Approved Costing Guidance – Standards

Mental health costing methods

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Contents

CM1: Medical staffing

Purpose: To allocate medical staff costs to the activities they deliver.

Objectives

1. To ensure all medical staffing costs are allocated in the correct proportion to the activities they deliver, using an appropriate cost allocation method.

2. To allocate the actual medical staffing costs to their named activity if available.

Scope

3. This standard applies to all medical staffing costs in the cost ledger.

Overview

4. Medical staff form a large proportion of your organisation's costs and are likely to deliver a significant proportion of patient-facing activities.

5. To ensure this activity is costed as accurately as possible, you should allocate the actual medical staff costs to their own named activity if available. Non-consultant medical staff costs should be allocated as for other staff groups to the correct resources and activities.[1]

6. For example, Dr Stringer is a consultant psychiatrist who undertakes outpatient contacts and admits patients under her name. Dr Stringer's costs should be allocated to her activity using the prescribed cost allocation methods in columns F and G in Spreadsheet CP3.3.

[1] If you do allocate non-consultant medical staff and other named healthcare professional costs directly to patients, this is a superior costing method. See superior method SCM7 in Spreadsheet CP3.5 for more information.

7. If clinicians are to use patient-level costing effectively to improve services, they need to be confident their activity is costed appropriately. Allocating their actual costs to the activity they have delivered, rather than an average cost, will increase their confidence in the cost data's accuracy.

8. To cost medical staff activities accurately you need to know what activities each medical staff group delivers in your organisation, eg ward rounds, outpatient care, care programme approach (CPA) meetings and outreach contacts.

9. You also need to understand which of the activities delivered by medical staff are patient-facing and which are 'other activities' (the latter include research and development and education and training).

Approach

10. Review the prescribed list of activities in Spreadsheet CP3.2 and identify those your medical staff deliver.

11. Allocate all medical staffing costs using the following resource IDs:

    - MHR253 Consultant – mental health
    - SGR062 Consultant
    - SGR064 Consultant – anaesthetist
    - SGR063 Non-consultant medical staff
    - SGR065 Non consultant medical staff – anaesthetist.

12. Table CM1.1 is an excerpt[2] from Spreadsheet CP3.3 showing the resource and activity links to use for consultant and non-consultant medical staffing. This list will be extended as we complete further work with mental health organisations.

13. For each resource and activity combination there is a two-step prescribed allocation method in Spreadsheet CP3.3

[2] Please note all excerpts in this standard are for illustrative purposes only. Use Spreadsheet CP3.3 to ensure all the resource and activity links you are using are correct.

Table CM1.1: Excerpt from Spreadsheet CP3.3 showing the resource and activity links for consultant and non-consultant medical staffing costs

Resource	Activity							
	A&E – MH liaison care	MH supporting contact 1:1 – inpatient unit	Ward round	R&D	Outpatient care	CPA meeting	Respite care	Psychological group contact
Consultant – mental health	£X	£X	£X	£X		£X		£X
Consultant			£X	£X	£X		£X	
Consultant – anaesthetist			£X		£X			
Non-consultant medical staff					£X	£X	£X	
Non-consultant medical staff – anaesthetist					£X		£X	
Nurse		£X			£X	£X	£X	£X
Medical and surgical consumables		£X			£X		£X	

14. Mental health consultants (resource ID: MHR253) must be separated from other consultants (resource ID: SGR062) within the costing system because they have distinct areas of work, such as psychiatry, forensic psychology, neuropsychology, etc.

15. Use resource ID: SGR062; Consultant for physical health specialists and resource ID: SGR064; Consultant – anaesthetist for anaesthetists and critical care intensivists.

16. This separation of mental health consultants is included to make reporting better at integrated and mental health providers that have staff from specific physical health specialties, eg to provide physical health support for post-traumatic stress disorder.

17. Allocate all non-consultant medical staffing costs using the resource IDs: SGR063; Non-consultant medical staff and SGR065; Non-consultant medical staff – anaesthetist.

19. You will need to identify the medical staff costs in the general ledger, using the expense codes for consultant and other grades of medical staff.

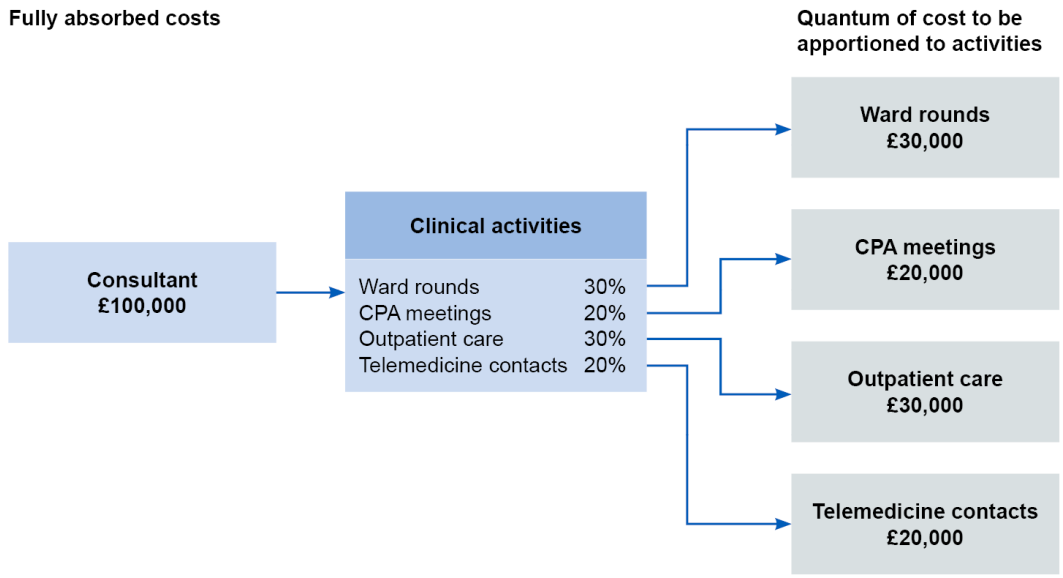
20. Map your medical staffing costs to the cost ledger according to the service in which the staff work (this may be at specialty level or a local team category).

21. You will need to identify the quantum of medical staffing costs to allocate to each type of activity using a percentage split of medical staffing costs by activity type. You can find this out through discussions with medical staff, using job plans or other sensible means, such as clinic set-ups, live job diary recordings or electronic clinical notes (see Figure CM1.1).

22. Do not apportion the same percentage split to all activity types unless evidence suggests that is appropriate. You must document the rationale for the percentage split you use in integrated costing assurance log (ICAL) worksheet 24: CM1 consultant % reasoning.

23. The apportionment should take place in your costing system to give you the quantum of cost for each activity type.

Figure CM1.1: Identifying the correct quantum of cost to be apportioned to activities



24. Once the quantum of cost for each activity type has been calculated, the costs are allocated using the prescribed cost allocation methods in Spreadsheet CP3.3.

Using payroll information for consultant medical staffing

25. The Mental Health Services Data Set (MHSDS) includes the consultant code (or other ID) in the 'healthcare professional local identifier' field; and this is built into both the admitted patient care (APC) and NAPC sections. This information is required to match consultants to named patients (see Spreadsheet IR1.2).

