Grant Thornton

hfma Healthcare Costing for Value Institute

Improving data quality for costing community and mental health services

Briefing

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Summary

The lack of robust data for mental health and community services makes it harder for health systems to progress with the integration agenda, deliver improvements in value or make the most of innovation.

Traditionally there has been less scrutiny of mental health and community data than acute data. As a result, the data for these two sectors is less well developed. In an Institute member survey, the majority of respondents working in mental health and community services stated that their data for services delivered in a community setting was of poor quality or incomplete.

This joint HFMA and Grant Thornton UK LLP briefing focuses on improving the quality of data for mental health and community services for the purpose of costing. However, the key messages are relevant to the wider group of stakeholders who use the data for multiple other purposes. These include:

Improving patient pathways

The NHS is moving to a more collaborative, integrated approach to designing, planning and delivering health services across local systems. Good-quality data is fundamental to providing the right care to the right patient in the right place. Patient-level costing information is integral to the decisions that need to be made across multiple services, pathways and organisations in order to manage current services and determine the future models of care. The lack of robust activity data for community and mental health services means that healthcare systems struggle to understand the use of resources across patient pathways, which hinders innovation.

Delivering better value

Future payment systems will support the activities that improve patient care and experience, and focus on the costs of care rather than price. Robust cost data has a major role to play in supporting the delivery of high-quality sustainable services across the NHS, providing the evidence of how resources are used, and supporting the reduction in unwarranted variation. Community and mental health services struggle to demonstrate their value within health systems due to a paucity of reliable and relevant data.

Tackling health inequalities

The Covid-19 pandemic has starkly highlighted the impact that inequalities can have on health and many NHS programmes seek to tackle this issue. Community and mental health services have a key role to play, but robust data is needed to support the delivery of improvements.

Good quality data is also key in understanding the underlying financial positions of systems and supporting the NHS when financial baselines are reset following the pandemic.

Definition of community and mental health services in this briefing

Community services are physical healthcare services delivered in the community by secondary care providers. This includes a wide range of services including community nursing, health visitors, school nurses and community hospitals.

Mental health services includes services delivered to mental health service users by mental health trusts, in hospital and out in the community.

In this briefing we outline some of the data quality challenges facing mental health and community services, and share some of the solutions that trusts have used to improve the accuracy and usability of their clinical data. These solutions include:

- governance and leadership, such as establishing a data quality panel chaired by a clinician, which identifies where improvements need to be made and how best to allocate resources to achieve this
- using data for decision-making. Trusts that have shared their activity and cost information with clinical staff through interactive reporting and dashboards have seen significant improvements in data quality, as clinicians review their activity and identify service improvements
- making the process of entering data clinically relevant, ensuring clinical system specifications align to how clinical activity is delivered so that the data produced provides clinically meaningful information
- building in checks to improve data quality, such as monthly activity sign-off with operational managers
- establishing a single-version-of-the-truth for activity data so that national and local reporting are aligned
- collaborative working between finance, informatics and clinical teams to improve understanding of the data and establish feedback loops to continually improve the data
- use of digital solutions to provide accurate and relevant information on workforce and estates.

Respondents also highlighted that a greater emphasis needs to be placed on the national data sets for mental health and community services, ensuring that data field definitions are clear and remain clinically relevant. HFMA members are keen to work with the national bodies to develop solutions to the challenges the national data sets face, ideally reaching a position where the national data sets provide a one stop shop for all mental health and community data.

Introduction

The recent Institute/ Grant Thornton briefing Costing and data quality: improving the quality of non-financial data required for costing highlighted the significant challenges costing practitioners face when costing community physical health services and mental health services due to the lack of high-quality activity data.

The mandation of patient-level costing (PLICS) for these services means that data quality is now a pressing issue.

The implementation of PLICS for both mental health and community is at an early stage for many trusts. This briefing has been written to support costing practitioners starting out on the PLICS journey. It articulates some of the key data quality challenges and discusses how some of the challenges need to be resolved at either a local or national level.

The evidence in this briefing is drawn from an Institute member survey, a workshop held at the Institute Costing Conference in April 2021, and a number of stakeholder interviews. Where relevant we have drawn on Institute case studies. The full case studies are only available to Institute members, who will need to log on to the HFMA website before accessing the resources.

Quality of patient activity data in main clinical systems

Information about patient-level activity delivered by clinical teams is the key data building block for understanding community and mental health services. The lack of robust activity data for non-admitted patient care in community and mental health services is a significant challenge for costing as well as other key stakeholders.

Institute survey and workshop poll highlight the poor quality of activity data for community and mental health services

In summer 2020 the Institute surveyed its members[1], asking how robust their non-financial data was for costing. Although 70% of respondents to our survey stated that the patient data from the main clinical system was robust and reliable for inpatients, confidence in the quality of the data diminished for those services which are not inpatients (figure 1).

