Healthcare Costing for Value Institute

Mental Health Value Challenge

How can we maximise the use of resources in mental health to provide the best possible outcomes for service users?

Discussion briefing

October 2020

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Summary

How can we know that we are spending the mental health pound well? This is a question which mental health services are grappling with as they seek to develop an evidence base to understand how well they use their resources.

While mental health trusts are keen to apply a value-based approach to service improvement, there are few examples of projects with a true focus on value - maximising the outcomes which matter to people at the lowest possible cost- with most projects focusing on improvements to productivity.

The Mental Health Value Challenge is the third value challenge undertaken by HFMA's Healthcare Costing for Value Institute. The Institute value challenge projects work with members to put the theory of value-based healthcare into practice.[1]

The first stage of the Mental Health Value Challenge has involved carrying out a wide range of interviews with those who have an interest in value in mental health. The Institute is grateful to all those listed in appendix A for their thoughts and ideas.

The term 'value' can mean different things to different people, for example service users, clinical teams, and finance. Any conversation about 'value' must start from the service user perspective – what are the outcomes that matter to a person with mental health problems? When we talk about 'value' in this briefing, we are referring to how mental health services can maximise the use of their resources to provide the best possible outcomes for service users.

This discussion briefing describes our findings so far and covers:

- the role of clinical and financial collaboration in improving value
- the data building blocks required to measure value
- how value can be improved in mental health.

The next phase of the Mental Health Value Challenge will explore with two mental health trusts how they can use their data to measure value across a service user pathway – a 'pragmatic proof of concept'. The learning from this part of the project will be shared in a second briefing.

What are your views about measuring value in mental health?

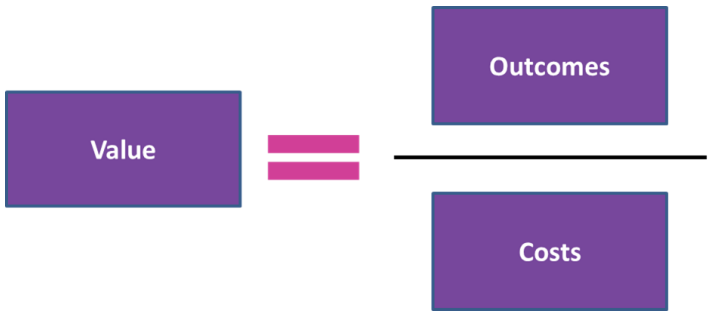
The Institute is interested to hear the views of others on how we measure value in mental health. Please email your ideas and comments to catherine.mitchell@hfma.org.uk

[1] The first two value challenges were Value Challenge Pilot and Value Challenge 2.0 How patient-level costing can support the implementation of Getting it Right First Time

Introduction

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 care (figure1). 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 successful track record of 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.

Figure 1: The value equation



Outcomes are the full set of service user outcomes over the service user pathway

Costs are the total costs of resources used to care for a service user over the service user pathway

Focus of Mental Health Value Challenge

At the 2018 HFMA annual conference, Sir Norman Lamb argued the need for a renewed focus on how we spend money on mental health services. He noted that data shows an enormous variation in clinical practice, and that often there is no clinical justification for the variation in length of stay or admission rates.

Sir Norman Lamb's challenge to the HFMA audience was 'let's look in an evidence-based way how we use our resources in mental health'. Sir Norman Lamb's quote provides the focus for the Institute's Mental Health Value Challenge.

The Mental Health Value Challenge is exploring how mental health services can use the data sets available to answer the question:

'Are we spending the mental health pound well?' or in other words **'How do we maximise the value of the mental health pound?'**

Context

Mental health trusts are keen to adopt an evidence-based approach to understanding how they are using their resources, and whether they are being maximised in the delivery of high-quality care. While there are examples of trusts delivering individual projects focusing on improving value, this is not widespread, and most examples are about improving productivity. The Mental Health Value Challenge aims to support trusts as they start to grapple with the challenges of developing a value-based approach.

National initiatives supporting the value agenda in mental health in England

There are a number of initiatives currently underway in England which support the value agenda for the NHS.

- Getting it right first time (GIRFT) - see appendix B for more detail
- Patient-level costing (PLICS)
- The Model Hospital (Model Mental Health)

All three initiatives include the use of data held in the Mental Health Services Data Set (MHSDS), which brings together information captured on clinical systems as part of service user care. All organisations that provide NHS-funded secondary mental health, learning disabilities and autism services have to collect and submit service user-level data to the MHSDS. It contains 375 data fields.

Those interested in finding out more about GIRFT for mental health and Model Mental Health may wish to watch two Institute webinars:

Improving value in mental health - an update from the mental health GIRFT team July 2020

Taking a closer look at Model Mental Health March 2019

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.

Discussion briefing focus

The aim of this briefing is to discuss our analysis of measuring value in mental health from desktop reviews and interviews to date. It is hoped that the briefing will stimulate further discussions, which we will incorporate into future work.

The topics covered are:

- the role of clinical and financial collaboration in improving value
- the data building blocks required to measure value
- how value can be improved.

Next steps – pragmatic proof of concept

The next phase of the Mental Health Value Challenge is exploring with two mental health trusts how they can use their data sets to measure value across a service user pathway. We are calling this a 'pragmatic proof of concept.' The learning from this part of the project will be written up as a second briefing.

The role of clinical and financial collaboration in improving value in mental health

Good collaborative relationships are required between finance and clinicians to ensure value is at the centre of decision-making. Every clinical decision is a financial decision, and finance and clinical professionals need to share responsibility for deciding priorities and allocating resources.