26. The 'healthcare professional local identifier' field may also include non-consultant medical staff (or other healthcare professionals), according to local policy. Where this is the case, these staff are responsible for the patient while they remain on the dataset (episode or contact). A permitted substitution is costing them at named activity level. Each patient admission may have multiple episodes of care, with responsibility changing from one to the next. Each should have cost associated with it.

27. This standard requires consultant cost to be allocated at patient level for individual staff. So, in Figure CM1.1, the resource shown as 'consultant' would be one individual.

28. The costing standards do not require allocation at patient level for individual staff from other staff groups. So, in this context, ‘consultant’ in Figure CM1.1 would be all staff in that resource.

29. If you are already costing non-consultant staff members’ activity at patient level and linking this to the individual staff, continue to do so and document it in your ICAL; this approach is a permitted substitution.

30. If you are not already linking named staff to named patients, you need to identify activity that does not incur a named consultant cost. The activity rows should be removed from the matching of named staff to named patients, to avoid double counting the costed resources to the patient – that is, from both the named professional costing and the standard non-medical staff process.

31. The costs of non-consultant medical staff will be allocated across all the appropriate patient-facing activities in accordance with Standard CP3: Allocating costs to activities.

Consultant resources

32. Consultant job plans can inform allocations to activities for consultants.

33. An example template for gathering this information is included in ICAL worksheet 23: CM1 Consultant % split.

34. Do not use consultant job plans as a basis to allocate other medical staffing costs, such as those for non-consultant medical staff or consultant nurses. Allocate those costs based on discussions with those staff groups and other information sources.

35. For some medical staff, the percentage split of medical staffing costs by activity type may be divided further for specific groups of patients. For example, in Figure CM1.1, outpatient care could be divided between two different services, such as £10,000 for child and adolescent mental health services (CAMHS) relating to teenage transition patients and £20,000 for adult services.

Ward rounds

36. Ward rounds are regular or planned consultant visits to the ward to review a range of patients. Ward rounds can also involve psychiatric nurses, non-consultant medical staff, therapists, psychologists and other staff. (Note: where material, the costs of all these staff should be identified as part of the ward round activity.)

37. The activity ID: SLA098; Ward round should show the cost of the relevant resources for the staff attending the ward round.

38. If the clinical service deems all ward rounds to be identical, the split of activity to patient level can be based on number of patients alone. No further information is needed.

39. If medical staff in your organisation care for patients with different conditions, or other specific characteristics, and ward rounds vary in duration because of this, find out from discussions with medical staff what the average duration of a ward round is for the different patient groups.

40. Table CP3.4 in Standard CP3: Allocating costs to activities contains a template for a statistic allocation table for ward rounds. This allows you to develop relative weight values (RWVs) for patient groups who require longer, complex or weekend ward rounds.

41. Use this information as a RWV alongside length of stay to allocate ward round costs that better reflect the time medical staff spend with patients.

Inpatient supporting contacts

42. Discussions with the service teams will provide information on the other elements of medical staff time,[3] to allow their cost to be allocated to the correct activity and inpatient episode.

43. Supporting contacts are consultant ward visits additional to the formal ward rounds or general ward care, usually for one (or more) specific patient

[3] Supporting contacts are described further in Mental health Standard CM3: Non-admitted patient care and Mental health standard CM13: Admitted patient care. They also will include other staff types – such as therapists.

contacts, or to a ward that is not their normal area. Use the supporting contacts feed[4] (feed 7) in accordance with Spreadsheets IR1.1 and IR1.2. These activities on inpatient wards can have different formats but the most frequent are:

- **One-to-one sessions with the patient**, which may be informal or in a private location. These are detailed in Mental health standard CM3: Non-admitted patient care – the standard describes the treatment of the contact even where the meeting takes place during an inpatient episode.
- **Multidisciplinary contacts:** defined as one patient and more than one staff member. These are detailed in Mental health standard CM3: Non-admitted patient care and Mental health standard CM9: Clinical MDT meetings. The latter describes how to treat such contacts even when they takes place during an inpatient episode. Use activity ID: MHA259; Mental health supporting contact multidisciplinary – inpatient unit.
- **Group sessions:** these involve more than one patient and one or more staff members. These are detailed in Standard CM14: Group sessions.
- **Care programme approach (CPA) meetings**, where one patient and multiple professionals meet to agree the formal care plan. These usually take place annually but may be more frequent. These are detailed in Mental health standard CM9: Clinical MDT meetings. There is a separate activity for CPA meetings in response to the need for clearly costed information in the sector. Use activity ID: MHA261; CPA meeting.

44. You should record these types of contact – where the patient is seen during an inpatient episode – on the supporting contacts feed (feed 7). This will allow allocation of actual time spent with patients (in addition to ward rounds and ward work) using the activities in Table CM1.2.

45. Medical staff may also take part in other multidisciplinary team (MDT) meetings: where a patient is not present, a meeting between staff members that specifically relates to one patient. As the patient is not present, it is not a patient contact but can be recorded as an activity. These should be recorded on a standalone clinical MDT database feed (feed 14). See Mental health standard CM9: Clinical MDT meetings for further information.

[4] This is a superior costing method.

Table CM1.2 Excerpt from Spreadsheet CP3.2 showing the activities relating to admitted patient care

Activity ID	Activity
MHA258	MH supporting contact 1:1 – inpatient unit
MHA259	MH supporting contact multidisciplinary – inpatient unit
MHA261	CPA meeting
SLA128	Other multidisciplinary meeting
MHA260	Psychoeducational group contact
MHA280	Skills development group contact
MHA281	Cognitive behaviour/problem-solving group contact
MHA282	Interpersonal process group contact

Non-admitted patient care and outreach care

46. The NAPC – mental health feed (feed 3b) will record these activities at patient level.

47. In accordance with Mental health standard CM3: Non-admitted patient care, use the activity ID: SLA135; Outpatient care, where a consultant or other healthcare professional holds formal outpatient clinics in their usual setting – for example, a hospital-based mental health consultant holds a clinic in a hospital setting; or a community-based consultant holds a clinic in a community clinic setting.

48. Staff members also have non-admitted contacts in locations other than standard clinics. We have identified the following:

    - Outreach contacts are contacts outside the standard clinical setting that have required significant additional time ‘searching’ for the patient. Use the activity ID: SLA101; Outreach visit. You should allocate this activity using the total duration of contact in accordance with the ‘clinical contact duration of care contact’ field, plus local information at patient level for the searching time.
    - Visits to the patient’s home or current place of residence – use the activity ID that reflects the care given; eg MHA289; Initial assessment or SLA135;

Outpatient care. These can include contacts at hostels or shelters, temporary residence at a friend's/family's home and where the homeless person lives on the street, and are identified by the 'activity location type code' field. Use the duration of the contact in accordance with the 'clinical contact duration of care contact' field.

- For contacts in prisons or judicial settings, use the activity ID relating to the care given. The location is identified by the 'activity location type code' field. Use the duration of the contact in accordance with the 'clinical contact duration of care contact' field.
- Sessions providing A&E – mental health liaison services in an acute department. Use the activity ID: SLA153; A&E – mental health liaison care.

49. These can all be formal booked clinics, drop-in clinics or ad-hoc contacts.

50. Electroconvulsive therapy (ECT) or other medical interventions performed in a mental health outpatient setting should be identified under the activity ID: SLA136; Outpatient procedure.

51. Such interventions can be identified from their coding in the MHSDS. Use field 'coded procedure and procedure status (SNOMED CT)' in Spreadsheet IR1.2 to identify patients who have received this type of intervention.