Only 13% of respondents reported that their non-admitted community data was robust and reliable. 55% said it was incomplete, 16% noted it was inaccurate and the remaining 16% said it was not in a useable format.[2]

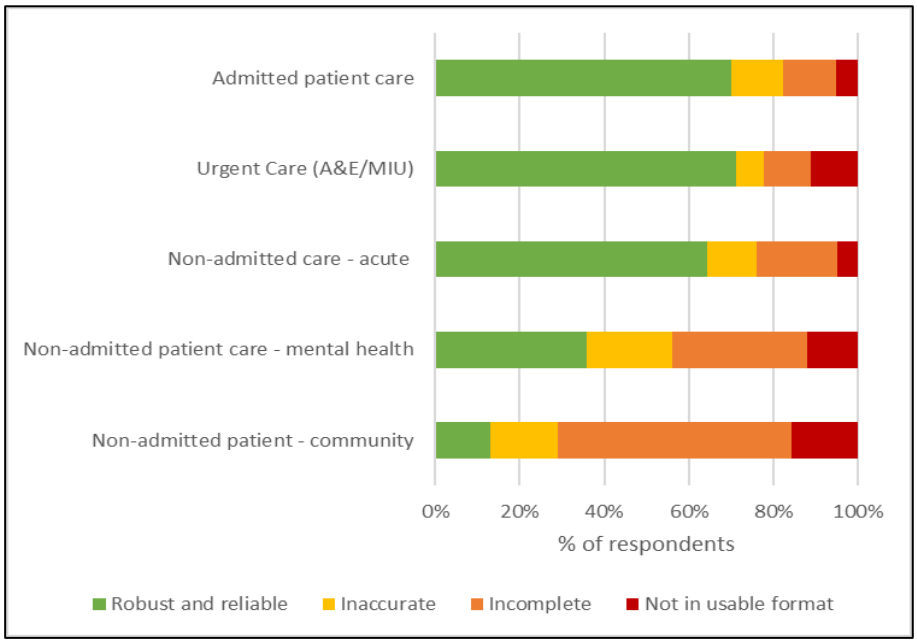
The picture was slightly better for non-admitted mental health data, but not great. 36% reported the data was robust reliable, 32% said it was incomplete, 20% noted it as inaccurate and the remaining 12% said it was not in a useable format.[3]

[1] To gain a better understanding of the current practical challenges in obtaining good-quality data for use in costing, the HFMA's Healthcare Costing for Value Institute surveyed its members in July and August 2020. Responses were received from costing staff from 55 NHS trusts, representing a mix of acute, mental health and community trusts as well as a selection of combined trusts and a Welsh Health Board.

[2] Sample size was 38 trusts with community services

[3] Sample size was 25 trusts with mental health services

Figure 1: Quality of patient data from main clinical system



In a poll at the Institute costing conference workshop in April 2021, delegates were asked how reliable their trust data was to answer a number of key questions – data which is fundamental to costing patient care, as well as for many other uses.[4]

75% of delegates said that their trust had reliable data to answer all the questions about inpatients (figure 2). However, only 25% of delegates said that their trust had reliable data for non-admitted care (figure 3).

Figure 2: 75% of delegates had reliable data to answer all these questions about inpatients

- How long did the service user/patient stay on the ward?
- Which ward did they stay on?
- What was the ward type?
- Which nursing staff work on the ward?
- Which medical staff work on the ward?

Figure 3: 25% of delegates had reliable data to answer all these questions about non-admitted care

- Has the patient activity been recorded?
- What was the duration of the contact?
- Which care professional delivered the care?
- What was the type of activity (e.g. tissue viability care, diabetic care, health visiting)?

[4] 28 costing practitioners working at trusts with community services took part in the poll

How can trusts improve their patient activity data?

The quality of patient activity data is not the responsibility of costing practitioners, but without access to high-quality data that describes the care delivered they cannot generate reliable and robust cost information. Good data quality is not only needed for costing. The primary use of the data is a clinical one. The same data underpins service redesign and the monitoring of clinical quality, as well as the Model Health System and Getting it Right First Time.

In this section we look at some of the basics required for better data:

- governance and leadership
- systems and processes for a high-quality data pathway
- collaborative working between finance, informatics and clinical teams
- using data for decision-making.

Governance and leadership

Senior leaders need to ensure that there are robust data governance processes in place to ensure high quality data (figure 3). Only 31% of workshop delegates reported that such processes existed in their organisation. When boards and clinical leaders understand the importance of data quality and their role in data governance, the management information in an organisation improves.

