Healthcare costing standards for England

Mental health: Costing methods

For data being collected in 2020 for financial year 2019/20

Final

collaboration   trust   respect   innovation   courage   compassion

	Mandatory (Mental Health)
Publication status	Final
Publication date	27 February 2019
Relates to financial year data	2019/20
Collection year	2020

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

Introduction

This final version of the *Healthcare costing standards for England – mental health* should be applied to 2018/19 and 2019/20 data and used for all national cost collections. It supersedes all earlier versions. All paragraphs have equal importance.

These standards have been through three development cycles involving engagement, consultation and implementation. We thank all those who have contributed to the standards during the development cycles.

The main audience for the standards is costing professionals but they have been written with secondary audiences in mind, such as clinicians, informatics and finance colleagues.

There are three types of standards for mental healthcare costing:

- **information requirements:** describe the information you need to collect for costing.
- **costing processes:** describe the costing process you should follow.

The above two sets of standards are the **core standards** and should be implemented in **numerical order** before the other type of standard, contained in this document:

- **costing methods:** focus on high volume and high value services or departments. These should be implemented after the information requirements and costing processes, and prioritised based on the value and volume of the service for your organisation.

We have ordered the standards linearly but, as aspects of the costing process can happen simultaneously, where helpful we have cross-referenced to information in later standards. We have adopted the same numbering as for the acute standards: this means there are gaps in the sequential order where a standard relevant to the acute sector is not relevant to the mental health sector.

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New for this version, we have begun to integrate some of the standards with other sectors, to allow the many providers that have more than one sector to cost to be able to work from the same set of documents. In this version:

- costing process standards are integrated across all sectors
- information requirement standard 2 is integrated across all sectors
- some costing methods are integrated across all sectors
- information requirement standard 1 is sector-specific
- some costing methods are sector-specific
- where applicable, costing approaches are sector-specific (acute only).

The costing processes are published separately from the information requirements this year, so there are three documents for mental health providers: costing processes, information requirements (combining both integrated and sector-specific standards) and costing methods (combining both integrated and sector-specific standards).

The accompanying **technical document** contains the information required to implement the standards, which is best presented in Excel. Cross-references to spreadsheets (eg Spreadsheet CP3.3) refer to the technical document.

The technical document includes elements that are integrated across acute, mental health and community sectors to enable integrated trusts to implement them using one technical document. The contents page of the technical document contains more information. Please note, if you are implementing more than one sector, you will need to refer to the other sector technical documents for the sector-specific elements.

We also cross-reference to relevant costing principles. These principles should underpin all costing activity.[1]

We have produced several tools and templates to help you implement the standards. These are available to download from:
https://improvement.nhs.uk/resources/approved-costing-guidance-2019

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[1] For details see *The costing principles*, https://improvement.nhs.uk/resources/approved-costing-guidance/

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Please note: while we refer to 'patients' in the context of patient-level costing, we recognise that people who access mental health services prefer to be referred to as service users, clients or residents. The use of the term 'patient' across all sectors allows us to maintain consistent standards throughout an individual's health and social care pathway.[2]

If you would like to give us feedback on the standards, please complete the evidence pro forma and send it to: costing@improvement.nhs.uk

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[2] Note: traditionally, the mental health sector did not use the term 'episode' for an inpatient stay. The Mental Health Minimum Data Set does now use this term, so episode is used throughout the *Healthcare costing standards for England – mental health*.

CM1: Medical staffing

Purpose: To allocate medical staff 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 consultant medical staffing costs to their named activity.

3. To allocate the non-consultant medical staffing costs according to the costing processes for other staff groups, within the appropriate resources and activities.

Scope

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

Overview

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

6. 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 their activity, rather than an average cost, will increase their confidence in the cost data's accuracy.

7. To ensure this activity is costed as accurately as possible, you should allocate the actual consultant medical staff costs to their own named activity. Non-

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consultant medical staff costs should be allocated as for other staff groups to the correct resources and activities.[3]

8. 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.

9. 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.

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

What you need to implement this standard

- Spreadsheet CP3.8: Ward round data specification

Approach

11. Review the prescribed list of activities in column B of Spreadsheet CP3.2 and identify those your consultant medical staff deliver and those delivered by other medical grades. These may be similar or very different in nature, so both types should be understood. You should record this information in your integrated costing assurance log (ICAL) worksheet 23: CM1 consultant and other medical staff % split.

12. Allocate all medical staffing costs using the resources in Table CM1.1.

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[3] 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 SCM27 on Spreadsheet CP3.5 for more information.

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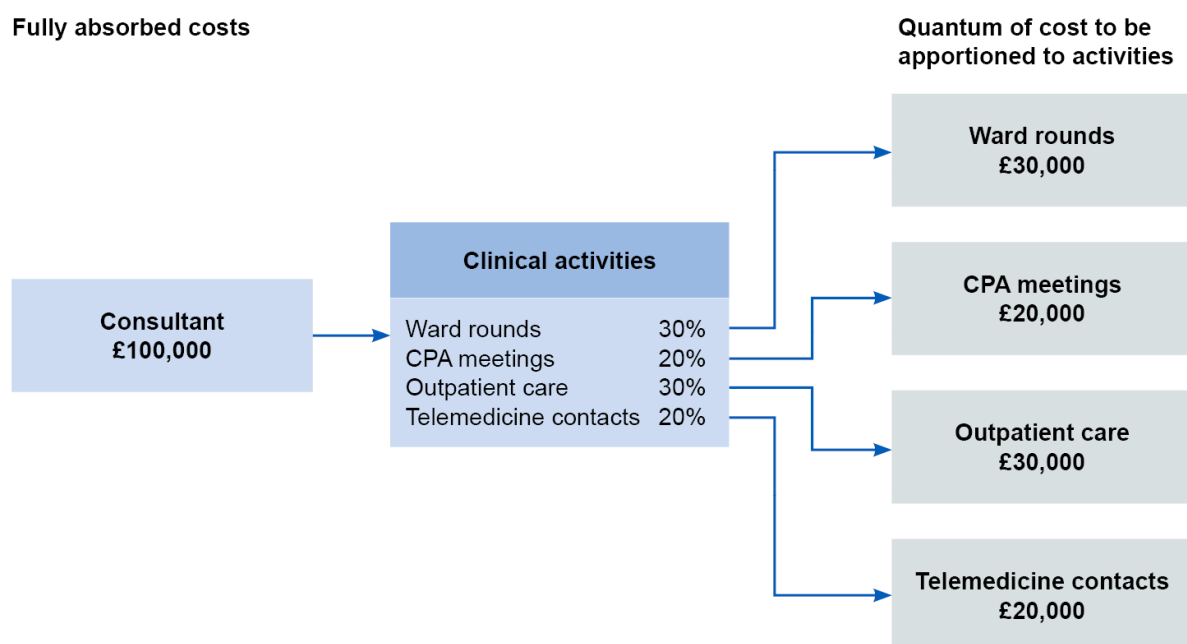**Table CM1.1: Excerpt from Spreadsheet CP3.1: Resources for patient-facing and type 2 support costs**

Resource ID	Resource
MHR253	Consultant – mental health
SGR062	Consultant[4]
SGR064	Consultant – anaesthetist
SGR063	Non-consultant medical staff

13. 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. Resource ID: SGR062; Consultant relates to physical health specialists, and resource ID: SGR064; Consultant – anaesthetists relates to anaesthetists and critical care intensivists. The separation of mental health consultants is included to provide better reporting 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. Allocate all non-consultant medical staffing costs using the resource ID: SGR063; Non-consultant medical staff.

14. 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.

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

16. For each resource and activity combination, identify the correct quantum of cost to be allocated to the patient-facing activities using a percentage split of medical staffing costs by activity type. You can find out what this is by talking to 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).

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[4] This resource is for consultants who specialise in physical health areas.

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

Fully absorbed costs

Quantum of cost to be apportioned to activities

Consultant
£100,000

Clinical activities

Ward rounds	30%
CPA meetings	20%
Outpatient care	30%
Telemedicine contacts	20%

Ward rounds
£30,000

CPA meetings
£20,000

Outpatient care
£30,000

Telemedicine contacts
£20,000

Using payroll information for consultant medical staffing

17. To allocate actual consultant costs over their named activity you may need to set up local resources to provide this level of detail in your costing system. All NHS organisations have a financial duty to record payroll information in their general ledger, and to map staff costs to the separate categories in the financial accounts. Therefore, the information in the general ledger will be sufficient to understand staff types for costing to more detailed resources.

18. 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 non-admitted patient care (NAPC) sections. This information is required to match consultants to named patients. See Spreadsheet IR1.2.

19. 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 for the time they are on the dataset (episode or contact). These may be costed at named activity level as a superior costing method – see SCM27 in Spreadsheet CP3.5. Each patient admission may have multiple episodes of

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care, with responsibility changing from one to the next. Each should have cost associated with it.

20. 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.

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

22. If you are already costing non-consultant staff members' activity at patient level and linking to the individual staff, continue to do so and record what you do in your ICAL worksheet 15: Superior costing methods. This is an accepted superior costing method in accordance with Spreadsheet CP3.5 with ID SCM27 – Staff cost to named patient activity.

23. 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. The costs of non-medical staff will be allocated across all the appropriate patient-facing activities in accordance with Integrated standard CP3: Appropriate cost allocation methods. You should record the reasoning for not using staff level data in your ICAL worksheet 24: CM1 Consultant % reasoning.

Consultant resources

24. Table CM1.2 below is an excerpt[5] from Spreadsheet CP3.3 that shows examples of activities the consultant resource is linked to in the technical document. This list will be extended as more work is done with mental health organisations.

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[5] Please note this is an excerpt for illustration purposes only. Use Spreadsheet CP3.3 to ensure you are using all the correct resource and activity links.

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Table CM1.2: Excerpt from Spreadsheet CP3.3: Methods to allocate patient-facing resources, first to activities and then to patients, showing resource and activity links for the most frequent medical staffing resources

Resource and activity link ID	Resource	Activity
MHR253 – MHA258	Consultant – mental health	Mental health supporting contact 1:1 – inpatient unit
MHR253 – MHA260	Consultant – mental health	Psychoeducational group contact
MHR253 – MHA261	Consultant – mental health	CPA meeting
MHR253 – SLA098	Consultant – mental health	Ward round
MHR253 – SPA152	Consultant – mental health	DNA
MHR253 – MHA289	Consultant – mental health	Initial assessment
MHR253 – SLA135	Consultant – mental health	Outpatient care
MHR253 – SLA149	Consultant – mental health	Telemedicine contact
MHR253 – SPA155	Consultant – mental health	Research and development
SGR063 – SPA152	Non-consultant medical staff	DNA
SGR063 – SLA150	Non-consultant medical staff	Ward work
SGR063 – SLA153	Non-consultant medical staff	A&E – mental health liaison care
SGR063 – SLA154	Non-consultant medical staff	Palliative care support contact

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

26. An example template for gathering this necessary information for consultants (or other staff) is included in Spreadsheet CM1.1.

27. As in Integrated standard CP2: Clearly identifiable costs, some areas will need further allocation to ensure the costs are in the correct proportions for allocating to activities. For some medical staff, the percentage split of medical staffing costs by activity type may be divided further for specific groups of

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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.

28. 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 your ICAL worksheet 13: % allocation bases.

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

30. Once the quantum of cost for each type of activity has been calculated, the costs are allocated using the prescribed cost allocation methods.

Ward rounds

31. Ward rounds are regular or planned consultant visits to the ward to review a range of patients. Ward rounds can also include 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.)

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

33. 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.

34. 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.

35. Spreadsheet CP3.8 contains a template for collecting information on ward rounds. This allows you to develop relative weight values for patient cohorts who require longer, complex or weekend ward rounds.

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Ward work

36. Ward rounds tend not to be as formal in mental health as in other sectors. Most consultant inpatient work is continual; their presence on a ward is interspersed with one-to-one care. To ensure their time on a ward that is not spent on patient-specific activities is allocated to patients appropriately, a separate activity type should be used – activity ID: SLA150; Ward work.

37. Ward rounds and ward work are exclusive from each other. You should discuss the allocation between the two with the service. This activity should be costed in accordance with Spreadsheet CP3.3.

Inpatient supporting contacts

38. Discussions with the service teams will provide information on the other elements of medical staff time,[6] to allow allocation of their cost to the correct activity and inpatient episode.

39. Supporting contacts are consultant ward visits additional to the formal ward rounds or general ward care, usually for one (or more) specific patient contacts, or to a ward that is not their normal area. 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.) Use the supporting contacts feed (feed 7) in accordance with Spreadsheets IR1.1 and IR1.2.

- **Multidisciplinary contacts:** defined as one patient and more than one staff member. These are detailed in Mental health standard CM3: Non-admitted patient care – which describes how to treat this contact even when it takes place during an inpatient episode – and Mental health standard CM9: Multidisciplinary meetings. Use the supporting contacts feed (feed 7) in accordance with the technical guidance in Spreadsheets IR1.1 and IR1.2, and activity ID: MHA259; Mental health supporting contact multidisciplinary – inpatient unit.

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

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- **Group sessions:** these involve more than one patient and one or more staff members. These are detailed in Mental health standard CM14: Group sessions. Use the supporting contacts feed (feed 7) in accordance with technical guidance in Spreadsheets IR1.1 and IR1.2.
- **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 multidisciplinary meetings and the supporting contacts feed (feed 7), in accordance with technical guidance in Spreadsheets IR1.1 and IR1.2. 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.

40. 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 CM1.3.

41. 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 14). See Mental health standard CM9: Clinical multidisciplinary team meetings for further information.

Table CM1.3 Excerpt from Spreadsheet CP3.2: Activities for patient-facing type 2 support costs relating to admitted patient care

Activity ID	Activity
MHA258	Mental health supporting contact 1:1 – inpatient unit
MHA259	Mental health supporting contact multidisciplinary – inpatient unit
MHA261	CPA meeting
SLA128	Other clinical multidisciplinary meeting
MHA260	Psychoeducational group contact

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Activity ID	Activity
MHA280	Skills development group contact
MHA281	Cognitive behaviour/problem-solving group contact
MHA282	Interpersonal process group contact
CMA308	Support or other group contact

Outpatient and outreach care

41. The NAPC feed will include activity recorded at patient level for these activities.

42. 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.

43. 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. This could include contacts made at hostels or shelters, temporary residence at a friend's/family's home and where the homeless person lives on the street, which is identifiable by the 'activity location type code' field. Use the duration of the contact in accordance with the 'clinical contact duration of care contact' field.

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- For contacts in prisons or judicial settings, use the activity ID relating to the care given. The location is identifiable 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 (see also paragraphs 49 to 51).

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

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

46. 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.

Table CM1.4: Excerpt from Spreadsheet CP3.2: Activities for patient-facing and type 2 support costs relating to non-admitted patient care

Activity ID	Activity
SLA135	Outpatient care
SLA101	Outreach visit
SLA136	Outpatient procedure

Telemedicine (non face-to-face) contacts

47. These can include telephone and video consultation contacts (telemedicine), and other types of non face-to-face contacts recorded on the NAPC feed using the data field 'consultation medium used'.[7] The working definitions of these contacts are given in Table CM1.5.

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[7] We appreciate that some methods of communication are widely used, such as text and email, but such contacts 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 an appropriate recording method for the clinical teams, and document what is counted in your ICAL worksheet 3: Local activity definitions.

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48. The definitions and codes for 'consultation medium used' are given in the NHS Data Dictionary.[8]

Table CM1.5: Excerpt from Spreadsheet CP3.2: Activities for patient-facing and type 2 support costs

Activity ID	Activity	Activity description
SLA149	Telemedicine contact	Telephone call or video consultation made instead of a face-to-face contact
SLA102	Other non face-to-face contact	Non face-to-face contact that is not via a telephone call/video consultation, eg text, email, online medicine module, etc

Liaison with A&E departments

49. Where medical staff[9] work with A&E departments, the cost of these medical staff should be allocated to the activity this relates to. Physical care and mental healthcare should use separate activities.

Table CM1.6: Excerpt from Spreadsheet CP3.2: Activities for patient-facing and type 2 support costs

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 health professionals within A&E and emergency care facilities

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

51. Where no activity is available for this service, the cost should be disaggregated before the cost ledger, so the cost is not allocated to the organisation's own activities.

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[8] 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

[9] Other mental health staff may provide care for this service. Use the relevant resource and the activity ID as in Table CM1.6.

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Non-clinical activities

52. Where medical staff perform central oversight roles for research and development (R&D) and education and training (E&T) activities, these should be attached to the activity IDs in Table CM1.7.

    Table CM1.7: Excerpt from Spreadsheet CP3.2: Activities for patient-facing and type 2 support costs

Activity ID	Activity
SPA154	Education and training
SPA155	Research and development

53. For more information on E&T allocation of cost, please refer to the E&T costing standards for England – transitional method.

54. Training time and time spent on R&D projects that involve patient-facing activities are not currently costed separately. Therefore, the cost of these services is allocated over the patient-facing activity.

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

Non-consultant medical staffing resources

56. Non-consultant medical staff may take part in any of the activities described above. Use the resource ID: SGR063; Non-consultant medical staff to match the cost to the correct activity.

57. As most non-consultant medical staff will have different workloads from consultants, their resource should be allocated to activities or patients based on their pattern, not that of consultants. Do not use consultant job plans as a basis to allocate other medical staffing costs, such as non-consultant medical staff or consultant nurses. Allocate them based on discussions with those staff groups and other information sources.

58. Table CM1.8 below shows the resource–activity combinations for non-consultant medical staff.

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Table CM1.8: Excerpt from Spreadsheet CP3.3 showing the resource and activity links for the non-consultant medical staff resource

Resource and activity link ID	Resource	Activity
SGR063 – SLA150	Non-consultant medical staff	Ward work
SGR063 – SLA098	Non-consultant medical staff	Ward round
SGR063 – MHA258	Non-consultant medical staff	Mental health supporting contact 1:1 – inpatient unit
SGR063 – MHA259	Non-consultant medical staff	Mental health supporting contact multidisciplinary – inpatient unit
SGR063 – MHA261	Non-consultant medical staff	CPA meeting
SGR063 – SLA128	Non-consultant medical staff	Other multidisciplinary meeting
SGR063 – SLA149	Non-consultant medical staff	Telemedicine contact
SGR063 – SLA102	Non-consultant medical staff	Other non face-to-face contact
SGR063 – MHA266	Non-consultant medical staff	Prison contact
SGR063 – MHA260	Non-consultant medical staff	Psychoeducational group contact
SGR063 – MHA281	Non-consultant medical staff	Cognitive behaviour/problem-solving group contact
SGR063 – MHA280	Non-consultant medical staff	Skills development group contact
SGR063 – MHA282	Non-consultant medical staff	Interpersonal process group contact
SGR063 – CMA308	Non-consultant medical staff	Support or other group contact
SGR063 – SPA152	Non-consultant medical staff	DNA[10]
SGR063 – SLA121	Non-consultant medical staff	A&E – mental health liaison care

[10] For guidance only.