Telemedicine (non face-to-face) contacts

52. These can include telephone and video consultation contacts (telemedicine), and other types of non face-to-face contacts recorded on the NAPC – mental health feed (feed 3b) using the data field 'consultation medium used'.[5] The working definitions of these contacts are given in Table CM1.3.

53. The definitions and codes for 'consultation medium used' are given in the NHS Data Dictionary.[6]

[5] We appreciate that some methods of communication are widely used, such as text and email, but contacts using them are not recorded. As recording protocols for these contacts are part of the patient pathway, we have included them in the standard. If you are not yet recording these contacts and this activity is material, we recommend you work with your informatics team to support the development of an appropriate recording method for the clinical teams, and document what is counted in ICAL worksheet 3: Local activity definitions.

[6] www.datadictionary.nhs.uk/data_dictionary/attributes/c/cons/consultation_medium_used_de.asp?shownav=1?query=%22consultation+medium+used%22&rank=100&shownav=1

Table CM1.3: Excerpt from Spreadsheet CP3.2 showing activities related to telemedicine (non face-to-face) contacts

Activity ID	Activity	Activity description
SLA149	Telemedicine contact	Telephone call, audio/visual call made in place of a face-to-face contact
SLA102	Other non face-to-face contact	Other non face-to-face contact that is not telemedicine, eg text, email, online medicine module, etc

Liaison with emergency departments

54. Where medical staff[7] work with A&E departments, their cost should be allocated to the activity it relates to, eg physical care or mental healthcare. The working definitions of these activities are given in Table CM1.4.

55. If this activity lies within a different organisation, the cost should be shown in the reconciliation statement under 'other activities'.

Table CM1.4: Excerpt from Spreadsheet CP3.2 showing activities related to A&E care

Activity ID	Activity	Activity description
SLA121	A&E – medical care	Medical care provided during A&E attendance
SLA153	A&E – mental health liaison care	Time spent by mental healthcare professionals within A&E and emergency care facilities

56. Where activity is not available for this service, you should disaggregate the cost before it is entered into the cost ledger, so the cost is not allocated to your organisation's own activities.

Non-clinical activities

57. Education and training (E&T) activities should be costed in line with the E&T transitional method.

[7] Other mental healthcare staff may provide care for this service. Use the relevant resource and activity ID shown in Table CM1.4.

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58. E&T activities should not be matched to patients but reported under the ‘education and training’ cost group.

59. Research and development (R&D) activities should be costed using your current methods and these documented in ICAL worksheet 20: Research and development. Cost R&D using activity ID: SPA155; Research and development.

60. R&D activities should not be matched to patients but reported under the ‘research and development’ cost group.

61. Other non-clinical activities should be allocated to clinical activities using the actual cost of the clinical activity as a relative weight value.

CM3: Non-admitted patient care

Purpose: To ensure all types of non-admitted patient care (NAPC)[8] activity are costed consistently.

Objective

1. To cost non-admitted services to a service team session or clinic level, then to allocate them to the patients attending that clinic or visited in the community on that day.

2. To cost all NAPC based on the staff present.

3. To allocate the cost to patients, based on the duration of the contact.

4. To ensure all types of NAPC activity are costed correctly, including consultations, procedures and telemedicine.

Scope

5. This standard applies to all NAPC activity, including hospital (outpatient) clinic appointments, other clinical settings (community mental health outpatient attendances) and contacts in the patient's residence (community mental healthcare contacts).[9]

6. This standard covers the NAPC – mental health feed (feed 3b) and Improving Access to Psychological Therapies feed (feed 16), in accordance with Standard IR1: Collecting information for costing and Spreadsheet IR1.1. Please note the source data requirements for these feeds are the Mental

[8] NAPC is used throughout this standard to cover all forms of non-admitted patient care contacts.
[9] Please note that integrated trusts will also need to refer to the Acute and/or Community standard CM3: Non-admitted patient care as appropriate.

Health Services Data Set (MHSDS) and the Improving Access to Psychological Therapies Data Set (IAPT) respectively.

Overview

7. NAPC takes place in many different settings, including formal outpatient clinics held in hospitals or community settings, and the patient's residence. Some appointments are booked in advance; others are 'drop-in'.

8. See Standard IR1: Collecting information for costing for detail on the source datasets. In summary, for all sectors the NAPC data used should be that which is submitted nationally to the:
   - Commissioning Data Set (CDS): the source for acute outpatient appointment data
   - Community Services Data Set (CSDS): the source for community care contact data and community clinic data
   - Mental Health Services Data Set (MHSDS): the source for mental health outpatient appointment or mental health community care contact data
   - Improved Access to Psychological Therapies Data Set (IAPT): the source for IAPT NAPC data.

9. The nature of the mental health patient cohort means some contacts are deemed to be 'outreach', defined here as a professional meeting with the patient at a non-standard location, eg that in a hospital between a hospital-based therapist and a patient.

10. Some mental health professionals also 'search' for the patient to ensure they continue their treatment plans, holding the contact wherever it is possible to do so rather than necessarily in a clinical setting. Without these contacts, patients may not attend appointments, take medication or follow self-care plans. Telephone and text communication are used widely (to patients and their support network), and patients may be visited in their own or others' homes.

11. Some interventions may include management of medicines/substances and a wide range of talking therapies are used, enabling the patient to manage or improve their condition. Costing such complex non-admitted mental health services needs a good understanding of the staff working in these services,

and how the information recorded about them may be used to 'count' activity and allocate cost.

12. NAPC activity should be costed based on which staff are in the clinics/ sessions[10] and how long the attendance is (in minutes).

13. Some outpatient procedures may require input from a healthcare professional who is not a normal member of the clinic staff. For example, electroconvulsive therapy (ECT) may require an anaesthetist or practitioner to be present. Their cost needs to be allocated to the relevant patient, based on the duration of their attendance.

14. You must ensure the outpatient department costs – such as those for the varied care professionals, administration, support nursing, etc – are allocated to all patients in the department, using the appropriate cost allocation method.

15. Outpatient procedures or interventions may take place in the outpatient clinic or a specialist treatment room. You need to ensure the correct department costs and clinical non-pay items are allocated to the procedure (see Standard CM21: Clinical non-pay items for more information).

16. Contacts and procedures may also take place outside the outpatient department, such as in a patient's residence. The cost of these, including travel costs, must also be allocated using the duration of the contact in minutes.

17. Information on most NAPC contacts will be recorded on a pro forma completed by clinical staff. The main 'procedures' performed during the contact will be recorded by procedure codes (hospital care). Clinical coders will apply these codes or agree a set template of codes with you for the NAPC contact.

18. Many procedures and care activities are carried out in NAPC, so the materiality principle applies when prioritising the time you give to these. We recommend that in the first instance you identify either the five most frequent or highest value (regular performed) NAPC procedures or interventions for your organisation and work with the department to refine the cost allocation

[10] This does not include staff present for education and training purposes.

methods for these – for example, identifying if a particular consumable is used or an extra staff member is involved. You should use OPCS or SNOMED CT clinically coded information from the local data, where available.

19. Non face-to-face (also called 'telemedicine') contacts are increasing and it is important to include them in costing[11]

Approach

20. Obtain the patient-level feeds for all NAPC activity as prescribed in Standard IR1: Collecting information for costing and Spreadsheets IR1.1 and IR1.2.