Figure 3: Data governance - getting the basics right

- Is there a board member with overall strategic responsibility for data quality?
- Does the board know how good the data is in its organisation?
- Are the accountability structures for data quality clear?
- Is there an overarching senior forum with oversight of data governance?
- How does senior leadership communicate the importance of data quality to staff?
- What is the framework to review and improve data quality?

Case study - Data quality panel at Nottingham University Hospitals Trust

The Trust set up a data quality panel in 2010 to support the implementation of PLICS and drive through improvements and development to the system. The panel reports to the PLICS board, which has executive-level sponsorship. It meets monthly and is chaired by a consultant physician.

The panel provides a critical review, using a number of data quality reports to identify where improvements need to be made and how best to allocate resources to achieve this.

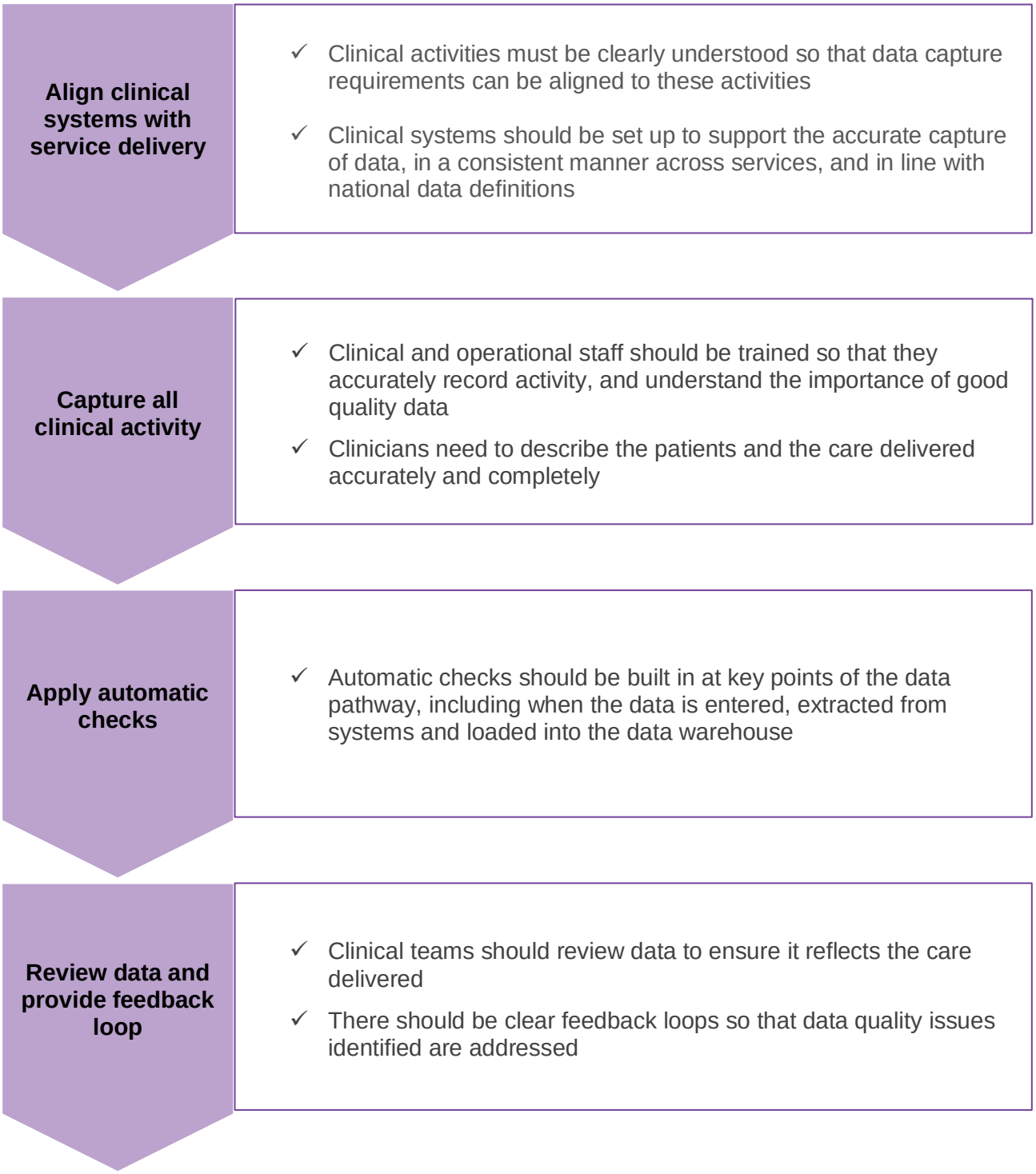
Panel membership comprises:

- Head of costing
- Head of clinical coding
- Head of informatics
- ICT data warehouse colleagues
- Chair of PLICS board

Systems and processes for a high-quality data pathway

Organisations need to have in place systems and processes which secure the quality of data as part of business as usual (figure 4).