'There is mounting evidence of the quality and productivity improvements that result when clinical and finance staff collaborate. Their joint efforts can highlight inconsistencies in service delivery, reduce waste, improve patient safety and identify new pathways of care '

(Academy of Medical Royal Colleges 2014, Department of Health 2013).

The Institute and Future-Focused Finance Engagement Value Outcome (EVO) pilots[2] have demonstrated the power of getting the right people in the room to look at the data about their service to improve value (figure 2).

Figure 2: Value improvement requires a multi-disciplinary approach

Source: HFMA and FFF, *EVO pilot summary,* December 2019

[2] https://www.hfma.org.uk/our-networks/healthcare-costing-for-value-institute/institute-frameworks/evo

Speaking a common language and focusing on the service user pathway

A conversation with a finance team about costs and budget statements will rarely be a successful way to engage clinical teams in considering the use of their services' resources. More effective is the use of clinically meaningful data in a joint discussion on how best to use mental health services' resources to provide high-quality care.

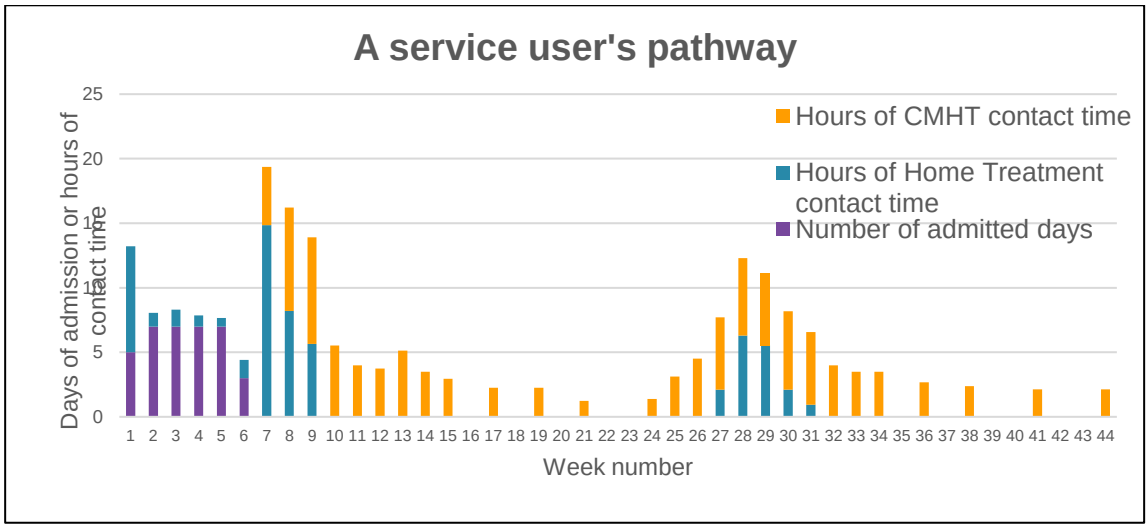
Some ways mental health services view value include:

- 'we talk about clinical and delivery variation rather than about costs'
- 'we need to look in an evidence-based way how we use resources in mental health. How can we describe the pathways for different cohorts of service users and measure outcomes?'
- 'we want information to support the delivery of services, not for transactions'
- 'our benchmarking identifies warranted and unwarranted variation'
- 'there is huge clinical variation between service users, for example how often or for how long they are seen. Teams are working in very different ways. We have not yet defined what good looks like yet, but we have unearthed some really interesting stuff about service users, some of whom should not have been on the caseload.'
- 'we have so much data, and we use very little of it.'

Looking at the data from a service user view

Providing a visual depiction of a service user's pathway is something that will attract the interest of clinical teams. Figure 3 shows the use of community and inpatient services by a service user over a number of months.

Figure 3: Focusing on a service user's pathway – presenting data in a clinically meaningful way