21. Use the prescribed matching rules in Spreadsheet CP4.1 to ensure the auxiliary patient-level feeds, such as medicines dispensed (feed 10), match to the correct NAPC contact.

22. For clinic attendances use the following prescribed activities:

- MHA289 Initial assessment
- SLA135 Outpatient care (used for attendances where there has already been an initial assessment)
- SLA136 Outpatient procedure
- SLA149 Telemedicine contact (where calls to the patient are part of the clinic)
- SPA152 DNA (for those costing did not attends (DNAs) for local business intelligence).

23. For other NAPC contacts including MHCCC use the following prescribed activities:

- MHA293 CMHT care
- MHA261 CPA meeting
- SLA101 Outreach visit (proactive contacts and searching)
- SLA149 Telemedicine contact (where telephone calls are ad hoc)

[11] If this activity is not recorded in or not submitted to the national datasets, work with your informatics teams to progress this. The non face-to-face contacts may form a large part of 'hidden activity', as discussed in Standard IR1: Collecting information for costing. It is essential to include this activity as care models change, so the outcome benefits can be understood.

- MHA267 Other telemedicine contact (see definitions in the *Costing glossary*).

24. For groups of patients, see Standard CM14: Group sessions.

25. Table CM3.1 is an excerpt[12] from Spreadsheet CP3.3 showing the resource and activity links to use for an NAPC attendance.

26. For each resource and activity combination there is a two-step prescribed allocation method in Spreadsheet CP3.3.

Table CM3.1: Excerpt from Spreadsheet CP3.3 showing the resource and activity links for NAPC attendance costs

	Activity				
Resource	**Outreach visit**	**Outpatient care**	**Telemedicine contact**	**CPA meeting**	**Other non face-to-face contact**
Community psychiatric nurse	£X	£X	£X		
Dietitian		£X		£X	
Nurse manager		£X			
Primary mental health worker	£X	£X	£X		
Counsellor		£X	£X		£X
Consultant				£X	
Non-consultant medical staff		£X			
Specialist nurse		£X			£X
Healthcare assistant		£X			
Psychologist			£X	£X	
Therapist	£X		£X	£X	

[12] Please note all excerpts in this standard are for illustrative purposes only. Use Spreadsheet CP3.3 to ensure you are using all the correct resource and activity links.

27. Other activities on the NAPC feed (feed 3b) will have been assigned their own prescribed activity. Review the list of activities in Spreadsheet CP3.2 and identify which may be included on your NAPC – mental health feed (feed 3b) to ensure you use the correct prescribed activity and do not incorrectly assign their costs to the prescribed activities 'outpatient care' or 'outpatient procedure'.

28. ECT uses specialised equipment and may take place in a special procedure suite. You should ensure the costs of these are allocated only to patients who have this therapy using the activity ID: MHA279; Electroconvulsive therapy.

29. Care programme approach (CPA) meetings review a patient's care plan. They must be held annually but can be more frequent and either in a non-admitted setting or while the patient is an inpatient. You should ensure the costs of these meetings are allocated to activity ID: MHA261; CPA meeting.

30. CPA meetings will be recorded on the NAPC – mental health feed (feed 3b) if they are held in the outpatient setting but may not be identifiable from other types of contact. You should work with your informatics and service teams to understand how to identify them. See Mental health standard CM9: Clinical MDT meetings for more detail.

Costing using the NAPC data feeds[13]

31. The MHSDS and IAPT data feeds require all NAPC contacts to be recorded. However, the quality of the data in some areas is known to be variable. If fields required for PLICS are not recorded fully on your NAPC – mental health feed (feed 3b), the information may be available from another system recording pro formas (one per patient) or summary sheets completed by clinical staff.[14] You should use this information to guide discussions with clinical and service leads and enable you to enter non-MHSDS and IAPT patient-level data into your NAPC feed. You may need to create proxy records for services that do not keep a record of patient contacts, see Standard IR2: Managing information for costing for more details.

[13] Including multidisciplinary clinics.
[14] See also Standard IR1: Collecting information for costing for how to work with missing data or poor data quality.

32. To allocate the cost using duration of attendance or contact, use the following data fields in Spreadsheet IR1.2:

    - CDS: field 'appointment duration'
    - CSDS: field 'clinical contact duration of care activity'
    - MHSDS: field 'clinical contact duration of care contact'
    - IAPT dataset: this does not have a field for duration of contact; you need to calculate the duration locally and enter it into the 'duration of contact' field on the IAPT feed (feed 16).

33. If your organisation does not record the duration of attendance in minutes for a particular service, work with your services and informatics teams to develop this information feed. While waiting for this information to become available and including it in your NAPC – mental health feed (feed 3b), continue to use your current method for costing outpatient activity and record this in integrated costing assurance log (ICAL) worksheet 14: Local costing methods.

34. To help you cost NAPC, column D in the NAPC – mental health feed (feed 3b) in Spreadsheet IR1.2 contains the fields for each attendance/contact, as shown in Table CM3.2[15] and Table CM3.3.

Table CM3.2: Excerpt from Spreadsheet IR1.2 showing the fields in the NAPC – mental health feed (feed 3b) for costing types of NAPC contacts

Feed name	Field name	How does the costing process use this field?
NAPC	Consultation medium used	Identifies the communication mechanism used to relay information between the **care professional** and the **person** who is the subject of the consultation, during a **care activity**. The telephone or telemedicine consultation should directly support diagnosis and care planning and must replace a face-to-face clinic attendance. A record of the telephone or telemedicine consultation must be retained in the **patient's** record. Telephone contacts solely to inform **patients** of results are excluded.

[15] For the acute and community sectors, please refer to the relevant feed in Spreadsheet IR1.2 and the Acute or Community standard CM3: Non-admitted patient care.

Feed name	Field name	How does the costing process use this field?
NAPC	Multiprofessional contact	Used to identify where a multiple staff resource is used. This is not currently available on the MHSDS but is a requirement for costing.

35. The MHSDS and IAPT datasets do not currently contain suitable fields to identify multiprofessional and multidisciplinary activity separately from single professional activity. You will need to collect additional information about who else is present in a clinic to ensure the correct costs are allocated to the correct clinic or service and build this into your NAPC – mental health feed (feed 3b). A field has been added to both this feed and the IAPT feed (feed 16) to identify multiprofessional contacts. This is key information to ensure you can cost NAPC correctly.

36. Use this information to build RWVs to allocate the appropriate staff costs to each of the clinics; see Spreadsheet IR1.2.

Table CM3.3: Excerpt from Spreadsheet IR1.2 showing the fields in the IAPT feed (feed 16) for costing IAPT types of NAPC contacts

Field name	Field description
Service request identifier	The unique identifier for a **service request** for the healthcare provider. This ID will be used to link PLICS data to MHSDS data already submitted to NHS Digital.
Appointment date	The date of an **appointment**. In the case of a **patient** attending an outpatient clinic without prior notice or **appointment**, the **patient** will be given an outpatient appointment.
Appointment time	The time of an **appointment**.
Local patient identifier (extended)	A identifier used to identify a **patient** uniquely within a healthcare provider
NHS number	The primary identifier of a person within the NHS in England and Wales.

Field name	Field description
Date of birth	The date on which a person was born or is officially deemed to have been born.
Postcode	The postcode of an address nominated by the patient and classified as their 'main permanent residence' or 'other permanent residence'.

37. Be aware that, in the patient-level information, a clinic may be assigned to the healthcare professional with overall responsibility for it; that healthcare professional is not necessarily present in the clinic.

