: hire
Office equipment and
materials: purchase
Office equipment and
materials: repairs
Other general provisions
Other transport costs
Packaging and storage
Patients appliances: lease
Photographic materials
Postage and carriage
Public relations expenses
Radio communications
Removal expenses
SHO
Services from local
authorities
Social worker – qualified
Social worker – unqualified
Spec registrar
Staff grade pract
Staff uniforms and
clothing
Support staff bank
Taxi and other vehicle hire
Training expenses
Training travel and
subsidence
Travel and subsistence
Vehicle insurance
Vehicle leases
Vehicle running costs: fuel
Vending machine rental/
maintenance
X-ray equipment: purchases

VARIABLE
Agency admin and
clerical
Agency consultants dental
Agency HCAs and
support staff
Agency nursing
Agency other
Agency other career
grades
Agency prof and tech
Agency scientific
Agency SHOs and HOs
Agency social worker
Alac: disabled living aids
Alac: limbs
Alac: special cushions
Alac: special seating
Alac: wheelchairs
Anaes: accessories and
equipment
Anaes: temp control
B3 unqlfd bank nurse
Bedding and linen: disposable
Catering equipment –
disposable
Cleaning materials
Contact lenses and
spectacles
Continence products
Contractual clinical
services
Dietetic products
Dressings
Drugs
Enteral feeding
FP10s
Funeral expenses
General materials
(e.g EBME OT etc)
Healthcare from
commercial sector
Healthcare from
independent sector
Healthcare from voluntary
sector
Hearing aids: purchases
Home loans
Laboratory bottles and
containers
Laboratory chemicals
Laboratory external tests
Laboratory reagents
Laboratory test kits
Laundry materials
Locum dental consultant
Materials – building
Materials – electrical
Materials – mechanical
Med surg eqpt disposable
Med surg eqpt general
Medical gases
Minor works
Other clinical costs
Other general supplies
and services
Other patients expenses
Patients appliances: purchase
Patients appliances: repairs
Patients clothing
Patients travel exp/
allowances
Printing costs
Protective clothing
Provisions
Staff benefits expenses
Stationery
Sterile products
Surgical instruments:
general
Therapy equipment and
materials
Vending machine supplies
Welfare foods
Appendix C

Summary of the clinical costing process

**Ledger**

<table>
<thead>
<tr>
<th>Expenditure</th>
</tr>
</thead>
</table>

**Standard 1**
Classify costs as direct, indirect and overhead

**Standard 2**
Allocate overhead costs

**Standard 3**
Classify costs as fixed, semi-fixed and variable

**Standard 5**
Treatment of income

**Standard 6**
Treatment of costs of non-service user core activities

**Assign fully absorbed service costs to resource categories**

**Resource categories**
- Community mental health nurses
- Ward nurses
- Consultant medical staff
- Catering
- Drugs

**Fully absorbed service costs**

**Standard 2**
Allocate cost of resources to service users

**Standard 7**
Ensure source data is of high quality

**Standard 8**
Assess quality of costing approach

**Standard 9**
Audit data and processes
Appendix C
Summary of the clinical costing process (continued)

The first step in the costing process is to determine the costs in the general ledger directly driven by service user care (for example, doctors’ and nurses’ time) and those more loosely tied to service user activity. This means all cost centres in the ledger are assigned to a direct, indirect or overhead cost category (Standard 1).

However, some adjustments are needed. For example, many NHS organisations receive separate funding for clinical training and education. The costs incurred in delivering this training are not related to the treatment of service users. So to produce accurate costs for the treatment of individual service users, these costs – both the direct costs of time spent training and a proportion of indirect/overhead costs – need to be stripped out (Standard 6).

Similarly, costs may have been incurred delivering a corporate service for an external organisation. For instance, the trust may be paid to deliver payroll or other financial services for a neighbouring trust. It would not be appropriate for the costs of delivering these ‘additional’ services to be allocated to service users. Or, if they are allocated down to service users, then they should be clearly identifiable so that the costs relating to the delivery of service user care can be viewed separately. Non-material amounts of cost and income from ‘additional’ services can remain with the service user care costs.

Once these adjustments have been made, overhead costs need to be allocated or apportioned to the direct and indirect cost centres (Standard 2).

Organisations should classify costs into variable (those that flex with service user numbers), semi-fixed (costs that stay the same until a certain activity threshold is reached, at which point costs change) and fixed (those that remain fixed regardless of the number of service users treated) – Standard 3.

Once any adjustments have been made to establish the appropriate totality or quantum of costs, fully absorbed direct and indirect costs can be assigned to a resource category. Once costs are assigned to a resource category, they can be allocated to service users.