Figure 4: System and processes - getting the basics right



Our research highlights that many trusts with community and mental health services have a way to go before they have got these basics right, as shown in the case study examples below.

Case study : **Systems don't always support the accurate capture of data**

'We have a patient administration system (PAS) which is used as an administration system – did the patient attend the appointment yes/ no. We have identified several hundred paper documents still used by services. A group of clinicians are deciding which documents should be included in the PAS, but it will be some time before this data is available from the data warehouse.'

'Community staff are asked to input their data when they are out and about, but this can be challenging in areas where connectivity is poor'

'We know that a lot of community activity is not recorded, and system design does not help. Until recently nurses could not record telephone calls unless they were in the office.'

'Our IT systems don't fully reflect the care that we are providing and consequently the information we extract is incorrect. This can be due to confusion on how to classify a contact, or how the IT system is structured.'

Trusts need to ensure that clinical information systems are aligned to clinical need and local and national data requirements, so that they produce accurate and relevant data.

Case study: Building in checks to improve data quality

'The national costing assurance programme review raised the need to include duration caps in the costing system. When we looked at the duration of contacts, some had a very long duration, for example over 24 hours, some looked fine, but we also had some negative durations! We are trying to work out what is going on.'

'The big data quality issue is how and who is recording data. Activity data variance is not looked at in the same way as finance budgets! Our trust should have a document outlining the internal processes for ensuring data is correct. It would be great to have a monthly activity checks/sign-off with operational managers as a standard monthly process in the same way as monthly budget finance variance reports.'

Trusts need to build in automatic checks to the data pathway, as well as have clear review and feedback procedures in place.

Collaborative working between finance, informatics and clinical teams

Closer working between finance, informatics and clinical teams leads to improvements in data quality.

> *'Our combined costing and informatics team have improved the quality of our mental health data by continually looking at the main data feeds and sharing data quality issues with the clinical staff/ directorate leads.'*
>
> *'The quality of our data for community services is poor. It's not just about the quality of the data input by clinical teams - it's also about the quality of the mapping tables developed by the information team when generating data for the Community Services Data Set (CSDS). Some of the fields required in CSDS are not in the electronic health records, so have to be created by mapping tables, for example consultation type and team type. It was only when the costing team showed the data to the clinical teams that we found out that the data was wrong for these two data fields which had a significant impact on quality of the outputs.'*

Some informatic departments are small which means they may have little time to support costing, or they may not be aware of the importance of PLICS and the National cost collection. Trusts report that greater collaborative working between costing and informatics so that both have a greater understanding of each other's roles can be helpful.

> *'I have a business information analyst for two days a week in my costing team, which is invaluable'*
>
> *'The costing team needs to help BI colleagues by creating a summary of the data fields required for PLICS and work with them to do a gap analysis. We need to develop a template with them with a list of common issues to look out for, for example valid data range, change in cluster dates, activity count, attendance codes and monthly occupancy levels'*

Case study – A clinical analyst's perspective on improving data quality at Nottinghamshire Healthcare NHS Foundation Trust

'In my role as a clinical analyst, I support clinical teams to generate better quality data. My experience is that clinicians don't mind providing data, but there is a general lack of understanding about what the purpose of the data is. A lot of clinicians don't realise how we can support them to make data helpful to their challenges.

The people who have the power to improve the quality of the data are the people inputting the data. Although buy-in from the board is important, they can't force staff to input accurate data. It's about understanding your teams and working closely with them.

We had very poor completion rates for 'referral reason' in the Mental Health Services Data Set. The clinical teams said that the list of referral reasons didn't represent their patients, which meant they didn't want to fill it in because they wanted to accurately reflect what was happening. The result was that they either put in nonsense or nothing at all. Working with the teams, I provided them with a longer list which was meaningful to them but which I could aggregate to submit to MHSDS. This has made a massive difference to compliance – increasing from 3% to 90%.'

Case study – Understanding community activity data at Buckinghamshire Healthcare NHS Trust

To support the implementation of PLICS for their community services, the costing team spent time getting a better understanding of the services and their activity data.

'*We had a session with the person who trains staff on how to input to the PAS. It was helpful to see the front end of the system, and it gave us a better understanding of some of the data quality challenges.*

We also talked to some of our clinical teams to understand what they record. These conversations really helped us to get a better understanding of how community healthcare is delivered.

We have joined the quarterly PAS user meetings which include clinicians and informatics. This has proved really helpful and gives us the opportunity to explain to the group how we are using the data for costing.'