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Ward work

59. Much of the inpatient work for many non-consultant medical staff is on a ward managing care. Therefore, to ensure these tasks are allocated to patients appropriately, a separate activity type should be used – activity ID: SLA150; Ward work.

60. This should be costed in accordance with Spreadsheet CP3.3.

Other considerations

61. It is important to identify medical staffing activity not recorded on any of your organisation's main databases. Through discussions with medical staff we recommend you identify patients or patient types with whom significant time is spent in addition to ward rounds and other activity. Relative weight values should then be set up to allocate this medical staffing cost to those patients using this ward round activity.

Example: Resource and activity mapping

Table CM1.9 shows what medical staffing costs for one patient could look like as part of the resource and activity matrix.[11]

Table CM1.9: Example of medical staffing costs for an inpatient episode in the resource and activity matrix

Resource	Activity			
	Ward round	Ward care	Ward work	Supporting contact
Consultant – mental health	XX			XX
Non-consultant medical staff		XX	XX	
Psychologist		XX		XX

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[11] This example is still being developed – please provide feedback on appropriate inclusions for mental health inpatients, via costing@improvement.nhs.uk

CM2: Incomplete patient events[12] (integrated)

Purpose: To cost incomplete patient events, in-year costs are allocated to in-year activity.

Objectives

1. To ensure consistent costing of:

    - episodes[13] started but not completed in the current costing period (open)
    - episodes started in a previous costing period and completed in the current costing period (ended)
    - episodes started in a previous costing period that remain incomplete at the end of the current costing period (open).

2. To address other issues relating to incomplete patient events – for example, where a medicine is dispensed or a diagnostic test is carried out in a costing period different from the one to which it relates.

Scope

3. This standard applies to all activity relating to admitted patients who are:

    - not discharged at the end of the costing period, or
    - admitted before the beginning of the costing period.

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[12] These are often known as 'work in progress'. Our change in terminology acknowledges that as the NHS is a service organisation it is not appropriate to use manufacturing terminology.

[13] All sectors use the term episode, as does the Commissioning Data Set (CDS) and the Mental Health Services Data Set (MHSDS), so it is used throughout the costing standards to indicate a mental health inpatient stay under a single named healthcare professional.

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Overview

4.   Episode is the most detailed recorded level of admitted patient care, and all sectors with admission units should cost at this level.

5.   As defined in the NHS Data Dictionary, an episode is a period of activity where a named healthcare professional is responsible for the patient. See also Mental health standard IR1: Collecting information for costing.

6.   An episode starts when the patient is admitted or when their care is transferred. Examples of transfers of care are:

- A consultant transfer occurs when the responsibility for a patient transfers from one consultant (or general medical practitioner acting as a consultant) to another within a hospital provider spell. In this case, one consultant episode (hospital provider) will end and another one begin (from NHS Data Dictionary).
- A transfer of responsibility may occur from a consultant to the patient's own general medical practitioner (not acting as consultant) with the patient still in a ward or care home to receive nursing care. In this case, the consultant episode (hospital provider) will end and a nursing episode will begin (from NHS Data Dictionary)
- A consultant leaves the organisation and the patient is transferred to another healthcare professional. A long-stay or residential patient may have many such transfers
- Examples:
  - When the named care professional changes to reflect the change in the responsibility for the patient, a new episode will start – for example, when a patient transfers from a paediatric to an adult service
  - When the named care professional changes due to a change in the patient's condition, and a new episode may start under the new responsible care professional – for example, when a mental health patient's condition changes in severity and they are moved to a different care professional for the new part of the care programme.

7.   Community care and some other settings may record a named healthcare professional who is not a consultant. In this case, a consultant name is not

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required for costing, and the appropriate costs of the named healthcare professional should be allocated to the patient.

8. A spell is defined as a currency and represents the period between admission to and discharge from a hospital unit.[14] There will always be at least one episode within a spell. Please note: **spells** are the measure that is submitted for the PLICS mental health collection 2019..

9. An incomplete patient event is defined as one where the patient's current **episode** is ongoing – that is, they are still in a bed at midnight on the last day of the costing period.

10. By definition, if there is an incomplete episode, the spell will also be incomplete, but this is not costed separately from the episodes within it. You can have one or more complete episodes (patient events) and an incomplete event within the same spell.

11. Costing an episode based on the start and end dates means patients whose care started in an earlier costing period will be recognised as having costs incurred during the current costing period; and those discharged after the end of the current costing period can be identified and costs allocated according to when they were incurred.

12. If costs in the current costing period were allocated to discharged patients only, those yet to be discharged would not incur any cost. Incomplete episodes would be under-costed and the costs of complete episodes inflated by those absorbed from the incomplete episodes.

13. Costing complete and incomplete events allows costs for patients staying in hospital, other inpatient settings or residences to be allocated according to when they occur. This is particularly important in mental health, specialist units and community care organisations with long-term facilities, to ensure costs of patients who have not been discharged are not allocated to those who have been.

14. Note: a change of ward does not start a new episode (see Mental health and community standard CM13: Admitted patient care for further information).

[14] In accordance with the NHS Data Dictionary.

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What you need to implement this standard

- Costing principle 2: Good costing should include all costs for an organisation and produce reliable and comparable results.

Approach

15. To accurately cost your organisation's activities, it is important that only resources consumed in delivering the event are allocated to the event. To achieve this, costs need to be allocated to all patient events regardless of whether they are complete or incomplete at the end of the costing period.

16. While incomplete patient events may not be material for some providers, for those that provide specialist and/or long-term physical or mental healthcare, such as spinal units or high secure units, they can be significant.

17. We know that 'work in progress' is included in financial accounts. Organisations are required to follow the principles of IAS18 in relation to revenue recognition; for example, income relating to partially completed episodes at financial year-end should be apportioned across the financial years on a pro-rata basis. Costs of treatment are then accumulated as they are incurred.

18. Given the timing of the completion of the final accounts and cost data, the values for work in progress and for incomplete patient events will be different. There is no requirement to reconcile them, though the incomplete patient events cost data may be helpful in future assessments of income due for annual accounts purposes.

Calculating incomplete patient events

19. Incomplete events need to be calculated each time you run your costing model to derive patient-level costs. You should work with your informatics team to arrange a suitable way to do this, in conjunction with your costing software.

20. You should ensure that your admitted patient care (APC), ward stay (WS) and other feeds can recognise the incomplete events as valid patient records and bring them into the costing system. They should not be rejected during data

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quality checks, eg validation checks on the 'discharge date' or 'discharge flag' fields.

21. To calculate incomplete APC events for an in-year cost period, use the APC feed (feed 1) and WS feed (feed 4) as required by your sector (see Spreadsheet IR1.2).[15] One way to do this is to put the date of the end of the costing period in the 'discharge date' field.

22. The APC feed should then include information on patients still in a bed at midnight on the last day of the costing period.

23. To calculate incomplete events for A&E attendances for an in-year cost period, use the A&E feed (feed 2). You should consider the materiality of this information and ensure that incomplete events for the largest are calculated first.

24. Patients not discharged at the end of the costing period are identified by the derived field 'discharge flag' in the APC feed; see Spreadsheet IR1.2.

25. Incomplete events are then included in the matching process to ensure costed activities such as medicines dispensed can be matched to incomplete episodes.

26. You should ensure that patients admitted before the start of the costing period are included in the PLICS feeds.

27. For local reporting purposes, users of the patient-level costs should see the information in Table CM2.1 below.

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[15] See Mental health standard IR1: Collecting information for costing for more information on this feed.

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**Table CM2.1: Example of incomplete patient events in a reporting dashboard**

Specialty X	Cost (£)	Income (£)
Patients discharged	100	90
Patients not discharged	60	
Total costs incurred in month on delivering patient care	**160**	

Year-end incomplete patient events

28. Figure CM2.1 shows which part of an episode should be costed in the collection year. There are four types of event:

- all episodes started in a previous year (over start period) and finished in the current collection year; to correctly allocate the right proportion of costs, eg ward costs, to these episodes, in your costing system calculate the proportion of the episode in days falling in-year

- all episodes started in the current collection year but incomplete at year-end (over end period)

- all episodes that started and finished in the period (in period); these do not require a specific calculation at year-end

- all episodes started in a previous year and incomplete at year-end (ongoing throughout period); to cost these long-stay patients, count the number of in-year days to ensure the in-year costs are only allocated to in-year activity.

29. The 'episode end date' field should be used to identify whether an episode is complete or incomplete. See Mental health standard IR1: Collecting information for costing and Spreadsheet IR1.2.

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Figure CM2.1: Part of an episodes to be costed
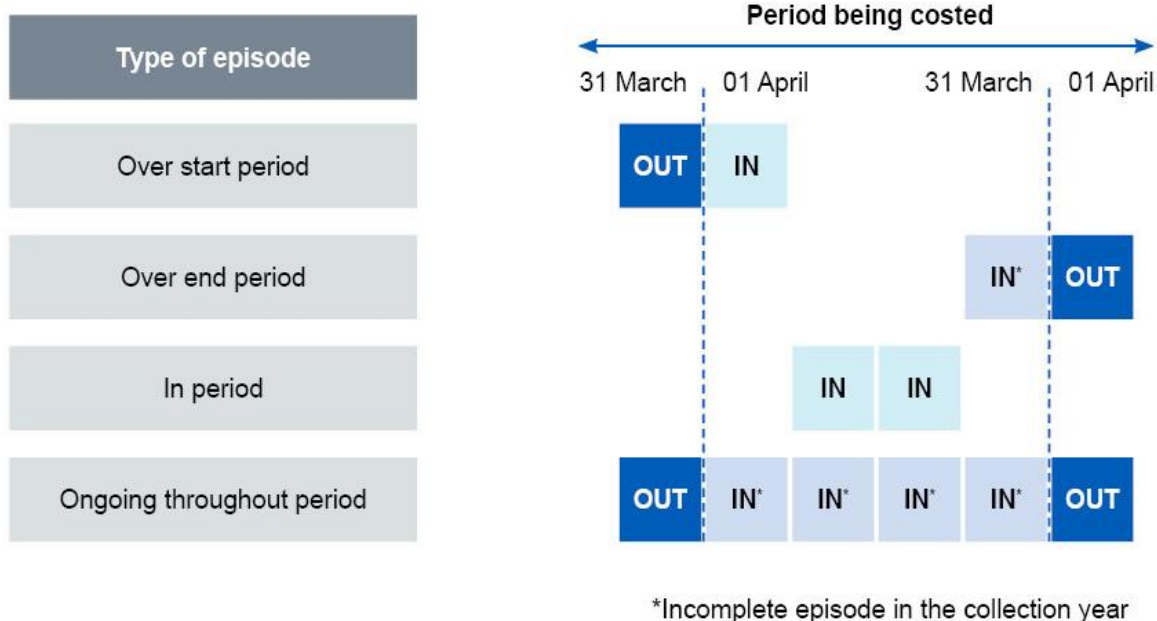
Matching costed activities to incomplete patient events

30. As information regarding incomplete patient events is included in the APC feed and the A&E attendances feed, and because the auxiliary patient-level feed(s) include all activity in-month, the matching rules in columns H to O in Spreadsheet CP4.1 will ensure costed activities from other patient-level feeds such as medicines dispensed or diagnostics will make a match to the incomplete event.

31. Where activities take place in a different year from the inpatient episode,[16] outpatient attendance or contact to which they relate, this costed activity shows up in the costing system as unmatched. However, this is not a true unmatched activity; rather, it cannot be matched because matching is not done across years.

32. Review all activity that is unmatched at year-end to identify why it is unmatched. See Integrated standard CP4: Matching costed activities to patients for more information on this.

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[16] This only applies where diagnostic tests are done for the spell but occur before the spell starts or after it ends.

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33. Where you identify that costed activity is unmatched because the episode, attendance or contact to which it relates is in a different costing year, you should flag it as 'unmatched – incomplete patient event'. Then report this under incomplete patient events, not under unmatched. The time spent doing this should be proportional to the value of the unmatched activity for your organisation, in line with the costing principles.

34. Where an expensive prosthesis is used in a cross-year episode, you need to use the 'date of implant' field in the prostheses and high cost devices feed (feed 15) in column D in Spreadsheet IR1.2 and allocate this cost to the correct part of the episode. For example, if the episode spans 26 March XX to 6 April XY, and the prosthesis was inserted on 26 March XX, the prosthesis cost should be assigned to the part of the episode that falls in year XX.

35. Incomplete patient events should be flagged in the costing system.

36. The benefits of this method of allocating in-year costs to in-year activity are:

   - full reconciliation to the audited accounts
   - cost of completed events is not inflated by the costs of the incomplete events
   - when the multi-year events are completed, their full costs can be derived.

37. We recognise that costing systems are not set up to hold multi-year data in one model. Where events span more than one reporting period, you must link the costs of a patient event across years using the episode in each costing model for the years they appear. This can be done outside the costing system – perhaps in your provider's costing reporting dashboard, as these often contain multi-year cost information. This enables the full cost of the patient event to be derived and used in the provider's local reporting dashboard.

38. While we currently collect only in-year costs and activity, in future this data will be linked to help us understand the true cost of these patients, particularly those whose care spans several periods and is likely to be complex or address specialist needs.

PLICS collection requirements

39.   Please refer to the *Mental health PLICS collection guidance* for collection of incomplete episodes.[17]

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[17] https://improvement.nhs.uk/resources/approved-costing-guidance-2019/

CM3: Non-admitted patient care

Purpose: To ensure all types of non-admitted patient care (NAPC)[18] activity are costed consistently.

Objective

1. To cost community mental health services to a service team session, and then to allocate them to the patients visited at their residence or attending clinics in the costing period.

2. To cost mental health outpatient contacts at clinic level, and then to allocate them to patients attending the clinics.

3. To cost all NAPC based on the healthcare professionals present.

4. To allocate the session cost to the patients based on the duration of the patient contact.

5. To ensure other NAPC activity is costed correctly.[19]

Scope

6. This standard applies to all NAPC activity.

7. The feeds covered by this standard are feeds 3b and 16, in accordance with Spreadsheet IR1.1.

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[18] NAPC is used throughout this standard to cover all forms of non-admitted patient contacts.
[19] For additional information for groups, see Mental health standard CM14: Group sessions.

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Overview

8. Non-admitted mental healthcare takes place in many different settings, including formal clinics (held in hospitals and community settings) but also a wide range of community settings. Some appointments are booked in advance; others are 'drop-in'.

9. Because of the nature of the patient cohort, some professionals will have patient contacts in a formal 'outpatient' (or NAPC clinic) setting. Other contacts are deemed to be 'outreach' in nature, defined here as a professional meeting the patient at a non-standard location. For example, a hospital-based therapist meeting with a patient in a community setting. Some outreach visits may be to the patient's residence or a prison.

10. Some healthcare 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 in a clinical setting). Without these contacts, patients may not attend appointments, take medication or follow self-care plans. Telephone calls and texts 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, but a wide range of talking therapies are also 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 present in the sessions/clinics[20] and how long the attendance is (in minutes).

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

14. The data sources for this standard are shown in Spreadsheet IR1.1. The NAPC feed (feed 3b) will come from the Mental Health Services Data Set

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

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(MHSDS) and may include other local datasets where necessary. The data for the Improving Access to Psychological Therapies (IAPT) feed (feed 16) will come from the IAPT dataset.

15. The MHSDS field for duration of contact is 'clinical contact duration of care activity' in accordance with Spreadsheet IR1.2.

16. If your organisation does not yet record the minutes of attendance, please 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 feed, continue to use your current method for costing outpatient activity and record this in your ICAL worksheet 14: Local costing methods.

17. The IAPT dataset has no field for duration of the contact, so the cost should be allocated to clinics, and allocated evenly to patients within that session. If you have local information on duration for these patients, this is considered a superior costing methodology. See ID SCM28 on Spreadsheet CP3.5.

18. You must ensure that formal[21] outpatient clinic costs are allocated to all activity that takes place in that department, using the appropriate cost allocation method. For example, the costs of staff in a clinic location should be allocated as appropriate to resources/activities and matched to the patients seen in that location.

19. Contacts may also take place outside the outpatient department, such as at patient residences. The cost of these must also be allocated using the duration of the contact in minutes to allocate cost.

20. Use of non face-to-face (also called 'telemedicine') contacts are increasing and it is important to include them in costing.[22]

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[21] In this context, 'formal' means a standard booked outpatient clinic or drop-in clinic that is held over a defined period, eg a morning or afternoon session.

[22] If this activity is not recorded in or not submitted to the MHSDS, 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 Mental health standard IR1: Collecting information for costing. It is essential to include this activity as care models change, so the outcome benefits can be understood.

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Approach

21. Obtain the patient-level feeds for all non-admitted patient activity as prescribed in paragraphs 66 to 83 in Mental health standard IR1: Collecting information for costing and Spreadsheets IR1.1 and IR1.2 (in accordance with the MHSDS and IAPT feeds).

22. Use the prescribed matching rules in columns H to O in Spreadsheet CP4.1 to ensure the auxiliary patient-level feeds such as medicines dispensed match to the correct NAPC contact.

Non-admitted patient care data[23]

23. Due to the varied nature of NAPC contacts it is important you identify the different type of clinics and the staff involved in each. For example, a clinic may be service-specific with a consultant, non-consultant medical staff and nurse. It may be multidisciplinary or multiprofessional, consultant, psychologist, therapist or nurse-led.

24. The MHSDS and IAPT feeds requires all NAPC contacts to be recorded. However, it is known that not all organisations have yet achieved this. If this is not recorded fully on your NAPC feed, the information may be available from either recording pro formas (one per patient) or summary sheets that are completed by the clinical staff. You should use this information to guide discussions with clinical and service leads.

25. To help you cost NAPC, column D in the NAPC patient-level feed (feed 3) in Spreadsheet IR1.2 contains the fields for each outpatient attendance, as shown in Table CM3.1.

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[23] Including multidisciplinary clinics.