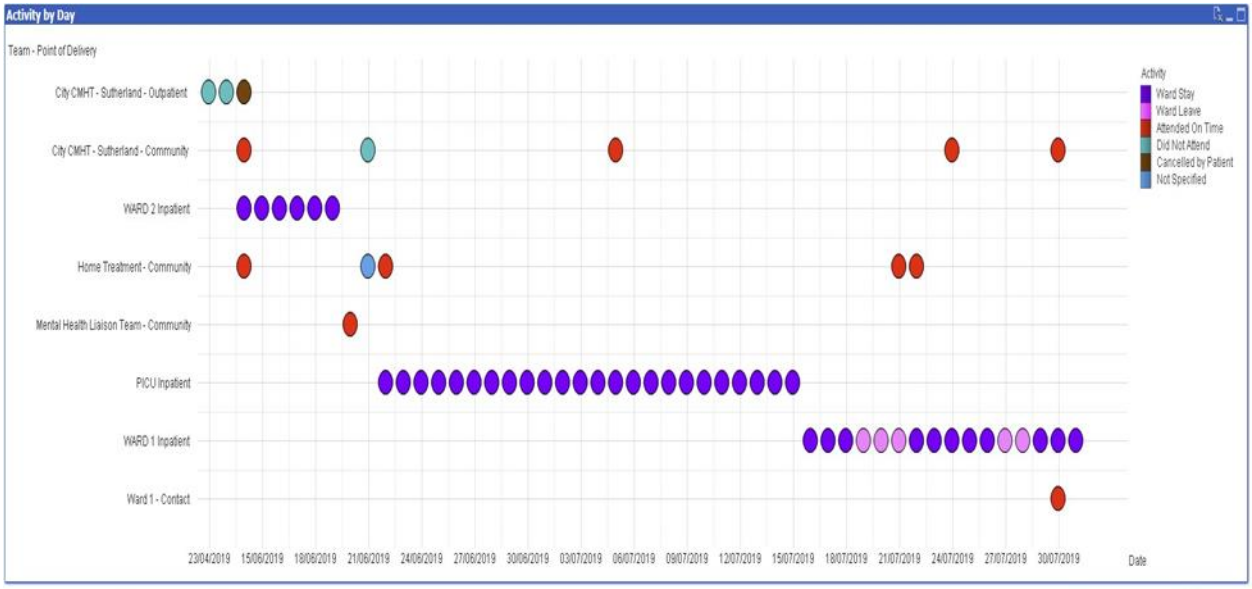


Source: Healthcare Costing for Value Institute, *PLICS Toolkit for Mental Health Services,* 2017[3]

The costing team at North Staffordshire Combined Healthcare NHS Trust has developed a dashboard with their clinical colleagues which allows clinical teams to review service user pathways. Figure 4 shows one service user's pathway and the interventions along the pathway. This individual had inpatient stays on three wards during the period, with some periods of home leave towards the end, but also had contacts with other Trust teams.

[3] Healthcare Costing for Value Institute, PLICS Toolkit for Mental Health Services, 2017

Figure 4: Service user timeline



Source: Healthcare Costing for Value Institute, *Using PLICS to drive value in mental health services,* 2019

The data blocks required for measuring value in mental health

To measure value, the following data building blocks are needed at the service user level:

- **method of categorising service users** – grouping service users with similar needs or characteristics
- **interventions** - non-pharmacological and pharmacological, for example cognitive behaviour therapy and drugs prescribed
- **outcome measures** – the change in health attributable to an individual or series of interventions
- **use of resources** - the resources consumed during the intervention, for example staff time, medicines. The currency for measuring the amount of resources used is usually costs, but could be something more meaningful to clinicians, for example the number of hours a member of staff spent caring for a service user.

A discussion about the data available for the different building blocks is provided later in the briefing.

Measuring value across the whole service user pathway

Understanding value requires interventions and outcomes to be measured over time, along the service user pathway. An inpatient stay might achieve a good outcome, but could the same or a better outcome be delivered in the community using fewer resources? Looking at the whole service user pathway enables the identification of high and low value interventions.

Measuring value across organisations

Mental health trusts are not the only organisations supporting and caring for service users with mental health problems. This provides an additional challenge when measuring value. How can interventions and outcomes be collated and measured across a range of organisations, including social care, the voluntary sector and other non-NHS organisations, whose approach to recording data will differ?

'The move to greater system working means that it is all the more important that mental health services can articulate how they use their resources and why resources are needed.'

Taking a holistic approach to using data when benchmarking

Identifying what 'good looks like' requires looking at a range of metrics, otherwise there is the danger of drawing incorrect conclusions.

Model Mental Health, the mental health version of the Model Hospital, provides a series of metrics to allow trusts to compare their productivity. Trusts interviewed commented on the need to think in the round when reviewing the metrics, for example Trust A may have higher staffing levels than Trust B for their home treatment teams. This is not necessarily 'bad' if Trust A's bed base is lower and their home treatment teams have service users with higher acuity on their caseloads. Interpretation of the data may require bringing in data from other sources to draw accurate conclusions.

What can services do to improve value?

To ensure that outcomes improve or remain the same, services can:

- **change the interventions** - would a different intervention achieve a better outcome?
- **change the use of resources** – could the intervention be delivered by a different professional group? Are there opportunities to improve the productivity of staff or teams?

Figure 5 provides an example of a change in intervention, while figures 6 and 7 provide examples of changes in the use of resources.

Figure 5: Review of memory assessment pathway leads to change in interventions

Clinicians worked with the costing team in North Staffordshire to map the current memory assessment pathway, looking at interventions and costs. The review led to a new memory service pathway which directs service users to the nurse or consultant best equipped to deal with the complexity of the service user's needs. This means that that the correct clinical questions can be asked to ensure service users are only referred for the correct tests, and not referred at all if they don't need a head scan. The service expects that there will be a reduction in the numbers and costs of scans, but that some service users will need an additional appointment with a nurse. [4]