Case study – A multi-disciplinary approach to improving data quality at Gloucestershire Health and Care NHS Foundation Trust

The costing team at Gloucestershire Health and Care NHS Foundation Trust has been proactive in driving improvements in the collection and interpretation of data on the use of community services in the county. Key to their success has been the engagement of clinical colleagues to review and improve the quality and extent of patient data, which has led to a better understanding of service delivery.

While a patient may be referred to a community service for a specific intervention, many will have other comorbidities, and this will clearly influence the extent of care required. The Trust now collects information on comorbidities for nursing and therapy patients.

An example of the type of analysis produced for the district nursing service is shown below. The Trust has analysed both the average number of long-term conditions per patient as well as the average number of contacts per patient by the number of long-term conditions recorded. The data shows that the most significant variation in the number of contacts per patient between the localities were with those with no long-term conditions, i.e., the least complex cohort.

Patient comorbidities by community nursing team

Locality	% of patients with diabetes	Average number of LTCs per patient in	Contacts per patient with LTCs				
			0 LTCs	1 LTCs	2 LTCs	3 LTCs	4 LTCs
Locality 1	10%	1.36	6.4	6.5	12.4	20.1	28.2
Locality 2	10%	1.36	7.6	7.2	13.3	22.6	40.9
Locality 3	9%	1.34	4.9	6.2	10.4	17.6	42.5
Locality 4	13%	1.52	6.0	6.2	11.7	20.2	29.8
Locality 5	9%	1.35	10.0	6.5	12.6	22.6	25.7

Locality 4 has the highest average number of long-term conditions per patient but does not have the highest number of contacts per patient, regardless of the number of long-term conditions the patients have. Access to this information has helped nursing teams to see differences in practice between localities and start to investigate whether this is warranted or unwarranted variation.

Institute members can read the full case study[5]

Using data for decision-making

Data quality improves when it is used for decision-making. Experience of implementing PLICS in the acute sector has shown that as cost information is shared with clinical teams, the quality of the activity data used to build costs improves. Costing teams are understandably anxious about showing the cost data to clinical teams when they are aware that there are data quality issues, but without sharing the data it will not improve.

[5] Improving patient-level costing in community services – Gloucestershire Health and Care NHS Foundation Trust (hfma.org.uk)

Case study – Using PLICS to drive value in mental health services at North Staffordshire Combined Healthcare NHS Trust

The use of block contracts for mental health services in England means that there has historically been less focus on recording mental health activity data, leading to poorer data quality and under reporting of service activity across the country.

The small costing team at the mental health trust were struggling to roll out the use of PLICS data. They developed an activity information dashboard, using data from PLICS and the trust PAS. The dashboard has been crucial in engaging clinicians to review their activity and identify service improvements, which has then led to improvements in data quality.

> '*The ability to access real time activity data at a team level has dramatically improved our ability to analyse trends and identify issues as early as possible'*
>
> *'The service user timeline is a great way to look at the pathway and consider best practice, number of contacts compared with other similar service users and the Health of the Nation Outcomes Scales score for the individual.'*

Institute members can read the full case study[6]

Case study – Becoming a data-driven organisation: engaging clinicians in reviewing and using data and information at Southern Health NHS Foundation Trust

The mental health and community trust procured a data visualisation tool (Tableau) to enable the automatic delivery of information to clinical and corporate staff. The aim was to deliver near real-time information to pro-actively support staff delivering patient care. The tool allowed users to access information from multiple sources when they needed it, rather than receiving a standard set of data.

The most significant benefit in the first year was a major improvement in data quality. Service teams identified their own errors and acted to correct them. Errors in data on the electronic patient record can be amended directly from Tableau via a 'click and correct' option. There is an expectation that it is the responsibility of clinical teams to both enter patient data and correct errors in a timely manner. Other errors, such as incorrect allocation of staff to teams, should be amended by the responsible department.

The automation of report generation released business analyst time which was re-allocated to provide more in-depth analysis and support for clinicians using the data.

Institute members can read the full case study.[7]

[6] Using PLICS to drive value in mental health services (hfma.org.uk)
[7] Case studies (hfma.org.uk)

National data sets for mental health and community services

Mental health and community services are required to submit activity data from their local systems to three national data sets:

- Mental Health Services Data Set (MHSDS)
- Improving Access to Psychological Therapies (IAPT)
- Community Services Data Set (CSDS)

The content of the data sets are used by a wide range of stakeholders, including costing teams.

NHS Digital has worked to improve the data quality of the MHSDS and IAPT in a number of ways in recent years including:

- establishment of a cross arm's length bodies data quality improvement board, which identifies where improvements need to be made and prioritises resources to achieve this
- support for trusts to improve data quality with webinars, guidance and new data quality tools such as the MHSDS Data Quality Dashboard and MHSDS SNOMED data quality dashboard
- improved timely access to the data, including information about data quality to hold trusts to account for the data submitted
- introduction of a multiple submissions model for MHSDS which allows trusts to resubmit data throughout the financial year.