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Table CM3.1: Excerpt from Spreadsheet IR1.2 showing the fields for recording types of NAPC contacts – feed 3b MHSDS

Feed name	Field name	How does the costing process use this field?
Non-admitted patient care	Organisation identifier (code of commissioner'	This is the 'organisation identifier' of the 'organisation' commissioning healthcare (used to determine the administration category).
Non-admitted patient care	Local patient identifier (extended)	This is a number used to identify a 'patient' uniquely within a healthcare provider. It may be different from the 'patient's' case note number and may be assigned automatically by the computer system. 'Local patient identifier (extended)' is used where IT systems have a 'local patient identifier' that is longer than 10 characters and cannot be used for data submission.
Non-admitted patient care	NHS number	A number used to identify a 'patient' uniquely within the NHS in England and Wales.
Non-admitted patient care	Person's date of birth	The date on which a person was born or is officially deemed to have been born.
Non-admitted patient care	Language code (preferred)	'Language code (preferred)' is the language the 'patient' prefers to use for communication with a healthcare provider. 'Language code' is based on the ISO 639-1 two-character language codes: see the ISO 639.2 Registration Authority website, plus five communication method extensions.
Non-admitted patient care	Healthcare professional local identifier	A unique local 'healthcare professional identifier' within a healthcare provider, which may be assigned automatically by the computer system.
Non-admitted patient care	Patient pathway identifier	An identifier, which together with the 'organisation code' of the issuer uniquely identifies a 'patient pathway'.
Non-admitted patient care	Care contact identifier	The 'care contact identifier' is used to uniquely identify the 'care contact' within the healthcare provider. It is normally automatically generated by the local system on recording a new care contact, although it can be manually assigned.

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Feed name	Field name	How does the costing process use this field?
Non-admitted patient care	Care contact date	The date on which a care contact took place or, if cancelled, was scheduled to take place.
Non-admitted patient care	Administrative category code	This is recorded for 'patient activity'. A 'patient' who is an overseas visitor does not qualify for free NHS healthcare and can choose to pay for NHS treatment or private treatment. If they pay for NHS treatment, they should be recorded as 'NHS patients'. The 'patient's administrative category code' may change during an episode or spell. For example, the 'patient' may opt to change from NHS to private healthcare. In this case, the start and end dates for each new 'administrative category period' (episode or spell) should be recorded. The category 'amenity patient' is only applicable to 'patients' using a hospital bed.
Non-admitted patient care	Clinical contact duration of care contact	The total duration of the direct clinical contact at a 'care contact' in minutes, excluding any administration time before or after the 'care contact' and the 'healthcare professional' travelling time to the 'care contact'. 'Clinical contact duration of care contact' includes the time spent on the different 'care activities' that may be performed in a single 'care contact'. The duration in minutes of each 'care activity' is recorded in 'clinical contact duration of care activity'.
Non-admitted patient care	Consultation medium used	Identifies the communication mechanism used to relay information between the 'healthcare 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 outpatient attendance consultant, clinic attendance nurse or clinic attendance midwife type of 'care activity'. A record of the telephone or

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Feed name	Field name	How does the costing process use this field?
		telemedicine consultation must be retained in the 'patient's' records. Telephone contacts solely for informing 'patients' of results are excluded.
Non-admitted patient care	Group therapy indicator	An indicator of whether a care activity was delivered as group therapy. Group therapy is a 'session' where more than one 'patient' attends at the same time, to see one or more care 'professionals'. Clinical notes are recorded in each 'patient's' case notes.
Non-admitted patient care	Attended or did not attend code	This indicates whether an 'appointment' for a 'care contact' took place. If the 'appointment' did not take place, it also indicates whether warning was given.
Non-admitted patient care	Group session identifier	The 'group session identifier' is used to uniquely identify the 'group session' within the healthcare provider. It is normally automatically generated by the local system on recording a new group session, although it can be manually assigned.
Non-admitted patient care	'Clinical contact duration of group session'	The duration of a group session in minutes, excluding any administration time before or after the group session and the 'healthcare professional' travelling time to the 'location' where the group session was provided.
Non-admitted patient care	Number of participants in the group session	The number of people who participated in the group session, excluding the healthcare professionals.
Non-admitted patient care	Activity location type code	The type of 'location' for an 'activity': - where 'patients' are seen - where 'services' are provided or - from which requests for 'services' are sent.
Non-admitted patient care	Multiprofessional contact	Field to identify where multiple staff resource is used. This is not currently available on the MHSDS but is a requirement for costing.

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Feed name	Field name	How does the costing process use this field?
Non-admitted patient care	Care programme approach review date	Used in the superior costing method for CPA meetings in accordance with Mental health standard CM9: Clinical multidisciplinary meetings.
Non-admitted patient care	Coded procedure and procedure status (SNOMED CT)	The 'SNOMED CT expression' is used to identify a procedure plus the status of the procedure.

Table CM3.2: Excerpt from Spreadsheet IR1.2 showing the fields for recording types of NAPC contacts – feed 16: IAPT

Field name	Field description
Organisation code (code of provider)	This is the organisation code of the organisation acting as a healthcare provider.
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.
Appointment type	The type of IAPT appointment.
Mental health care cluster code (final)	The final allocation of the mental health care cluster code by the healthcare professional. The determination of the adult mental health care cluster code may or may not have involved the use of the National Tariff Payment System clustering algorithm. Please note this is the cluster at the time of the appointment, not the patient's final cluster in their pathway.
Local patient identifier (extended)	An 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.

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NHS number status indicator code	Codes in this field indicate whether the patient's NHS number is present, and if it is verified. If the NHS number is absent, the indicator gives the reason why.
Date of birth	The date on which a person is 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'.
Gender	The current gender of the patient. Note: the classification is phenotypical rather than genotypical – ie it does not provide codes for medical or scientific purposes.
Attended or did not attend	An indication of whether an appointment for a care contact took place.
Referral request received date	Date referral received.
Multiprofessional flag	Identifier that this was a multiprofessional contact.
Duration of contact	Local feed showing duration of contact.

26. The MHSDS and IAPT feeds do not currently contain suitable fields to identify multiprofessional and multidisciplinary activity separately from single professional activity.[24] 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 and build this into your NAPC feed. A field has been added to identify multiprofessional contacts to both feeds. This is key information to ensure you can cost non-admitted patient contacts correctly.

27. Use this information to build relative weight values to allocate the appropriate staff costs to each of the clinics[25] – see Spreadsheet IR1.2.

28. 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.

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[24] We are currently working with NHS Digital to understand developments of the MHSDS to allow additional fields. This is part of the information standards for mental health costing.
[25] We acknowledge this information is not widely collected currently.

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Costing NAPC services

29. Mental health contacts can be formal booked clinics, drop-in clinics or healthcare professionals searching for and finding the patient in a non-clinical location.

30. Use the prescribed activities in Table CM3.3.

31. For group contacts, see Mental health standard CM14: Group sessions.

Table CM3.3: Excerpt from Spreadsheet CP3.2 showing the activities for non-admitted patient care

Activity ID	Activity
MHA261	CPA meeting
MHA267	Other telemedicine contact
SLA101	Outreach visit
SLA135	Outpatient care
SLA136	Outpatient procedure
SLA149	Telemedicine contact

32. Use the 'activity location type code' field in the NAPC feed to identify formal clinics, outreach visits, patient's own residence and prison visits (see Spreadsheet IR1.2).

33. Where healthcare professionals perform formal outpatient clinics in their usual setting, use the activity ID: SLA135; Outpatient care – for example, if a community psychiatric nurse holds a clinic in a community setting, or a hospital-based psychiatric nurse holds a clinic in their hospital clinic setting.

34. Where staff have to 'search' for the patient to hold the contact, use activity ID: SLA101; Outreach visit. The location recorded will be the location where the patient was seen, and this can encompass any non-standard location. Use fields 'outreach contact' and 'outreach duration' to add the duration of the searching to the duration of the contact, to allocate the cost of the staff to the patient.

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35. Where some professionals have a mix of outpatient clinics and outreach contacts, you should base the method you use on the structure of the appointment setting.

36. Table CM3.4 is an excerpt[26] from Spreadsheet CP3.3 showing the resources the NAPC activities are linked to. For each of the resource and activity combinations below, a prescribed two-step allocation method is given in columns F and G in Spreadsheet CP3.3.

37. Review the list of activities in Spreadsheet CP3.2 and identify those to include in your NAPC feed to ensure you use the correct prescribed activity and do not incorrectly assign their costs.

Table CM3.4: Excerpt from Spreadsheet CP3.3 showing some of the resource and activity links for the outpatient activities

Resource and activity link ID	Resource	Activity
CMR305 – ISLA101	Community psychiatric nurse	Outreach visit
MDR033 – SLA135	Dietician	Outpatient care
MDR046 – MHA266	Medical and surgical consumables	Prison contact
MHR250 – SLA135	Psychiatric nurse	Outpatient care
MHR252 – SLA135	Support worker	Outpatient care
MHR253 – SLA149	Consultant – mental health	Telemedicine contact
MHR256 – SLA135	Nurse manager	Outpatient care
MHR257 – MHA261	Primary mental health worker	CPA meeting
MHR260 – SLA135	Counsellor	Outpatient care
SGR062 – SLA102	Consultant	Other non face-to-face contact
SGR063 – SLA135	Non-consultant medical staff	Outpatient care
SLR082 – MHA261	Specialist nurse	CPA meeting
SLR084 – SLA101	Healthcare assistant	Outreach visit

[26] 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.

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Resource and activity link ID	Resource	Activity
SLR090 – SLA149	Psychologist	Telemedicine contact
THR001 – SLA101	Therapist	Outreach visit

CPA meetings

38. CPA meetings review a patient's care plan. They must be held annually but can be more frequent and can be held while the patient is an inpatient. They will be recorded on the NAPC feed if they are performed 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 multidisciplinary meetings for more detail.

Costing individual outpatient attendances

39. Due to the varied nature of outpatient clinics, it is important that you identify the different types of contact provided and the staff involved in each. For example, a morning session 'clinic' may be service-specific and involve medical staff only, or it may be multidisciplinary or led by another healthcare professional.

40. Column D in the NAPC patient-level feed (feed 3) in Spreadsheet IR1.2 contains the following fields for each outpatient attendance to help you cost.

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Table CM3.5: Excerpt from Spreadsheet IR1.2 showing fields to record types of outpatient clinics

Feed name	Field name	Field description
Non-admitted patient care	Clinical contact duration of care contact	The total duration of the direct clinical contact at a 'care contact' in minutes, excluding any administration time before or after the 'care contact' and the 'healthcare professional' travelling time to the 'care contact'. 'Clinical contact duration of care contact' includes the time spent on the different 'care activities' that may be performed in a single 'care contact'. The duration of each 'care activity' (in minutes) is recorded in 'clinical contact duration of care activity'.
Non-admitted patient care	Healthcare professional local identifier	A unique local 'healthcare professional identifier' within a healthcare provider that may be assigned automatically by the computer system.
Non-admitted patient care	Consultation type	This indicates the type of consultation for a service.
Non-admitted patient care	Multiprofessional contact	Field used to identify where a multiple staff resource is used. This is not currently available on the MHSDS but is a requirement for costing.

41. 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. Use this information to provide relative weight values to allocate the appropriate staff costs to each of the clinics.

42. Be aware that, in the patient-level information, a clinic may be assigned to the consultant with overall responsibility for it: this consultant may not necessarily be present in the clinic.

Outpatient care – clinic staff (non-medical)

43. Use activities as above for the relevant type of activity.

44. In the costing system a cost per clinic needs to be calculated using information obtained about which staff attend which clinics in your organisation.

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45. Calculate the correct quantum of staffing costs in their separate resource types, to be allocated to healthcare professionals involved in the clinic.

46. Healthcare professionals' individual costs can be identified from a payroll data source[27] and used in the costing system to calculate the staff cost per contact. This is Mental health superior costing methodology SCM27: Staff costs to named patient activity, on Spreadsheet CP3.5.

47. If you do not have the payroll information from which to calculate the costs of the actual staff present, set up relative weight values that include all appropriate staff and use a weighting to calculate an average cost per clinic minute for staffing.

48. The total staff cost for the clinic is then allocated to all patients seen in that clinic based on the duration of their attendance.

49. We recognise that using actual cost is difficult currently for most providers, but it is the aim for the future.

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

Patient's own residence contacts

51. Use activity IDs as above. The location will be identified from the location code within the dataset.

52. We recognise that identifying the time each staff member spends searching and on flexible outreach activities is difficult for most providers, but it is the aim for the best possible costed information for these patient contacts.

53. For example (see Table CM3.6), a substance misuse practitioner ran a formal clinic on Monday morning at which they saw four patients. This activity is outpatient care. On Monday afternoon, the practitioner's time was spent entirely on searching for and speaking to one patient. This is an outreach

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

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contact – and will take much longer than each contact in the morning. Each session lasts four hours and costs £120 (under Agenda for Change contracts).

Table CM3.6: Example of staff costs split by patients illustrating use of duration time

	Morning – outpatient care duration	£ Morning session	Afternoon – outreach contact duration	Searching time	£ Afternoon session
Patient 1	1 hour	£30			
Patient 2	1 hour	£30			
Patient 3	1 hour	£30			
Patient 4	1 hour	£30			
Patient 5			1 hour	3 hours	£120

Costing individual outpatient interventions

54. Some outpatient procedures may require input from a healthcare professional who is not one of the normal clinic staff. For example, Electroconvulsive therapy (ECT) may require an anaesthetist or practitioner. Their cost needs to be included for the relevant patient, based on the duration of the attendance.

55. The procedure should be identified using the 'coded procedure and procedure status (SNOMED CT)' field in the NAPC feed.

56. Use the activity ID: SLA136: Outpatient procedure; or if appropriate, activity ID: MHA279; Electroconvulsive therapy.

Medical and surgical consumables and equipment

57. We are advised that consumable item costs of mental health NAPC contacts are negligible. But if you find these costs are material, per patient or in total, apply the procedure below.

58. Medical and surgical consumables and equipment are divided into the following categories for costing:

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- consumables and equipment on hand in all outpatient clinics for simple investigations and treatments
- consumables and equipment on hand in specific outpatient clinics
- expensive consumables and equipment required for more complex procedures.

59. For consumables and equipment on hand in the outpatient clinic for simple investigation and treatment, allocate cost to all patients in outpatients based on duration of their attendance in minutes.

60. For consumables and equipment on hand in specific clinics, allocate cost to the patients in those clinics based on duration of their attendance in minutes.

61. Use resource ID: MDR046; Medical and surgical consumables and resource ID: MDR047; Medical and surgical equipment and maintenance.

62. For expensive consumables[28] and equipment required for complex procedures, identify which outpatient procedures use these. Then set up relative weight values so that the expected costs can be used as a relative weight value to allocate the consumable and equipment costs to patients undergoing procedures that use them.

63. Use resource ID: MDR052; Patient-specific consumables.

Table CM3.7: Example of how a multidisciplinary eating disorder unit outpatient attendance might look in the resource and activity matrix

Resource	Activity	
	Outpatient care	**Interpreting – language**
Consultant	XX	
Non-consultant medical staff	XX	
Psychiatric nurse	XX	
Healthcare assistant	XX	
Dietician	XX	

[28] We do not define what an 'expensive consumable' is; that can be decided locally.

Mental health costing methods

Resource	Activity	
	Outpatient care	**Interpreting – language**
Medical and surgical consumables	XX	
Interpreters		XX

Non face-to-face (telemedicine) consultations

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

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

66. Other non face-to-face contacts include text conversations, email, patient-online schemes and patient letter review.[29] These need to be separated from those made via telephone, as the duration of 'patient contact' will be different. Use activity ID: SLA102; Other non face-to-face contacts.

67. These are all countable within the NAPC dataset using the 'consultation medium used' field.[30] See Table CM3.8 showing the NHS Data Dictionary codes for this field.

Table CM3.8: NHS Data Dictionary codes for different consultation media

01	Face-to-face communication
02	Telephone
03	Telemedicine web camera
04	Talk type for a person unable to speak
05	Email

[29] 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 your ICAL worksheet 1.3: Local activity definitions.
[30] Detailed definitions and recording protocols for text and email are not given yet in the NHS Data Dictionary.

Mental health costing methods

01	Face-to-face communication
06	Short message Service (SMS) – text messaging
98	Other

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

69. Non face-to-face contacts that directly support diagnosis and care planning as part of the care plan should be counted and costed. These non face-to-face contacts often replace the need for a face-to-face contact, and often prevent condition escalation, making an effective contribution to agreed pathways.

70. A non face-to-face contact should only be costed if it was made in line with the definition in the NHS Data Dictionary for consultation medium. Non-clinical telemedicine contacts should not be counted or costed. Contacts just to arrange appointments should not be counted as activity or costed. The cost of this activity is absorbed by the healthcare professional's recorded activity.

71. For costing, telemedicine consultations are classified as clinical in nature in the same way as an outpatient attendance. Include eligible non face-to-face consultations in the NAPC feed. If services record their non face-to-face calls on a separate database to the PAS, you need a patient-level feed that includes all important identifiable information.

72. You need to find out if the time recorded for a non face-to-face consultation is the actual call duration or if it also includes the time to prepare and write-up the patient notes. **Only the duration of the phone call should be costed** for consistency with costing outpatient attendances, with the additional cost being absorbed. Preparation is treated as administration time, not contact time.

73. The 'clinical contact duration of care contact' field for the appointment duration in hours and minutes is included in column D in the NAPC patient-level feed in Spreadsheet IR1.2.

74. Telemedicine and other non face-to-face calls would normally have only one staff member involved. However, it is possible that the contact was

multiprofessional. The appropriate resources should be attached to the activity accordingly.

Group sessions

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

76. Group contacts are identified by the 'group therapy indicator' field in the NAPC feed (see Spreadsheet IR1.2).

77. The costing method for these is detailed in Mental health standard CM14: Group sessions.

Separate datasets

78. Some discrete services in the organisation may have separate information feeds that do not show contacts in the MHSDS. These should be costed in the same way as other NAPC contacts, using the duration of the contact. Examples include:

   - learning disabilities
   - addiction services, including drug and alcohol
   - perinatal mental health services
   - psychiatric liaison.

79. These datasets, where available, should be added to the NAPC feed so the information is consistent. They will need to provide the same data items as the MHSDS as it applies to PLICS.

Learning disabilities

80. Use the NAPC activities as for other NAPC contacts, as described above.

81. Usually individuals who have limited ability to comprehend complex information or are not self-reliant in day-to-day decision-making are referred to as patients with learning disabilities. The individual's mental development challenges may have been apparent since childhood. They may also have medical conditions that do or do not impact on the non-admitted mental health contact.

Mental health costing methods

82. Cost of the contact should include the cost relating to 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 in the cost for the mental health element.

83. If the physical element is provided by your organisation – that is, the costs sit in your ledger – you should cost this using the acute or community standards,[31] resources and activities (according to the setting of care).