38. Use the ‘activity location type code’ field in the NAPC – mental health feed (feed 3b) to identify formal clinics, outreach visits, patient’s own residence and prison visits (see Spreadsheet IR1.2).

Costing individual outpatient attendances and procedures

39. The total cost for the clinic is allocated to all patients seen in the clinic, based on the duration of their attendance. The field for the appointment duration in hours and minutes is included in column D in the NAPC – mental health feed (feed 3b) in Spreadsheet IR1.2.

40. Some outpatient contacts may require input from a healthcare professional who is not a member of the normal clinic staff. Their cost needs to be included for the relevant patient based on the duration of their attendance.

41. Healthcare professionals’ individual costs can be identified from a payroll data source[16] and used in the costing system to calculate the staff cost per contact. This is a permitted substitution as per SCM7 in Spreadsheet CP3.5.

Medical and surgical consumables and equipment

42. We are advised that the item costs of consumables used in mental health NAPC contacts are negligible. If you do find these costs are material, per patient or in total, please refer to Standard CM21: Clinical non-pay items. You

[16] This version of the standards does not specify a payroll feed as a minimum requirement.

should pay particular attention to the consumables used during outpatient procedures/interventions.

Day care

43. Day care is where a group of non-admitted patients benefit from care services in a group setting – usually over a few hours. A range of care professionals may provide care over the period of attendance. The activity may be recorded as NAPC or it may be on a standalone local system.

44. The staff involved are most likely to be nurses/therapists but in some areas there can be medical input. The model of care may be termed 'social' or 'medical' depending on its clinical content. There are two cost centres in the cost ledger should you need to keep the models separate.[17] See Standard CM14: Group sessions for more information.

45. You should use the activity ID: MHA262; Day care.

Non face-to-face (telemedicine) consultations

46. Non face-to-face contacts are a vital part of clinical care for many patients.

47. Most of these contacts will be by telephone, but video messaging is increasingly being used. For costing purposes, both are defined as 'telemedicine'. Use activity ID: SLA161; Telemedicine contact (telephone and video consultation).

48. Other non face-to-face contacts include text conversations, email, patient-online schemes and patient letter review.[18] These need to be separated from those made by telemedicine, as the duration of 'patient contact' will be different. Use activity ID: SLA102; Other non face-to-face contact.

[17] Note: Day care – even surgical or medical day care – is different from 'day hospital', which is an admitted patient care (APC) unit.

[18] Note: As there is no current guidance for these communication methods in the NHS Data Dictionary, we apply the same guidance as for telephone contacts. If you include these in your PLICS, we recommend you include your local policy on what constitutes the currency in ICAL worksheet 1.3: Local activity definitions.

49. Clinical calls are all countable within the NAPC dataset using the 'consultation medium used' field.[19] See Table CM3.4 showing the NHS Data Dictionary codes for this field.

Table CM3.4: NHS Data Dictionary codes for different consultation media

Code	Method of communication
01	Face-to-face communication
02	Telephone
03	Telemedicine web camera
04	Talk type for a person unable to speak
05	Email
06	Short message service (SMS) – text messaging
98	Other

50. Telemedicine and other non face-to-face contacts are often 'hidden activity' (see Standard IR1: Collecting information for costing). Therefore, you may need to identify where there are gaps in your NAPC data.

51. Where there is a clinical element to the contact – for example, to support diagnosis, treatment and care planning – the contact is countable within the NAPC dataset.[20] These contacts should be counted and costed as they often replace the need for a face-to-face contact and prevent condition escalation, making an effective contribution to agreed pathways. Non face-to-face contacts simply to make bookings or pass on results without advice and guidance are not countable.

52. If services record their non face-to-face calls on a separate database to the patient administration system (PAS), you need a patient-level feed that includes all important identifiable information.

53. You need to find out if the time recorded for a non face-to-face consultation is the actual call duration or if it includes preparation and write-up time. **Only the**

[20] Detailed definitions and recording protocols for text and email are not given yet in the NHS Data Dictionary.

duration of the phone call should be costed for consistency with the costing of outpatient attendances, with the additional cost being absorbed. Preparation time is treated as administration time, not contact time.

54. The 'clinical contact duration of care contact' field for the appointment duration in hours and minutes is included in column D in the NAPC – mental health feed (feed 3b) in Spreadsheet IR1.2.

55. Only one staff member is likely to be involved in telemedicine and other non face-to-face contacts, but multiprofessional contact is possible. The appropriate resources should be attached to the activity accordingly.

56. For costing, telemedicine and other non face-to-face contacts should be treated in the same way as face-to-face contacts.

Group sessions

57. These are when several patients have a contact with a single or multiple healthcare professionals at the same time.

58. Group sessions are identified by the 'group therapy indicator' field in the NAPC – mental health feed (feed 3b) (see Spreadsheet IR1.2).

59. The costing method for these is detailed in Standard CM14: Group sessions.

Separate datasets

60. The information feeds for some discrete services in the organisation may be separate from those showing contacts in the MHSDS. These should be costed in the same way as other NAPC contacts, using the duration of the contact. Examples include:

- sexual health (see Community standard CM16: Sexual health services)
- dentistry (see Community standard CM17: Dental services)
- assisted reproduction
- addiction services, including drug and alcohol
- perinatal mental health services
- psychiatric liaison.

Mental health costing methods

61. These datasets, where available, should be added to the NAPC – mental health feed (feed 3b) so the information is consistent. They will need to provide the same data items as the MHSDS as it applies to PLICS.

62. The costing of some mental health services requires additional guidance.

63. **Learning disabilities:** The contact should include the cost for both mental and physical elements of the appointment, if both are provided by the mental health organisation. If the physical element is provided by another organisation and the cost for this is in the general ledger for that organisation, it should not be included with the cost for the mental health element. Any activity in your systems should be treated under Standard CM8: Clinical and commercial services supplied or received.

64. **Drug and alcohol services:** These typically include treatment contacts with patients, but also supervised consumption and needle exchange. If the cost of consumable items is material, refer to Standard CM21: Clinical non-pay items; or if the material costs are medicines, refer to Standard CM10: Pharmacy and medicines.

65. If the patient is not registered with the service provided or chooses to remain anonymous, or if the patient activity is not recorded, you need to obtain a count of the patients seen and use this information to allocate costs to **a** patient not **the** patient. The activity should be included in the NAPC – mental health feed (feed 3b) under a pseudonym or 'proxy record'; see Standard IR2: Managing information for costing for details. You should cost as for a standard patient.

66. **Perinatal mental health services:** Patients may need treatment for a mental health condition during pregnancy or after the birth. The costed activity is for the mental healthcare provided to the mother only, although there may be additional costs for nursery nurses. Ensure the nursery nurse costs are allocated across the patients (mothers) using the unit in the period, unless patient-level information is available.

67. **Mental health liaison service:** Patients reporting mental health illness in an acute care setting may require assessment and/or treatment for their mental health condition as well as their physical health. Mental health liaison teams work in acute providers; usually in emergency department but they can work

in other areas such as outpatient clinics, emergency wards or elderly care wards supporting patients with dementia.

68. The cost of these services will be recorded in the:
    - mental health organisation's ledger or
    - acute provider's ledger.

69. The costing of treatment will depend on the how the service is treated financially, see Standard CM8: Clinical and commercial services supplied or received for more details.