Costs should be allocated on the basis of actual usage of resources or using an allocation method that most closely reflects actual usage (Standard 2). Different allocation methods will be appropriate for different types of cost. For instance, ward nursing staff costs could be allocated on the basis of time spent on ward, with an adjustment for the level of observations. However, the costs of community clinical staff may be allocated to the actual care delivered to a service user based on duration of face to face contacts.

Recognising the different cost drivers will produce more accurate service user-specific costs. A hierarchy of allocation methodologies are identified for different resource types and the overall ‘accuracy’ or quality of the costing information can be measured by calculating a material and quality score or MAQS (Standard 8).

While the costing process is important in ensuring robust service user-level costs, the overall results will only be as good as the core data used in the process. This ranges from the simple accuracy of assigning the right clinical codes to service user episodes and the correct entry of the service user information through to the accurate linking of service user resources to service user records. Accurate costing is as much dependent on colleagues in informatics and information as it is on costing teams (Standard 7). Audit also plays an important part in assuring and developing data accuracy and the robustness of the costing process (Standard 9).
## Appendix D

### Reviewing cost information

Examples of good performance taken from Monitor’s report *Reference cost assurance programme: Findings from the 2014/15 audit*

#### Compliance with reference costs guidance

<table>
<thead>
<tr>
<th>Area</th>
<th>Assessment criteria</th>
<th>Examples of good performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Checklist</strong></td>
<td>Trusts are required to complete a self-assessment checklist to say how they checked the national submission.</td>
<td>• All mandatory and non-mandatory validations in the reference costs workbook investigated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use of benchmarking information embedded, using different sources and available to services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Draft reference costs submission circulated to services for clinical review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• All activity reconciled against national and local data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Outcomes of all checks documented, with an audit trail of changes made</td>
</tr>
<tr>
<td><strong>Accuracy of quantum</strong></td>
<td>The total costs (the quantum) included in the reference costs submission should reconcile back to the audited accounts and should be completed in line with guidance.</td>
<td>• Quantum completed or approved by chief accountant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Review of quantum part of senior sign-off process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Exclusions and amendments reviewed annually with services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clear working papers linking quantum worksheet to final accounts and costing system outputs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Non-NHS patients identified, costed and removed from the quantum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• All changes in guidance discussed with services</td>
</tr>
<tr>
<td><strong>Senior sign-off</strong></td>
<td>National guidance stipulates that the reference costs submission should be subject to the same senior scrutiny as other financial returns submitted by the trust.</td>
<td>• Senior scrutiny part of the ongoing costing process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Frequent detailed review by deputy director of finance, linked to sign-off by director of finance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Documented senior sign-off by director of finance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sign-off process included review of all validations, checks and benchmarking</td>
</tr>
<tr>
<td><strong>Board assurance</strong></td>
<td>National guidance requires boards to provide visible leadership to the process costing within trusts. Each year boards must confirm that the approach to costing at the trust is satisfactory.</td>
<td>• Senior clinical support to costing across the services, and costing viewed as a clinical tool</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Quarterly PLICS report and draft reference costs submission presented to board or delegated committee, including unit costs level information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use of internal audit to measure compliance with national standards as part of board assurance process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A non-exec is nominated to lead on costing issues</td>
</tr>
</tbody>
</table>
### Appendix D

Reviewing cost information (continued)

#### Accuracy of costing

<table>
<thead>
<tr>
<th>Area</th>
<th>Assessment criteria</th>
<th>Examples of good performance</th>
</tr>
</thead>
</table>
| Accuracy of currencies       | Currencies are the units by which activity is measured. This ranges from episodes and spells in admitted patient to the number of high-cost drugs or the repair of wheelchairs.                                                | • All data provided centrally  
• Data signed off by services as part of validation of costs  
• Activity validated by clinicians alongside cost information  
• Changes in counting guidance discussed with service                                                                                                                   |
| Allocations and apportionments| The costing principles in Monitor’s approved guidance describe how costs should be accurately identified and then allocated to currencies in the way that best describes the costs of the care being delivered.                                      | • Bases of allocations reviewed and signed off by all services in-year  
• Costing team has access to floor area system  
• Patient-level information available for all material cost drivers                                                                                                     |
| HFMA standards                | HFMA standards describe how costs should be classified, and how income and other non-patient activities should be handled.                                                                                           | • Clear classification of costs in line with national standards  
• Income and non-patient activity handled in line with national standards                                                                                               |
## Appendix E

### Summary of key changes between mental health clinical costing standards 2015/16 and 2016/17

The scope of the 2015/16 standards covered services that use the mental health care cluster approach – mental health services for adults and older people. The scope of the 2016/17 standards has been increased to include all mental health services – for example, child and adolescent mental health services (CAMHS), drug and alcohol services, secure mental health services and specialist mental health services.