84. Multiple team members in the contact should be included, whether multidisciplinary or multiprofessional.

85. This service may be provided in a community setting. Staff travel costs should be included where relevant.

86. Although costing for learning disability services has traditionally not been included in national submissions, the resources and activities applying to this service can be costed according to the costing standards. Apply the principles and costing standards to produce resources, activities and patient-level costs in accordance with all other activity.

Drug and alcohol services/substance misuse

87. Use the NAPC activities as described above for other NAPC contacts.

88. Substance misuse refers to excessive use of drugs or alcohol, which can lead the individual to harm themselves or others.

89. The service provision typically includes treatment contacts with patients, but also supervised consumption and needle exchange. If the cost of consumable items is material, refer to paragraphs 57 to 63 above; or if the material costs are medicines, refer to Mental health standard CM10: Pharmacy and medicines.

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[31] The community standards are in development but will follow the costing principles. If further guidance is needed before these standards are released, you can follow the acute standards for outpatient services.

Mental health costing methods

90. Ad-hoc contacts as well as booked appointments should be included on the NAPC feed, as they are included in the specifications of the MHSDS.

91. In some organisations, staff provide outreach services to locations where patients are commonly found, such as substance sources, to prevent crises. Work with the service to understand the activity recorded and encourage improved recording where necessary. Costing should be based on the information available.

92. If the patient is not registered with the service provided, 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 feed under a pseudonym or 'proxy record'. Cost as for a standard patient.

Perinatal mental health services

93. Use the NAPC activities as described above for other NAPC contacts.

94. Patients may need treatment for a mental health condition during pregnancy or after the birth, and this may fall under the perinatal mental health service.

95. This is often a discrete service that carries out activity in a community setting, clinics and dedicated mother and baby units. (The ward care provided on the inpatient unit should record the activity ID: MHA256; Mental health other inpatient unit – ward care.)

96. The costed activity is for the mother only, although there may be costs for nursery nurses in addition to those costs for the mental healthcare provided to the mother. Ensure the nursery costs are allocated across the patients using the unit in the period, unless patient-level information is available. For nursery nurses, use the resource and activity as shown in Table CM3.9.

Mental health costing methods

Table CM3.9: Resources and activity for nursery nursing in a perinatal mental health unit

Resource and activity link ID	Resource	Activity
MHR262 – MHA278	Nursery nurse	Nursery nursing

Psychiatric liaison service

97. Patients reporting illness in an acute care setting may require assessment or treatment for their mental health condition as well as their physical health. Psychiatric liaison teams work in the acute provider to support this need. These teams usually work in the A&E department (see Mental health CM1: Medical staffing) but can also provide care in other areas such as outpatient clinics, emergency wards, or elderly care wards supporting dementia patients.

98. These services will be recorded in the:

- mental health organisation's ledger or
- acute provider's ledger.

99. Where the liaison service staff costs are recorded in the mental health organisation's ledger, and there is no corresponding pay recharge to the acute provider, the cost should be identifiable.

100. If activity information is available on the contacts performed, this may be included as a costed patient-level dataset, with the pay recharge allocated to the activity in accordance with Integrated standard CP2: Clearly identifiable costs. Use the activity for SLA135: Outpatient care.

101. However, the more likely scenario is that this information is not available. Treat this as a resource with no patient-level activity and enter it in the reconciliation under 'other activities'.

102. If there is a pay recharge to the acute provider and the activity is not recorded in your organisation, there will be no balance to deal with as this should be netted off the costs of the staff providing the service. See Integrated standard CP2: Clearly identifiable costs, paragraph 17.

Mental health costing methods

NAPC DNAs – for guidance only

103. Did not attend (DNA) is the designation providers use to record that a patient did not attend their scheduled appointment in an outpatient clinic. Was not brought (WNB) is the corresponding term for children and vulnerable adults who are not brought to appointments.[32]

104. **This section is for guidance only.** You are not required to cost DNAs for this version of the standards or the cost collection, but if required for local purposes this is our recommended approach.

105. We recognise that costs associated with DNAs may seem immaterial to some providers, particularly those that overbook outpatient clinics to allow for some patients not attending. However, costing these separately can establish the true cost of DNAs to the organisation and the sector. Ignoring these costs means the true cost of all other patients attending appointments will be inflated as they will absorb the full costs of the clinic.

106. The important DNA cost is the cost of any action required if a patient does not attend or, in the case of a child or vulnerable adult 'was not brought' to clinic. For example, the consultant may have 'graded' the referral to identify which clinic should be booked and the patient will have been booked to that clinic by the admin team. At the end of the clinic a consultant may review the notes and decide whether to send the patient another appointment or refer them back to their GP. There will be admin time typing letters and confirming the ongoing action. Finally, in some cases, the healthcare professional will not be able to use the time productively on other patients or administration (such as contacts at the patient's residence where the patient is not present when the healthcare professional arrives), so the full duration of the patient slot is wasted time.

107. You need to find out if your organisation has a DNA policy; if it does, this tells you what action is taken when a patient does not attend. The cost of this action should be included in the cost of a DNA.

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[32] Vulnerable adults are defined as those unable to manage their care without the assistance of another adult. This includes incapacity to understand clinical and complex information and make decisions about care. It can be a permanent or temporary state.

Mental health costing methods

108. A patient not attending or not being brought to clinic may indicate a safeguarding issue, so the provider will follow a course of action as part of its safeguarding policy. This action incurs a cost that needs to be calculated.

Costing DNAs for business intelligence

109. The DNA can be identified from the NAPC patient-level feed, using the 'attended or did not attend code' field in accordance with Spreadsheet IR1.2.

110. Review your organisation's DNA policy to identify the DNA pathway. A high-level example of a DNA pathway may be:

    - patient does not attend
    - consultant reviews the notes and decides to send another appointment – five minutes
    - medical secretary produces and sends an appointment letter – five minutes
    - associated support costs are allocated.

111. Set up relative weight values for costing DNAs based on the information collected above. The relative weight values will apply to all DNAs irrespective of the reason given for the DNA.

112. As the DNA feed contains the named healthcare professional, you should use an actual healthcare professional cost.

113. Document your review of your organisation's DNA policy in your integrated costing assurance log (ICAL) worksheet 25: CM3 DNAs, as well as the decisions you make on the costing approach in your ICAL worksheet 18: Decision audit trail.

PLICS collection requirements

114. DNAs should not be costed for the national cost collection. The costs need to form part of your outpatient attendances.

115. For the collection, allocate the costs of outpatients only to patients who attended, using the prescribed cost allocation rules in columns F and G in Spreadsheet CP3.3, and using the activities outpatient care (and outpatient procedures where needed).

CM7: Private patients and other non-NHS funded patients (integrated)

Purpose: To ensure private patients and other non-NHS funded patients are costed in a consistent way.

Objective

1. To ensure the activities relating to private patients,[33] overseas visitors, patients funded by the Ministry of Defence, and other patients funded from outside NHS commissioning in England, are costed in line with the healthcare costing standards for England.

2. To ensure the associated income for these patients is correctly identified and matched to the correct episode, attendance or contact.

Scope

3. This standard applies to activities relating to all private patients, overseas visitors, patients funded by the Ministry of Defence, and other patients funded from outside NHS commissioning. This is on the basis that all patients for whom care is provided by the NHS should be costed in the same way, irrespective of the way their funding is provided.

4. Patients funded by English NHS commissioners, but managed and paid for via a third party, **should not** be excluded from the quantum of costs because they remain classified as NHS patients for tariff calculation.

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[33] For our definition of private patient care, see *Approved costing guidance: glossary*.
https://improvement.nhs.uk/resources/approved-costing-guidance/

Mental health costing methods

Overview

5. These patients should be costed in the same way as patients funded by the English NHS using the prescribed resources, activities and cost allocation methods in Spreadsheets CP3.1, 3.2 and 3.3., with the addition of any specific administration or management costs that should be attributed solely to these patients. They should also be included in the allocation of support costs.

6. The relevant episodes, attendances and contacts must be flagged in the costing system.

7. Costed activity for these patients should be reported as 'own-patient care' and along with the corresponding income for local reporting and business intelligence purposes.

8. We recognise that there may be issues with recording these patients. For example, if a patient changes from private status to NHS or vice versa during an inpatient episode, this may not be assigned correctly in the patient administration system (PAS). The informatics department should work with the relevant service to address this if it is an issue for your organisation.

Approach

9. Identify who funds the care of the patient for each patient episode, attendance or contact from their organisation identifier (code of commissioner) and their administrative category code in column D in Spreadsheet IR1.2.

10. The patient's 'administrative category code' may change during an episode. For example, the patient may choose to change from NHS to private healthcare. In this case, the start and end dates for each new 'administrative category code' (episode) should be recorded in the APC feed, so all activity for private patients, overseas visitors, patients funded by the Ministry of Defence and other non NHS-funded patients can be correctly identified and costed accurately.

11. Non-admitted patients cannot change status during one contact.

12. Private patients' administration and overseas visitor managers' costs have been classified as a type 2 support cost in the standards. These costs are to

be allocated directly to private patients as prescribed in Spreadsheet CP3.4. It is inappropriate for this administration cost to be allocated as a type 1 support cost as it needs to go directly to the subset of patients who used this resource, and not be allocated to nurses or other staff who care for NHS and non-NHS patients alike.

13. Table CM7.1 shows the resource and activity combinations to be used for private patient administrators and overseas visitor management teams.

Table CM7.1 Excerpt from Spreadsheet CP3.4 showing the resource and activity links for private patient administration and overseas visitor management

Resource and activity link ID	Support resource	Support/patient-facing activity
SPR125 – SPA167	Overseas visitor management team	Overseas visitor management
SPR127 – SPA171	Private patient administrator	Private patient administration

14. Do not include any costs in the costing process for these patients where the incurred costs do not sit in the organisation's accounts. For example, where a consultant saw a patient using NHS facilities and staff but separately invoices the patient/healthcare company for their time, you should allocate the facilities and other staff cost to that patient, but not the consultant time.[34]

15. Therapy, drugs, diagnostic tests, critical care, social care and other costs should be included in the costing process unless they do not sit in the organisation's accounts.

16. If the patient receives a service that is additional to those received by an NHS-funded patient, the costs should be identified and allocated to the private patient, for example:

- private room costs
- additional catering costs
- additional clinical or holistic treatments, tests and screening not normally available on the NHS patient pathway

[34] This example presumes the patient contact was recorded on an NHS data system.

Mental health costing methods

- privately or charitably-funded specialist limbs/equipment, including those provided to veterans and children.

17. It is important that the income received for caring for these patients is allocated to the correct episode, attendance or contact. This will ensure that where there is an element of profit, it is shown against the private patient and not netted off from the NHS funded patient care costs.

PLICS collection requirements

18. Private patients and non-NHS patients are out of scope for the PLICS patient-level extracts. The costs for these patients should be reported in the reconciliation file only; see the *Mental health PLICS cost collection guidance*[35] for more information.

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[35] https://improvement.nhs.uk/resources/approved-costing-guidance-2019/

CM8: Other activities (integrated)

Purpose: To ensure all other activities provided to or by another organisation are costed in a consistent way.

Objectives

1. To ensure activities delivered by your organisation on another organisation's behalf are costed in a consistent way, including direct access (**contracted-in services and commercial services**).

2. To ensure activities delivered on your organisation's behalf by another organisation are costed in a consistent way (**contracted-out services**).

Scope

3. This standard applies to all activities performed by a provider that do not relate to the care of its own patients. These include care provided to direct access patients and commercial activities where non-patient care services are provided.

Overview

4. Patient care that is classified as 'other activities' needs to be flagged in the information feeds using the contracted-in and contracted-out indicators in column D in Acute spreadsheet IR1.2.[36]

5. You should cost all activities delivered by your organisation on another organisation's behalf (contracted-in activity) in the same way as your

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[36] This currently applies to acute only. We are looking at how other activities can be identified in the mental health and community care activity datasets.

Mental health costing methods

organisation's own-patient activity but report separately so the cost and any patient activity are not included in the costed own-patient care.

6. You should cost all activities undertaken by another organisation on your organisation's behalf (contracted-in activity) using activity information provided by the other organisation and report using the prescribed resources and activities.

7. Work with contract managers and other finance colleagues to understand the basis of the service-level agreements, as this helps you to identify the nature of these activities.

Approach

Contracted-in activity

8. Where this activity is in your activity feeds, you need to understand the different service users for departments that deliver this activity (see Figure CM8.1).

Figure CM8.1: Services with different service users
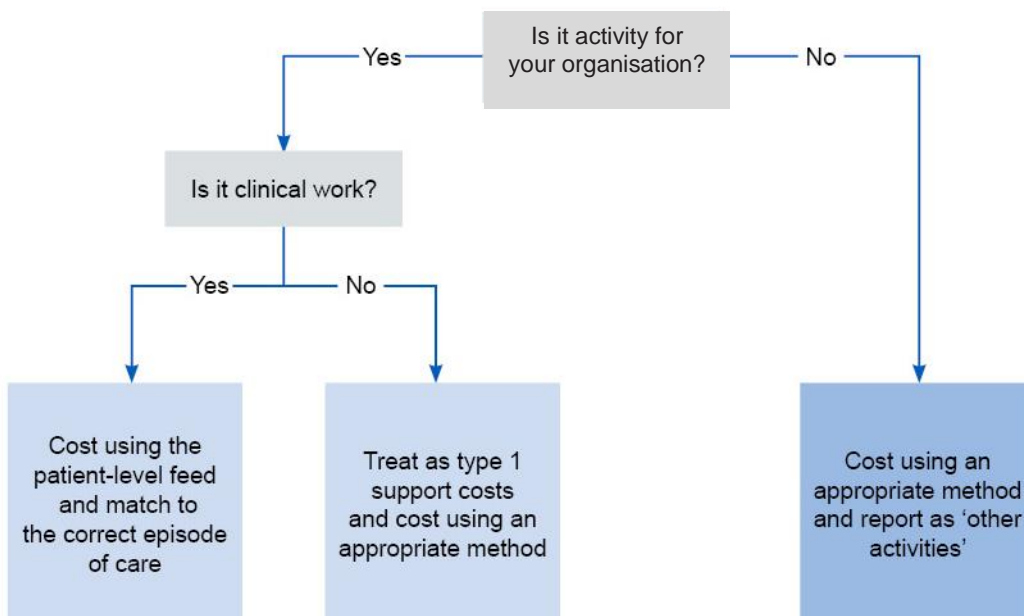
9. The patient-level activity feeds you obtain from the relevant departments need to contain each department's entire activity, not just the activity for your organisation's own patients.

Mental health costing methods

10. Contracted-in activity needs to be flagged in the information feeds using the contracted-in indicator in column D in Spreadsheet IR1.2.[37]

11. Contracted-in activity should be flagged in your costing system.

12. Contracted-in activity should be costed using the resources, activities and cost allocation methods as described in Spreadsheets CP3.1 to CP3.3.

13. Costed contracted-in activities are not matched to the provider's own activity but are reported under the 'other activities' cost group.

14. If it is unclear whether an activity is own-patient care or contracted-in activity, discuss it with the service manager to agree an appropriate apportionment and document this in your integrated costing assurance log (ICAL) worksheet 13: % allocation bases.

15. For contracted-in non-clinical services, use the proportion of costs that should be attributed to the services it supports if the department has a system for recording this information. If it does not, develop a relative weight value with the service and the financial management team for use in the costing process.

Commercial activities

16. Some NHS organisations have developed commercial services,[38] which generate additional income that is reinvested in patient care. These may include but are not limited to:

- commercial research and trials
- international healthcare management and consultancy
- pathology, pharmaceutical production, toxicology
- occupational health
- retail space and site rental
- facilitating market entry for new services to the NHS.

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[37] This is for acute only. We are looking at how other activities can be identified in the mental health and community care activity datasets.
[38] www.england.nhs.uk/nhsidentity/identity-examples-categories/income-generation/

Mental health costing methods

17. This activity should be costed where possible in the same way as other activity, so you need to identify the costs and activity information relating to it.

18. All commercial activity should be flagged in the costing system.

19. Commercial activity should be costed using the resources, activities and cost allocation methods as described in the technical document (Spreadsheets CP3.1, CP3.2 and CP3.3).

20. Costed commercial activities are not matched to the provider's own activity but are reported under the 'other activities' cost group.

21. These activities should be reported under 'other activities' with their associated income for business intelligence purposes. For details, please see Integrated standard CM12: The income ledger.

Direct access activity

22. **You do not need to calculate direct access activity at individual patient level or individual test level.** From a system perspective, there is no need to run multiple calculations if the correct costs and activities are used.[39]

23. Direct access should be reported under the cost group 'other activities'.

24. Use activity ID: SLA118; Direct access services.

Neonatal screening programme

25. If your organisation has a contract for delivering a neonatal screening programme, you do not need to calculate this activity at patient level.

26. Neonatal screening programmes should be reported under 'other activities' alongside the corresponding income for business intelligence purposes.

27. Use these for neonatal screening:

- activity ID: MDA073; Neonatal audiology screening
- activity ID: CLA054; Neonatal pathology screening.

[39] You should continue to calculate direct access at patient level if you already do so.

Mental health costing methods

28. For all other screening use activity ID: SLA131; Screening.

Contracted-out activity

29. Contracted-out services may be:

   - the whole spell, to a private or voluntary provider or neighbouring NHS provider
   - part of an episode, such as pathology, pharmacy or diagnostic imaging
   - type 1 support services, such as payroll or shared services.

30. This activity should be costed where possible in the same way as other activity, so you need to identify the costs and activity information relating to it.

31. All contracted-out activity should be flagged in the costing system.

32. The costs relating to this activity are in the form of invoices charged to the general ledger. You need to identify these costs in the cost ledger.

Patient-facing services

33. Where the contract relates to patient facing activity, the patient record for that service provided needs to be entered into the relevant feed, and flagged in the information feeds using the contracted-out indicator in column D in Spreadsheet IR1.2.

34. Where you cannot obtain a breakdown of the resources use the resource IDs:

   - CLR026   Contracted-out pathology testing
   - CLR027   Contracted-out pharmacy services
   - CLR028   Contracted-out radiology scans
   - MDR036   Orthotics
   - CLR016   External contracts – clinical.

35. If the activities provided on your organisation's behalf by another organisation are recharged at a fixed value per patient or per treatment, use this as a relative weight value in the costing process.

Mental health costing methods

36. The fixed value will contain an element of type 1 support costs. You do not need to classify the fixed value between patient-facing and type 1 support costs as all are patient-facing costs to your organisation.