NHS England and NHS Improvement have recently provided additional investment so that NHS Digital can improve the data quality of the CSDS in a similar way.

The level of completion and accuracy of NHSDS, CSDS and IAPT varies between trusts. Some of the issues highlighted by HFMA members include:

- improvement in definitions about what should be included in each data field is needed to support more consistent recording
- further work is required to ensure all data fields remain clinically relevant and represent the best fit between care delivery and data capture to improve compliance rates and benchmarking (for example in the MHSDS the only referral reason for older adults is organic brain disorder, and it can be hard to match national service classifications to local ones)
- it is only possible to correct CSDS data submissions for the past two months – if a significant error is identified by a trust, they can't correct the data for the whole year.

The HFMA's Mental Health Steering Group is currently considering the burden of data collection requirements on the sector. As completion of the MHSDS is still patchy, a number of other returns have been created by different programmes in order to understand activity, costs and outcomes; for example, there is a monthly data return that focuses specifically on IAPT services. These additional returns shine a brighter light on particular parts of the mental health sector, meaning that attention is diverted from improving the accuracy and completion percentage of the MHSDS. There is concern that these additional collections create unnecessary burden for mental health trusts without always giving any useful local data for service improvement or assessment of value.

'Without a greater consistency of data capture and a broad consensus on the data sets, clinical teams are less likely to proactively use the data for service improvement.'

The ideal scenario is that the MHSDS provides a one stop shop for all mental health data, allowing reporting to be carried out for a range of requirements and programmes at both local and national level. However, mental health trusts require support to develop their systems and processes to do this successfully, as well as the time to do it. One of the key requirements is clarity over what should be included in each data field.

HFMA members are keen to work with national bodies to develop solutions to these challenges so that the national data sets are fit for purpose for all users of the data sets.

Using the national data sets for costing

Costing practitioners report a number of challenges when using the national data sets for costing.

Too many versions of the truth

Trusts vary how they access their activity data for costing. Some access the data from the national data sets, while the access route for others is different. This can lead to too many versions of the truth.

When trusts submit their PLICS files for the National cost collection, NHS Digital match the data to the data that trusts have submitted to the MHSDS. The approved costing guidance requires PLICS activity to reconcile to MHSDS activity to within a tolerance level of 0.5%.

Some trusts find this problematic, when the activity data sourced for PLICS does not come directly from the MHSDS. If the relevant data fields in the PLICS data submitted to NHS Digital are not identical to those in MHSDS, matching is unsuccessful. The same is true if the PLICS data includes activity not included within the MHSDS. Understanding the differences can be very time consuming for the local costing team. Similar challenges are reported for the IAPT data set.

> *'We found that we had more data in our PLICS dataset (which isn't driven from MHSDS/IAPT dataset) than what was in the MHSDS/IAPT national datasets. A huge amount of work is needed to understand why and then correct the issues within the MHSDS - we risk missing data if we just focus on what is currently in MHSDS as these datasets have not robustly been used for years'*

One member summed up the challenge and the solution well:

> *'There needs to be a clean, single version of the truth, both at a local and national level. There is far too much local (and national) manipulation of data, much of which has been driven by costing standards, contracting arrangements and tariff mechanisms. The data set needs to be the data set, whether it's being summarised at a national level or being used operationally at a local level.'*

However, another member warned about the considerable work required:

> *'I believe the solution is to ensure that all reporting is built from the single mandated dataset, but for many trusts that means a huge amount of re-work to existing activity feeds that would have evolved over time, in order to be confident that activity reconciles.'*

Understanding the national data sets

Costing practitioners reported that they struggle to understand the scope and content of the national data sets, but are keen to have a better grasp of the data fields and how they might support costing, as well as providing them with additional data to explore unwarranted variation.

> *'What is the level of knowledge amongst costing practitioners about the national datasets? There are so many assumptions made at the moment with regards to the level of knowledge costing practitioners have around MHSDS/IAPT datasets and whilst costing practitioners can't be experts in all areas, I believe it is going to be critically important once the quality of costing stabilises to be able to utilise the richness of data in these datasets to really start to tackle unwarranted variation head on.'*

> *'More work needs to be done on understanding exactly what is being collected by the national data sets, and how it is being collected. Are there any national standards? Is every trust collecting data for the data set in the same way?'*

> **'***Mental health and community costing staff have a vast work remit, many with very little support from the information team and their finance team not understanding the amount of data knowledge required for the costing role. In the acute sector the data has been considerably improved over time (supported by payment by results) but in mental health and community the costing teams are still trying to understand the national data sets.'*

The costing team at NHS England and NHS Improvement will continue to run learning sessions on the national data sets with NHS Digital, to support costing practitioners extract the relevant data for costing. The Institute will include topics on the national data sets in their future programme to support members gain a better understanding of how the data sets can support the use of cost data locally.