70. For either type of organisation, if activity information is available, it may be brought into the NAPC feed (feed 3b) and costed at patient level. However, this should not be submitted as part of the outpatient activity collection but used for business intelligence only.

71. If this activity information is not available, treat this as a resource with no patient-level activity and enter it in the reconciliation under 'other activities'.

NAPC DNAs – for guidance only

72. We do not prescribe how to cost DNAs in this version of the standards or the cost collection, but if required for local purposes, our recommended approach is available to download from the Open Learning Platform (OLP).[21]

[21] https://www.openlearning.com/nhs/courses/costing-improvement/HomePage/

CM9: Clinical MDT meetings

Purpose: To ensure clinical multidisciplinary team (MDT) meetings are costed consistently.

Objective

1. To cost all clinical MDT meetings hosted by the organisation that are not recorded elsewhere, eg in the non-admitted patient care (NAPC) – mental health feed (feed 3b).

Scope

2. This standard applies to all patient-specific clinical MDT meetings hosted by your organisation, with or without the patient present, for the purposes of reviewing their specific care programme or care plan.[22]

3. Clinical MDT meetings are reviews by staff of available treatment options and individual responses, and can include care programme approach (CPA) meetings.

4. Although this standard is specifically for CPA MDT meetings, the costing method can also be applied to other MDT meetings in your organisation. This is because all MDT meetings that incur a material cost should be costed and reported locally for business intelligence.

[22] MDT meetings that are not patient-specific are not to be costed separately.

Overview

5. You need to know the types of clinical MDT meetings hosted by your organisation, eg CPA and other MDT meetings.

6. Clinical MDT meeting costs are not allocated to individual patients but are reported at specialty level.

7. Clinical MDT meeting costs need to be reported locally alongside any corresponding income for business intelligence at service level.

8. Clinical MDT meetings should be reported under the cost group ‘own-patient activities’.

9. A CPA meeting is identified with a specific patient. The patient is usually present; but they may instead be represented by their care co-ordinator, who may be a social worker, community psychiatric nurse or occupational therapist.

10. The CPA activity should be reported separately from the inpatient episode or other NAPC contact cost. If your organisation records these meetings in the Mental Health Services Data Set (MHSDS), NAPC – mental health feed, they should be identifiable within that activity.

11. Other clinical MDT meetings are usually held without the patient present and relate to one or several specific patients.

Approach

12. Obtain the clinical MDT meetings feed (feed 14) from your organisation’s MDT meeting information database as prescribed by Standard IR1: Collecting information for costing and Spreadsheets IR1.1 and IR1.2.

13. The feed contains the number of times each MDT meeting is held during the calendar month or year.

14. Use activity ID: MHA261; CPA meeting and activity ID: SLA128; Other multidisciplinary meeting.

15. Table CM9.1 is an excerpt[23] from Spreadsheet CP3.3 showing the resource and activity links to use for MDT meetings.

16. This feed is classified as a standalone feed so prescribed matching rules are **not** provided in columns H to O in Spreadsheet CP4.1.

Table CM9.1: Excerpt from Spreadsheet CP3.3 showing the resource and activity links for the CPA and other MDT meeting costs

Resource	Activity	
	CPA meeting	Other multidisciplinary meeting
Community psychiatric nurse		£X
Dietitian	£X	
Psychiatric nurse		£X
Support worker	£X	
Consultant – mental health	£X	£X
Primary mental health worker	£X	
Multidisciplinary meeting co-ordinator	£X	£X
Therapist		£X
Speech and language therapist		£X

17. Set up relative weight values to calculate an average cost for the CPA/MDT meeting to be used in the costing process.

18. Use the costing template in ICAL worksheet 27: Clinical MDT meetings to identify the information you need to set up the statistic allocation table, including:

- meeting members, including whether they are internal or external staff and the department they belong to
- length of the meeting

[23] Please note all excerpts in this standard are for illustrative purposes only. Use Spreadsheet CP3.3 to ensure all the resource and activity links you are using are correct.

- number of meetings attended by each member over the last year to calculate the average number of each type of meeting each member attends
- preparation time for an MDT meeting, particularly the time staff spend reviewing diagnostic test results.

19. See column A in ICAL worksheet 27: Clinical MDT meetings for an example of the potential attendees at a clinical CPA/MDT meeting whose input may need to be costed.

20. Resource ID: SLR098; Multidisciplinary meeting co-ordinators have been classified as a type 2 support resource and are linked to activity IDs: MHA261; CPA meeting and SLA128; Other multidisciplinary meeting in Spreadsheet CP3.4.

21. Overheads (type 1 support costs), such as room use, catering, heating, lighting, printing and secretarial costs, need to be allocated appropriately.

22. CPA and MDT meetings are known to incur considerable preparation and follow-up costs. However, the costing standards only allocate cost based on the duration of the event.

Attendance at CPA/MDT meetings as subject matter experts

23. You will need to identify the frequency of these meetings and who from your organisation attends; for example, meetings to discuss an individual's fitness for court proceedings.

24. Use activity ID: MHA261; CPA meeting or activity ID: SLA128; Other multidisciplinary meeting.

25. Follow the costing principles for hosted clinical MDT meetings.

26. You will need to find out whether staff attend because your organisation's patients are discussed at these external meetings or as 'subject matter experts'.

27. If your organisation's patients are discussed, report the activity under the 'own-patient activity' cost group. If the attendees are 'subject matter experts',

report this activity under the ‘other activities’ cost group. See Standard CP5: Reconciliation for further information on cost groups.

Superior costing method SCM4

28. Patient-level information about CPA/MDT meetings may be available. Using this to match meetings to the patient contact is listed as a superior costing method in Spreadsheet CP3.5.

29. This information, including patient identifier and staff present, may be collected in a separate MDT database or developed from the MHSDS.

30. The date of the latest review should be available in the MHSDS field ‘care programme approach review date’.

31. These meetings should be recorded on the MHSDS as patient contacts. However, as they may not be linked separately from other contacts to either the NAPC or APC parts of the MHSDS, a supporting contact feed[24] (feed 7) entry will be required.

32. Understand and gather this information and use the supporting contacts feed (feed 7) to enter the data into the PLICS.

33. As with other patient contacts, the meeting duration should be recorded for each staff member present and used to allocate cost to the patient using the activities for CPA and the other multidisciplinary meetings in Table CM9.1.

[24] This is a superior costing method.

CM13: Admitted patient care

Purpose: To ensure admitted patient care (APC) is costed consistently.

Objective

1. To ensure costs are correctly allocated to episodes[25] of APC.

Scope

2. This standard applies to all mental health APC.

Overview

3. Inpatient mental health wards provide a safe and therapeutic environment for patients with acute mental health conditions. Some wards will be secure to ensure the safety of the individual and others. The type of wards established will depend on the level of care needed. Intensive treatment is provided on some inpatient wards, eg psychiatric intensive care units (PICU). Rehabilitation is promoted from admission on all wards, but some wards will be dedicated to rehabilitation.

4. The wards have programmes of activities – including one-to-one medical consultation, and single or group therapies such as arts, cooking, exercise classes and talking therapies. Longer-term patients may contribute to the 'work' of the ward, eg by serving meals or doing laundry.

[25] Traditionally, mental health services did not use the terms 'episode' or 'spell' for inpatient stays. These terms are now used in the Mental Health Service Data Set (MHSDS); therefore, they are used throughout the *Approved Costing Guidance (standards) – mental health*.