Support services

37. Where the contracted-out activity relates to support services, costs should be allocated using the same allocation method as though it were an in-house service.

38. For example, a contract for facilities (maintenance, cleaning, etc) with NHS Property Services would be disaggregated to show cost allocation of:

- maintenance – use the same allocation method as T1S030 Estates, buildings and plant, facilities maintenance costs – floor area (sq m)
- cleaning – use the same allocation method as T1S013 Cleaning and other hotel services (pay and non-pay costs) – floor area (sq m) occupied by an area weighted by the number of times cleaning is carried out.

Other considerations

39. Activities provided on another organisation's behalf by your organisation, may need to be apportioned an element of your organisation's own support type 1 costs for administering the contract. You need to identify which support type 1 costs to apply and in what proportion.

Services funded in part or in full by local authorities

40. If your organisation has the costs but not the activity, or vice versa, these should not be included in the costing process and reported as 'cost and activity reconciliation items'.

41. If your organisation has the costs and the activity, these should be costed using Integrated standards CP1 to CP6 and reported as 'other activities'.

PLICS collection requirements

42. Contracted-out activity is excluded from the national cost collection. The provider receiving contracted-out services must report their cost in the collection cost reconciliation.

Mental health costing methods

43. Costs for commercial services should be allocated to patient care for the collection. The income for commercial services is netted off against patient care costs.

44. Direct access cost and activity is not collected at a patient level. These must be reported in the reference costs workbook.

45. For more information on other activities, see Section 4 of the *Mental health PLICs collection guidance 2019*.[40]

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[40] https://improvement.nhs.uk/resources/approved-costing-guidance-2019

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) feed).

Scope

2. This standard applies to all patient-specific MDT meetings hosted by your organisation, with or without the patient present, for the purposes of reviewing their specific care programme or care plan.[41] Reviews are those for available treatment options and individual responses and include care programme approach (CPA) meetings.

3. Although this standard is specifically for CPA MDT meetings, the costing approach 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.

Overview

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

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

Mental health costing methods

5. MDT costs are not allocated to individual patients but are reported at specialty level.

6. MDT meeting costs need to be reported locally alongside any corresponding income for business intelligence.

7. MDT meetings should be reported under the cost group 'own-patient activities'.

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

9. The CPA activity should be reported separately from the inpatient episode or NAPC cost. If your organisation records these meetings in the Mental Health Services Data Set (MHSDS) NAPC feed, they should be excluded from that activity.

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

11. If you already identify these meetings and cost at patient level, you should continue to do so and record this in your ICAL worksheet 15: Superior costing methods. This is superior costing method SCM4 in accordance with Spreadsheet CP3.5.

What you need to implement this standard

- ICAL worksheet 27: Clinical MDT meetings.

Approach

12. Obtain a feed (feed 14 in Spreadsheet IR1.1) from your organisation's MDT information database as prescribed by Mental health 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.

Mental health costing methods

14. This feed is classified as a standalone feed so prescribed matching rules are **not** provided.

15. For CPA meetings, use activity ID: MHA261; CPA meeting; for other MDT meetings, use activity ID: SLA128; Other multidisciplinary meeting.

Table CM9.1: Excerpt[42] from Spreadsheet CP3.3 showing the resource and activity links for the CPA and other MDT meeting activity

Resource and activity link ID	Resource	Activity
CLR015 – MHA261	Technician	CPA meeting
CMR305 – SLA128	Community psychiatric nurse	Other multidisciplinary meeting
MDR033 – MHA261	Dietician	CPA meeting
MHR250 – SLA128	Psychiatric nurse	Other multidisciplinary meeting
MHR252 – MHA261	Support worker	CPA meeting
MHR253 – SLA128	Consultant – mental health	Other multidisciplinary meeting
MHR257 – MHA261	Primary mental health worker	CPA meeting
MHR257 – SLA128	Primary mental health worker	Other multidisciplinary meeting
SLR098 – MHA261	Multidisciplinary meeting co-ordinator	CPA meeting
THR001 – SLA128	Therapist	Other multidisciplinary meeting
THR007 – SLA128	Speech and language therapist	Other multidisciplinary meeting
THR015 – MHA261	Cognitive behavioural therapist	CPA meeting
THR016 – SLA128	Emotional and wellbeing therapist	Other multidisciplinary meeting
THR017 – MHA261	Practitioner	CPA meeting

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[42] 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.

Mental health costing methods

16. Set up relative weight values to calculate an average cost of a CPA/MDT to be used in the costing process.

17. Use the costing template in ICAL worksheet 27: Clinical MDT meetings to identify the information you need to set up the relative weight values including:

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

18. See column A in ICAL worksheet 27: Clinical MDT meetings for an example of the potential attendees at an MDT whose input may need to be costed.

19. MDT meeting co-ordinators have been classified as a type 2 support resource and are linked to the MDT meeting activity in Spreadsheet CP3.4.

20. Support type 1 costs, such as room use, catering, heating, lighting, printing and secretarial costs, need to be allocated appropriately.

21. 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 MDT meetings as subject matter experts

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

23. Use activity ID: SLA128; Other multidisciplinary meeting.

24. Follow the costing principles for hosted MDT meetings.

Mental health costing methods

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

26. 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.

Table CM9.1: Example of what a CPA meeting might look like in the resource and activity matrix

Resource	Activity	
	CPA Meeting	Multidisciplinary meeting
Consultant – mental health	XX	XX
Non-consultant medical staff		XX
Psychiatric nurse	XX	XX
Social worker (employed by mental health organisation)	XX	
Music therapist		XX
Occupational therapist		XX
Psychologist	XX	XX
MDT co-ordinator	XX	XX

Superior costing method

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

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

Mental health costing methods

29. The date of the latest review should be available in the MHSDS field 'care programme approach review date'.

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

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

32. 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 other multidisciplinary meetings in Table CM9.1 above.

PLICS collection requirements

33. Clinical MDT meetings are not collected at patient level in the PLICS collection. Costs should be reported in the reference cost workbook: see Section 10 of the *Mental health PLICS cost collection guidance 2019*[43] for more information.

34. All other clinical MDT meetings should be allocated to the patient using the other MDT collection activity.

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[43] https://improvement.nhs.uk/resources/approved-costing-guidance-2019/

CM10: Pharmacy and medicines

> Purpose: To ensure costs of pharmacy staffing and medicines are consistently allocated to the activities they deliver.

Objectives

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

2. To ensure medicine costs are allocated to the correct patient episode, attendance or contact.

Scope

3. This standard applies to all pharmacy staffing costs and all medicine costs in the cost ledger.

Overview

4. For the NHS as a whole, medicines are a material cost second only to staffing; for mental health providers, they are a significant cost. Therefore, ensuring medicines are costed appropriately, then allocated or matched to the correct patient episode, attendance or contact, is important for the overall accuracy of the final patient cost.

5. Pharmacy staff carry out significantly more activities than simply dispensing drugs. Pharmacy pay costs may therefore be associated with a range of services which should be understood for the most effective costed patient activity.

Mental health costing methods

6.   Pharmacy services have an infrastructure, governance and clinical (IGC) model in which the infrastructure and governance elements should be costed separately from the clinical element of the service provided. The elements are:

   • patient-facing clinical services: includes prescribing, supporting patient self-care and medicine reviews

   • infrastructure: includes managing supply of medicines, outsourced pharmacy service contracts, formulary development and medicines information

   • governance: includes policies and procedures development, safe management of medicines, audit of clinical practice and recording information.

7.   This standard provides guidance on how to identify the activities that pharmacy staff undertake in your organisation and how to apportion their cost to those activities.

8.   If your pharmacy service is provided by an external party, there may be limited access to cost and drug issue data. As the medicines dispensed feed is a required field for PLICS, work with your informatics team and chief pharmacist to access sufficient information.

9.   Medicines cost should be treated separately from that of the pharmacy service, with the cost allocated using patient-level information.

Approach

Medicines

Medicines identifiable at patient level

10.   Paragraphs 91 to 108 in Mental health standard IR1: Collecting information for costing and Spreadsheets IR1.1 and IR1.2 provide guidance on the costing and collection of the medicines dispensed patient-level feed (feed 10) to be used when costing medicines. The information required for this feed is collected in a locally-held database.

Mental health costing methods

11. Some medicines may be issued directly to patients,[44] so the pharmacy information system will have patient-level information for these medicines. We refer to these as 'patient-identifiable drugs'. Examples are the antipsychotics clozapine, paliperidone, risperidone, aripiprazole and zuclopenthixol decanoate; and methadone and melatonin: all of which are a significant cost in an individual's care. Use the activity ID: MDA063; Dispensing high cost drugs and activity ID: MDA068; Dispense all other medicine scripts.

Table CM10.1: Excerpt[45] from Spreadsheet CP3.3 showing the resource and activity links for drugs

Resource and activity link ID	Resource	Activity
MDR044 – MDA068	Drugs	Dispense all other medicine scripts
MDR044 – MDA065	Drugs	Dispense non patient-identifiable drugs
MDR044 – SLA126	Drugs	Homecare medicines
MDR044 – MDA067	Drugs	Dispense chemotherapy drug scripts
MDR061 – MDA063	High cost drugs	Dispensing high cost drugs

12. The costs on the medicines dispensed feed are used as relative weight values to allocate the costs in the cost ledger. This is so that if the total cost to the pharmacy is £1,000 but only £900 is in the cost ledger, a negative cost is not incurred by allocating more cost using the pharmacy feed than is on the cost ledger code. For reporting purposes, ensure that your medicines dispensed feed includes the generic name of the medicine, not the brand name.

13. Medicines information at patient level will be provided by your organisation's own pharmacy system, an outsourced partner (where the service is delivered in-house), or via FP10HP prescriptions on ePACT2.[46]

14. We understand that there are few 'high cost drugs', as defined under the NHS Digital HRG structure, in mental healthcare. If your organisation does issue

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[44] The term 'non-stock items' is often used in mental health organisations. We use the term 'patient-identifiable drugs'.

[45] 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.

[46] This is the system used to record the FP10s.

qualifying drugs – for example, where you are an integrated trust – refer to Acute standard CM10: Pharmacy and medicines for more information on how to treat these.

15. Use the prescribed matching rules in columns H to O in Spreadsheet CP4.1 to match costed medicines activities from this patient-level feed to the correct patient episode, attendance or contact.

Medicines not identifiable at patient level

16. Where drugs are not identifiable at patient level – for example, ward stock or 'stock' items[47] – use the non patient-identifiable field in the source data to identify these costs and use the 'requesting location code' to allocate them to the ward, department or service. Then allocate them to all the episodes, attendances and contacts using those areas based on duration in hours and minutes. Use the activity ID: MDA065; Dispense non patient-identifiable drugs.

17. Pharmacy input fluctuates as the patient moves between wards or is discharged to primary care, rather than necessarily because of their acuity. Pay particular attention to ensuring all medicines are identified for each transition of care, such as admission, transfer between wards and discharge, and are then matched to the correct episode, attendance or contact.

Negative costs in the medicines dispensed feed

18. It is likely that the medicines dispensed feed will contain negative values due to products being returned to the department, eg it may contain the dispensing, supply and returns for a patient's drug.

19. These issues and returns are not always netted off within the department's pharmacy stock management system. If this is the case, you need to net off the quantities and costs to ensure only what is used is costed.

20. All negative costs need to be removed. The returns are not a reconciliation item.

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[47] This terminology is widely used for non patient-identifiable medicines.

Mental health costing methods

21. Be aware that partial returns may take place, and you may need to calculate the drug cost that should remain in the feed.

22. Also, the return unit cost may be different from the dispensing unit cost and you need to calculate the appropriate value for partial recalls.

23. If an issue is made in one month (month 1), but returned the following month (month 2), remove the negative value from the feed and remove the dispensation from the previous month. However, if you are reporting monthly, the cost of the drug recalled in month 2 will have already been allocated to the patient in month 1. You do not need to adjust for this as it falls under the materiality principle.

Treatment of FP10 costs

24. FP10 prescription information is useful as part of the patient pathway as it shows how the medication regimen continues outside the clinical setting; though currently it may not be included in your main pharmacy information system. Where community pharmacies or the NHS Business Services Authority – NHS Prescription Services[48] charges your provider for these drugs, you will have the costs for them in the general ledger.

25. However, where possible you should try and obtain a dataset[49] to understand which patient prescription each cost relates to, so it can be matched to the relevant patient contact. The information should be added to the medicines dispensed feed as shown in Spreadsheet IR1.2 and matched to the patient contact as described in Integrated standard CP4: Matching costed activities to patients. See Table CM10.2 for the resources and activities to use.

[48] Formerly the Prescription Pricing Authority.
[49] The NHS Prescription Services section of the National Health Service Business Services Authority is trialling a reporting model that will allows inclusion of patient-level information.

Mental health costing methods

Table CM10.2 Excerpt from Spreadsheet CP3.3: Methods to allocate patient-facing resources, first to activities and then to patients

Resource and activity link ID	Resource	Activity
MDR044 – MDA068	Drugs	Dispense all other medicine scripts

26. Where patient-level information is not available but the cost is in the general ledger, you should still gather it into the appropriate resource and then allocate it equally to all patients who used the service. It should be included in the unmatched reconciliation, not matched to patients, to ensure the cost is not spread over patients who did not receive these medicines.

27. Note: in areas where community or private pharmacies dispense drugs, they charge the clinical commissioning group (CCG) directly for this, not the mental health provider. The cost will therefore not be in the organisation's accounts and there is no requirement to gather information on it.

Other considerations

28. Where your organisation purchases its pharmacy services and/or medicines from an acute provider (or other external party), you will have to request sufficient information to support the PLICS. This will include:

    - patient-level information on drug cost using the NHS number for drugs issued to prescription
    - information on non patient-identifiable drug issues – these will be delivered to a trackable location from where they are issued to the required units. The costs can then be allocated to the activity and allocated in the same way as an internal pharmacy service.

Pharmacy services

29. Cost of pharmacy services is separate from the cost of the medicines. Pharmacy services have an infrastructure, governance and clinical model. You will need to identify which staff grades perform which tasks.

30. Only a small percentage of a pharmacist's time is likely to be spent dispensing drugs – the rest is spent performing the infrastructure and governance

elements of the service (this may include providing the legal presence to permit drug supply to patients, provider-wide strategy, governance and education services). You will therefore need to identify the percentage of pharmacy staff's time spent:

- dispensing drugs (clinical)
- working with patients on wards to manage the medicines (clinical)
- other activities supporting the effective, safe use of medicines (infrastructure and governance).

Clinical services

31. Clinical services include dispensing drugs and direct patient support in clinical units.

32. For dispensing medicines, allocate identified pharmacy staff costs for dispensing using the allocation methods in columns F and G in Spreadsheet CP3.3. Use activity ID: MDA063; Dispensing high cost drugs (patient-identifiable), and activity ID: MDA065; Dispense non patient-identifiable drugs.

33. Wards may receive a ward-based pharmacy service, with input determined by specialty, clinical need and patient turnover. Use activity ID: MDA066; Pharmacy work.

34. Where pharmacy staff time is dedicated to a particular service or wards, the pharmacy staffing cost should be allocated only to those patients using this service or ward.

35. You should speak to your chief pharmacist to identify how many pharmacy staff work with dedicated services, and then set up relative weight values to ensure their costs are allocated only to patients using those services/wards.

36. As well as supporting specialty areas, pharmacy staff provide generalist input in clinical areas. You will need to identify and include them in your relative weight values.

Mental health costing methods

37. Services that typically receive dedicated pharmacy services include:[50]

    - high secure units
    - crisis units
    - forensic units
    - learning disability services
    - eating disorders services
    - drug and alcohol services (substance misuse).

38. The same principle applies for pharmacy staff who may work over multiple areas. You will need to find out how their time is split between the areas: for example, 20% in area 1, 30% in area 2 and 50% in area 3. You will need to set up relative weight values to ensure the costs are allocated to these areas only using relative weight values based on those percentages.

39. Further things to consider when developing relative weight values for allocating pharmacy staffing costs are:

    - Should there be a relative weight value of inpatients to outpatients/community services?
    - Do psychiatric intensive care units require a higher percentage pharmacy staffing cost?

Infrastructure and governance

40. Work on infrastructure and governance should be considered when agreeing the allocation of cost to activities. Therefore, the resources identified for pharmacy should include the time spent working on these areas. Use the activity ID: MDA066; Pharmacy work.

41. Take care not to allocate organisation-wide pharmacist costs to areas that have already received pharmacy costs through the two steps described above (unless this is appropriate).

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[50] These examples have been suggested. Please comment on their suitability and let us know of others that receive specialist pharmacy support.

Mental health costing methods

Table CM10.3: Excerpt from Spreadsheet CP3.3 showing the resource and activity links for pharmacy services

Resource and activity Link ID	Resource	Activity
MDR042 – MDA063	Pharmacist	Dispensing high cost drugs (patient-identifiable)
MDR042 – MDA065	Pharmacist	Dispense non patient-identifiable drugs
MDR042 – MDA066	Pharmacist	Pharmacy work
MDR043 – MDA063	Pharmacy assistant	Dispensing high cost drugs (patient-identifiable)
MDR043 – MDA065	Pharmacy assistant	Dispense non patient-identifiable drugs
MDR043 – MDA066	Pharmacy assistant	Pharmacy work
MDR054 – MDA063	Pharmacy technician	Dispensing high cost drugs (patient-identifiable)
MDR054 – MDA065	Pharmacy technician	Dispense non patient-identifiable drugs
MDR054 – MDA066	Pharmacy technician	Pharmacy work

Table CM10.4: Example of how pharmacy and medicines might look in the resource and activity matrix

Resource	Activity	
	Dispense drug scripts	Pharmacy work
Pharmacist		XX
Pharmacy technician	XX	
Pharmacy assistant		XX
Drugs	XX	

CM11: Integrated providers (integrated)

Purpose: To ensure providers of integrated services cost all their services in a consistent way.

Objective

1. To ensure providers of integrated services cost in a consistent way across all services.

Scope

2. This standard applies to all services provided by NHS integrated providers.[51]

Overview

3. Many providers are integrated. For example, your organisation may be an integrated mental health and community provider or provide mental health and acute services. Where your services fall within the scope of a standard, that standard for patient-level costing should apply.

4. Primary care services and local authority/social care services do not need to be costed at patient level, but you should ensure the costs relating to these areas are recorded against the correct service if they are in your general ledger. They should be reported under the 'other activities' cost group.

5. All providers of NHS services in England must follow the **same** costing process. This one process is described in the Spreadsheet: costing diagram.