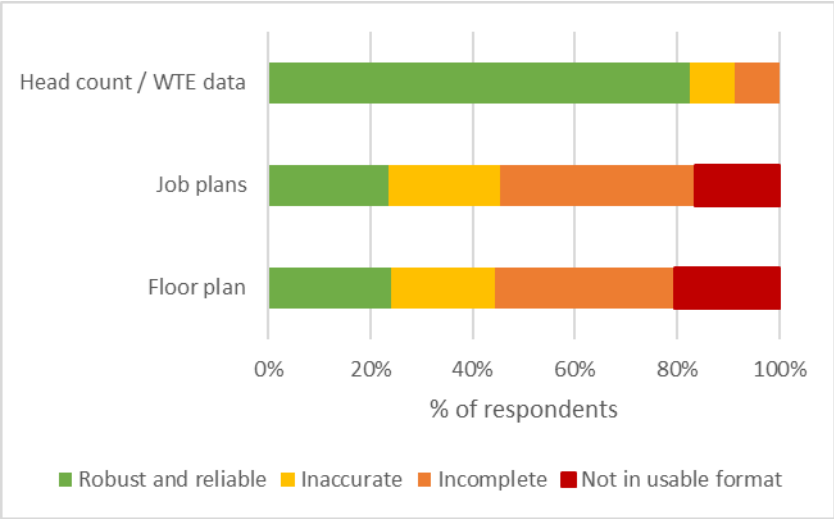
Other data items required for costing

Members reported challenges with data quality for the following areas:

- job plans for medical staff
- information for allocating overheads
- allocating drug costs at patient level.

These areas are not only a challenge for the mental health and community sectors. Respondents from all sectors to the Institute survey reported significant concerns about the quality of data in medical staff job plans and floor plans (figure 6).

Figure 6 : Workforce and infrastructure data



Job plans for medical staff

Many trusts report a lack of robust and reliable data about workforce, in particular medical staff job plans. The lack of information about medical staff activity makes it hard for services to explore new ways of working.

> *'The cost of consultants at my mental health trust are approximately £14m compared to the drug costs of about £2m for the year and are therefore more material in terms of correct allocation at patient level. Many trusts don't have up-to-date medical job plans or job planning systems and if they do have a system, it isn't set up to match the costing system headings.'*

Accurate information around medical staffing job plans across the varying grades have been a challenge since healthcare costing was introduced. Community and mental health providers will also need to understand the activities of all clinical staff across all settings so that they can allocate costs appropriately. The introduction of digital solutions such as e-rostering within NHS organisations provides the opportunity to access and interrogate workforce information in the same manner as other data feeds. Costing leads should ensure that workforce leads understand and are able to provide the necessary information to support accurate costing. Where technical solutions are available or being procured, costing leads should engage with workforce so that these digital workforce solutions are able to output information in line with their requirements.

Information for allocating overheads

Mental health and community services tend to operate out of many sites, which makes allocating overheads challenging. Although NHS England and NHS Improvement have simplified the allocation rules in the approved costing guidance, some costing practitioners report that they struggle to source the necessary data required for allocating overheads. Poor estates information makes it harder for organisations to efficiently use their assets.

> *'We have nearly 100 building and staff often move around buildings or offices without notifying IT teams or the estates departments. This is very difficult to monitor, and the estates team don't have the manpower to constantly review the floor space. They offer us the option of paying for the cost of sending out an external surveyor to the trust buildings which will take at least six months full time to properly map, draw and document all the buildings, their size, room number, floor space and identify teams who occupy the space. By the time this process ends, it will almost be time to start again.'*

'The challenge is that whilst we need to focus on the big items, without focusing on these smaller areas which are often a radical change for the organisation to start capturing if they don't already, then trusts won't be able to meet the costing standards. The discussions needed internally often take a very long time to progress into action for any extra data to be collected and often the costing team is the first to ask for this data.'

'For these allocations we need things like number of computers by each area, floor area for each team (which is a huge ask for community and mental health services as we are not just located on an acute site - we can be occupying space in our own buildings scattered across the boroughs, or in council space which we don't pay anything for due to "gentleman's arrangements" etc and staff can move rooms quite regularly with walls knocked down to rework space etc as services merge/change. We don't have sophisticated estates information or a tracking mechanism to capture this on an ongoing basis.'

Some trusts, however, are fortunate to have more robust data on the use of estates.

'We have a room booking system, which is primarily aimed at capturing other providers' use of our space. However, this also shows where our own services are using our hospital space. For the other clinical spaces, we have a view from our estates team of which services reside in which buildings across the county, and we use this as our space allocations.'

