Mental Health Finance Faculty
Providing a platform for influence

hfma Healthcare Costing for Value Institute

# National cost collection - mental health

## Views of HFMA Institute and Mental Health Faculty members

November 2019

## Introduction

In September 2019 a few members of the Healthcare Costing for Value Institute notified the Institute that they had some significant concerns about the 2019 patient-level costing (PLICS) voluntary collection for mental health services and the mandation of PLICS for mental health in 2020. The Institute decided to work jointly with the HFMA Mental Health Faculty to seek the views of all mental health trusts to understand what the concerns were. The HFMA Mental Health Faculty includes all mental health trusts in England.

An email was sent in October, noting that we had heard from some Institute members that they had concerns about the national cost collection (NCC) for mental health and asking for views and comments. We received 18 responses, representing 31% of all mental health trusts. Virtually all responses were from trusts involved in the 2019 voluntary collection.

This report provides:

- a brief summary of two reports written by the Institute this autumn about the NCC which focus on the acute sector, but contain messages relevant to the mental health sector
- a summary of the responses received from the mental health sector.

The report will be shared with NHS England and NHS Improvement (NHS E&I) and all mental health trusts.

The HFMA Institute and Mental Health Faculty are keen to discuss the issues noted by the mental health sector with NHS E&I and consider how they can help NHS E&I to address the challenges raised.

## The importance of robust patient-level cost data

The HFMA and its Institute have been strong advocates for robust patient-level cost data for a number of years.

Costing has a major role to play in supporting the delivery of sustainable services across the NHS. It should underpin decision-making, ensuring local decisions are informed by a clear understanding of current costs and the likely costs of new ways of working. Good cost and activity data at the patient level can help health economies to understand variations in care between different patients, helping to optimise service delivery.

The recent Institute briefing What finance data is required to drive value at a population level? emphasises the need for robust cost data to understand how resources are currently distributed across healthcare systems.

The Institute programme supports the NHS to improve costing, turn data into powerful patient-level information, champion multi-disciplinary engagement and ultimately drive value.

## Institute reports on the NCC in 2019

This is the third report that the Institute has written on the NCC in 2019. The other two reports are described below. While the reports focus on the acute sector, many of the findings and recommendations are relevant to acute, mental health and community services.

**1. National cost collection – views of Institute members August 2019**[1]

This briefing lists the areas of concern raised by acute costing practitioners, grouped under a number of themes:

- healthcare costing standards and guidance
- open learning platform
- cost collection process
- NHS E&I costing team
- recruitment and retention of cost accountants
- data quality of submissions.

The HFMA met with Chris Walters, Director of Pricing and Costing at NHS E&I and agreed a number of actions to address the issues raised.

**2. Healthcare acute costing standards for England – recommendations October 2019**

One area of concern raised by the acute sector was the healthcare costing standards, which members felt were too complicated and included elements which were unnecessary, impractical or impossible to implement. More experienced costing practitioners queried whether those newer to the profession would be costing accurately, given the complexity and length of the standards.

It was agreed that the HFMA Institute would review the standards and provide a list of recommendations. A second report was sent to NHS E&I in October setting out our findings and recommendations. This report has been shared with Institute members.

Members developed a set of criteria against which to measure the costing standards. Figure 1 describes what they think good looks like.

[1] HFMA, *National cost collection - views of Institute members August 2019*

**Figure 1 What does good look like for costing standards?**

| | |
|---|---|
| **Proportionate** | The level of resources consumed to produce the cost data as specified by the standards needs to be proportionate to the benefits it provides. |
| **Achievable** | The standards should be achievable in all trusts using data that is already mandated in a national data set. |
| **Deliver high quality comparable cost data** | The standards and associated tools should support trusts to produce high quality cost data in a consistent manner. This includes providing clear messages on how and where to focus their efforts on improving the quality of costing. |
| **Easy to understand** | The standards should be easy to read and understand. |
| **Provide useful information for local and national use** | The standards should generate useful information for local use to support improvements in efficiency and patient care. At a national level the standards should generate data which is useful for setting prices and creating national benchmarking data sets. |

Members' views are that the current acute standards do not currently meet this set of criteria. Their reasons are outlined in the report, together with recommendations on how to improve the standards.

Our members' view is that a new set of standards should be worked on in time for 2021 which, as a minimum, should take account of the recommendations in this report. While the report focuses on the acute sector, most of the recommendations are relevant to acute, community services and mental health. The HFMA Institute members are keen to work with NHS E&I on the new set of standards.