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[51] Integrated providers are organisations delivering services across acute, mental health, community and ambulance sectors. Primary care services are not included. Local authority care and social care are outside the funding structures of the NHS and are also not included.

Mental health costing methods

6. This costing process is further described in Integrated acute, mental health and community standards CP1 to CP6. Ambulance services are included in these where they are provided by an organisation that also provides services from one of the other sector(s).[52]

7. We have also developed sector-specific standards for each healthcare sector to accommodate their different information requirements and terminology, as well as needs for different examples.

8. The information each sector requires for costing is described in the relevant Standards IR1: Collecting information for costing[53] and IR2: Managing information for costing.

9. The contents page for each sector's costing methods standards lists those relevant to each sector. Where your integrated provider delivers services not listed in the costing methods standards document for the main sector of its services, you should refer to the other sector-wide documents as appropriate.

10. For example, if an acute provider also delivers sexual health services, it should use the costing methods in this document as relevant and refer to Community standard CM16: Sexual health.

11. The costing approaches standards apply to all organisations providing the specific services to which they relate– although we expect them to apply largely to the acute sector.

What you need to implement this standard

*   Costing principle 6: Good costing should be consistent across services, enabling cost comparison within and across organisations.

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[52] Ambulance services currently have their own standards and these include elements of the integrated standards. In the future we intend to include ambulance services in the integrated standards where appropriate.
[53] The different healthcare sectors will have different information feeds.

Mental health costing methods

Approach

12. We have developed the standards to be consistent[54] across acute, mental health and community services because integrated providers mostly provide these services.[55] This supports the costing of integrated services and a fully integrated cost collection. For example, Integrated standard CP2: Clearly identifiable costs and Spreadsheets CP2.1 and CP2.2 providers delivering these services, irrespective of the main sector of the provider. We have also developed standards for ambulance service providers.[56]

13. One set of costing process standards (Integrated standards CP1 to CP6 applies to all services as the core principles of the costing process are the same for all services. This enables consistent costing across services. Relevant spreadsheets (the CP spreadsheets) are also integrated.

14. Use the appropriate information requirements, costing methods and costing approaches for each service: the acute standards to cost your acute services, the mental health standards to cost your mental health services, including CAMHS, and the community standards to cost your community services.

15. You should obtain all the information feeds required for the different sectors you provide services for. Spreadsheets IR1.1 and IR1.2 for each healthcare sector show these feeds and the data fields in each information feed.[57]

16. We do not expect you to set up individual cost ledgers for acute, mental health and community services. You should use the integrated cost ledger in Spreadsheet CP2.1.

17. The spreadsheet is easier to use if you filter it by noting the services and codes you use in column Q. However, you should ensure that all rows are put into your costing software.

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[54] If you find inconsistencies or gaps across the three sets of standards, please raise them with us as a matter of urgency; costing@improvement.nhs.uk

[55] We looked at the reference costs 2016/17 to assess how many organisations provide integrated services.

[56] Ambulance services are only rarely supplied by acute, mental health or community providers, but should your organisation supply some, use the ambulance costing standards for that proportion of your costs.

[57] If you find identical field names across the standards that prevent you costing your sector, please raise these with us as a matter of urgency: costing@improvement.nhs.uk

Mental health costing methods

18. If any departments or individuals work across sectors – for example, in both mental health and community services – we expect you to set up appropriate cost allocation rules and relative weight values to ensure the correct costs are allocated in the correct proportion to the correct services. For example, we do not expect to see community-specific costs allocated to mental health activities. Document your rules and relative weights in the ICAL worksheet 13: % allocation bases.

19. Corporate functions such as human resources will most likely support all services in the organisation. Relative weight values for them should include the relevant information for all services, so they receive their appropriate share of these support costs.

20. If you are provided with patient-level activity for different sectors in one feed, we expect that the sector the activities belong to will be identifiable to support the costing and collection process – for example, those that are acute activities.

21. If patient-level information is provided in one auxiliary feed – eg medicines dispensed – your matching rules must ensure the medicines activities are matched to the correct episode, attendance or contact irrespective of the sector where the care was given.

Other considerations

22. If your organisation provides integrated social care, primary care or public health services, you should apply the costing principles and:

- ensure that the costs of these services are clearly identified, and apply the costing processes
- map the services to the rows in the cost ledger where appropriate rows exist adding local rows to the cost ledger where they do not
- follow Integrated standard CP2 to apply any appropriate resources and if not present, create local resources with appropriate allocation methods[58]
- use existing activities where possible and create local activities if they are not present

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[58] A resource application hierarchy flowchart is available on the Online Learning Platform to assist with this process.

Mental health costing methods

- ensure these services share the support costs, so their cost quantum is not understated.

23. If your organisation has the costs but not the activity for a service, or vice versa, these should be costed using Integrated standards CP1 to CP6 and reported as 'other activities'. Please see also Integrated standard CM8: Other activities.

CM12: The income ledger (integrated)

> Purpose: To assign income to the correct costed activities in the correct proportion.

Objective

1. To support providers to accurately produce their service-line reports.

Scope

2. This standard is for guidance only. There are no plans to collect income in the cost collection.

3. This standard applies to all the income your organisation receives.

4. See paragraph 21 in Integrated standard CP2: Clearly identifiable costs for where income needs to be treated as part of the costing process.

Overview

5. All the income your organisation receives needs to be aligned to all the costs incurred for the purposes of service-line reporting and management, so that it can be effectively used internally in decision-making.

6. You need to understand the different types of income recorded in the general ledger and what costs they relate to, so that the outputs from the costing system can be reconciled to the accounts.

What you need to implement this standard

- Spreadsheet CM12.1: Examples of block income allocation.

Mental health costing methods

Approach

7. The income codes in the general ledger are usually at an aggregated level. Income for care services is often in monthly contractual amounts from the commissioner and relates to a wide range of services. Several types of income for different activities may also be recorded on a single line in the general ledger.

8. Corporate income codes are often at an aggregated level – for example, central funding for a pilot project, or initiatives to improve estates.

9. Commercial income should be identified and costed to the reconciliation statement. Commercial income should not be netted off from cost: for example, income from vending machines should be shown separately (matched to the cost of providing those facilities).

10. The general ledger is not the only source of income information. Other sources may be more helpful in providing the detail that improves the allocation method for income at both patient and service-line level.

11. For internal reporting, to calculate income at service-line level and to understand surplus and deficit positions at a patient level, you need to obtain patient-level income information from either the informatics or contracting departments. Other income such as private patient income, if held in a database at patient level, should also be loaded into the income ledger.

12. Where more detailed income information is unavailable, you need to identify related income in the general ledger and develop local allocation rules to allocate it at the patient level.

13. To avoid duplicating income in the costing system, if more detailed income information is loaded into the income ledger from another source – for example, an income feed from the contracting team at patient level – the costing system should exclude the corresponding income value loaded from the general ledger output.

14. You should maintain a clear audit trail of all sources of information loaded into your costing system, ensuring it reconciles with the data reported in your organisation's accounts. Use the reports in Spreadsheet CP5.1 to do this.

Mental health costing methods

15. The income ledger[59] is divided into five income groups as shown in Figure CM12.1 – your organisation may not provide all the services shown and your list of income types may be shorter.

Figure CM12.1: Income groups
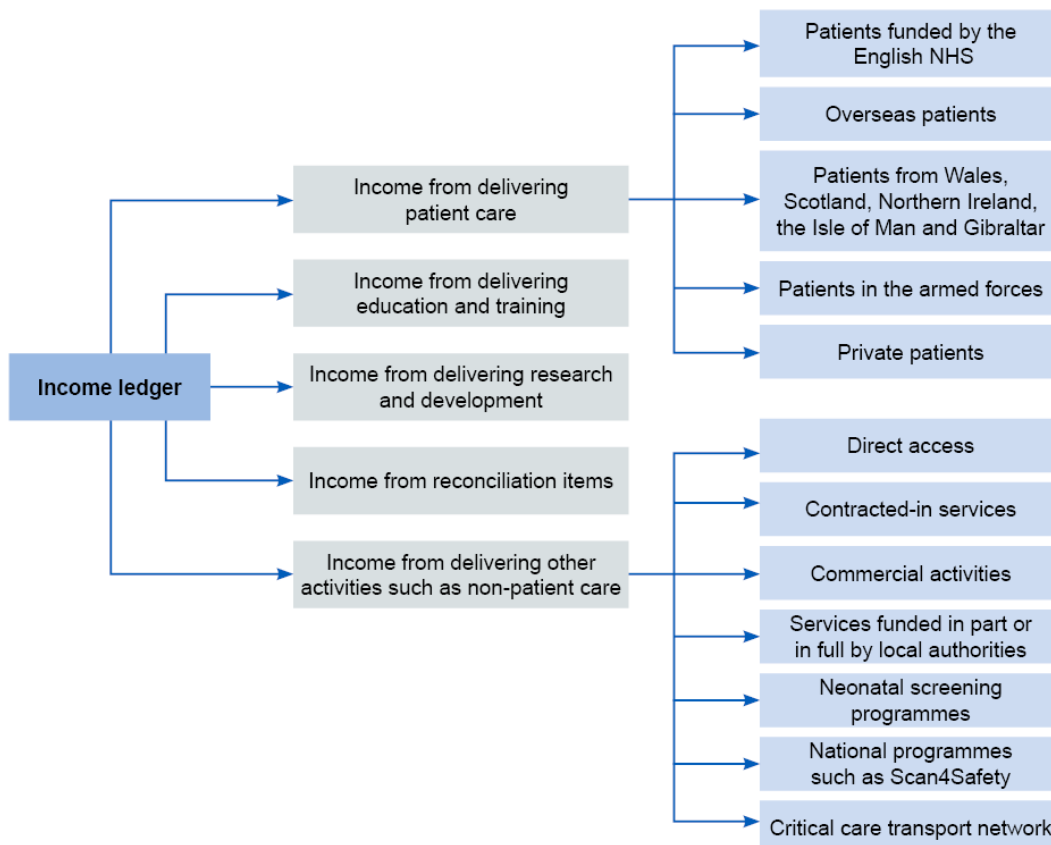
16. For reconciliation to the PLICS collection, the five income groups need to be separated into allowable and non-allowable income. For this purpose, and to clarify the reconciliation process, we recommend you understand how each general ledger code is categorised into the income centres[60] in Spreadsheet CP2.1:

- Category A income – Patient contract income. This is the core patient income from English NHS commissioners, and patient income from the devolved administrations, the Ministry of Defence, the Isle of Man and Gibraltar. This category also includes other income considered 'not allowable non-contractual income' for reference costs. No planned 'profit' is

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[59] We do not provide a template for the income ledger.
[60] These are shown in the cost centre columns.

Mental health costing methods

expected within this income beyond what may occur from the difference between tariff prices and cost.

- Category B income – private patient and overseas visitor income. This covers private patients and overseas visitors. These patients are also NHS healthcare patients, but the funding will come from sources other than NHS or other agreed commissioners. It is expected that this income will include planned profit, which is why it is separate from Category A income.

- Category C income – other income. This is the remainder of the income and is also known as 'allowable income for the cost collections'. It can be netted off from the service area costs.

For more information on which items are allowable or not allowable in the PLICS collection, please see Tables 11 and 12 in the *Mental health PLICS collection guidance 2019.* [61]

17. The income ledger rows are identified by 'income centre codes' shown in columns A and B, Spreadsheet CP2.1. The codes are prefixed YYY to separate them from the cost centres. These rows can be expanded to meet the need of the organisation's general ledger, as long as the income is clearly identifiable throughout the costing system. This will help with the reconciliation of PLICS to the general ledger.

'Own-patient care' income group

18. The 'own-patient care' income group comprises the income from the provider's own-patient care activity. This includes income from:

- patients funded by the English NHS through national pricing, local pricing or block contracting arrangements (also known as healthcare income)
- overseas patients, both from countries with and without reciprocal charging arrangements
- patients from Wales, Scotland and Northern Ireland
- patients from the Isle of Man and Gibraltar
- armed forces personnel funded directly by the Ministry of Defence

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[61] See *National cost collection guidance* Section 4 for a list of 'not allowable non-contractual income'.

Mental health costing methods

- private patients, defined as those who choose to be treated privately and are responsible for paying the fees for their care: see also Mental health standard CM7: Private patients and non-NHS funded patients.

19. The income for the different patient groups needs to be identified and allocated to them only. You can do this using the codes for organisation identifier (code of commissioner)[62] and administrative category code[63] in column D in Spreadsheet IR1.2.

20. This is important, as you need to be able to check that private patients are not being cross-subsidised by NHS income.[64]

21. Healthcare income is defined as the income a provider receives for the activity it undertakes for NHS commissioning organisations. For acute services, it is often recorded in a separate recording system at patient-spell level, which means this information can be used to allocate the income at patient level. For mental health and community services, this information may not be available in the same format if the income is in block contracts.

22. There are different types of healthcare income:

- income paid based on national prices, other than block contract income
- income paid based on locally agreed prices, other than block income
- block contract income
- income for pass-through costs such as high cost drugs.

23. An organisation's patient care income and services may be derived from and commissioned by different sources, including:

- CCGs – via various payment methods, including national tariff income or locally determined prices
- NHS England specialised commissioning

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[62]www.datadictionary.nhs.uk/data_dictionary/data_field_notes/c/cd/cds_prime_recipient_identity_de.asp
[63] www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/administrative_category_code_de.asp
[64] Mental health standard CM7: Private patients and non-NHS funded patients gives guidance on how to cost patients not funded by the English NHS.

Mental health costing methods

- private (non-NHS funded) patients
- local authority
- voluntary and other third-party sector (NHS and non-NHS).

24. All healthcare income streams should be allocated at patient level based on the activity undertaken or outcomes. National prices, local prices and pass-through income is recorded by patient, point of delivery and date(s) of treatment in some provider's income-monitoring systems. The income for services using national prices includes the market forces factor, excess bed days and specialist top-ups. Other services use locally agreed prices.

25. Where a contract is paid for with a block income, this income needs to be allocated using a locally agreed and appropriate method. ICAL worksheet 19 gives examples of ways you can allocate block income and suggests a template for recording your chosen method. Please note that none of the allocation methods in ICAL worksheet 19 is mandatory but must be agreed locally.

26. Although the activity relating to block contracts does not drive the income value, you need to know the currency of the service provision, so this can be used to drive the income allocation.

27. Although treatment function codes in acute settings may be useful in allocating block income, they may cover a range of patients wider than the cohort covered by the block contract. To avoid this, use a look-up table of the patients in the cohort to allocate the income, with appropriate consideration of the materiality and availability of the information.

28. NHS care is provided for overseas patients via reciprocal agreements, healthcare insurance or self-funding. Where income for overseas visitors is received at patient level, it should be allocated at patient level, and where received as a block value for reciprocal agreements, it should be allocated in the same way as NHS healthcare block income (see paragraph 25).

29. Private patient income at a higher tariff than standard NHS care may be received from self-funding patients or healthcare insurance companies. Some overseas visitors may pay at this higher rate. These income streams are received at patient level and should therefore be allocated to patient level.

Mental health costing methods

30. Non-English NHS income comes from overseas patients, military personnel and patients from Wales, Scotland, Northern Ireland, the Isle of Man and Gibraltar. This may be recorded in the income monitoring system or separately – for example, in a line on the relevant consultant's cost centre. The income needs to be allocated to the relevant patients for reporting against the associated costs.

Education and training income group

31. The 'education and training (E&T)' income group comprises the income the provider receives for E&T activities.

32. The learning and development agreement issued by Health Education England breaks down this income by the courses it relates to, and you should refer to this to allocate this income. Please see Education and training costing standards for details.

33. This income may be held in corporate cost centres or department cost centres. You need to identify where the income is held and ensure it is all reported in the E&T income group.

34. Please also see Standard E&T2: Clearly identified E&T costs and income for details.

35. E&T income needs to be netted off for the mental health PLICS collection. Please see Standard E&T6: Netting off E&T income for details of the process to follow.

Research and development income group

36. The 'research and development (R&D)' income group comprises the income the provider receives for R&D activities. You should set the allocation method, with the R&D department for this income, which includes:

- commercial clinical trial income where the funder is the sponsor
- commercial income where the funder is not the sponsor (eg a commercial grant)
- investigator-led income that is non-commercial but funded by a commercial company

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- National Institute for Health Research (NIHR) income (biomedical research centres, fellowships, research capability funding, clinical research facilities, research for patient benefit)
- NIHR income via the Clinical Research Network
- grants from charities and other organisations.

37. This income may be held in corporate cost centres or department cost centres. You need to understand where the income is held, and ensure it is all reported in the R&D income group and allocated to research activities.

'Reconciliation items' income group

38. The reconciliation items income group includes income for which there is no corresponding activity, such as:

- grants or donations received by the organisation
- income for a staff member such as a youth worker employed by your organisation for activity undertaken by the local council, where your organisation cannot obtain the activity information for inclusion in the costing system
- income for which the costs cannot be identified, such car parking.

39. As the income for the period must match the income reported to the board, a full reconciliation must be kept showing how the ledger income maps to the income loaded into the costing system.

40. Follow the guidance in Integrated standard CP5: Reconciliation and use the reconciliation report 'Input accounting reconciliation' in Spreadsheet CP5.1. This information will also be part of the assurance information reported to the board in accordance with Integrated standard CP6: Assurance of cost data, to ensure that the costs and income have been treated appropriately.

'Other activities' income group

41. The 'other activities' income group includes the following provider income:

- contracted-in services
- commercial activities
- direct access services

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- neonatal screening programmes
- services funded in part or in full by local authorities
- national programmes such as Scan4Safety
- critical care transport network
- services for another organisation (eg therapy services).

42. Make sure both costs and income are reported in the correct costs and income group and allocated to the correct activities, so that any profitable commercial activities do not reduce the total cost amount for your organisation's own-patient activities.

43. A provider may receive income if it has a contract to carry out all or part of an activity on another provider's behalf, such as providing pathology services to other healthcare providers or psychotherapy services to a local organisation's employee assistance programme.

44. These contracted-in services are commercial activities. Their associated costs and income should be treated as described in Mental health standard CM8: Other activities.[65]

PLICS collection requirements

45. Income from education and training, research and development and some non-patient care activities/reconciliation items (designated 'allowable') must be netted off patient care costs for the national cost collection. For more information, see the *Mental health PLICS collection guidance 2019*.[66]

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[65] If your provider is the contracting or requesting organisation, the standards refer to this as contracted-out activity; see Mental health standard CM8: Other activities for further information.
[66] https://improvement.nhs.uk/resources/approved-costing-guidance-2019

CM13: Admitted patient care

Purpose: To ensure admitted patient care is costed consistently.

