

Health

National report

June 2006



# Managing finances in mental health

A review to support improvement and best practice

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Photograph: Getty Images

Front cover image incorporates material provided by Professor Gyles Glover in association with the Mental Health Mapping project at the University of Durham. It illustrates the distribution across England of scores on the Mental Illness Needs Index (MINI) and the location of mental health provider trusts.

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# Summary

## Background

Mental health problems are widespread; 16 per cent of people at any one time in the UK have a so-called common mental disorder. At the other end of the scale, it is estimated that between 1 and 3 per cent of people will have a psychotic illness such as schizophrenia or manic depression (bipolar disorder). At £7.2 billion, mental health (across all ages) represents the largest single element of programme budget spend in the National Health Service (NHS), amounting to 12.2 per cent of total NHS expenditure.

In recent years, the government has made mental health service reform a priority. Building on proposals set out in the mental health *National Service Framework* extra investment was distributed through the modernisation fund and general allocation. Targets were set for the introduction of new teams and services in *The NHS Plan* and further plans for service and financial reform are currently being implemented.

Despite this, and despite significant recent progress in the development of teams and services, mental health continues to be seen as the Cinderella of health service provision. Mental health is regarded as different from the acute sector, with a history of having the same basic institutions while proceeding along a parallel, but slower, development track. At national level, mental health services were not included in the early pilots for service and financial reform or early work to implement the National Programme for IT (NPfIT). There have been accusations of under-resourcing, problems associated with old, poorly maintained buildings, difficulties with recruitment and staff retention, and inequities in provision that particularly affect people with mental health problems from black and minority ethnic communities.

There are also challenges presented to mental health by NHS reorganisation, financial system reform and the slower pace of growth in investment within the NHS expected beyond 2008. And, although the first mental health foundation trusts (FTs) started on 1 May 2006, some two years after the first acute sector FTs, Payment by Results (PbR) is unlikely to be implemented for mental health services until 2009 at the earliest, partly because a sector-specific version is still being developed.

## Findings

The financial standing of mental health trusts (MHTs) over the last three years has been significantly better than trusts in the acute sector. They have broadly similar cost structures and have faced similar pressures on pay reform, for example, but MHTs are more likely to make a surplus and less likely to make a deficit.

There are also other differences. MHTs make almost six times as many contractual partnerships outside the NHS than trusts in the acute sector. Such contracts, with local authorities (LAs) and providers in the charitable and voluntary or private sector, support care appropriately provided across traditional boundaries to meet complex and long-term clinical mental health and social care needs. Most of these contracts are relatively small, but the remainder cover more than 1 per cent of turnover; their quality is variable and formal partnership agreements are not always made.

MHTs also lack the breadth and depth of information available to acute trusts and the quality of information available is generally inferior as previous Audit Commission studies on reference costs, waiting times and data quality more generally have also shown. Very few MHTs yet have arrangements that enable them to break down figures on overall activity and spend to more detailed ones linking treatment and cost. This makes it difficult for trusts to move beyond current block contracting arrangements. Block contract arrangements make it easier for trusts to adjust what they do to the finances available but they also mean that detailed information is not available to support benchmarking or national analysis of activity.

It also means that purchasers do not have the information available to understand fully the financial implications of current and potential alternative policies, programmes and activities, or to make evidence-based and rational investment decisions. Commissioners regularly reported frustrations about the incompleteness of the information they received from providers and the poor relations that resulted. For their part, MHTs commonly complain that commissioners fail to give their service agenda sufficient priority.

There are indeed large variations in spend by primary care trusts (PCTs): from less than £75 per head per year to over £300 in 2004/05. The King's Fund's enquiry *London's State of Mind* raised serious questions about variations in levels of investment and gaps in information, and our analysis shows that this variation cannot be explained entirely by differences in levels of need, differences in volume of activity, or differences in efficiency. These factors are important and there is also some evidence of cross-subsidisation between high- and low-spending neighbouring PCTs. But our data suggest that the remaining unexplained variation in expenditure relates more to long-term historical patterns of spend than to any more complex prioritisation of resources.

In conclusion, although MHTs perform well in terms of financial standing, other areas of financial management in mental health are weaker, particularly in having the information necessary for decision making and to ensure that resources are used to best effect. There are significant challenges to overcome. Our report highlights these issues in the context of service reorganisation, new commissioning arrangements, and the challenges to be faced by MHTs as they apply for FT status. As the pace of growth in NHS expenditure slackens, and greater emphasis is put on improving productivity through service redesign, MHTs may find themselves at a disadvantage compared with the acute sector. We set out some examples of good practice in financial management, covering data and information management, planning, decision making, monitoring and forecasting, reporting and stakeholder management to promote and support best practice.

# Recommendations

The general principles of good financial management are no different in mental health than in other sectors, and the recommendations in previous reports, such as *Achieving First-class Financial Management in the NHS*, are applicable across the board. We have made the following recommendations either because they are sector specific (for example in relation to out of area treatments) or because some general principles have particular relevance to the current circumstances in mental health (for example in relation to partnerships and data quality).

## Department of Health

- 1 The Department of Health (DH) has a key role in encouraging and supporting improvements in data quality through the national performance management framework. In partnership with the Health and Social Care Information Centre (HSCIC) and the Care Services Improvement Partnership, DH should support the development of a more transparent system for tracking expenditure and measuring activity and outcomes so services can be more closely related to need. This should permit measurement of the impact of change, benchmarking of performance, and support effective financial management by providers and PCTs.

## Mental health provider trusts

- 2 Effective financial management depends on good-quality data. The trust board should adopt a data quality strategy, setting out the priorities for the organisation, and how information will be integrated into the trust's operational, performance management and governance arrangements. It should cover:
  - a. the relevance of data quality to business objectives;
  - b. the corporate data quality requirements;
  - c. compliance with external standards; and
  - d. security of data.