# Summary of mental health responses received

The following sections of this report provide a summary of the views expressed by mental health trusts. We have grouped the responses under a number of themes:

- mandation of PLICS for mental health in 2020
- mental health not seen as a priority
- 2019 voluntary PLICS collection
- costing standards
- activity and resource data
- outputs from PLICS submissions
- clinical engagement
- mental health trust capacity to implement the costing standards
- trusts with mental health and community services
- NHS E&I response time to queries
- education and training cost submission.

## Mandation of PLICS for mental health in 2020

Over 50% of mental health trusts are taking part in the voluntary PLICS collection this autumn, which demonstrates the importance the mental health sector places on PLICS, and their desire to be part of the journey towards a comprehensive and consistent approach to costing in mental health.

> *'Now we're moving to all systems having fixed income arrangements, one of the big prizes in town seems to still be really understanding our cost drivers and managing these - whatever benchmarks we can reinstate to inform re-design and productivity assessments would be welcome.'*

> *'It would also be helpful to see how differential local investments in different aspects of whole pathways do/don't generate different outcomes e.g. on adult acute where we have different beds/staffing, crisis/IHTT, assertive outreach, CMHT etc but view this as one pathway comprised of different building blocks.'*

While mental health trusts are broadly supportive of PLICS, many trusts feel that mandation in 2020 is too early. The following sections describe why many mental health trusts feel that the pace is too fast.

## Mental health not seen as a priority

Members feel that both NHS E&I and the costing software suppliers are focusing on the acute sector, which is having an impact on mental health and community providers' ability to implement PLICS.

> *'As acute services have been chosen to be mandated first, software suppliers and NHS E&I have obviously been concentrating on those services and not being given the chance with limited resources to catch up with changes needed to meet the very different needs of mental health and community services.'*

> *'We feel like NHS E&I and our software supplier put the priorities of acute trusts first, and mental health and community are just left behind with no or little communication.'*

> *'The software suppliers are becoming overstretched as they take on more customers who are racing to meet the NCC deadlines – with the mental health model this is even more problematic as they have basically been building it as they went along once they realised how different it was to the acute model.'*

> *'We are struggling with getting our costing supplier to produce meaningful reports so we can investigate the outputs further, they seem to be very acute focused.'*

## 2019 voluntary PLICS collection

Trusts raised a number of concerns about the 2019 voluntary PLICS collection and the impact it has on the mandation of PLICS in 2020. Trusts take part in the voluntary submissions to prepare themselves for when PLICS is mandated and to support NHS E&I test out the methodologies. Their experience this autumn means that they feel neither aim will be met.

### Timescales

Members were concerned about the late notification of the timetable and the very tight timescales. Dates for the submission window were confirmed late in the process and the final guidance was released only 35 days before the submission window opened.

*'The dates of the mental health PLICS collection window (11th to 22nd November) were confirmed on 11th September – only two months before the window is set to begin. Until then we had been informed that the window would probably run from 4th to 15th November and had therefore used these dates to plan our annual leave. For planning purposes it would be useful to have deadlines confirmed much earlier in future particularly as most costing practitioners tend to work through the entire summer and then take annual leave when the collection window has shut.'*

As at 30 October trusts still did not have a functioning data validation tool (DVT) although it had been promised earlier in the month. The late publication of guidance and tools has a knock-on impact, as the costing software suppliers have to then make amendments to the software, before it can be used.

*'Our main concern is the timing of the return and running the data through the DVT and data quality issues mentioned above. It is difficult to anticipate the DVT issues as we are still awaiting publication of this tool to be able to run the data and test any issues that are coming out of the system. At the early implementer meetings other members have indicated it can take weeks to run, amend and rerun the data to be able to make a submission.'*

*'We still do not have a functioning DVT – although this was promised on 14th October, which means our costing supplier is unable to guarantee whether the output from our system will be uploaded successfully.'*

The very tight timescales mean that trusts are concerned that the voluntary collection will not provide the necessary learning before PLICS is mandated.