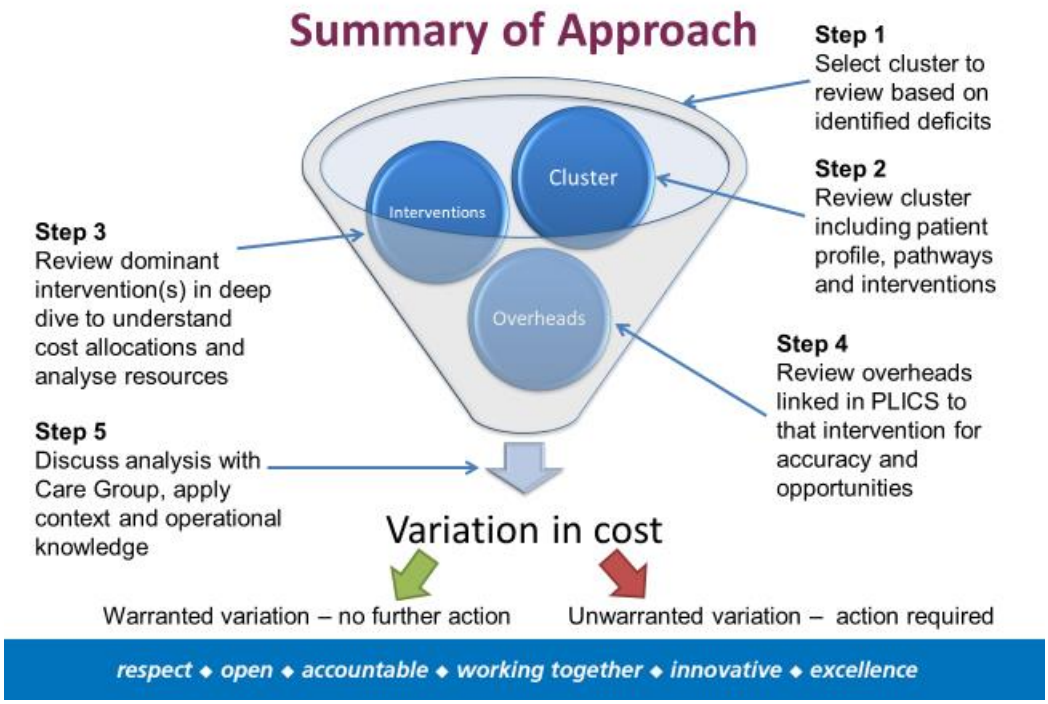
[4] Healthcare Costing for Value Institute & Future-Focused Finance, EVO case studies North Staffordshire Combined Healthcare NHS Trust, March 2020

Figure 6: Improving value in the treatment of depression by changing the use of resources

A study in Stockholm evaluated the cost-effectiveness of allowing psychologists to perform post-treatment assessment for the treatment of depression using internet-based cognitive-behavioural therapy (ICBT). Outcomes and costs were compared with the traditional approach where patients were seen by psychiatrists in an outpatient clinic. The research showed that treatment costs were reduced while treatment effectiveness was maintained.[5]

Figure 7: Deep dive at cluster level[6] identifies warranted and unwarranted variation in cost

Kent and Medway NHS and Social Care Partnership Trust have developed a deep dive approach to identifying variation in costs.



What data is available for the building blocks?

The following sections discuss in more detail what data building blocks are needed to measure value, and what data is currently accessible to mental health trusts.

[5] Samir El Alaoui & Nils Lindefors, Combining time-driven activity-based costing with clinical outcome in cost-effectiveness analysis to measure value in treatment of depression, October 2016

[6] Clusters are described in the following section

Categorising service users

As a first stage in any measurement of value, there needs to be a classification system – or a currency - so that service user care and service delivery can be compared, and resources allocated appropriately.

Care clusters

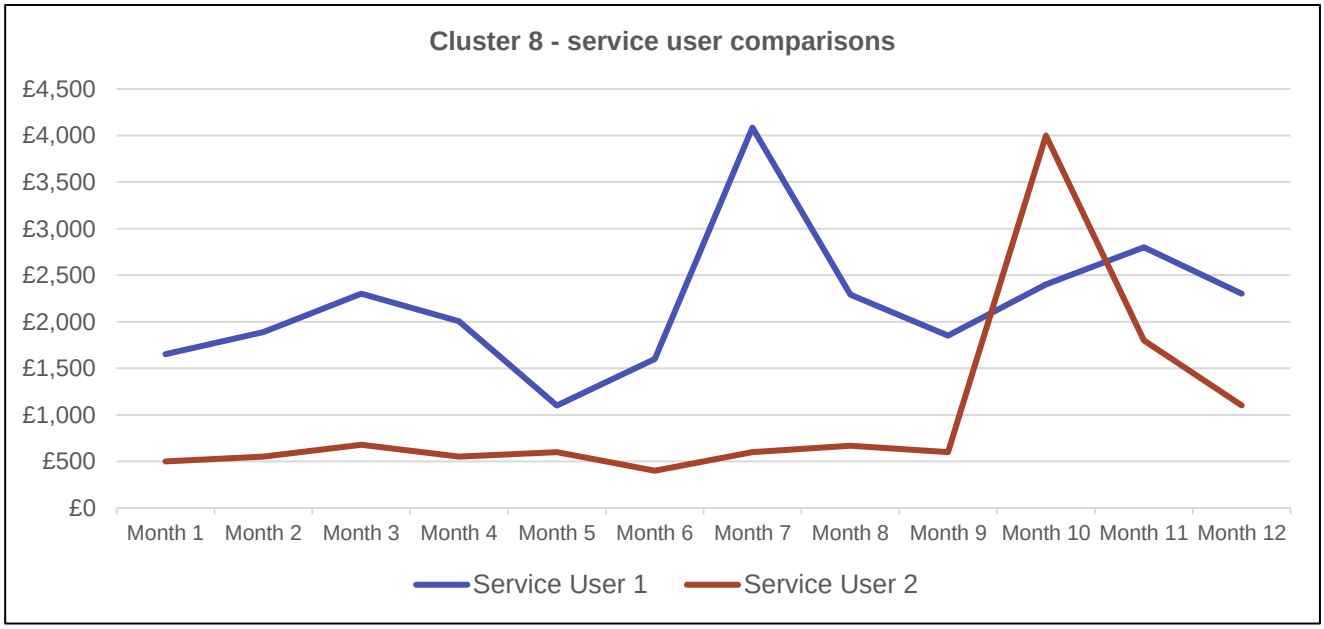
The current classification approach in England for mental health services for adults and older adults is care clusters. Providers have had to submit cluster-based costs for much of the last decade as part of their reference cost submissions.