Objective

1. To ensure costs are correctly allocated to episodes[67] of admitted patient care (APC).

Scope

2. This standard applies to all APC.

Overview

3. Inpatient mental health wards provide a safe and therapeutic environment for people with acute mental health problems. Wards have accommodation, living/work/activity areas and some have garden space. Some wards will be locked, to ensure the safety of the individual and others, depending on the level of care needed. Intensive treatment is provided on some inpatient wards – such as psychiatric intensive care units (PICU). Rehabilitation is promoted from the beginning of admission, although there are some specific rehab wards.

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, such as serving meals or doing laundry.

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[67] 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 *Healthcare costing standards for England – mental health*.

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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. Specific periods when patients are receiving APC are referred to as APC episodes regardless of whether these are short term, long term or residential.

7. Within an APC episode, the patient will incur costs by using patient consumables or being given medicines, and they will incur type 1 support costs related to running the ward, 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, it is important to include the cost of all activities, no matter who performed them.

10. All services provided to – or costs incurred by – a patient during an admitted episode should be recorded and costed at patient level using the prescribed list of activities in Spreadsheet CP3.2.

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 made by consultants with other staff types
- patient-specific consumables
- non patient-identifiable drugs (ward stock drugs)
- medical and surgical equipment (ward equipment)
- type 1 support costs related to running the ward (including admission and discharge administration)

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- observations and activity by ward staff, such as restraint or those prompted by serious untoward incidents
- MDT meetings with patients not present, relating to admitted patients, which review and discuss several patients[68]
- 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 separately categorises these into a range of activities that will gather resources for wards. The three main types are:

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

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

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

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[68] These meetings may be referred to as case reviews or 'whiteboard discussions'. They are included in ward care as organisations report that the time spent talking about specific patients cannot currently be recorded.

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14. Each of these is described below, with the specific activities listed for the appropriate cost driver. Where further information is contained in another costing standard, this is referenced.

15. The dataset for mental health admitted patient care is the Mental Health Services Data Set (MHSDS) as described in detail in the Mental health information requirement IR1: Collecting information for costing and Spreadsheets IR1.1 and IR1.2.

Ward care

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

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

Table CM13.1 Excerpt from Spreadsheet IR1.2: Patient-level field requirements for costing 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

18. The definition of 'acuity' used for this standard covers where patients incur different levels of resource, due to condition; including mental and physical health, behavioural and forensic issues.[69]

19. A standard-level acuity is understood by the type of ward. For example, a PICU ward will have a higher level of staffing than a rehabilitation ward; or 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,

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

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restraint, seclusion and rapid tranquilisation: these do not normally incur additional costs.

20. Unless otherwise informed, you can expect that all patients on the ward will use resources at a similar rate – which will be allocated according to the prescribed rules in Integrated standard CP3: Appropriate cost allocation methods.

21. The ward care activity will include these expected levels of resource use.

22. Information on the level of care provided for patients on a whole ward may be understood for costing purposes from the MHSDS fields as shown in Table CM13.2 and in Spreadsheet IR1.2.

Table CM13.2: Ward care level designation[70]

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

23. These can be used to identify the level of resource expected.

24. However, to improve the patient-level costs of the admission, you may use a superior costing method to allocate the costs of specialing/observations and escorted home leave more accurately by splitting the resources in a more detailed manner. See the superior costing method described in paragraphs 49 to 53.

25. The MHSDS for a single patient will contain a row for each ward that the patient spent time on. More than one ward can be recorded, in date order of the patient journey. Each ward's cost may be different, so to cost an individual patient's 'journey' appropriately, it is important to understand which ward the patient was on. The information available is shown in Spreadsheet IR1.2.

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

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Column B can be filtered to show which fields are relevant to ward stay apportionment.

26. As the MHSDS requires ward information and has been mandated, this is accepted as the data source for ward information. However, where the MHSDS in your organisation does not yet include wards, your PLICS APC feed may take data from different parts of your PAS.

27. You should use the fields shown in Table CM13.3.

    Table CM13.3: Ward care level designation

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

28. The hierarchy of information in the APC dataset is shown in Table CM13.4.

29. This hierarchy shows how the costs of different wards may be shown in the costed episode.

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Table CM13.4: 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.

30. Table CM13.5, an excerpt from Spreadsheet CP3.2, lists the ward care activities for mental health services. These show the type of inpatient unit.[71] The activities are separately identified by level of care and security and service, to facilitate meaningful local reporting.

Table CM13.5 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

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

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Activity ID	Activity
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

31. As these activities show the unit the patient was on during their admission, where the patient remains under one main specialty code/treatment function code, you can identify the changes in severity and care received. For example, many mental health admissions will fall under 710 Psychiatry, even if the patient moves from psychiatric intensive care to an acute ward, and then to a rehabilitation ward.

32. The ward-related resource-to-activities mapping is shown in Spreadsheet CP3.3.

33. Pharmacy staff working on the ward should be allocated using the resources described in Mental health standard CM10: Pharmacy and medicines and in Spreadsheet CP3.3.

Ward work

34. Medical staffing supports patients on the ward at regular intervals. In many mental health units, this support does not take the form of a traditional ward round; there is a more general form of supportive care.

35. For this work, use the activity ID: SLA150; Ward work to show the cost of medical staff time interacting with the patients on the ward. All wards will show the same activity for medical staff acting in this way.

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36. For further information on ward work see Mental health standard CM1: Medical staffing.

Ward rounds

37. 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.

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

39. 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

40. During their admission, the patient may attend care programme approach (CPA) meeting(s) about their care plan. Staff may also meet to discuss the care being given, without the patient present. Both types of meeting form a significant resource and are covered separately in Mental health standard CM9: Multidisciplinary meetings.

Group sessions[72]

41. Admitted patients may have access to activities such as groups for therapy, supervised sport, cookery or work preparation. The resources used by each patient accessing these activities are higher than for those on the basic ward, but because they share the staff and consumable resources with other patients, their costing is covered separately in Mental health standard CM14: Group activities.

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

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Supporting contacts from therapists or other healthcare professionals

42. 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.

43. A further example is where a physical health professional visits a secure ward from a different organisation. This should be added to the supporting contacts feed when your organisation is invoiced for this service at patient level (see also Mental health standard CM8: Other activities).

44. These activities 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 patient that it benefits, rather than patients in another service area (or organisation).

45. 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 is described in more detail in Mental health standard CM1: Medical staffing and Mental health standard CM3: Non-admitted patient care.

Non patient-identifiable and patient-identifiable drugs

46. 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 medicines dispensed feed.

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

48. Mental health standard CM10: Pharmacy and medicines details the allocation of medicine costs to admitted patients.

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Other considerations

Home leave

49. When a patient leaves the physical location of the ward for a period spent at home, this is recorded as home leave. See Spreadsheet IR2 for the fields in the MHSDS APC showing start and finish times for the period of home leave.

50. The ward care costs for these periods are lower than when the patient is present as, for example, there are no costs for food, fresh linen or on-ward staffing input, and there are no ward rounds or ward work with healthcare professionals.

51. 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 this additional split of information and allocations 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.

52. Patients may be escorted or unescorted during home leave. Escorted patients use significant resources, either from ward staff (the ward care activity) or separate staff. This cost may be treated using a superior costing method as described under Acuity below.

53. Home leave is up to six days.[73] Patients may also have escorted or unescorted short periods within a day away from the ward, eg trips to shops to develop independence. These short periods do not need to be adjusted for in the duration calculation for allocating activities to patients.

Perinatal mental health services

54. Some patients need to be admitted during pregnancy or following the birth of their child.

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[73] In accordance with the NHS Data Dictionary definition of home leave.

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

56. Where there is no specific unit, and patients 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.

57. The costed activity is for the mother only, although the cost on discrete units may include nursery costs in addition to the mental healthcare provided. Ensure the nursery costs are allocated across the patients using the unit in the period unless patient-level information is available.

Consumable items and equipment

58. There may be costs of consumables and equipment related to the admission. The term 'medical and surgical consumables and equipment' applies to all healthcare settings, and these items are divided into the following categories for costing:

    • consumables and equipment on hand in all wards for simple investigation and treatment
    • consumables and equipment on hand in specific wards
    • expensive consumables and equipment required for more complex treatments, therapies, or procedures, eg ECT.

59. Allocate consumables and equipment on hand in all wards or procedure suites to all patients admitted to that area based on duration of attendance in minutes.

60. Allocate consumables and equipment on hand in specific wards or procedure suites to all patients in those areas based on duration of attendance in minutes.

61. Use resource ID: MDR046; Medical and surgical consumables, and resource ID: MDR047; Medical and surgical equipment and maintenance.

62. Identify the complex treatments, therapies and procedures that use expensive consumables[74] and equipment. Then set up relative weight values so that the expected costs can be used as relative weight values to allocate the costs of these consumables and equipment to patients having that treatment, therapy or procedure. If your provider has an inventory management system logging consumable items at patient level, use this information.

Example

Knowing the team from which healthcare professionals originate is useful for understanding how care is delivered and for service-level reporting, but it does not affect whether the costs form part of the cost for the APC episode (see Figure CM13.1 below). Allocating costs using resources and activities should ensure that activities provided by internal and external teams can be aggregated or disaggregated as desired, if reports need to be generated at different levels.

Figure CM13.1: Example of activities for allocating costs during an APC episode

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[74] We do not define what an 'expensive consumable' is; that can be decided locally.

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Acuity

63. Patients in admitted care facilities will need different levels of support for their specific condition, treatment and safety.

64. Many systems reflect acuity: currently there is no national standard. Your organisation may have a local system for recording acuity. It is reasonable to use this: for example, if the patient is on a ward of lower acuity than they require for capacity reasons, or patients with different conditions – and therefore identifiable resource use – are on the same ward.

65. As a superior costing method, a higher level of resources could be allocated to some patients, based on their acuity. This is Mental health superior costing methodology SCM2: Ward acuity on Spreadsheet CP3.5.

66. Some of the additional staffing for acuity may be visible as agency/bank staffing costs.

67. In addition to acuity by condition/treatment, two specific areas – specialing/observations and escorted home leave – have been identified as having material additional resources. These are described further below.

Specialing and observations

68. Specialing and observations refer to a patient having additional care and/or reviews through the day. For example, one condition may have a different staffing need from another because the patient requires more frequent monitoring and recording of their behaviour, actions, interactions and reaction to medication, or one-one care. (The ratio of staff to patient will vary according to clinically agreed patient need.)

69. These elements should be recorded on the supporting contacts feed (feed 7) and matched to the patient episode using the matching rules in Integrated standard CP4: Matching costed activities to patients and Spreadsheet IR1.2 and Spreadsheet CP4.1.

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

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Escorted home leave

71. A patient who is admitted onto a mental health ward may take one or more leaves of absence. When authorised by their responsible healthcare professional, this is termed 'home leave' (see paragraphs 49 to 53). During home leave they may be escorted by a staff member or be unescorted. Unescorted home leave does not incur additional cost, so does not require additional information or consideration of acuity.

72. Home leave is recorded in the MHSDS using the fields in Table CM13.6 and is authorised for up to six consecutive days. Home leave is not a discharge. The patient episode continues.[75]

73. 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 need.

74. Although rare, the resources used when escorted leave occurs are significantly higher than those used by unescorted leave, and the additional cost is normally on the ward cost centre. So, it is important to reflect these costs against the specific patient, rather than to spread them over all patients.

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

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

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

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[75] 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 Mental health standard CM2: Incomplete events for guidance.

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Table CM13.6: Excerpt from Spreadsheet IR1.2: Patient-level field requirements for costing

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.

PLICS collection requirements

78. The list of all mental health ward care activities should be mapped to the single collection activity ID: WRD001; Ward care.

CM14: Group sessions

> Purpose: To ensure patient care given in a group is costed consistently.

Objective

1. To ensure costs are correctly allocated to patient episodes/contacts where there are multiple patients with one or more professionals.

Scope

2. This standard covers all group contacts.

Overview

3. Mental healthcare is often delivered in a group setting, such as talking therapies, occupational and physical activity sessions.

4. A group session involves multiple patients and one or more staff members. A group contact is the activity unit recorded for a single patient within a group session that also contained other patients.

Approach

Costing non-admitted groups

5. Mental health standard IR1: Collecting the information for costing and Mental health standard IR2: Management of information for costing specify the minimum information required to cost contacts in a group session within a non-admitted patient care (NAPC) setting.

6. There are two ways to identify group patient care within the Mental Health Data Set (MHSDS):

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- Where a patient record relates to care given within a group, the contact record should have a unique identifier in the 'group session identifier' field. Where this field is not null, it is a group contact. Use the activity codes shown in Table CM14.1

- Where no patient contact record is available – for example, in education groups where the attendees do not have a contact recorded in PAS – the MHSDS table MHS301 Group session gives the service/team providing the session. This can be used to allocate cost to the sessions separately from the single patient contacts. Use Type 1 Support code T1S130: Group session.

7. Use the service cost centre, and tailor the cost centre XXX584 Group Session without PAS contacts in Spreadsheet CP2.1 to disaggregate service team costs using a relative weight value agreed with the service team.

8. The service/team providing the group contact can be identified from the 'service or team type referred to (mental health)' field. This will include an alphanumeric code that indicates which resources the group contacts relate to.[76]

9. The NAPC feed should include a record of the time spent against each patient treated during the group contact or group session. Assume all patients spend the same time in the group session (although this can vary). This duration will be for the whole contact, so should be used to allocate the cost of providing the session against all the participants.

10. If the group contact fields are not routinely completed, work with your informatics department to ensure these can be recorded. Without this information the contact will be costed as though it were a single professional appointment (receiving a higher weighting of resource than was used by the patient).

11. The costing process can then link the staff cost to the resource for that staff group; and onwards to the activity for the types of group service. These are

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[76] See the MHSDS specification for the list of codes.

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shown in Table CM14.1. Your service teams will advise which of these the group session belongs to.

Table CM14.1: Excerpt from Spreadsheet CP3.2: Activities, for mental health group contacts

Activity ID	Activity
CMA308	Support or other group contact
MHA260	Psychoeducational group contact
MHA280	Skills development group contact
MHA281	Cognitive-behaviour/problem-solving group contact
MHA282	Interpersonal process group contact

Multiple staff input to group sessions

12. Group sessions with multiple professionals will have a different cost per patient than group sessions with a single professional. Depending on the number and type of staff involved, the cost could be higher or lower. It is necessary to identify the appropriate resources for each patient contact, to ensure costs are not attributed to the wrong patient activity (or spread across other activities).

13. The CSDS will only name the main healthcare professional, not additional staff, so a local information source is needed inform relative weight values identifying the resources involved.

14. The NAPC (CSDS) feed (feed 3c) and NAPC CDS feed (feed 3a) also have the field 'healthcare professional local identifier', to identify the clinically responsible lead for the group.

15. The NAPC (CSDS) (feed 3c) and NAPC (CDS) feed (feed 3a) also have fields for 'second healthcare professional identifier'. This information would come from a local system as the CSDS and CDS do not require this information. This will allow the cost of a second professional to be allocated to the appointment.

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16. For further staff members within groups, work with the relevant team/service/department and your informatics department to find a suitable method of recording multiple staff members' involvement in the group activities, and attribute their cost to resource, and then to the appropriate activity in accordance with Integrated standard CP3: Appropriate cost allocation methods.

Table CM14.2 Excerpt from Spreadsheet CP3.3 showing examples of resource and activity combinations for groups

Resource and activity link ID	Resource	Activity
THR001 – THA008	Therapist	Therapy group contact
THR002 – THA008	Therapy assistant	Therapy group contact
THR003 – THA008	Physiotherapist	Therapy group contact
THR004 – THA008	Physiotherapy assistant	Therapy group contact
THR005 – THA008	Occupational therapist	Therapy group contact
THR006 – THA008	Occupational therapy assistant	Therapy group contact
THR007 – THA008	Speech and language therapist	Therapy group contact
THR008 – THA008	Speech and language therapy assistant	Therapy group contact

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Table CM14.3: Example of how a group contact in two different group sessions might look in the resource and activity matrix

Resource	Frailty or other specialist group contact	Activity Therapy group contact
Non-consultant medical staff	XX	
Nurse	XX	
Healthcare assistant	XX	
Physiotherapy assistant	XX	
Occupational therapist		XX

Allocating the cost of multiple staff members across multiple patients

17. Allocate using prescribed methods in Spreadsheet CP3.3.

18. This method relies on several assumptions:

    - each staff member spends the same time with each patient
    - patients do not leave the session early
    - staff members do not leave the session early.

19. We acknowledge that these assumptions do not always hold true and the method will therefore not be a completely accurate representation of how care is delivered. As the ability to collect information improves, future versions of the standards will specify more accurate methods based on, for example, patient acuity or measuring actual time spent with specific patients.

20. If you already apply additional relative weight values to specific patients or adjust for staff presence in the relative weight values, continue to do so as this provides better information for costing.