*'None of this makes trusts taking part have any belief that completing the voluntary submission will mean any of us learn anything which is why we are doing it! The ridiculous time frame doesn't allow any time for learning. All we will be doing is processing with our fingers crossed that the suppliers' software changes and the tools NHS E&I give us have been fully tested so they will work. However, from my many years' experience of receiving late software updates that is never the case.'*

### Lack of involvement of NHS Digital

Members are concerned that the voluntary submission is being submitted through a local NHS E&I system, rather than the NHS Digital system. They understand that the November submission will include a smaller range of activity data fields, compared with the number required for the PLICS return to NHS Digital in 2020.

This means that there is no opportunity to test out the NHS Digital system before the mandatory submission in 2020.

*'The upload system for the voluntary submission will be a NHSI local system not the NHS Digital solution actually used for the annual submission – hence there is no opportunity to test the NHS Digital solution ahead of next summer's first mandatory return. This is concerning given the issues the acute trusts had submitting this year.'*

Members are also concerned that the lack of involvement of NHS Digital means that the submitted data will not be matched to the Mental Health Services Data Set (MHSDS).

*'This year is our last chance to try a mental health submission, but we are not going to get chance to submit to NHS Digital and thus not able to match the data to MHSDS submissions. This is a problem, as last year many of the 19 trusts that submitted found the matching element of the costing assurance tool the most challenging and now we don't have an opportunity to test changes to improve this before submissions are mandated.'*

*'This year is not a full submission in that there will be no matching so we will not be able to rectify any issues before mandating for mental health in 2020.'*

## Costing standards

Members expressed their concerns about the standards, which they feel are very long, too complicated, confusing and in some areas very challenging to implement.

*'One of the main reasons for introducing new standards was to address the major criticism of reference costs. At a national level there was a wide variation in the cost of delivering what was ostensibly the same level of clinical activity. The concern was that the variation was due in the main to the way costs had been complied.*

*Everyone agreed there was a need to address that concern, but the current standards are overly complicated and include elements which are very challenging to implement. There is too much focus on detail so take a lot of time to implement, reducing the time available to validate the final output.*

*PLICS guidance has grown exponentially. There have been in excess of 1000 pages of guidance issued with costing practitioners expected to understand and implement it. Apart from the sheer volume of information, there are multiple documents which are occasionally contradictory.'*

### Mapping the general ledger to the cost ledger

Concerns were raised about the amount of time it takes to map the general ledger to the cost ledger, and whether it was of value.

*'The cost ledger mapping process is extremely bureaucratic, overly prescriptive and of questionable value.'*

*'I find the standardised cost ledger unnecessary and would just map from the general ledger to resources.'*

*'Mapping the general ledger to the cost ledger takes a huge amount of time - two straight weeks of work to complete a task that is not useful to trusts.'*

### Lack of time to use PLICS data

Some trusts commented that the cost of production meant that they had little time to use the PLICS data.

*'I feel that the data burden on trusts is just becoming about the churn of data rather than giving the costing team the time to access and analysis the data. I am really not sure what NHS E&I are going to use so much data for.'*

## Activity and resource data

Members raised a number of concerns about activity and resource data.

### Lack of investment in activity recording systems

The lack of investment in activity recording systems for mental health means that the sector is considerably behind acute services in the availability of activity data.

> *'There has not been the same level of investment in PLICS for mental health and community when compared to acute services. Acute services have been driven by payment by results to be better at recording activity and costs (for income comparison). Mental health and community are generally commissioned on block, so have never had the same incentive to invest in such finance and activity recording systems and thus are generally starting their PLICS journey from a more basic activity information point. '*

### Mental health services data set

Despite the MHSDS being mandated, there are concerns about how complete the data fields are.

> *'MHSDS may be mandated, but it is not enforced and teams know that, so there is no incentive to actually make sure everything that is supposed to flow.'*

> *'One real issue I can currently see for next year's mandatory submission is how we would submit activity that is not recorded on our PAS system and is not currently on the MHSDS when it should be. At the moment with the voluntary submission only activity that is currently recorded on the MHSDS is to be submitted.'*

### Other gaps in data

Members provided examples where data required by the standards is not available at their trusts.