Care clusters group service users by their characteristics and needs, rather than the individual interventions they receive or their diagnosis. Service users are classified using the Mental Health Clustering Tool, which incorporates items from HoNOS and the Summary of Assessments of Risk and Need (SARN). There are 20 care clusters, and three super-clusters: non-psychotic disorders, psychotic disorders and organic disorders.

In some trusts use of clusters has been embedded well, with clusters providing the initial way to separate out different pathways and explore variation within them. Kent and Medway NHS and Social Care Partnership Trust's approach to identifying variation in cost starts by selecting a particular cluster (figure 7).

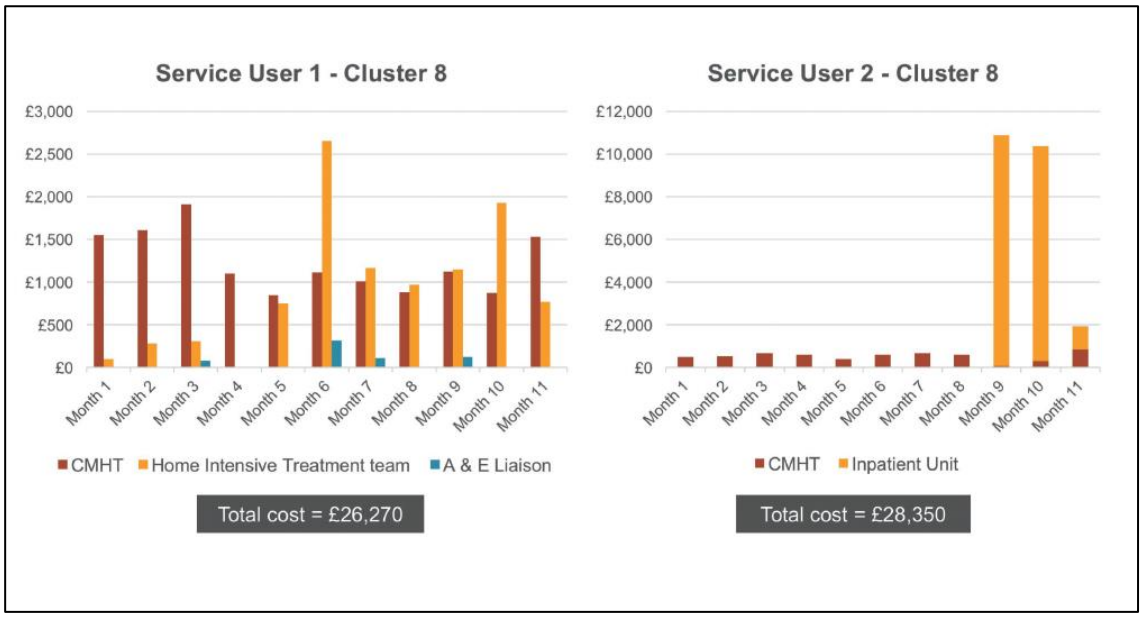
Comparing individual service users' pathways within one cluster can be a place to start when exploring differences in service delivery or service user need. Figure 8 compares the pathways of two service users in cluster 8 (non-psychotic chaotic and challenging disorders). It shows that service user and cost over the months varies considerably between the two service users. Figure 9 goes on to explain some of the variation, revealing very different patterns of care for the two service users. Is this need driven, or a result of the differences in service availability or clinical practice? And what were the outcomes?

Figure 8: Comparing service user pathways by cluster



Source: Healthcare Costing for Value Institute, *PLICS Toolkit for Mental Health Services,* 2017

Figure 9: Comparing service user pathways – cost and team input



Source: Healthcare Costing for Value Institute, *PLICS Toolkit for Mental Health Services,* 2017

While some trusts are using cluster data to inform service review, clusters are not universally popular amongst clinicians and managers (figure 10), and the level of completion of cluster data at some trusts is low.

Analysis of data from the May 2020 MHSDS performance report[7] shows that 43% of service users were assigned to a cluster at the end of the reporting period. The Mental Health Analysis Team at NHS Digital notes that:

- *'The MHSDS table that captures the care cluster information is not mandatory, and this is likely to play a large part in explaining why the proportion is as low as it is.*
- *Some individuals may not be assigned to a care cluster for reasons other than poor data quality. For example, if the cluster did not need to be assigned in order to drive the payment mechanism through which the care was delivered, it may not be completed at all. Unfortunately, we cannot readily assess the impact of this.'*

Figure 10: Views on clusters expressed at HFMA mental health workshop July 2019

'One deputy medical director at the workshop said clustering at his trust was seen as a bureaucratic exercise – with a system based on diagnosis and condition complexity likely to have more resonance with clinicians. However, there appears to be broader acceptance of the HoNOS scales that are used as a core part of the clustering process.

A finance director said clusters were not being universally used and were not well understood outside mental health secondary care. To really be useful in developing mental health services, GPs and social care would need to be familiar with their use, he said. The fact that this wasn't the case undermined moves to system working and integrated care.'[8]

[7] MHSDS Monthly: Performance May 2020 MHSDS Data File

[8] HFMA Healthcare Finance, Mental health - achieving the right focus, September 2019

Academic research indicates that the current number of clusters is not sufficient for categorising mental health service users.