- 3 Good financial management is only possible when financial planning and budget setting are developed alongside service strategies and linked to service activity and outcomes. In this way, financial and operational plans can be linked. MHTs should therefore:
  - a. collect valid data against all key data items in the core mental health minimum data set (MHMDS);
  - b. collect Mental Health Act-related activity;
  - c. work with their local implementation team to collect data for effective financial mapping; and
  - d. collect information about outcomes.
- 4 All trusts should have explicit, agreed and communicated agreements for purchasing out of area treatments (OATs). No trust should be required to pay an OATs bill for a patient where the decision has been made by a third party unless clear, written protocols have been agreed between them and widely shared. Each trust should have clear protocols governing how decisions should be made by its own staff to authorise OATs and how the financial consequences are identified, recorded and monitored.
- 5 MHTs should provide high-quality, contextualised finance and activity information to their PCT on at least a quarterly basis, so that commissioners are able to link activity to their expenditure and can question any changes. Such information should include the delivery of services by partner organisations on behalf of the MHT.
- 6 To support applications for FT status, and ongoing management of the trust, MHTs should take early steps to appraise the general and financial management skills and competencies of board members and, if necessary, provide training on risk and financial management to enable them to take responsibility and provide effective financial challenge.

## Partnership working

- 7 Mental health providers work in partnership with multiple, cross-sector organisations. It is therefore vital that partnership agreements between MHTs and their commissioners are delivered to good practice standards. As a minimum, there should be a partnership agreement which:
  - a. is signed by all partners in a timely manner, to ensure compliance with Section 31 of the Health Act 1999;

- b. provides clarity about ownership;
- c. sets out arrangements for governance and accountability for all provider contracts;
- d. sets out how risk management and conflict resolution arrangements, including how to re-allocate resources back to partners should the arrangement break down;
- e. clearly identifies how pooled budget expenditure, MHT income and assets are accounted for; and
- f. establishes an effective performance management system to enable partners to assess achievement against agreed targets and to evaluate pooled budget arrangements.

## PCTs

- 8 PCTs should benchmark their own expenditure compared with population need against that of their peers in order to account for and address any unexplained expenditure variation and to inform future investment decisions.
- 9 PCTs, in their contracts and service level agreements (SLAs) with providers, should include detailed service specifications about the mental health activity to be provided. This is particularly important where the range of services is commissioned using a block contract; the DH model contract provides an effective framework for this.
- 10 PCTs should ensure that their contracts with MHTs include the following specifications on information flows and performance monitoring:
  - a. information provided quarterly to enable the commissioner to monitor both the activity level set out in the SLA and progress on mental health targets;
  - b. timely, validated information and details of any variations; and
  - c. sanctions (for example a financial penalty relating to the baseline contract value) in the event that timely and complete information fail to be provided.
- 11 Joint commissioning arrangements between PCTs and LAs, through a joint commissioning team or partnership board should be strengthened to support:
  - a. planning for current and future mental health needs;
  - b. commissioning through service specifications and SLAs;

- c. the monitoring and performance management of service suppliers around, for example, expenditure, demand, budgetary pressures, volume and quality of services;
- d. service development and improvement;
- e. the overcoming of barriers to effective financial management caused by different financial regimes, different information and systems for data collection; and
- f. the achievement of local and national targets.

- 12 PCT commissioners in consultation with stakeholders and providers should collaborate in the development of a set of key mental health performance indicators. These can be used to support local service and financial planning; improve joint working between NHS and LA services; and help MHTs to prepare for FT status. The indicators would ideally include:
- a. access to crisis services;
  - b. systems to support Choose and Book;
  - c. Care Programme Approach; and
  - d. MHMDS implementation.

# 1

## Introduction

This report examines the financial management arrangements in place in secondary mental health NHS providers and their funding by PCTs. It highlights the financial issues they face now and in the future. It makes practical recommendations for strengthening financial management, supported by examples of notable practice.

It incorporates findings from:

- a questionnaire completed by the Audit Commission's appointed auditors for every NHS body;
- audited annual accounts and other national data;
- scoping interviews with mental health providers;
- responses to questionnaires sent to all mental health provider trusts in England; and
- opinions expressed in workshops with a sample of mental health PCT commissioners.

## Background

- 1 Mental ill-health, its cost, treatment and impact represents an important challenge for planners and providers at all levels in health and social care. Mental disorder accounts for 31 per cent of disability worldwide and depression is predicted to become the leading cause of disability in the world by 2020 (**Ref. 1**). National surveys (**Ref. 2**) of psychiatric morbidity carried out by the Office for National Statistics show that one in six adults in Great Britain have a so-called common or neurotic disorder (mainly mixed anxiety and depression) at any one time. At the other end of the spectrum of severity, between 1 and 3 per cent of people have a psychotic illness such as schizophrenia or manic depression (bipolar disorder).
- 2 At £7.2 billion, mental health represents the largest single element of programme budget spend (across all ages) in the NHS. This is equivalent to £150 per capita on average across all age categories and amounts to 12.2 per cent of total NHS spend<sup>I</sup>. LA national spend on adult mental health<sup>II</sup> is approximately £1 billion – typically £30 per capita. Overall, this represents a significant level of investment, although it masks widespread variation at PCT level – a finding that is discussed further in later chapters.

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<sup>I</sup> Programme Budgeting data 2004/05, DH.

<sup>II</sup> Personal Social Services return 2003/04.