> *'Lack of patient information regarding high level expenditure areas such as drugs, pathology and radiology will mean that some costs are allocated within cost pools and not to patients as this data is not available within the trust.'*

> *'MHSDS does not necessarily provide all the useful data required. For example. there is only a requirement to flow the final cluster and not a patient's cluster changes during care as per reference cost requirements. The final cluster may have little relevance compared to being able to understand the clusters throughout the patient's pathway of care.'*

> *'For admitted patient care we are required to identify the cost of each episode of care i.e. the period that a patient is under the care of a healthcare professional. However, episode start and end dates are not currently being recorded correctly on our patient administration system in line with the NHS Data Dictionary definition of a consultant episode.'*

> *'The allocation of the costs of consultants to the patients that they see and treat requires us to link their pay costs recorded in the financial ledger to their activity as recorded on the PAS. The standards recommend that we use the healthcare professional local identifier field in the admitted patient care and non-admitted patient care datasets to do this. However, this particular field is an alphanumeric one that is currently used only in the PAS which makes the process of allocating consultant costs to activity more complicated and potentially less accurate.'*

> *'The standards require drugs dispensed to patients to be matched to the relevant patient episode, contact or attendance using a combination of the patient's NHS number and the date that the drug was issued. However, in the patient level drugs dispensed data for 2018/19 that*

*we received from our pharmacy team around one-third of the drugs issued are missing the patient's NHS number.'*

*'The IAPT data set and the associated reference tables are very limited therefore does not support costing in the same way that non-admitted and admitted care data sets do.'*

*'Not all patient activity is currently being recorded on the PAS and is therefore obtained from other sources at a summarised level, for example criminal justice liaison services. Also, no activity data at all is currently available for prison mental health services and the suicide prevention team.'*

### Identifying NHS funded activity

The current guidance does not cover how to deal with integrated teams.

*'A key issue for mental health providers is that some services are jointly commissioned by NHS and social care – the cost submission is only meant to include NHS funded activity, but all activity from integrated teams is included in the MHSDS. There is no acknowledgement of these types of issues in the guidance.'*

There are additional challenges where services are jointly provided by a mental health trust and a non-NHS provider.

*'The NCC requires us to identify the cost to the NHS of treating NHS patients. However, some of our services (e.g. drug and alcohol services) are jointly provided by the trust and a non-NHS provider and we are currently unable to separately identify the activity provided by each organisation.'*

### Personal data

There are concerns about the level of personal data required for IAPT services.

*'Concerns have been raised by our IAPT service on the amount of personal information that is being requested by NHS E&I for the IAPT return (NHS number, postcode, date of birth and gender). Due to the methodology used in producing non-mandatory tariffs for IAPT last year, the service is extremely reluctant to provide any IAPT data to the centre.'*

## Outputs from PLICS submissions

Trusts who submitted PLICS data in 2018 are frustrated that they did not receive any useful outputs.

*'We waited with bated breath for the feedback – but the feedback was of no use. It didn't give us any idea of how our PLICS submission compared with other early implementers – all it did was give comparative information about the MHSDS and PLICS submission data.'*

*'As one of the early implementers we still haven't had any information fed back to us as to how this information will be used and presented.'*

*'For those organisations that did submit data for the voluntary PLICS submission in 2017/18, we have not received any meaningful feedback on the data submitted, so have been unable to demonstrate any benefits of the return within our organisation.'*

### Alternative to reference cost index

Trusts are concerned about the lack of clarity about how national costs for mental health will be presented once reference cost submissions are replaced by PLICS.

> *'When I asked the NHS E&I costing team what the reference cost measure is going to be from PLICS it wasn't known, and it didn't seem as though it had been thought about which is worrying. This is something we currently have with reference costs and is a measure that trust boards are very interested in.'*

> *'It is still unclear how a Patient Cost Index (PCI) will be calculated for either mental health or IAPT. There also appears to be a lack of awareness that activity data which has been submitted in the reference cost submission, will not be available in the PLICS submission (e.g. cluster days or mental health assessments).'*

> *'There are no clear messages on the alternative to the reference cost index. There will be a portal to access results and I assume against peers but the mental health portal has not yet been made available.'*

> *'Due to the use of the reference costs data internally for management information and benchmarking it is felt that ceasing the collection of reference costs activity for mental health services before PLICS data is widely recognised would impact on internal pricing and contracting arrangements.'*

## Clinical engagement

A number of members commented on the challenge to get clinical buy-in.