5. A range of staff work on wards, including nurses, psychiatrists, psychologists, therapists, pharmacists (in some areas), junior medical staff, support workers and activity co-ordinators.

6. As part of a longer care pathway, patients may spend time in an APC setting. The periods when patients are receiving APC are referred to as APC episodes regardless of whether they are short term, long term or residential. One care professional will be clinically responsible for the 'episode' even if they work as part of a team.

7. Within an APC episode, the patient will incur costs from the care given by staff, the use of consumables, being given medicines and overheads (type 1 support costs) from the ward running costs, such as ward administrator costs.

8. In some cases, the activities will be provided by staff from another organisation that provides specialist services.

9. To accurately record and compare the full cost of caring for a patient, the cost of all activities must be included, no matter who performed them.

10. The data for mental health APC activity will come from the Mental Health Services Data Set (MHSDS) as described in Standard IR1: Collecting information for costing and Spreadsheets IR1.1 and IR1.2.

Approach

General

11. Costs on a ward will include:

- psychiatric nurses, healthcare assistants and support workers providing care and supervision
- junior doctor tasks
- ward rounds by consultants with other staff types
- patient-specific consumables
- non patient-identifiable medicines (ward stock medicines)
- medical and surgical equipment (ward equipment)
- overheads (type 1 support costs) relating to the costs of running the ward (including admission and discharge administration)

- observations and activity by ward staff, such as restraint in response to a serious untoward incidents
- multidisciplinary team (MDT) meetings for the review of several admitted patients but with patients not present[26]
- care programme approach (CPA) meetings with patients present, during an admission
- therapies and interventions – actions taken to improve a disorder
- specialing or other one-to-one care
- depending on need, some patients may require additional security/ seclusion to avoid harming themselves or others.

12. The costing process categorises these into different activities that will gather resources for wards. The two main activities are:

- ward care – relates to nursing costs, consumables and medicines at an expected level of patient acuity
- ward rounds – consultant input to wards, often with other staff present.

13. Other activities that take place on a ward may include:

- MDT and CPA meetings (see Mental health standard CM9: Clinical MDT meetings)
- group sessions (see Standard CM14: Group sessions)
- supporting contacts[27] from therapists or other healthcare professionals
- non patient-identifiable and patient-identifiable medicines (see Standard CM10: Pharmacy, medicines and blood services)
- other considerations are:
  - home leave
  - perinatal mother and baby units
  - patient acuity, where measurement of the patient's intensity of nursing care incurs costs above what is expected for a ward's level of care; for this, a superior costing method may be used.

[26] These meetings may be referred to as case reviews or 'whiteboard discussions'. They are included in ward care because organisations report they cannot currently record the time spent talking about specific patients.
[27] Supporting contacts are a superior costing method.

Ward care

14. Admitted patients incur costs just by being on a ward. The 'accommodation' and basic care costs are allocated to the ward care activity, driven by length of stay in hours and minutes. The MHSDS includes date and time as required fields.

15. The fields in Table CM13.1 should be used as the cost driver.

Table CM13.1 Excerpt from Spreadsheet IR1.2 showing the patient-level field requirements for calculating length of stay by ward

Field name	Field description
Start date (ward stay)	The start date of a ward stay
Start time (ward stay)	The start time of a ward stay
End date (ward stay)	The end date of a ward stay
End time (ward stay)	The end time of a ward stay
Ward code	A unique identification of a ward in a healthcare provider

16. 'Acuity', as defined in this standard, describes the level of resource a patient uses due to their condition; including mental and physical health, behavioural and forensic issues.[28]

17. The standard level of acuity is understood from the type of ward – for example, a PICU ward will have a higher level of staffing than a rehabilitation ward; and a secure ward will have a higher level of staffing than an open ward. A ward is normally specifically staffed for some actions, including restrictive intervention, restraint, seclusion and rapid tranquilisation: these do not normally incur additional costs.

18. Unless otherwise informed, you can expect that all patients on the same ward will use resources at a similar rate; these will be allocated according to the prescribed rules in Spreadsheet CP3.3.

[28] Forensic mental healthcare is the interface between the patient's mental healthcare and the criminal justice system. Certain parts of the mental health service will specialise in this.

19. Information on the level of resource expected for patients on a whole ward may be understood for costing purposes from the MHSDS fields, as shown in Table CM13.2.

Table CM13.2: Ward care-level designation[29]

Feed name	Field name	Field description
Admitted patient care	Ward setting type (mental health)	The type of 'ward' setting for a mental health service's 'patient' during a hospital provider spell
Admitted patient care	Ward security level	The level of security for a ward.
Admitted patient care	Ward code	A unique identification of a 'ward' in a healthcare provider.

20. To improve the patient-level costing of the admission, you may use a superior costing method to more accurately allocate the costs of specialing/observations and escorted home leave, by splitting the resources in a more detailed manner. See superior costing methods SCM3 and SCM6 in Spreadsheet CP3.5.

21. Use activity ID: SLA097; Ward care to include these expected levels of resource use.

22. The MHSDS for a single patient will contain a row for each ward that the patient spent time on – identified by the field 'ward code'. More than one ward can be recorded, in patient journey date order (see Table CM13.3). Wards may differ in their costs, so to cost an individual patient's 'journey' appropriately, you need to know which wards the patient was on.

23. As the MHSDS requires ward information and has been mandated, it is the accepted data source for ward information. However, where the MHSDS in your organisation does not yet include sufficient ward information, your APC feed (feed 1b) may take data from different parts of your patient administration system (PAS).

24. You should use the fields shown in Table CM13.2.

[29] These fields are in the MHSDS but your organisation may not record in this field.

Table CM13.3: Examples of how patients are shown in the admitted care dataset hierarchy

Patient A		
Spell	Episode 1	Ward A
		Ward B
	Episode 2	Ward C
Patient A was admitted to ward A, moved to ward B, then transferred to a second care provider and moved to ward C, from where they were discharged.		

Patient B		
Spell	Episode 1	Ward B
		Ward C
Patient B was admitted to ward B and moved to ward C from where they were discharged.		

25. Table CM13.4 is an excerpt from Spreadsheet CP3.2 showing the prescribed ward care activities for mental health inpatient units.[30] The activities are separately identified by level of care, security and service, to facilitate meaningful local reporting.

26. These activities show which unit the patient was admitted to. So, where the patient stays under the same main specialty code/treatment function code, you can identify changes in severity for them and in the care they receive. For example, many mental health admissions will fall under 710 Psychiatry, even when the patient moves from psychiatric intensive care to an acute ward, and then to a rehabilitation ward.

27. The ward-related resource to activity links are shown in Spreadsheet CP3.3.

28. Cost of pharmacy staff working on the ward should be allocated using the resources described in Standard CM10: Pharmacy, medicines and blood services and in Spreadsheet CP3.3.

[30] Ward care has been broken down into appropriate activities using feedback from mental health providers.