- 3 The total cost of providing mental health treatment and care in the NHS is difficult to estimate accurately: existing figures are likely to be an underestimate. The majority of care for people with a mental illness (including a significant proportion of those with severe conditions) (**Ref. 3**) is taken up in primary care, where costs are not always clearly identified by care group. As in other parts of Europe, care for people with more severe conditions is still largely focused on secondary services provided in and around psychiatric hospitals, although this pattern is now beginning to change. Many people with mental disorders are not in contact with any statutory service (**Ref. 4**) and many access support and treatment outside the formal health system. A substantial proportion of the social and monetary cost of mental disorder is associated with difficulty in finding and keeping paid employment (**Ref. 5**), working productively and sustaining daily living.
- 4 Most specialised secondary mental health services (84 per cent) are delivered by stand-alone MHTs (see **Appendix 1** for a brief breakdown of type). Only 10 per cent are provided by PCTs and the remainder are provided by acute and other specialist trusts. Respondents reported total expenditure budgets for 2005/06 ranging between £750,000 and £250 million: they are therefore, on average, smaller than acute trusts. MHT spend on adult mental health typically ranges between £21 million and £60 million. Mental health services provided by PCTs are even smaller than this (less than £20 million), which is one reason, alongside NHS reorganisation, why most are now planning alternative means of provision.
- 5 Mental health secondary care providers deliver a range of services including community mental health teams (CMHTs) and specialised services. Our research identified that services, including psychiatric inpatient beds, psychiatric intensive care and residential and day provision in partnership with others, are typically provided across a number of sites (from 3 to 180). MHTs may also offer services to children and adolescents with mental health problems (CAMHS), people with learning disabilities, eating disorders, older people with mental health problems, those with problems associated with drug and alcohol misuse, and forensic and secure services.

- 6 Estimating activity levels in mental health services is a significant challenge nationally as well as locally, partly due to the shift in the pattern of delivery of mental healthcare and the variation in the way that services are defined. For inpatient care, both financial resource allocation and information systems rely on bed occupancy data as a measure. Occupied bed days, admission and re-admission rates and average lengths of stay are the common currency, even though these measures fail to identify relative treatment costs or reflect the balance of current provision between inpatient and community care. Furthermore, outpatient contacts with consultant psychiatrists (the leading measure of outpatient activity) do not reflect rates of growth in community contacts or contacts with specialised teams.
- 7 The Mental Health Strategies' autumn assessment provides a valuable account of mental health service provision, including community services<sup>I</sup>. Activity data on the services provided by Crisis Resolution and Home Treatment teams and Assertive Outreach teams show an increase of almost a third but is only available from 2004/05 to 2005/06<sup>II</sup> and is still very unreliable. Consistent with this, and policy to provide cost-effective care closer to home, the average daily number of NHS beds available for people with mental illness fell by approximately one-fifth between 1993/94 and 2003/04. This means that as more care is provided in the community, it has become more, rather than less difficult to assess efficiency or the cost effectiveness of mental health services overall.
- 8 High costs and high levels of disability were among the reasons that government prioritised mental health service reform (**Ref. 6**) in 1998. There have been widespread allegations of under-resourcing for mental health services, problems associated with old, poorly maintained buildings and problems of recruitment and retention of staff due to low morale. Mental health services were seen as different from those in the acute sector and development often proceeded on an alternative, slower path. At national level, for example, mental health services were not included in the early pilots for service and financial reform or early work to implement the NPfIT (now NHS Connecting for Health). There were also (and continue to be) inequities in provision that particularly affect people with mental health problems from black and minority ethnic communities (**Refs. 7 and 8**).

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I [www.mentalhealthstrategies.co.uk](http://www.mentalhealthstrategies.co.uk).

II Adult Mental Health Service Mapping, Durham University [www.dur.ac.uk/service.mapping/amh](http://www.dur.ac.uk/service.mapping/amh).

- 9 Mental illness was therefore identified as one of the key areas for action in *The Health of the Nation* (Ref. 9), *Our Healthier Nation* (Ref. 10) and *The NHS Plan* (Ref. 11). The National Service Framework (NSF) for Mental Health (Ref. 12) set standards for the delivery of mental health services, with the intention to guide commissioning and investment by setting out cost-effective models of care and set the context for performance assessment and improvement. Alongside additional investment and a range of policy implementation guidance, new national targets for mental health were set in 2000 and 2004 (Ref. 13).
- 10 Early evidence suggests that mental health services have made good progress towards implementing the NSF. There has also been an increase in investment in mental health services as a proportion of Hospital and Community Health Services spend (Ref. 14). Although there are still some significant gaps, a number of reports describe the new teams and services that are being developed (Ref. 15).
- 11 Despite a number of very positive changes, concerns about resource allocation and service development in mental health continue. The King's Fund's enquiry *London's State of Mind* (Ref. 16) raised serious questions about variations in levels of investment and gaps in information to support a full analysis of where resources are going. Audit Commission reports on reference costs, waiting lists and data quality (Refs. 17, 18 and 19) all highlighted deficiencies in mental health in these areas, over and above those applying in the acute sector.
- 12 In addition, respondents reported that two-thirds of MHTs' services are still commissioned solely on block, as opposed to cost and volume, contracts. Block contracts do not link activity and funding, and as a result, this makes it difficult to hold providers to account for differences in efficiency and value for money.
- 13 It is important that MHTs provide better information about their financial management arrangements and service provision, particularly in the context of a health economy characterised by high levels of demand and an increasing number of NHS bodies failing to achieve financial balance (Ref. 20). Important questions about variation in local expenditure are difficult to answer and it is equally difficult to relate spend to need or outcome.

- 14 These problems represent an even greater challenge to MHTs and commissioners as they move towards implementing financial system and organisational reform. All NHS trusts, including MHTs, have been given the opportunity to apply for FT status by 2008. The first three<sup>I</sup> MHTs were authorised by Monitor on 28 April 2006 to start as FTs from 1 May 2006. NHS FTs remain fully part of the NHS and primarily provide services to NHS patients<sup>II</sup>. FT status provides trusts with a number of both opportunities and challenges. FT status will enable freedom around decisions on service development, capital investment and new governance arrangement decisions, and also brings new borrowing powers.
- 15 We have reviewed financial management arrangements in the mental health sector in view of the challenges faced by MHTs in adapting to financial and structural reform in the NHS, and continuing concerns about the quality and nature of information available to providers and commissioners. We also explored future risks in the context of NHS reorganisation, financial system reform, and the expected slower pace of growth in investment within the NHS beyond 2008, and identify strategies to help address them.