'The key challenge for any payment approach is to introduce a classification system that accurately and consistently captures similarities and differences between patients. The categories of such a classification system need to be homogeneous in terms of both case-mix and resources, that is, patients within a given care cluster have similar needs profiles and their treatment requires approximately similar levels of resources. Our research (Jacobs 2016) shows that there is enormous variation within the current clusters in terms of activity and costs. Considerable variation in levels of need and case-mix within care clusters was anticipated from the outset (Bhaumik 2011; Jacobs 2014).'[9]

Diagnoses

Information about diagnosis could support the grouping of service users. Both primary and secondary diagnosis are data fields in the MHSDS, but the level of completion is poor in most trusts.

Analysis using data from the May 2020 MHSDS performance report[10] shows that 21.6% of people had a diagnosis recorded at the end of the reporting period for mental health and learning disability services. The Mental Health Analysis Team at NHS Digital notes that:

'Within the MHSDS collection, there are a lot of non-mandatory sections because the data sought does not necessarily apply to every person. For example, a person may be referred to an outpatient service and so no hospital spell record would be expected to flow. The same is true for the diagnosis data in that:

- *Not every person is diagnosed as part of their treatment.*
- *Mental health diagnoses can be complex and can take a long time to attain.*
- *In some cases, clinicians are reluctant to "officially" record a diagnosis as the repercussions can be substantial. One common example is learning difficulties - it can be difficult to diagnose exactly which learning difficulty a person has, and furthermore, the stigma around being diagnosed with a learning difficulty may mean that in some cases the diagnosis is not recorded, or else delayed to a point when the clinician can diagnose with more certainty.*
- *The diagnosis fields use ICD-10 or SNOMED. In some cases, providers do not have the capabilities to submit these, and so this too helps to explain why the proportion of people with a diagnosis recorded is small.'*

The challenge remains for mental health services to come to a common agreement on how service users should be categorised.

Interventions

Measuring value requires data on the interventions received by service users, so that services can identify what interventions work for which service user to provide the best outcomes. This includes both non-pharmacological and pharmacological interventions.

While trusts do collect activity data on a service user's hospital admissions and community contacts, they tend not to routinely collate data on interventions at the service user level, despite it being a data field in the MHSDS.

[9] BJPsych Advances, Rowena Jacobs, Martin Chalkley, Maria Jose Aragon, Jan R. Bohnke, Funding approaches for mental health services: is there still a role for clustering? November 2018

[10] See note 7

'At our trust, we currently have no way of determining what a contact is for (for example cognitive behavioural therapy), only who provided it. Indirect patient care, for example multi-disciplinary team meetings, care pathway meetings and safeguarding, are a major part of care provision, but are not currently recorded in a clear and consistent manner.'

SNOMED CT

Mental health trusts were required to adopt SNOMED CT – a structured clinical vocabulary for electronic health records - by April 2020. It includes a wide range of data fields including interventions, symptoms, laboratory test results, and diagnosis. The MHSDS requests patient-level clinical data to flow using SNOMED CT.

SNOMED CT concepts are organised into 19 distinct hierarchies. One hierarchy is 'procedure.' This represents activities performed in the provision of healthcare, for example specialist mental health assessment, promotion of family support, interpersonal psychotherapy, prescription of drug.

The NHS Digital case study about Tees, Esk and Wear Valleys NHS Foundation Trust's adoption of SNOMED CT provides a list of some of the procedures included in SNOMED for mental health.

The data captured on procedures using SNOMED CT could be useful for measuring value once it has been fully adopted by mental health services.

Those wanting to find out more about SNOMED in mental health may want to watch the NHS Digital webinar The link also provides a useful set of slides used in the webinar.

Proxy interventions

Until mental health services start to collate data on interventions more consistently and comprehensively, it is perhaps possible for some of the 'activities' listed in the NHS England and NHS Improvement costing standards to be used as proxy interventions, for example contact with a specific community team is not an intervention, but in the absence of other data might be used as a proxy when looking at value.

Outcome measures

Outcome data is a key building block in assessing the value of an intervention. Although the NHS collects a lot of clinical data, many of the measures focus on processes or outputs, rather than outcomes.

As well as looking at clinical outcomes, it is important to measure value in terms of the outcomes that matter to service users, for example patient-reported outcomes measures (PROMS) and experience measures (PREMS).

According to Australia's New South Wales Health Department a health outcome is the:

'change in the health of an individual, group of people or population which is attributable to an intervention or series of interventions.

This definition is helpful because it makes clear that determining health outcomes, first and foremost, involves measuring a change. Secondly, they can relate to individual patients or entire populations and finally, the outcomes are related to specific interventions.[11]

[11] Healthcare Costing for Value Institute, Introduction to Outcomes

Outcome measures are currently rarely used in mental health for measuring how effective services are.

'At the moment I know whether a service is over or under spent, but I can't say whether it is effective – the gap is not measuring outcomes.'

'We want to know if we make a difference.'

The following list of outcomes measures were mentioned in our interviews. (This is not meant to be a comprehensive list)

Health of the Nation Outcomes Scales (HoNOS)

HoNOS is a method of measuring the health and social functioning of people with severe mental illness. It is a clinician-rated outcome measure comprised of 12 scales that measure behaviour, impairment, symptoms and social functioning. Each domain is rated by the treating clinician on the scale of 0 to 4: 0 means no problem, 1 means a problem that probably requires no intervention and 2, 3 and 4 correspond to 'mild', 'moderate' and 'severe' problems.