The standards have been edited to provide a more consistent mental health focus. As a result, some of the examples listed have been amended.

The deletion of Standard 2 in the 2015/16 standards means that the standard numbers have changed in 2016/17.

<table>
<thead>
<tr>
<th>Standard number 2015/16</th>
<th>Standard number 2016/17</th>
<th>Key changes</th>
</tr>
</thead>
</table>
| 1                       | 1                       | The description of how indirect costs can be allocated has changed from ‘Indirect costs can usually be allocated on actual usage or across teams or services with a duration cost driver (actual length of stay or actual duration of face-to-face contacts)’. The description of how overhead costs should be allocated now includes ‘Overheads should not be spread equally over all services’.
A few changes have been made to the examples of cost centre classifications:
• Administrative staff directly linked to service user care has been moved from direct costs to indirect costs
• Out-of-area placements has been added to direct costs
• Departmental training has been moved from indirect costs to overheads. |
| 2                       |                         | This standard (Creation of cost pools and cost pool groups) has been deleted in 2016/17. The majority of mental health services do not group service costs into cost pool groups. As cost pool groups will not form part of the Costing Transformation Programme standards, it was decided that this standard should be removed. |
| 3                       | 2                       | The standard has been substantially revised. The HFMA Mental Health Costing Practitioner Group has undertaken a major refresh of the costing allocation methodologies for mental health services. The new materiality and quality score (MAQS) template supports costing practitioners to more accurately cost the delivery of care to individual service users. |
| 4                       | 3                       | No significant changes. |
| 5                       | 4                       | Updated to take account of the proposed new payment approaches in mental health. |
| 6                       | 5                       | No significant changes. |
| 7                       | 6                       | Name of standard changed to ‘Treatment of costs of non-service user care activities’.
| 8                       | 7                       | Name of standard changed to ‘Ensuring high-quality source data is used in the costing process’.
| 8a                      | 7a                      | The standard has been significantly edited to make it more relevant to mental health services. |
| 9                       | 8                       | The procedures for calculating the MAQS and scoring system have been updated to take account of the new MAQS template. |
| 10                      | 9                       | The standard has been updated to take account of the learning from the latest reference cost assurance programme. |
Understanding the general ledger for costing – executive summary

The HFMA Acute and Community Costing Practitioner Groups have developed two guidance papers which form part of Monitor’s Approved costing guidance for 2016/17. The full guidance papers can be found on the HFMA website, www.hfma.org.uk/costing/standards.

Robust cost information requires costing practitioners to map accurate financial data from the general ledger to the costing system so that all the costs are in the correct starting position for the costing process.

Costing practitioners, financial management and financial accounting all have a role to play in ensuring that patient-level costs are derived from accurate financial data. This guidance paper describes how costing practitioners and other financial colleagues need to work closely together to ensure that this happens.

Mapping the financial data in the general ledger to the costing system requires a good understanding of the detail in the general ledger at account/subjective code and cost centre level. Costing practitioners cannot do this on their own, but need to rely on financial managers to have this knowledge, and engage with them to support accurate mapping.

Costing practitioners may encounter a number of problems in extracting accurate financial data from the general ledger – for example, the merging of cost centres, incorrectly coded costs or incomplete accruals and prepayments. They need to engage with financial management and financial accounting so that all parties understand the impact these items can have on the costing process and come up with joint solutions to address the problems.

The costing system may require more granular financial data than the general ledger provides. Costing practitioners may need to break down some expense lines further, especially once the resource structure in Monitor’s Costing Transformation Programme has been defined.

It is vital that the total expenditure used for costing can be reconciled to board papers and the annual accounts, so that costing teams can demonstrate the integrity of the financial data used in the costing process.
Appendix G

Improving the quality of source information for costing in acute and community services – executive summary

The HFMA Acute and Community Costing Practitioner Groups have developed two guidance papers which form part of Monitor’s Approved Costing Guidance for 2016/17. The full guidance papers can be found on the HFMA website www.hfma.org.uk/costing/standards.

Trusts increasingly need robust data to meet the NHS’s challenges over the next few years and over the longer term. Information on costs and outcomes should underpin decision-making, ensuring local decisions are informed by a clear understanding of current costs and the likely costs of any new ways of working. It will also provide the bedrock for new payment systems.

To provide reliable and robust cost information, costing practitioners need access to high-quality non-financial data. No matter how sophisticated costing methodologies are, if the activity or other source data used is inaccurate or incomplete, this will lead to inaccurate patient-level costs.