## Methodology

- 16 We conducted six semi-structured scoping interviews with MHTs and PCTs to review current arrangements in the mental health sector, the challenges they face and the solutions they had found. A questionnaire based on the financial management principles outlined in *Achieving First-class Financial Management in the NHS (Ref. 21)* and the draft criteria contained in the auditors' local evaluation (ALE) key lines of enquiry was sent to all MHT directors of finance, to gain a national perspective. These were followed up with respondents to obtain examples of good practice. Almost two-thirds of MHT providers in England responded to our questionnaire. Responses were cross-referenced with feedback obtained from a questionnaire completed by the Audit Commission's appointed auditors for every NHS body, information from trust annual accounts and feedback from a sample of PCT commissioners. Where relevant, we have drawn comparisons with the acute sector. Further information about the methodology is provided in **Appendix 1**.

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<sup>I</sup> Oxleas NHS Foundation Trust, South Essex Partnership NHS Foundation Trust and South Staffordshire Healthcare NHS Foundation Trust.

<sup>II</sup> [www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/SecondaryCare/NHSFoundationTrust/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/SecondaryCare/NHSFoundationTrust/fs/en).

- 17 In the context of findings on financial standing and investment levels, **Chapter 2** describes how mental health providers currently perform in terms of their financial standing compared with acute trusts. It considers the variations in expenditure by PCTs and the explanations for this. **Chapter 3** sets out the current cost structures, pressures and risks to effective financial management, as reported by secondary mental health providers themselves, alongside evidence from other sources. **Chapter 4** sets out a framework for strengthening financial management, a key focus of which is ensuring that systems are supported by good-quality data and information systems to inform effective decision making. It also outlines the implications for all the leading players in the mental health system to help them prepare for the future as a FT. **Chapter 5** summarises the report's key conclusions. Examples of notable practice are set out throughout the report, along with contact details of providers who are content to be contacted for further information about their work.

# 2

## Spending and investment in mental health

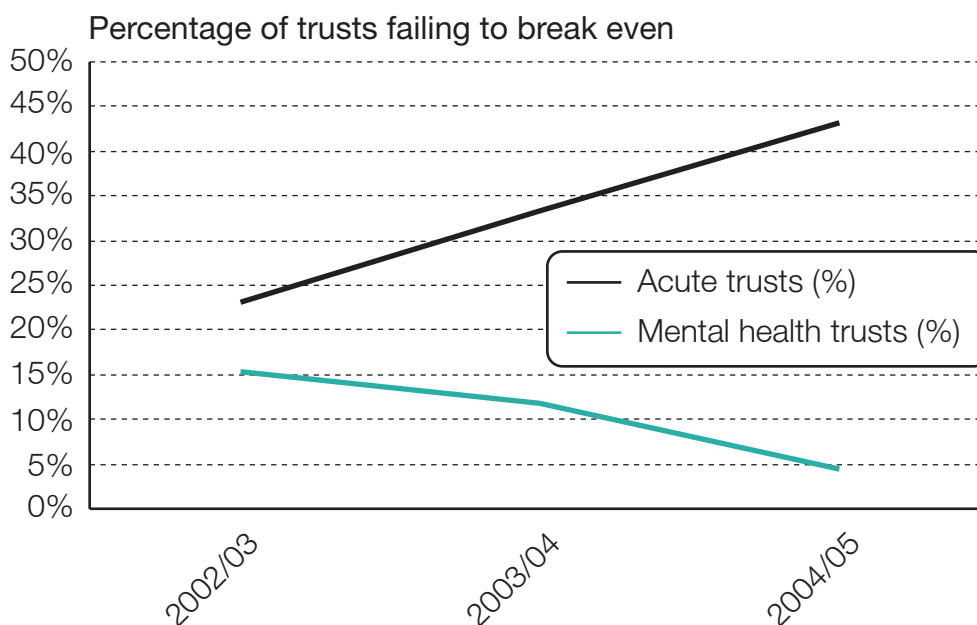
This chapter compares the financial standing of mental health and acute trusts; overall, MHTs perform significantly better. It also describes the variation between PCTs in terms of spend on mental health services and explores some possible reasons for this. It sets out how a currently positive headline for MHTs may disguise some risks for the future.

- 18 In reviewing financial standing, we found that MHTs achieve a good record, both relative to acute trusts and overall. On the whole, they manage their spending within the resources available to end the financial year either in surplus or at breakeven. Trust annual accounts show that almost all (95 per cent) MHTs broke even in 2004/05 compared with only 57 per cent of acute trusts. Thus, very few MHTs made a deficit compared with their acute counterparts.
- 19 **Figure 1**, overleaf shows that financial standing is improving in mental health in contrast to rising deficits in the acute sector. This positive picture is broadly supported by feedback from auditors on wider financial management issues. In 2004/05 auditors raised concerns about some aspects of financial management such as control over expenditure in only 14 per cent of MHTs (9 trusts) compared with a third (48) of acute trusts.
- 20 This positive picture is also being maintained for the current financial year. DH financial monitoring returns for 2005/06 for NHS trusts show only four MHTs forecasting a deficit. Almost all MHTs (93 per cent) forecast a year-end breakeven position at month 6 (September 2005) and of these, 11 predicted a surplus. For acute trusts, the picture is less positive as 51 trusts (40 per cent) predict a deficit; 75 trusts (60 per cent) forecast breakeven, of which 12 predicted a surplus at month 6. Therefore, if the forecasts hold, MHTs will account for just 2 per cent of the total deficit forecast for NHS trusts.
- 21 Almost two-thirds of mental health providers anticipated an in-year underlying deficit last year. Most had a financial recovery plan in place. These plans typically aim to reduce expenditure rather than generate income – a finding that applies across both sectors. Judging by the small number of mental health bodies in deficit at year-end, it appears that they have realised these plans.