All mental health trusts are required to collect HoNOS scores as part of the MHSDS, but there are concerns about whether the scores are recorded consistently.

An article published by the Royal College of Psychiatrists provides some examples of how trusts have used HoNOS scores to assess the quality of care delivered, as well as develop and test initiatives aimed at improving the services they provide.[12]

Recovering Quality of Life (ReQoL)

ReQoL is a new Patient Reported Outcome Measure (PROM) that has been developed to assess the quality of life for people with different mental health conditions, with a focus on the themes of recovery.[13]

DIALOG

DIALOG is an outcomes measure to support structured conversation between service users and clinician focussing on the service user's views of quality of life, needs for care and treatment satisfaction.

Hospital anxiety score and depression scale (HADS)

Completed by service users, the scale is used by clinicians to determine the levels of anxiety and depression that a person is experiencing.

Montreal Cognitive Assessment (MoCA)

The MoCA test is used for diagnosing service users with memory loss and other forms of cognitive decline.

EQ-5D

The EQ-5D tool is used for measuring the health-related quality of life in cost-effectiveness analysis. There are five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression.

[12] BJPsych Bulletin, Mike J. Crawford, Mo Zoha, Alastair J.D. Macdonald, David Kingdon, Improving the quality of mental health services using patient outcome data: making the most of HoNOS, 2017

[13] https://www.reqol.org.uk/p/overview.html

International Consortium for health outcomes measurement (ICHOM)

ICHOM has developed standard sets of outcome measures for a wide range of medical conditions including mental health, for example depression and anxiety, and dementia. They are available for free here

Figure 11: Practical challenges of collecting outcome measures

One mental health trust in London collects two outcome measures: HoNOS and HADS. The system prompts clinicians to complete HoNOS scores, and they can do it easily on the iPads. HADS is completed by service users on pieces of paper. The hassle of photocopying the form, inputting in the data later and the lack of a system prompt means that the completion of HADS is much lower than HoNOS. Having the infrastructure in place to make the collection of outcomes simpler would ensure a higher rate of completion.

Use of resources (costs)

As well as understanding what interventions have been delivered, data is required on what resources were consumed to deliver the interventions. The amount of resources used can be measured as costs. In mental health services most money is spent on staff costs.

From 2020 all mental health services are required to calculate the costs of service user care at patient-level (PLICS). Figure 12 overleaf illustrates the key steps. The PLICS approach costs 'activities' which are a mixture of interventions (for example prescription of drugs) and more generic activities (for example a contact with a community mental health team).

The traditional reference costs, which mental health trusts have been required to calculate and submit nationally until 2020, are not helpful for providing an accurate measurement of the resources consumed to provide care. Unit costs were calculated at cluster level as a 'cost per cluster day'. This is unhelpful for measuring the value of a service model, for example, if a service user is seen twice but stays on the books for a year, this looks very 'cheap' compared to a service user who receives a more intense period of treatment followed by discharge.

Costing at the service user level provides organisations with the flexibility to group costs and activity data in different ways for different purposes – for example, by service user, clinician, team, service line or pathway. This flexibility of reporting means the outputs can easily adapt to different requirements – from mapping the pathway of individual service users to generating service line reports.