Source data used in costing is of variable quality. Generally, the data used in acute services to support billing for income is of a higher quality than other source data, which has a higher risk of being of poor or unknown quality. This can have a significant impact on the quality of costing information, which can lead to poor decision-making, inaccurate price-setting, weaknesses in assessing value and inadequate information for managing savings plans.

The quality of source data is not the responsibility of costing practitioners. The data used for costing comes from across the organisation, and responsibility for getting it right is similarly broad. Effective trust board engagement to support costing is crucial to driving improvements in the quality of underlying source data. Trusts should have clear senior accountability structures for data quality so that the quality of all source data improves for all end users.

While costing practitioners are not responsible for the quality of source data, they do have an important role to play in helping their organisation improve its quality for costing. They are often the first port of call when a clinician spots data quality problems and are ideally placed to feed this into the organisation’s data quality management process.

This guidance paper suggests ways in which costing practitioners and informatics colleagues can work with others in their trust to achieve improved data quality. The good practice and case studies in this document come from costing practitioners, often working jointly with clinicians or informatics leads, demonstrating the partnership approach needed to improve data quality.

Clinical and operational engagement is key to improving data quality. Experience shows that by sharing cost information across the trust, the quality of the source data used to build the costs improves as staff identify data quality issues. And clinical and other operational staff have an important role to play in ensuring that the data input to the systems is accurate at the point of entry.

The trust’s informatics function should be responsible for the management of all source data required for costing, and for checking and assuring its quality. Costing practitioners need to work closely with their informatics colleagues to support the design of systems that ensure high-quality data.

Apart from working with others in their trust to improve the overall quality of data, costing practitioners typically get involved in resolving a wide variety of specific data quality challenges. These include linking clinical staff costs to patient-level activity, measuring patient dependency, and issues for service areas such as operating theatres and outpatient departments. This guidance paper describes practical approaches that costing practitioners have adopted to support their trust to resolve such challenges.
Appendix H

HFMA Mental Health Costing Practitioner Group

Work to update the 2016/17 version of the mental health clinical costing standards has been led by Catherine Mitchell, HFMA head of costing and value, and Scott Hodgson, HFMA costing standards lead. It has been informed by a survey of practitioners in NHS organisations and site visits, and has involved considerable debate and discussion with the HFMA Mental Health Costing Practitioner Group. The HFMA would like to thank all those individuals and their teams who have been involved in the group.

- John Graham, Royal Liverpool and Broadgreen University Hospitals NHS Trust (chair)
- Lorna Bocquet, Devon Partnership NHS Trust
- Graeme Burgess, South London and Maudsley NHS Foundation 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
- Clare Crossland, Coventry and Warwickshire Partnership NHS Trust
- Alan Doe, North Essex Partnership NHS Foundation Trust
- Pamela Farrow, West London Mental Health NHS Trust
- Gordon Folkard, Avon & Wiltshire Mental Health Partnership NHS Trust
- Ada Foreman, Kent and Medway NHS and Social Care Partnership Trust
- Mark Fox, Norfolk and Waveney Mental Health NHS Foundation Trust
- Patrick Grubb, Somerset Partnership NHS Foundation Trust
- Carol Hawley, Cornwall Partnership NHS Trust
- Clare Jacklin, Humber NHS Foundation Trust
- Haffejee Knight, Oxford Health NHS Foundation Trust
- Deborah McEvoy, Lancashire Care NHS Foundation Trust
- Michael McMillan, Central and North West London NHS Foundation Trust
- Dawn Murphy, Pennine Care NHS Foundation Trust
- Alex Packard, Dorset Healthcare University NHS Foundation Trust
- Kathryn Prescott, Derbyshire Healthcare NHS Foundation Trust
- Michelle Printemps, Hertfordshire Partnership NHS Foundation Trust
- Jennifer Tait, South West London & St Georges Mental Health NHS Trust
- Steven Tait, Tees, Esk and Wear Valleys NHS Foundation Trust
- Gideon Vandyke, East London NHS Foundation Trust
- Sally Wade, Mersey Care NHS Trust

Acute Group representatives
- Jason Dean, Alder Hey Children’s NHS Foundation Trust
- Michael Parsons, Birmingham Children’s Hospital NHS Foundation Trust

Support provided by
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- Scott Hodgson, HFMA costing standards lead
- Julia Gray, Monitor
- Dinah McLannahan, NHS Trust Development Authority
- Nisha Mistry, Department of Health
- Catherine Mitchell, HFMA head of costing and value
- Sue Nowak, NHS England
- Ben Renshaw, HFMA committees manager
- Yang Tian, Monitor
- Becky Vine, HFMA Healthcare Costing for Value Institute manager
Work to update the 2016/17 version of the mental health clinical costing standards has been led by Catherine Mitchell, HFMA head of costing and value, and Scott Hodgson, HFMA costing standards lead.

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