**Figure 1**

**Percentage of trusts in the mental health and acute sectors failing to break even (2002/03 – 2004/05)**

Financial standing is improving in mental health in contrast to rising deficits in the acute sector.



**Source:** Trust annual accounts; FT published accounts 2004/05

- 22 The headline figures for financial standing are clearly better for mental health than acute trusts. There are a number of possible explanations for this. Firstly, mental health commissioners and trusts have fewer targets to meet than the acute sector. In addition, as two-thirds of MHT services are commissioned solely on a block contract basis (the remainder, particularly more specialised services, are commissioned using a combination of block, and cost and volume contracts), information about activity levels and costs is not normally required. As a result, mental health providers are not held accountable for activity levels and are able to change these to manage their financial position.

- 23 Two other factors may also have a bearing. Although approximately one-third of acute trusts and MHTs are involved in the delivery of private finance initiative (PFI) schemes<sup>1</sup> the capital values of these schemes across the sectors are very different. In the acute sector the capital value is approximately £17 billion, and in mental health the figure is approximately £0.7 billion, so costs in this sector are therefore significantly lower. If MHTs do not have to focus on managing large capital projects to the same extent as acute trusts, it may be easier to concentrate on managing their financial position.
- 24 We also found that strategic health authorities (SHAs) were more likely to provide financial support for MHTs than acute trusts. One possible explanation for this is that the sums required are much smaller in mental health than the acute sector and can therefore be more easily supplied. Of 12 MHTs heading towards an end-of-year deficit larger than or equal to £0.5 million in 2004/05, 83 per cent (10) received funds from their SHA, compared with just over one-third (30) of acute trusts (**Table 1**).

**Table 1**

**Volume and proportion of support provided by SHAs to trusts in mental health and acute sectors**

	Number of trusts	Number of trusts with deficit of $\geq$ £0.5m before support given	Financial assistance required for these trusts with deficit of $\geq$ £0.5m	Total financial support given (by SHAs and NHS Bank) to these trusts with deficit of $\geq$ £0.5m	Trusts receiving sufficient support to at least break even
Mental health trusts	63	12	£23.49m	£24m	83%
Acute trusts (excl. FTs)	131	84	£655.41m	£316.79	36%

**Source:** Trust annual accounts, 2004/05

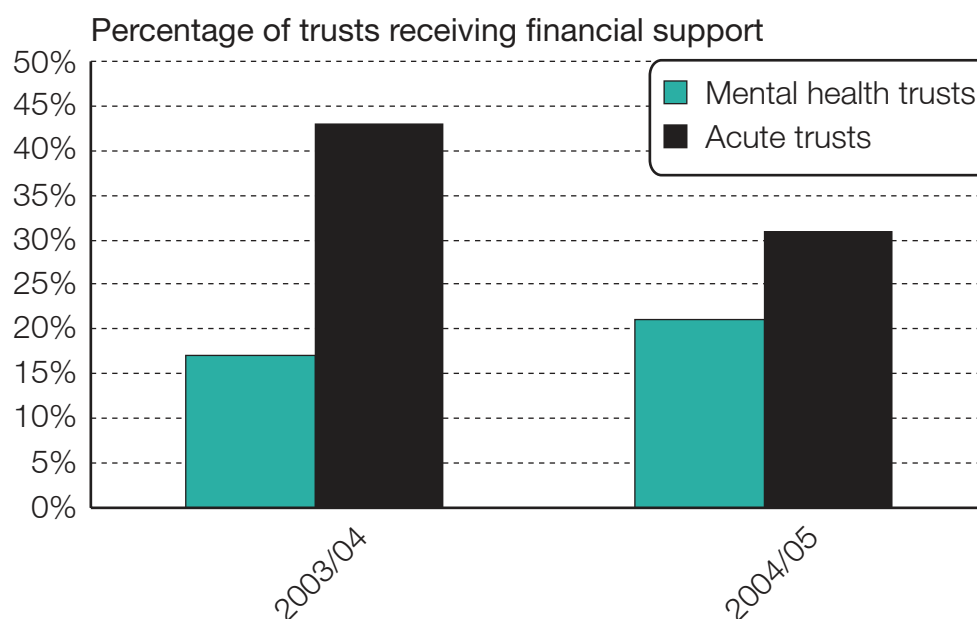
<sup>1</sup> Both operational and non-operational, prioritised and non-prioritised PFIs.

- 25 In addition (see **Figure 2**) it appears that over the period 2003/04 to 2004/05, in the context of a rising rate of deficits in the acute sector, SHAs have supported a diminishing percentage of acute trusts. Only 31 per cent of acute trusts needing financial support received any in 2004/05 compared with 43 per cent the year before. This can be contrasted with a growing level of financial support (21 per cent compared with 17 per cent) over the same period for MHTs. In any case, SHAs will not provide either sector with such support in the future.

**Figure 2**

**Percentage of trusts receiving financial support**

Over the period 2003/04 to 2004/05, in the context of a rising rate of deficits in the acute sector, SHAs appear to have supported a smaller proportion of acute trusts.



