HFMA's response to the *Mental health currency review*

Who we are

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA Hub is made up of a number of networks which represent all sectors of the NHS. All mental health providers in England subscribe to the HFMA's Mental Health Network, giving a rounded perspective on relevant issues.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

Introduction

Clustering has not worked as a currency for mental health and the HFMA welcomes this currency review[1]. Through our work with members across the finance community and clinicians with a particular interest in finance, data, and value, we have heard that clusters are generally unpopular and frequently lack clinical buy-in. Service users within a cluster do not necessarily use a similar level of resources so the approach has not fully supported either clinical or financial reporting processes. It is essential that the lessons of clustering are learnt so that the same problems do not emerge for the new MHRGs.

There are a number of positive intentions set out in the review document. We fully endorse the need to develop a new approach that is clinically supported, reduces data burden and produces nationally comparable data; the subjective nature of clustering and its inconsistent use means that it is impossible to have a good understanding of mental health activity and costs across the country. We welcome the attempt to develop an effective currency and to include a regular review process for the groupings.

This is a significant change for the mental health sector. The currency review seeks to improve upon a model which is not universally accepted or used but the engagement around it has not been well publicised. The timescales for response were too short to gather meaningful responses. In our opinion an opportunity to engage well with the sector, and address one of the early flaws in the introduction of clustering, has been missed. The mental health sector has demonstrated with clusters that if an approach is not supported, it is not implemented, regardless of mandation.

The HFMA welcomes the flexibility that has been given in responding to this review, but we believe that further work is needed with both the finance and clinical community to ensure that any new currency is fit for purpose.

The engagement paper is very brief. We are aware that significant work has gone into developing this model. However, the lack of detail included in the paper means that we are unable to answer questions fully. For example, the paper does not include evidence that the new MHRGs meet the factors that the stakeholder group said were important for any currency model.

The remainder of this paper addresses the questions included in the review document. The HFMA's Mental Health Steering Group is keen to work with NHS England and NHS Improvement on all aspects of mental health finance and would welcome further involvement in the development of the new currency.

Are the proposed groups clinically meaningful, structured by disorder group and severity level?

The engagement document does not contain enough detail to answer this question. We understand that the process has included clinician engagement through the Royal College of Psychiatrists, but it would be helpful to set out the development process that has been undertaken, to provide reassurance where necessary.

A number of concerns have been raised by our members in response to this question with a key one being around the use of subjective terms such as mild, moderate, or severe. This classification can vary depending upon clinician experience and local comparability for that cohort. It can be also be impacted by the level of support being given; should a patient be classified as severe if that is where they would be without support, for example, or should they be classified as moderate because of the treatment that they receiving? This concern must be addressed if the data is to be nationally meaningful.

[1] NHS, *Mental health currency review*, November 2020

It is unclear how people will be allocated to a MHRG and whether a tool will be used in a similar manner to clustering, which makes use of HONOS methodology. The method of allocation is an essential part of implementing a robust and well-supported currency.

Co-morbidities need to be considered and it is expected that people will move between MHRGs, so clarity is needed about the process for this.

Any new currency must be implemented well. There will be significant training needs to do this across different professions. One of the reasons that clusters were not clinically supported by many areas was that they were seen purely as a payment mechanism, with little clinical value. It is essential that work is undertaken to explain what a currency is and its role in supporting clinical activity data as well as financial processes. The NHS England and NHS Improvement definition of a currency[2] states that *'each unit of currency must be evidence-based and analytically identifiable, but most importantly it must be clinically meaningful. The currency must be rooted to the care the patient receives and be practical to implement.'* Ensuring that the clinical use of the currency is well defined and enables better care, will support the effective implementation.

Are the proposed groups administratively meaningful to support counting activity and payment?

The NHS England and NHS Improvement definition of a currency states that *'a currency is a way of grouping patients' activities into units that are clinically similar and have broadly similar resource needs and costs.'* To be administratively meaningful, this definition has to hold true. The proposed model assumes similar levels of resource are consumed by people within a single MHRG but there is no evidence included to demonstrate that this is the case. Therefore, we are unable to answer this question.

The currency model assumes that all service users in crisis care consume a similar level of resource, regardless of the underlying condition that has caused the crisis. This is not true and grouping all crisis care together removes any granularity around service model costs. For example, community crisis teams may avert an inpatient stay. Conversely, a lack of community crisis services could create a long length of stay as a consequence. The proposed model does not support organisations to understand whether the service being provided is the right one. In addition, people in crisis still fall into a disorder group and will move once that crisis is abated so clarity is needed about movement between MHRGs.

There is a need to recognise assessment time that may not result in a diagnosis or further treatment, as this can be significant in both clinical time and resources used.

With consideration to use by local systems and any additional burden or workload, should MHRGs be determined locally and flowed to the MHSDS, or should the individual items needed to determine the MHRG be flowed to the MHSDS i.e. disorder group, severity and setting, and MHRGs determined at a national level?

In order to answer this question, it is important to understand whether current clinical practices really enable classification at assessment? Is the required information already collected routinely and consistently? If a change in practice is required to implement the new currency, then the importance of gaining clinical buy-in is increased. The coding role in an acute setting is not replicated in mental health trusts so it is essential that any new currency builds on current practice if it is to be implemented well and in a timely manner.

[2] NHS, *A new approach to supporting community healthcare funding*, May 2019

Members have highlighted that the national turnaround for data can be slow. If the currency data is to be useful for trusts, and it has to be or it will not be collected, then it needs to be available in real time. Therefore, it is suggested that MHRGs should be determined locally.

Should there be one review group for the whole model, or a number of different review groups providing input on each of the A to G disorder groups specifically?

Whether there is one review group or a number, any assessment of changes must consider the implications of changes in one part of the model, on the other areas. A review process is also essential to ensure that currencies are being applied consistently across the country to allow effective benchmarking.

Contact

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