Figure 12: Key steps in patient-level costing

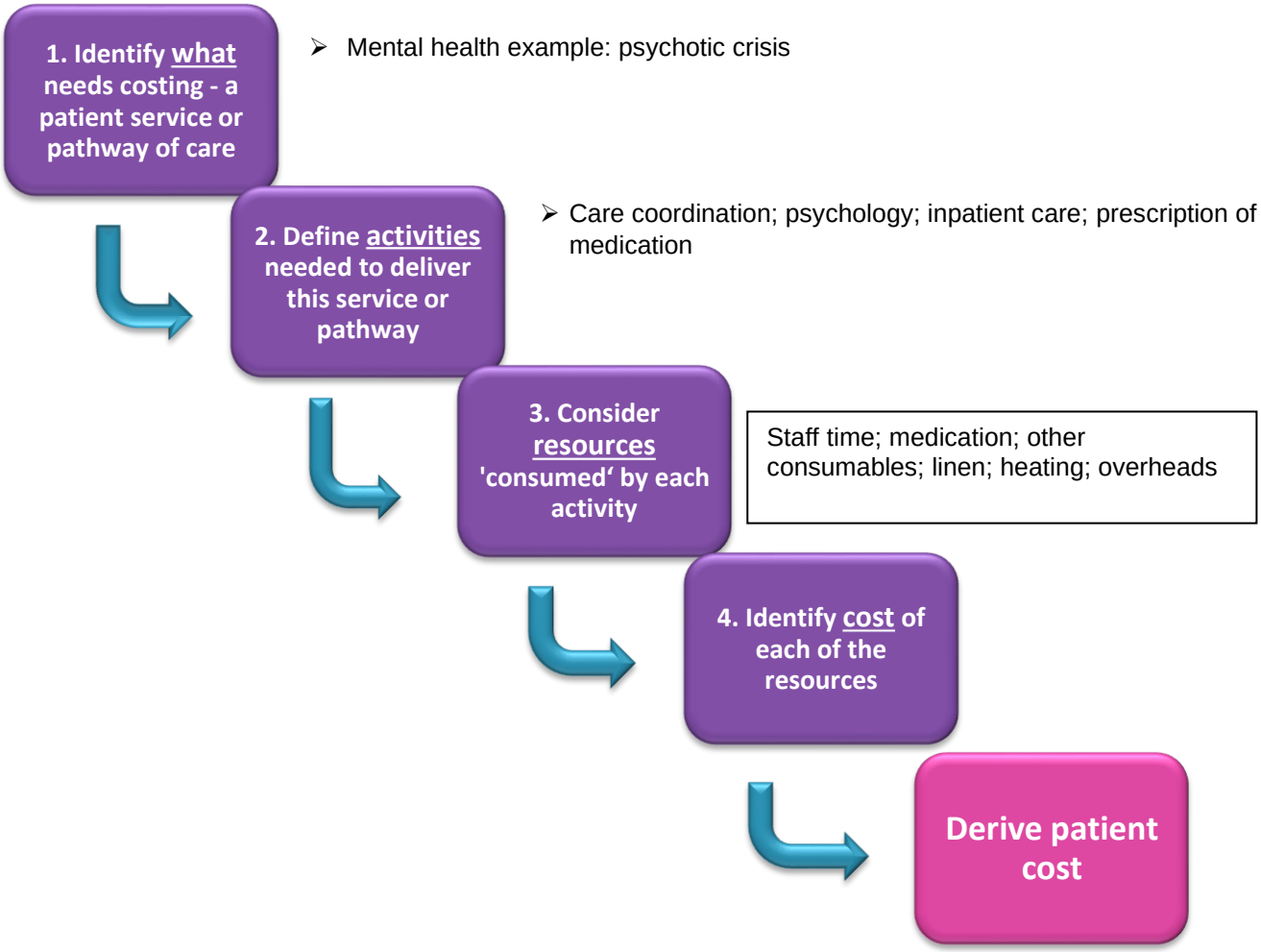


Figure 13 highlights the depth and type of information that is available within PLICS. The example shows the types of resources consumed by the service user and the associated costs over one week.

Figure 13: Example of use of resources for one service user

Week 20 – Service user reference number 696556											
		Admitted care			Non admitted care						
Date	Day	Ward	OBD	Cost	Team	Staff ID	Staff Name	Grade	Duration (mins)	Cost	Total cost
4th	Sunday				A&E Liaison	12225	A Adams	Band 6	125	£70.00	£70.00
4th	Sunday				HITT	13226	J Jones	Band 6	165	£92.40	£92.40
4th	Sunday				HITT	15689	S Smith	Consultant	45	£79.65	£79.65
5th	Monday	Lilac Ward	1	£374.50							£374.50
5th	Monday				HITT	15689	S Smith	Consultant	35	£61.95	£61.95
6th	Tuesday	Lilac Ward	1	£374.50							£374.50
7th	Wednesday	Lilac Ward	1	£374.50							£374.50
7th	Wednesday				CMHT East	16512	B Brown	Band 6	25	£14.00	£14.00
8th	Thursday	Lilac Ward	1	£374.50							£374.50
8th	Thursday				CMHT East	16512	B Brown	Band 6	67	£37.52	£37.52
9th	Friday	Lilac Ward	1	£374.50							£374.50
9th	Friday	Lilac Ward	1	£374.50	CMHT East	15689	S Smith	Consultant	38	£67.26	£441.76
10th	Saturday	Lilac Ward	1	£374.50							£374.50
Total				**£2,621.50**						**£180.73**	**£2,427.73**

Source: Healthcare Costing for Value Institute, *PLICS Toolkit for Mental Health Services,* 2017

Conclusion

Transforming services and improving value – ensuring that resources are used well and effectively – is only possible where there is good collaborative working between clinicians and finance. Jointly discussing how to best use the resources available to provide high-quality care, and presenting data in a way which is clinically meaningful is a good first step for closer working.

A number of key data building blocks are required to measure value in mental health. This presents a number of challenges as the data for some of the building blocks is not routinely collected, or the data collected is not always complete. Inconsistent service definitions and the lack of information about case mix can make benchmarking with others difficult. In addition, mental health does not have a classification system which is universally accepted.

However, mental health services can make more of the data that they do hold to understand how they are using resources, and start to unpack warranted and unwarranted variation. It is important to measure value across the whole service user pathway – rather than individual points of care - to identify high and low value interventions. Changing interventions or using different resources, while improving or maintaining the same outcomes, can improve value.

Appendix A Acknowledgements

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Appendix B Getting it Right First Time (GIRFT)

One major 'value' initiative being rolled out currently across England is the Getting it Right First Time (GIRFT) programme.

'Getting It Right First Time is designed to improve the quality of care within the NHS by reducing unwarranted variations.

By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

Importantly, GIRFT is led by frontline clinicians who are expert in the areas they are reviewing. This means the data that underpins the GIRFT methodology is being reviewed by people who understand those disciplines and manage those services on a daily basis. The GIRFT team visit every trust carrying out the specialties they are reviewing, investigating the data with their peers and discussing the individual challenges they face.'[14]

GIRFT has three mental health workstreams.

Adult crisis and acute mental health

https://gettingitrightfirsttime.co.uk/medical-specialties/mental-health-adult-crisis-and-acute-mental-health/

Child and adolescent mental health services

https://gettingitrightfirsttime.co.uk/medical-specialties/mental-health-child-and-adolescent-mental-health-services/

Rehabilitation

https://gettingitrightfirsttime.co.uk/medical-specialties/mental-health/

[14] https://gettingitrightfirsttime.co.uk/

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.

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