**Source:** Trust annual accounts, 2003/04 and 2004/05

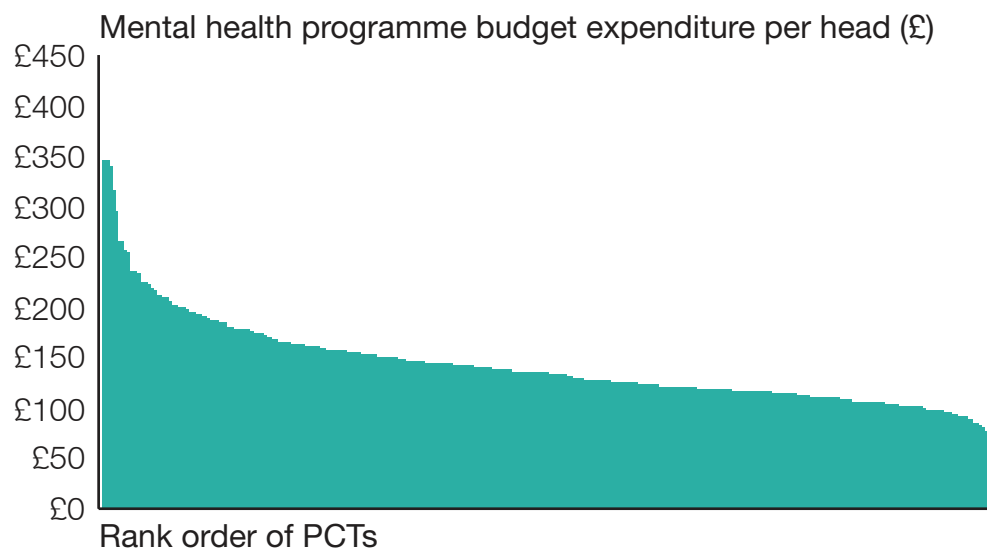
## Relating expenditure to activity and need

- 26 The headline figures for financial standing in mental health compared with the acute sector are clearly good: however, this is only one measure of effective financial management.
- 27 A basic principle of financial management is the need to understand the drivers behind expenditure decisions, that is, being able to relate money to activity and then apply resources where they are needed. MHTs need to be able to match costs to activity and commissioners need to understand how resources relate to need in their local population in order to plan spending and investment.
- 28 To explore this further, we looked at PCT expenditure on mental health, drawing on DH programme budget data. It is important to note that programme budget data has limitations, which need to be considered when drawing conclusions from its analysis. The data help us to draw a clearer relationship between health needs and levels of investment, but it is not yet possible to compare mental health and acute sector spend in these terms.
- 29 Although the overall mental health programme budget share (which covers spend on all ages and specialised care, including community drugs costs) is £7.2 billion, and accounts for 12.2 per cent of national NHS spend, this is actually lower than levels would suggest if spend were related proportionately to need. **Figure 3** shows the variation in PCT expenditure on mental health across England as a whole. Some (predominantly, but not exclusively, those in rural settings) spend less than £75 per head per year whereas others (PCTs in central London) spend over £300.
- 30 In looking at the variation, we extended the work undertaken by The King's Fund report (**Ref. 16**) in London, which explored the relationship between need and spend using three different multivariate models. By factoring in population density, age distribution, gender, ethnicity, crime and unemployment, the authors were able to account for a maximum of 69 per cent of variance in NHS expenditure: more than could be accounted for alone by indices of social deprivation (the York index) or mental health need (the Mental Illness Needs Index, MINI). However, some localities were spending up to 67 per cent less than expected and others 29 per cent more. The authors explained this situation in terms of different levels of priority afforded to mental health coupled with poor information.

### Figure 3

#### Variation in PCT spend on mental health

Some PCTs (predominantly, but not exclusively, those in rural settings) spend less than £75 per head per year whereas others (PCTs in central London) spend over £300.



Source: Programme budgets 2004/05

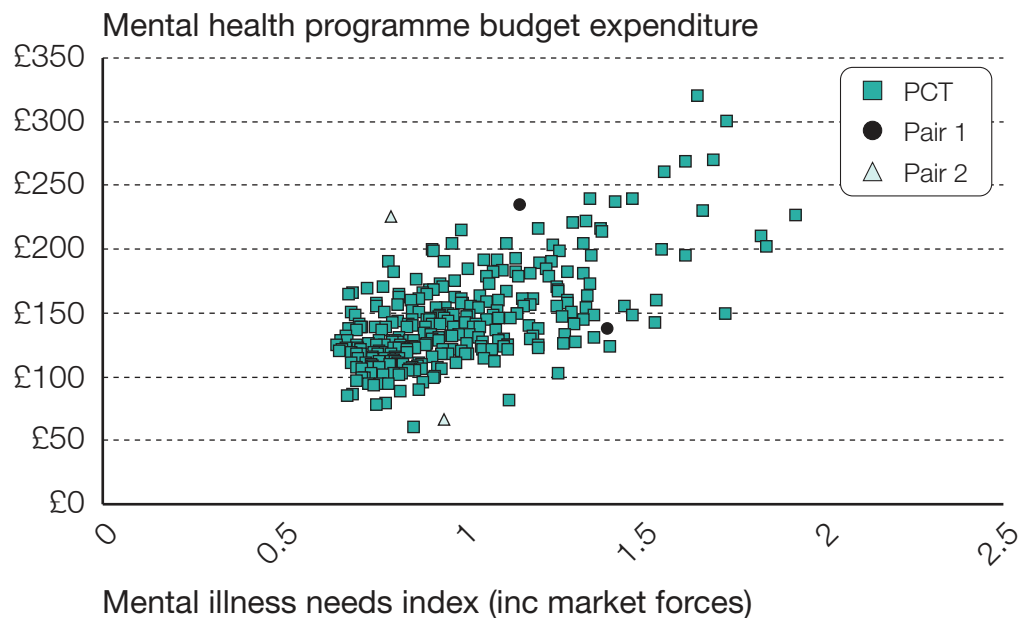
- 31 **Figure 4** shows the relationship across England between need (as assessed by scores for the population on the MINI<sup>1</sup>) added to the Market Forces Factor (MFF) (designed to correct for unavoidable variations in healthcare costs around the country) and expenditure per PCT. As expected, spend is related to need. However, we found that need accounted for less than half (42 per cent) of the variation in PCT spend. One-third was due to variation in scores on the MINI, a little less than the 45 per cent of variation between London PCTs described in the King's Fund report. **Figure 4** furthermore shows that there is wide variation in spend between PCTs serving populations in the most deprived areas. Overall, our data indicate that spend and need are correlated, and our findings are similar to those reported by the King's Fund. But other factors are needed to explain spending variation.