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Figure CM14.1: Diagram showing how multiple or single staff members are attributed to resources, activities and patients*
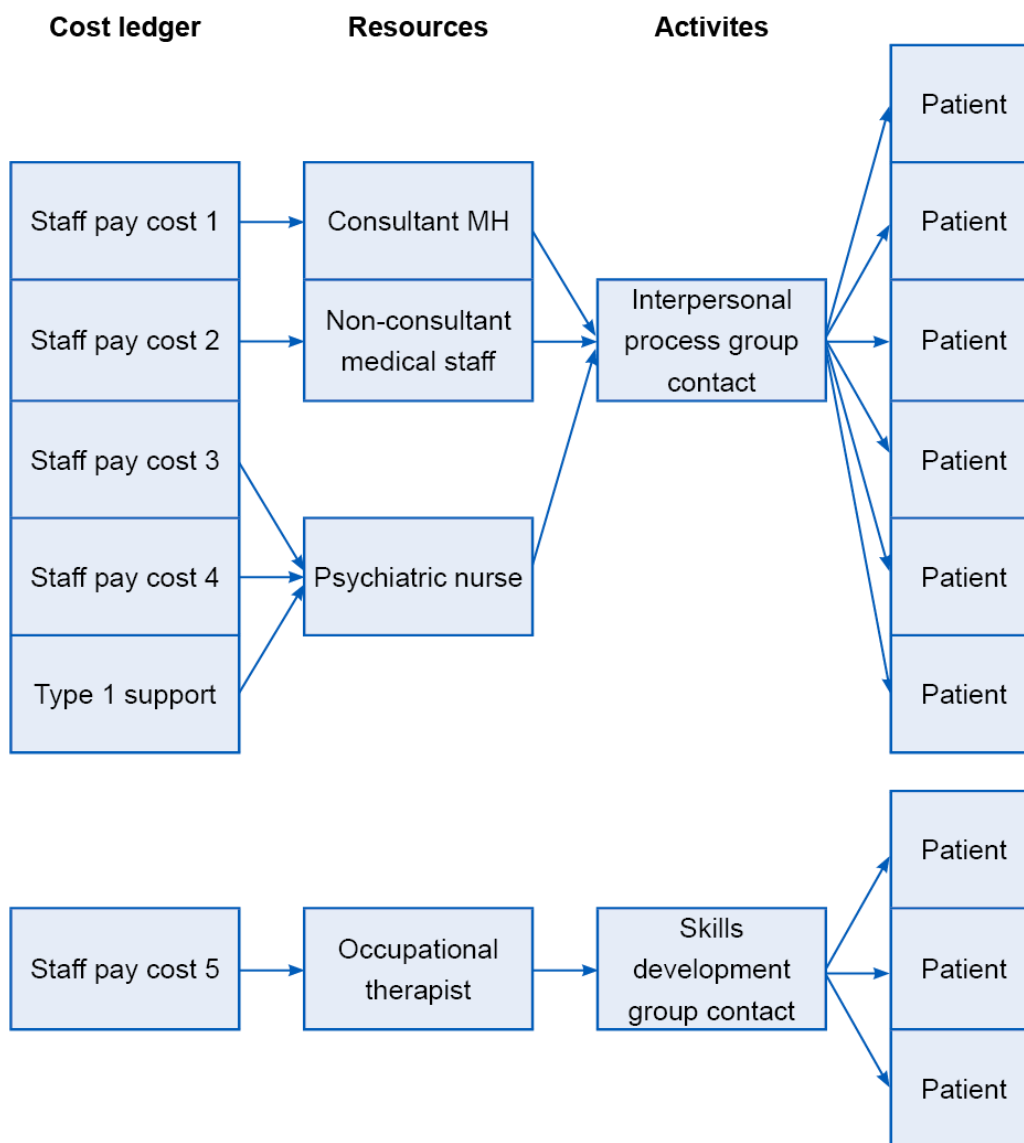
*How each resource is sent to other activities is not shown.

Allocating non-pay costs to group contacts

21. Many group contacts will not involve significant equipment, drugs or patient consumables, or will only use negligible items. However, for some activities such as specialist sporting sessions (including trips out), identifying the costs in a more detailed manner may be beneficial. The materiality principle should be used when developing detailed models for attributing this cost. Use the methods prescribed for consumable items in Mental health standard CM3: Non-admitted patient care.

CM15: Cost classification (integrated)

Purpose: To correctly classify costs on each ledger line as fixed, semi-fixed or variable.

Objective

1. To ensure costs are classified as fixed, semi-fixed or variable in a consistent way across all providers.

2. To enable providers to analyse costs based on which elements are fixed, semi-fixed or variable.

Scope

3. All costs in the cost ledger will be eligible for classification, including research and development (R&D) and education and training (E&T). Income and balance sheet items are not costs and therefore do not currently have this classification.

4. This standard **will not** provide guidance on bottom-up costing exercises for contract negotiation. It is expected the outputs from the costing process can be used to inform those costing exercises.

5. This standard **will not** identify the fixed portion of cost and the portion that is variable in the semi-fixed quantum of cost. This standard applies to all staffing costs incurred by leading and administering E&T activities to other staff or external parties.

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Overview

6. Classifying costs as fixed, semi-fixed or variable is not part of the costing process but rather a classification showing how costs behave based on the level of activity.

7. This classification is important for a trust's internal financial management as well as tariff purposes, as often contracts are calculated to fund the fixed costs of maintaining the infrastructure and with a variable cost element based on the activity. For example, a specialist paediatric hospital was the national centre for bowel transplants. This meant the infrastructure for the activity needed to be constantly maintained even though on average there were only three bowel transplants a year.

What you need to implement this standard

- Costing principle 2: Good costing should include all costs for an organisation and produce reliable and comparable results
- Costing principle 6: Good costing should be consistent across services, enabling cost comparison within and across organisations
- Costing principle 7: Good costing should engage clinical and non-clinical stakeholders and encourage use of costing information.
- Spreadsheet CP2.1: Standardised cost ledger

Approach

8. You should classify each line in your cost ledger as fixed, semi-fixed or variable, based on a timeframe of 12 months.

9. For the *Healthcare costing standards for England*, the definitions adopted for fixed, semi-fixed and variable costs are given below.

10. Details of the classification of costs can found in column R in Spreadsheet CP2.1.

Fixed costs

11. Fixed costs remain the same regardless of the level of activity.

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12. Typical examples of fixed costs include rates, standing charges, financial charges and board of directors' costs.

13. Agenda for Change (AfC) staff at Band 8a and above are also classed as fixed, as the AfC guidelines state that these grades do not qualify for overtime. Staff at Band 8a or above employed during the year will be classified according to this rule, irrespective of the role or duties they were employed for.

Semi-fixed costs

14. Semi-fixed costs remain the same until a certain level of activity is reached, then the costs increase in proportion to the level of activity.

15. Costs are defined as semi-fixed when the level of cost needed to maintain, and the infrastructure needed to deliver, the contracted activity level is fixed. The costs incurred to deliver additional activity above that level are thus variable.

16. An example of semi-fixed costs would be contracted staff who can work, and be paid, for overtime. A consultant's basic pay must be paid regardless of their activity, so this is fixed; however, for example, additional sessions that reduce waiting lists will be variable.

17. AfC staff up to and including Band 7 also fall into this category, based on current AfC guidelines.

Variable costs

18. Variable costs increase in proportion to the level of activity.

19. Variable costs are only incurred to deliver activity – for example those for drugs, patient consumables and hire of equipment – and they will vary depending on the level of activity.

20. Agency and bank staff will also fall into this category. We understand that sometimes agency and bank staff are contracted to cover longer term absences (eg for leave and staff sickness). However, for this version of the standards, we maintain these absences would usually be covered by the

service establishment,[77] so the choice to use agency and bank staff represents increased volume.

Classification of resources

21. As each cost ledger line is mapped to a classification, resources will inevitably end up containing all three cost classifications, based on how type 1 support costs are allocated in the costing process. For this version of the standards, the classification of fixed/semi-fixed/variable will be applied at the cost ledger level. Therefore, resources will not map to a single classification.

Other considerations

22. Activities are not classified as either fixed, semi-fixed or variable.

23. The classification of costs into fixed, semi-fixed or variable depends on the time period being assessed. In the long term, all costs are variable, so you should base this classification on a 12-month period.

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[77] This will be discussed further with technical focus groups during 2019.

CM20: General practitioner services in secondary care settings (integrated)

Purpose: To allocate GP costs within NHS trusts and NHS foundation trusts to the activities they deliver.

Objectives

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

Scope

2. This standard applies to all GP costs in the cost ledger.

3. This standard applies to NHS provider organisations.

4. This standard requires patient-level costs for secondary care activities only.

5. The standard applies to other staff grades who provide primary care services.

Overview

6. GPs provide:

   - care in primary care settings, such as GP surgeries and health centres
   - care related to a special interest in secondary/tertiary care
   - core cover for agreed services such as community hospitals and GP out-of-hours services.

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7. Most of a GP's work is usually in the primary care setting. However, their patient care activities in other settings and their training activities need to be understood to ensure accurate costs within NHS providers.

8. Some GP work in non-primary care provider settings helps meet the increasing demand for NHS services and/or is for the GP's personal development. Non-primary care may facilitate both of these activities – for example, the agreed operational model may be for a GP to provide medical cover for wards in an intermediate care unit.

9. GPs may have undergone specialist training for the clinical area they work in or be developing skills in that area.

10. GP work in a non-primary care[78] provider is of two types:

   - Patient-facing activities – where the GP sees the patient in place of a one of the provider's medical staff. For example, a GP with a special interest in the stroke service may work up to two sessions per week in the acute stroke or stroke rehabilitation unit as part of their contract.
   - Other activities – include where the GP is attending academic training sessions or is shadowing other healthcare professionals. For example, a GP in the process of developing a special interest may shadow the clinical team but not yet contribute to the medical service.

11. The primary care GP cost to a non-primary care provider should be understood to ensure the quantum of cost is accurate, but it does not need to be allocated to patient level.

12. The costing team should understand the nature of GPs' contribution to the care provided so their costs can be allocated appropriately.

What you need to implement this standard

   - Mental health standard CM1: Medical staff
   - Spreadsheet CP2.1: Standardised cost ledger
   - Spreadsheets CP3.1: Resources for patient-facing and type 2 support costs
   - Spreadsheet 3.2: Activities

[78] 'Non-primary' in this context includes secondary care, tertiary and specialist care.

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- Spreadsheet 3.3: Methods to allocate patient-facing resources, first to activities and then to patients

Approach

13. You should ascertain whether – and where – the cost of GPs is in the general ledger. The cost of the GP will usually be in the provider's ledger through:

- a recharge on a session basis
- as a payroll entry in the same way as for other medical staff.

14. Map your medical staffing GP costs to the cost centres in the cost ledger according to the service they work in. This may be at specialty level or a local team category.

15. Where GPs provide primary care within your organisation, use the cost centres in Table CM20.1.

Table CM20.1: Excerpt from Spreadsheet CP2.1: Standardised cost ledger

Cost centre	Description
XXX057	GP and primary care services
XXX232	Research and development
XXX273	Education and training
XXX640	GP out-of-hours services

16. You will also need to identify the expense codes used in the general ledger and map them to the expense codes for GPs in the cost ledger. Use the following expense codes:

- 5361 General practitioners – primary care
- 5363 General practitioners – secondary care.

17. These expense codes will flow GP costs using the resource IDs in Table CM20.2.

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Table CM20.2: Excerpt from Spreadsheet CP3.1: Resources for patient-facing and type 2 support costs

Resource ID	Resource
SGR077	General practitioner – secondary care
SPR115	Research and development
SPR114	Education and training
CMR313	General practitioner – primary care

18. You should review the first output of this process, to ensure the cost of the GP has been allocated to the correct resource. If it has not, the general ledger codes should be disaggregated and remapped to the cost ledger expense codes and resources using information from the service manager or clinical lead in the service area in the same way as other medical staff time is allocated. Any primary care service provided should be kept separate from the secondary care service cost.

19. For the resource CMR313: General practitioner – primary care, you should map to the activity shown in Table CM20.3 only. There is no requirement to obtain or cost at patient level for primary care, but this process will ensure you can reconcile all costs within your system.

Table CM20.3: Excerpt from Spreadsheet CP3.3 for primary care activities

| Resource ID: Activity ID	Resource	Activity
CMR313 – SGA091	General practitioner – primary care	GP and primary care service
CMR313 – AMA191	General practitioner – primary care	GP out-of-hours service (OOH)

20. For resource ID SGR077; General practitioner – secondary care, you should map to the relevant activity at patient level, in accordance with Spreadsheet CP3.3.

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Patient-facing activity

21. The activity (that is, special interest or medical cover for contacts, appointments, support of inpatients, etc) will usually be shown in in your provider's patient administration system (PAS). Therefore, the cost of the GP should be allocated to the appropriate patient care, in the same way as for other medical staff (See Integrated CP3 and Mental health CM1). An example is shown in Figure CM20.1.

Figure CM20.1: Identifying the correct quantum of cost to be apportioned to activities
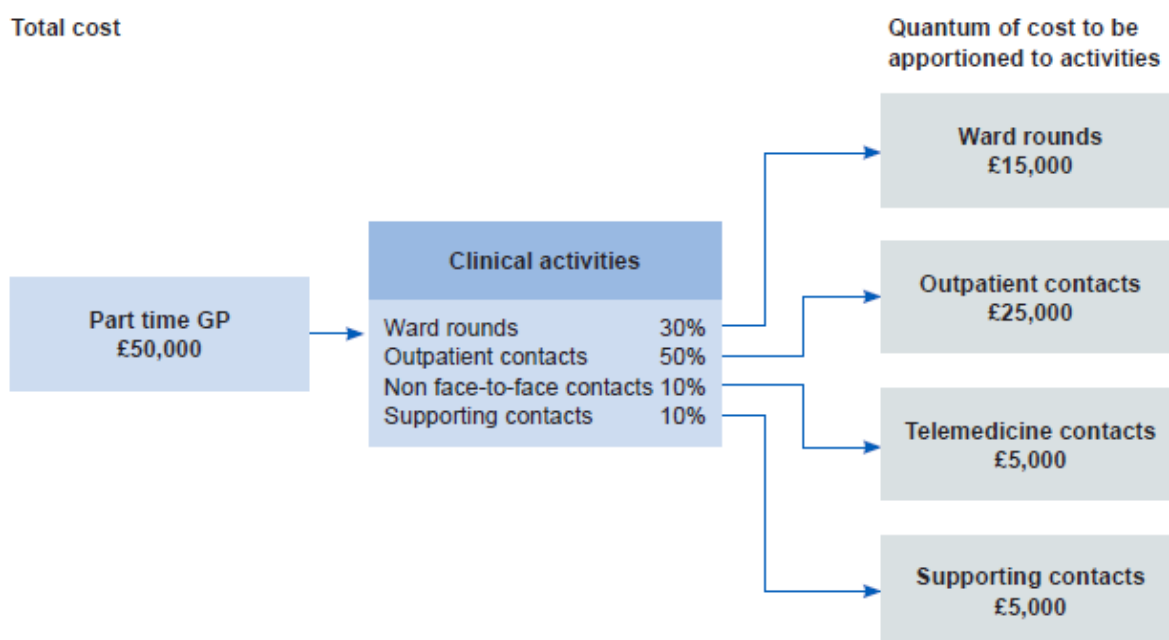
22. The 'healthcare professional local identifier' field in the PAS should include where a GP has been responsible for the contact or admission according to local policy. Where this is the case, the GP is responsible for the patient for the period of time they are in the dataset (episode, attendance or contact). Each patient admission may have multiple episodes of care, with responsibility changing from one to the next. See also Acute standard CM1: Medical staff.

23. In accordance with Mental health standard CM1: Medical staff, this standard requires the costs for individual GPs performing a consultant role to be allocated at patient level. So, in Figure CM20.1 the resource shown as 'Part time general practitioner' would be one individual.

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24. Table CM20.4 is an excerpt[79] from Spreadsheet CP3.3 showing examples of the activities the GP resource is linked to.

Table CM20.4: Excerpt from Spreadsheet CP3.3 showing some resource–activity combinations for care provided by GP to secondary care patients

Resource ID – Activity ID	Resource	Activity
SGR077 – CLA150	General practitioner – secondary care	Mortuary services – internal work
SGR077 – CMA308	General practitioner – secondary care	Support or other group contact
SGR077 – MHA258	General practitioner – secondary care	MH supporting contact 1:1 – Inpatient unit
SGR077 – MHA259	General practitioner – secondary care	MH supporting contact multidisciplinary – inpatient unit
SGR077 – MHA260	General practitioner – secondary care	Psychoeducational group contact
SGR077 – MHA261	General practitioner – secondary care	CPA meeting
SGR077 – MHA262	General practitioner – secondary care	Day care
SGR077 – MHA263	General practitioner – secondary care	Respite care
SGR077 – MHA280	General practitioner – secondary care	Skills development group contact
SGR077 – MHA281	General practitioner – secondary care	Cognitive behaviour/problem-solving group contact
SGR077 – MHA282	General practitioner – secondary care	Interpersonal process group contact
SGR077 – MHA289	General practitioner – secondary care	Initial assignment
SGR077 – SGA081	General practitioner – secondary care	Theatre – surgical care

[79] Please note this is an excerpt for illustration purposes. Use Spreadsheet CP3.3 to ensure you are using all the correct resource and activity links.

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Resource ID – Activity ID	Resource	Activity
SGR077 – SLA098	General practitioner – secondary care	Ward round

Other activities

25. The GP should have no named patient responsibility while involved in purely training activities.

26. This portion of their cost should be allocated to the cost centre XXX273: Education and training, to ensure the cost of patient care is not inflated.

27. Where the GP performs R&D activity, the appropriate proportion of the cost should be mapped to cost centre XXX232: Research and development

GP out-of-hours services run by providers

28. Where these services are provided in a secondary care organisation by GPs or other staff (such as nurse practitioners and paramedics), the cost may be recharged to the GP practice(s) that require cover, and the income may be included in the contract with clinical commissioning groups (CCG) or in a separate income stream.

29. You should use the resource for the staff group providing the service (eg 5363: General practitioners – secondary care). The cost centre in the cost ledger should be XXX640: GP out-of-hours services.[80]

30. You should use the activity ID: AMA191; GP out-of-hours service (OOH).

31. Services which are part of the contract with a CCG should be shown in the 'own patient care' cost group.

32. For out-of-hours services recharged to primary care practices, the general ledger codes should be identified and shown under cost group 'other activities' in the reconciliation.

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[80] If new combinations for this cost centre are required, please contact NHS Improvement at costing@improvement.nhs.uk.

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Primary care services run by secondary care providers

33. Some providers run GP surgeries and services. These are largely recorded in a separate PAS and reported separately from the secondary care activity. However, the cost of providing these services is as important as that for other areas and the quantum of costs for it needs to be accurate.

34. Staff types other than GPs may also contribute to this service. These should be identified in the cost ledger as primary care staff, in the same way as the GPs (paragraphs 21-32 but using the relevant staff expense code and resource.

35. Currently there is no requirement to bring this information into the costing system.

36. However, for business intelligence, we recommend the services are costed locally in a way that is consistent with the costing of the other services provided.

Other considerations

37. Primary care services and GP out-of-hours services are currently out of scope of the PLICS collection. There is therefore no requirement currently to cost of these services at patient level for national purposes. This section is for information only and to ensure the cost quantum for provider services are accurate. It will be for the provider to decide whether patient-level detail is useful for local purposes.

38. Where services are provided by secondary care teams in GP surgeries or other primary care settings, and the cost is within the provider organisation, these should be costed according to the relevant sector costing standards.

39. In some cases, the commissioner may pay the GP the cost directly, particularly if they work across several providers. The patient activity will be present but without the cost of the GP. The costing process should identify the areas where this is the case and recognise that, while the cost to the organisation may be appropriate, the true cost of care for the wider health economy will not be shown. This activity should be reported in the

reconciliation statement and a note made in your ICAL worksheet 22: Other notes for reference, to appropriately inform discussions on cost.

PLICS collection requirements

40. GPs as a resource in secondary and tertiary care services should be reported under the relevant resource within the PLICS collection. Primary care services and GP out-of-hours services are currently out of scope of the PLICS collection.

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