The primary use for estates data should be an operational one, with costing practitioners being secondary users. If the information is poor, costing practitioners need to take account of materiality when deciding on the level of detail required to meet the costing standards and weigh up the cost of obtaining the data with the benefits of having the data to generate costing information.

Allocating drug costs at patient level

Trusts report that allocating drug costs at patient level can be challenging in mental health and community services. The costing standards require the allocation of drugs at patient level for controlled drugs and high-cost drugs.

When it comes to community prescribing the majority is done via FP10s. However, we can't get patient-level information from the NHS Business Services Authority to enable us to allocate the costs.'

'We struggle when looking at the FP10 drugs as we just can't get data at patient level and much of our drugs are this type which is similar to many other mental health trusts. I do think that pharmacy is material enough to invest the time to get it right.'

'Drugs allocations for high-cost drugs are probably the only material enough drugs costs to warrant the effort of allocating to patient level in community services. However, if decisions are likely to be made as a result of allocating drugs at a more granular level (for example does the use of a certain drug speed up recovery) then I feel the extra effort to allocate lower-costing drugs would be worthwhile. These decisions should be made on a trust-by-trust basis, and not mandated.'

While trusts need to initially focus on getting pay costs allocated to individual patients, there is work to be done at a local level to develop systems that allow the allocation of high-cost drugs at patient level. Allocating FP10 drugs at patient level requires a national solution.

The Healthcare Costing for Value Institute programme is built around four themes:

Confident costing

Supporting improvements in costing

Costing is high on the NHS agenda with NHS Improvement's mandation of new costing standards. The Institute provides a support network where members have the opportunity to discuss costing challenges with their peers, as well as share learning. Our wide range of Confident costing events and publications ensure we support both those new to costing as well as more experienced costing staff.

Translating data

Making the most of patient-level cost data

Providers of NHS services have increasingly large amounts of data about their patients, with the roll-out of patient-level costing (PLICS) across the NHS. The challenge is how to make the most of patient-level cost data to support improvements in patient care and deliver efficiencies. The Institute has a series of toolkits to support members turn the data generated by PLICS into powerful intelligence. The Institute's support network allows members to share examples of how they have embedded PLICS within their organisation and encouraged clinicians to use PLICS data to support service redesign.

Driving value

Improving patient outcomes at lowest possible cost

The concept of 'value' in healthcare – maximising the outcomes which matter to people at the lowest possible cost – is increasingly seen as a key lever for supporting the delivery of high quality sustainable healthcare. The challenge is how to do this in practice. What is clear is that clinicians and finance staff need to work more closely together to support improvements in value. The Institute has a growing reputation for bringing together senior finance and clinicians to explore what value means for the NHS. Institute members have the opportunity to hear from those at the cutting edge – both nationally and internationally – and take back practical ideas for their own organisations. Our value challenge projects work with members to put the theory of value into practice.

Innovation

Pushing costing and value boundaries

The Institute continues to push forward and promote costing and value-based healthcare. This is supported by Institute-led projects which aim to challenge current practices and the existing culture. The Institute works with its Members, Partners and Associates to learn from and share good practice in the UK and internationally. We are always looking for new ideas and opportunities to ensure that we are at the cutting edge of costing and value.

About the Healthcare Costing for Value Institute

HFMA's Institute champions the importance of value-based healthcare for supporting the delivery of high-quality financially sustainable healthcare. Through its member network, it supports the NHS to improve costing and make the most of patient-level cost data to drive improvements in patient care and deliver efficiencies. By bringing together senior finance and clinicians to explore what value means, the Institute helps the NHS to turn the theory of value into practice and make value-based healthcare a reality.

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff working in healthcare. For 70 years it has provided independent support and guidance to its members and the wider healthcare community. It is a charitable organisation that promotes the highest professional standards and innovation in financial management and governance across the UK health economy through its local and national networks. The association analyses and responds to national policy and aims to exert influence in shaping the healthcare agenda. It also works with other organisations with shared aims in order to promote financial management and governance approaches that really are 'fit for purpose' and effective.

About Grant Thornton

Grant Thornton UK LLP is a leading business and financial adviser with client-facing offices in 27 locations nationwide. We have been working with the NHS and local authorities for over 30 years and are the largest employer of CIPFA members and students in the UK. Our national team of NHS specialists, including those who have held senior positions within the sector, work closely with our clients to provide the growing range of assurance, tax and advisory services the NHS requires. Our approach combines a deep knowledge of the NHS, supported by a wider understanding of public sector issues. We understand regional differences and, through proactive, client-focused relationships, our teams deliver solutions in a distinctive and personal way, not through pre-packaged products and services. Overall, we provide audit and assurance services to over 30% of NHS Trusts and CCGs.

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