<sup>1</sup> Glover, G, Arts, G and Wooff, D, A needs index for mental healthcare in England based in updatable data, *Social Psychiatry* (2004) 39: 730-738.

**Figure 4**

**Relationship between need and spend illustrating evidence of cross-subsidisation of spend between neighbouring PCTs**

There is wide variation in spend between PCTs serving populations in the most deprived areas.



**Source:** Programme budgets 2004/05, DH allocations

32 One explanation to account for the unexplained variation is a degree of cross-subsidisation between PCTs, given our finding that there are some relatively high-spending PCTs that are geographically adjacent to PCTs with very low spend on mental health. Four pairs of neighbouring PCTs (in one case a third PCT was involved) showed this pattern to a significant degree (**Figure 4** highlights two examples of neighbouring PCTs with inversely proportional spend). There may be other, less visible examples where this is also occurring. Although there may be arrangements in place to cross-charge, or an understanding between the PCTs, where one may well be the lead mental health commissioner, PCT leads contributing to our discussion said there was little rationale behind the practice. In any event, plans to reorganise commissioning and merge PCTs should reduce cross-subsidisations between neighbouring PCTs.

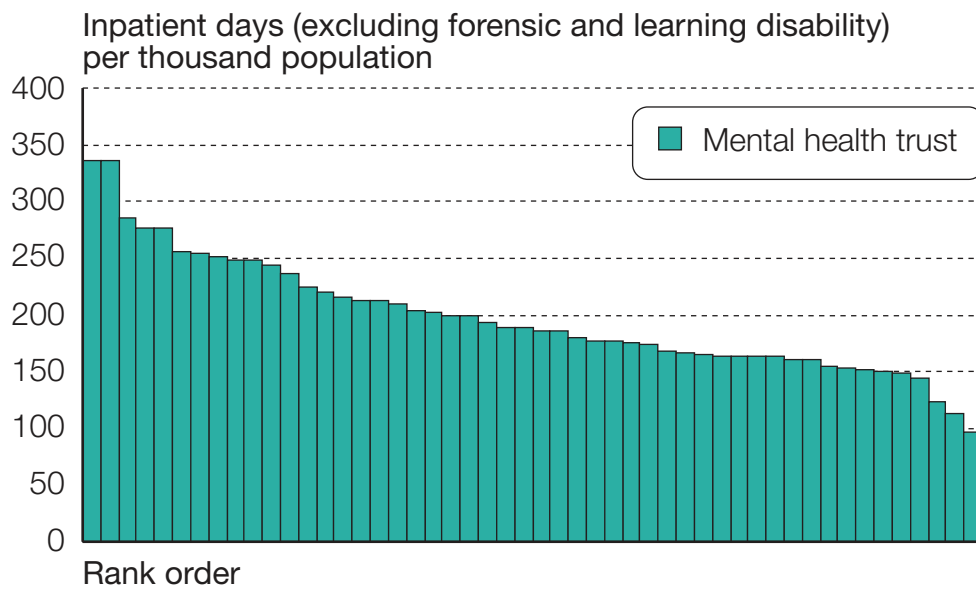
- 33 Cross-subsidisation is also thought to occur between PCTs and LAs. Consequently, we explored whether high-spending PCTs spend more because their LA spends less or vice versa. After taking account of need, we found no observable relationship: both LAs and the NHS spend more where deprivation<sup>1</sup> is high. This finding goes some way to dispel the myth that councils have to spend more because the NHS is under-funded or that the NHS has to spend more because councils are not investing enough.
- 34 If population needs and cross-subsidisation cannot account for all the variation in expenditure, two possible further factors should be considered. First, that MHTs with higher costs for the same level of service are potentially inefficient, and second, that providers deliver different volumes of activity for a given population.
- 35 Evidence relating to the reference cost index (RCI), a measure permitting some comparison between trusts in relation to their efficiency, suggests that levels of efficiency within MHTs do not vary by much. It is difficult to get an accurate picture of efficiency, however, given data limitations. Having said this, PCTs served by the higher cost MHTs (in other words, RCI over 107 per cent) do tend to spend slightly more. There is also a tendency for PCT providers of specialised mental health services to be slightly more expensive than specialised MHTs, given the low volume of the services provided.
- 36 There is also evidence that variation can be partly explained by looking at volumes of service provision. Some MHTs deliver three times more activity per head of population than others: more than can be explained by the demands of population need alone. Also, PCTs buying services from those MHTs with high levels of service provision spend significantly more per head than would be expected on the basis of their population size and need, even allowing for market forces. **Figure 5** shows the wide variation in activity using the number of inpatient bed days, even though this measure is a poor proxy for mental health activity as a whole.

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<sup>1</sup> Measured by the Index of Multiple Deprivation (IMD).

**Figure 5**  
**Mental health activity per head of population**

There is wide variation in activity using the number of inpatient bed days, even though this measure is a poor proxy for mental health activity as a whole.



**Source:** TFR2 2003/04, MHT annual reports 2003/04

- 37 The most appropriate explanation to account for the majority of unexplained variation appears to be historical. Cross-subsidisation and differences in provider efficiency and activity alone are not sufficient to explain it. Variation in need is also insufficient. Indeed, several MHTs reported that their PCTs had simply rolled forward block contracts from the previous year – a common compromise in the absence of accurate information to support an alternative approach. Few PCTs also appear to have undertaken detailed or more complex needs-based commissioning or have in place the financial management arrangements that would ensure a more robust approach. Overall there appears to be no clear rationale or appraisal of investment and outputs.