> *'So far we have struggled to get any clinical engagement in the PLICS process although this may change when we have some outputs to share after we've submitted our 2018/19 PLICS data. However, the main difficulty in trying to "sell" PLICS has been that many of the incentives that exist in the acute sector (such as surgeons competing amongst themselves to reduce the amount of time that their patients spend in theatre) do not translate easily into mental health.'*

> *'Clinical buy-in and engagement is key to success and our clinicians simply do not buy the current focus including clusters as being in any way clinically useful or value adding.'*

> *'We have not had the capacity to discuss any of the PLICS detail with our clinicians during the 2018/19 process.'*

> *'Clinical engagement is limited as we cannot provide interesting/ useful data to the clinicians to engage with, until it has reached a reasonable point of development.'*

## Mental health trust capacity to implement the costing standards

Members questioned whether there was sufficient capacity in the sector to implement the costing standards.

### Investment required

Mental health trusts start from a low base point with regards to infrastructure, and those trusts who have implemented PLICS have discovered it requires significant additional investment.

*‘As PLICS is a new development in mental health and community, it was not clear exactly how much more hardware investment was required to process so many more lines of data transactions when providing so many community-based services with high volumes of individual activity. Significant additional investment has been identified as necessary within our trust, in server hardware, RAM /processing capacity, PC / Laptops and additional SQL licensing. Trusts who have not joined the early implementation process, may not be able to react quickly enough to provide such resources.’*

### Size of costing teams

Many mental health trusts have small costing teams, which makes implementing the new PLICS standards a challenge. Recruitment and retention are also a concern.

*‘In mental health we are very small costing teams and the loss of an experienced team member can be devastating on the ability of a trust to submit. Our full costing team is only 1.8 whole time equivalent, and we have been running at 48% capacity for 12 months due to recruitment challenges.’*

*‘Costing team members have a much wider skill set than their management or financial accountant counterparts, we don’t just have to be experts in the general ledger, but need to know and understand a wide variety of systems and how to extract, understand and use data held in each of them, to know all of the funnies in those systems and data. This is not knowledge that can be gained quickly but takes time to learn. Training takes time to complete. We have over 70 sites, multiple services (mental health, community services, general practices, property services), we don’t just have a single patient administration system but currently use four across the trust (one of which has multiple modules that are all configured differently) – so everything gets complicated really quickly.’*

*‘Within our mental health trust, our single cost accountant focuses on supplying and reporting our existing top down information into the commissioning discussions taking place across our STP. This is used to try to ensure our trust remains sustainable. Who is left to now pick up the technical implementation of PLICS in the current financial climate?’*

Members living a distance from London found getting to the early implementer and technical focus group meetings challenging, especially given the small size of the costing teams.

## Trusts with mental health and community services

Some trusts with both mental health and community services are required to submit PLICS data for mental health and reference costs for community services in 2020. This creates some challenges, and additional work to already stretched costing teams.

*‘For summer 2020 I will need to do a mental health PLICS submission but my community element at the trust will need to be done by the old reference cost way. It would be better if I was doing everything the same way as you need to reconcile to the audited annual accounts and this will mean more work with our costing provider to set up reference costs in a new costing system as we only have PLICS set up in it. We have previously done reference costs in an old system but wouldn’t be able to use two systems as you would never reconcile to the accounts.’*

## NHS E&I response time to queries

Mental health trusts have raised similar concerns to the acute sector about the speed of response times by the NHS E&I costing team to queries.

> *'Whilst we are appreciative of the new guidance received and feel it is helpful in shaping our development for patient level costing, there is currently a delay in receiving responses to queries raised. At times responses are taking between five to ten days and in addition the phone line is only manned between 10-12. Could we propose the phone line is extended and manned 9-5 each day to support more timely responses, especially as we head towards the mandated return and the likely demand increases?'*

## Education and training cost submission

Given all the challenges listed in this report, the view of members is that the education and training cost submission should not be introduced until PLICS has stabilised.

## 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.

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## About the Mental Health Faculty

The HFMA Mental Health Faculty is a group of organisations and finance professionals that share experience and expertise. All mental health trusts in England are members of the faculty and use their combined numbers to influence thought and policy in the sector. The faculty provides a combination of learning, technical development and networking opportunities; supporting and representing the interests of finance professionals in the faculty. Being part of the faculty gives organisations and finance professionals an opportunity to share learning and work on solutions for common issues within challenging financial constraints.

## 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.

The HFMA is the biggest provider of healthcare finance and business education and training in the UK. It 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 association is also an accredited provider of continuing professional development, delivered through a range of events, e-learning and training. In 2019 the HFMA was approved as a main training provider on the Register of Apprenticeship Training Providers and will be offering and developing a range of apprenticeships aimed at healthcare staff from 2020.

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