Table CM13.4: Excerpt from Spreadsheet CP3.2 listing the ward care activities for mental health inpatient units

Activity ID	Activity
MHA250	MH inpatient high secure unit – non-forensic – ward care
MHA251	MH inpatient medium secure unit – forensic – ward care
MHA254	MH inpatient low secure unit – non-forensic – ward care
MHA255	MH inpatient high secure women's services – ward care
MHA256	MH inpatient adult – other – ward care
MHA257	MH inpatient high secure deaf services – ward care
MHA268	Perinatal mother and baby inpatient unit – ward care
MHA269	Psychiatric intensive care – ward care
MHA270	CAMHS inpatient – eating disorder – ward care
MHA275	MH inpatient personality disorder – medium secure – ward care
MHA276	MH older adult inpatient other – ward care
MHA277	Drug and alcohol inpatient unit – ward care
MHA283	LD learning disability ward/residential high secure – ward care
MHA286	LD learning disability ward/residential other – ward care
MHA287	MH inpatient high secure unit – forensic – ward care

Ward rounds

29. Formal ward rounds are usually driven by the lead healthcare professional, who may be a member of the medical staff. They are less common in mental health settings than in acute settings.

30. To record ward rounds, use the activity ID: SLA098; Ward round, to show the cost of the time medical staff spend interacting with patients in this manner.

31. For further information on ward rounds, see Mental health standard CM1: Medical staffing, which describes the medical staff elements in more detail.

CPA and MDT meetings

32. During their admission, the patient may attend CPA meeting(s). Staff may also meet to discuss the current care, without the patient present. Both types of meeting form a significant resource and are covered separately in Mental health standard CM9: Clinical MDT meetings.

Supporting contacts from therapists or other healthcare professionals

33. Healthcare professionals external to the ward may provide contacts while the patient is admitted; for example, where a specialist therapist from another service visits the patient on the ward.

34. A further example is where an external physical healthcare professional visits a secure ward at your organisation. This activity should be added to the supporting contacts feed (feed 7) when your organisation is invoiced for this service at patient level (see Standard CM8: Clinical and commercial services supplied or received).

35. This activity will not be part of the standard care provided on the ward. The cost is likely to be part of another service area's expenditure, eg the 'specialist therapy' budget. The cost should be matched to the patients who benefitted from the activity, rather than patients in another service area (or organisation).

36. The activity should be entered into the supporting contacts feed (feed 7). The activity and cost can then be matched to the correct patient. This feed is a superior costing method. This is described in more detail in Mental health standards CM1: Medical staffing and CM3: Non-admitted patient care.

Group sessions[31]

37. Admitted patients may have access to group sessions such as therapy, supervised sport, cookery or employment preparation. Patients accessing these activities use more resources than those on the same ward who do not.

[31] Activity associated with group activities should be recorded as a contact in your APC or NAPC data feed. For more information see Standard IR1: Collecting information for costing purposes.

38. Where these session include all patients on the ward and are run by the staff from the ward budget, which is already allocated equally to all patients on the ward, there is no requirement to separate the cost and show it as a group session on the ward.

39. However, the supporting contacts feed[32] (feed 7) should be used to allocate cost to patients attending group sessions where:
    - the costs of running the sessions are not in the ward budget
    - only some of the ward's patients attend the group.

40. Where an acuity measure is used in the ward allocation method, you should consider whether allocating the group's ward costs to all patients on the ward would result in each patient receiving an appropriate cost.

41. You should follow the materiality principle when prioritising work on group sessions.

42. For further information on group sessions see Standard CM14: Group activities.

Non patient-identifiable and patient-identifiable medicines

43. Patient-identifiable medicines dispensed during an admission should be matched to the APC episode using the prescribed matching rules in Spreadsheet CP4.1 and the medicine dispensed feed (feed 10).

44. Non patient-identifiable medicines costs should be allocated across all the patients on the ward.

45. For more detail, refer to Standard CM10: Pharmacy, medicines and blood services.

Consumable items and equipment

46. Refer to Standard CM21: Clinical non-pay items for more information on the treatment of these costs.

[32] This feed is a superior costing method.

Other considerations

Home leave

47. When a patient who is admitted onto a mental health ward leaves the ward for a period at home, this is recorded as 'home leave'. Patients may be escorted or unescorted during home leave.

48. Escorted leave is where the patient is under a staff member's supervision 24/7 to ensure they do not put either their own safety or that of others at risk. The number of healthcare professionals who attend the patient on escorted leave depends on the patient's needs. This cost may be treated using a superior costing method.

49. Unescorted home leave does not incur additional cost and therefore does not require additional information or consideration of acuity.

50. Home leave is recorded in the MHSDS using the fields in Table CM13.5 and is authorised for up to six consecutive days. Home leave is not a discharge. The patient episode continues.[33]

51. The ward care costs for these periods are lower than when the patient is present as, for example, the patient does not incur any costs for food, fresh linen, on-ward staffing input, ward rounds or ward work with healthcare professionals.

52. There may be some costs for the facilities kept available on the ward for the patient (and not used by other patients), eg heating their bedroom. However, in this version of the standards we are not prescribing allocating costs to the patient for ward care, ward rounds and ward work during home leave, as doing so is beyond the level of costing required. Therefore, the net length of stay on the ward is the primary cost driver for ward care and ward work – after the home leave period has been subtracted.

53. Although rare, the resources used for escorted leave are significantly higher than those used for unescorted leave, and the additional cost is normally on

[33] If the patient does not return after six days, the patient spell will be closed with a discharge. If this happens after the end of a costing period, refer to Standard CM2: Incomplete patient events for guidance.

the ward cost centre. So, it is important to reflect these costs against the specific patient, rather than to spread them over all patients.

Table CM13.5: Excerpt from Spreadsheet IR1.2 showing the patient-level field requirements for costing home leave

Field name	Field description
Start date (home leave)	The start date for a period of home leave for patients **not** liable for detention under the Mental Health Act 1983.
Start time (home leave)	The start time for a period of home leave for patients **not** liable for detention under the Mental Health Act 1983.
End date (home leave)	The end date for a period of home leave for patients **not** liable for detention under the Mental Health Act 1983.
End time (home leave)	The end time for a period of home leave for patients **not** liable for detention under the Mental Health Act 1983.
Escorted home leave	Additional field, showing whether the patient had staff accompaniment during the home leave.

54. The relevant fields for identifying escorted home leave as a superior costing method are shown in Spreadsheet IR1.2.

55. When costing escorted home leave, use the activity ID: MHA288; Escort during home leave.

56. If you are already using these methods, continue to do so and document them in ICAL worksheet 15: Superior costing methods.

Perinatal mental health services

57. Some women need to be admitted during pregnancy or following the birth of their child.

58. This may be to a specific mother and baby unit, the discrete costs for which should be attributable to the correct cohort of patients.

59. Where there is no specific unit and women are admitted to other wards, care must be taken to ensure that the appropriate relative weight values for duration and number of observations are used. This care will need to be discussed with the service as there is no mandated field in the MHSDS for it.

60. The costed activity is for the mental healthcare provided to the mother only, although there may be additional nursery costs on discrete units. Ensure the nursery costs are allocated across the patients (mothers) using the unit in the period, unless patient-level information is available.

Specialing and observations

61. Specialing and observations refer to a patient receiving additional care and/or reviews throughout the day. For example, one condition may differ in its staffing need from another because the patient requires more frequent monitoring and recording of their behaviour, actions, interactions and reactions to medication, or one-one care. (The staff-to-patient ratio will vary according to the clinically agreed patient need.)

62. These elements should be recorded on the supporting contacts feed (feed 7) and matched to the correct patient episode using the matching rules in Spreadsheet CP4.1.

63. Use the duration of contact as a relative weight value to allocate the cost of the medical staff present to the APC activity for that patient.

Contact us:

costing@improvement.nhs.uk

NHS England and NHS Improvement
Wellington House
133-155 Waterloo Road
London
SE1 8UG

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