## Recommendation

**PCTs should benchmark their own expenditure compared with population need against that of their peers in order to account for and address any unexplained expenditure variation and to inform future investment decisions.**

## Looking beneath the headlines

- 38** The headline figures for financial standing in mental health compared with the acute sector are clearly good. However, the evidence points to considerable variation in expenditure on mental health across PCTs, some of which appears to be due to historical factors rather than considered investment. In addition, the nature of the existing financial regime in mental health makes it difficult to get a clear picture of performance across the sector. MHTs cannot take for granted that their financial performance and financial management arrangements are sound. In the following chapters, we look at cost structures, pressures and risks facing mental health providers and commissioners and review financial management arrangements in more detail.

# 3

## Cost structures, pressures and risks

This chapter describes the leading risks and pressures identified by mental health providers and commissioners compared with the acute sector. Although cost structures and pressures are broadly similar across the two sectors, there are some differences that will represent a risk to the management by MHTs of their business in the future.

Cost structures in mental health and acute trusts are similar, although MHTs have a particular issue with bank and agency staff

- 39 Mental health cost structures and cost pressures are similar to those in the acute sector. According to trust annual accounts, income from activities grew by just over 11 per cent in both sectors between 2003/04 and 2004/05 (see **Table 2** below)<sup>1</sup>. This figure is made up of income from activities earned under contracts with NHS bodies and others for the provision of healthcare services, including income for forensic provision, learning disabilities and older adults' services. This disguises considerable variation in levels of expenditure by PCTs on mental health services, as discussed in **Chapter 2**.

**Table 2**

### Increase in income (from activities) in mental health and acute trusts

	2003/04 (£m)	2004/05 (£m)	Percentage increase
Mental health trusts	£4,675	£5,198	11.2
Acute trusts	£20,238	£22,485	11.1

**Source:** Trust annual accounts 2003/04 and 2004/05

<sup>1</sup> Some organisations were excluded from the analysis because of organisational change between 2003/04 and 2004/05 (eg, FTs in the acute sector and trusts where a merger had taken place).

- 40 Staff salaries and wages represent the leading cost in both sectors and are a significant cost pressure: 74 per cent in MHTs and 69 per cent in the acute sector in 2004/05. The pay bill rose by 12.5 per cent and 13 per cent in the mental health and acute sectors respectively between 2003/04 and 2004/05. *Agenda for Change* (Ref. 22) represents a significant cost pressure for both MHTs and acute trusts. Almost all MHTs who responded to our questionnaire reported this, and costs ranged between £74,000 and £2 million.
- 41 Many MHTs find the cost pressure from agency staff challenging to manage. MHTs spend proportionately almost twice as much as the acute sector on agency staff costs<sup>I</sup>. In 2004/05 this accounted for 4.5 per cent of mental health expenditure as compared with 2.5 per cent in the acute sector. Our respondents reported costs of up to £9.4 million per trust but DH figures<sup>II</sup> show rates in some trusts of up to £20 million, amounting to over £300 million nationally. In fact in 2004/05, 28 per cent of all medical locum (agency staff) spend was in MHTs<sup>III</sup>. We found several examples of good practice. Humber Mental Health Teaching Trust, for example, has entered into a partnership with a North Lincolnshire Purchasing Confederation, which has helped them to reduce their costs in this area (Case study 1).

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### Case study 1

#### Humber Mental Health Teaching NHS Trust

In North and East Yorkshire, contracts for the appointment of agency staff for Humber Mental Health Teaching Trust are now made by the Northern Lincolnshire Purchasing Confederation. This arrangement, alongside better coordination of the use of bank and agency staff within the Trust, has led to a significant reduction in costs.

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<sup>I</sup> Non-NHS staff line in trust annual accounts.  
<sup>II</sup> [www.ParliamentToday.com](http://www.ParliamentToday.com) 21 April 2006.  
<sup>III</sup> 2004/05 trust financial returns.

- 42 Cheshire and Wirral Partnership Trust undertook an audit with their SHA designed to improve the management of temporary staff using NHS Professionals, an England-wide service designed to bring greater coordination and consistency to the use of temporary agency staff inside the NHS (**Case study 2**).

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## Case study 2

### Cheshire and Wirral Partnership NHS Trust

The Trust undertook an audit with the SHA based on 35 standards set out in the Health Service Circular (2001/02). In April 2005 the Trust initiated a project to ensure that all wards and departments within the Trust complied with an agreed commissioning and controls process. The SHA allocated a £40,000 project grant to procure software, to map current services and produce the business case. It is projected that replacing agency and overtime staffing with bank staffing will make a saving on agency costs of £81,277 in year one and £116,110 in year two. This is based on 2004/05 expenditure for agency nursing of £580,551.

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- 43 Drug costs are a commonly reported cost pressure across all sectors of the NHS. However, in MHTs they represented just over 1.5 per cent of turnover compared with 6.2 per cent in the acute sector in 2004/05. The proportion spent on drugs is usually lower in mental health than in the acute sector. In 2004/05, however, the size of the difference can be explained by a drop in mental health drug costs of 46 per cent. This fall has been attributed to the fact that a leading anti-psychotic drug came off patent, and therefore reduced significantly in price.

OATs represent a particular risk. The financial consequences are not well represented in trust annual accounts and clinical decision makers are seldom informed about the financial implications of their practice

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- 44 Management of in-year cost pressures rests on good-quality data about current performance and identified risks. It requires clear profiling of costs and cashflow over time. The majority (70 per cent) of respondents said they manage unforeseen in-year cost pressures satisfactorily or well. However, only a quarter said they had a sound longer-term approach to address in-year cost pressures.

- 45 OATs are an example of a recurring cost pressure that MHTs can find difficult to manage. OATs arise if MHTs refer patients to other providers, including those in the private and/or non-statutory sector when essential treatment cannot be supplied locally. This can lead to disagreements about who should retain financial responsibility for the patient once the episode of care is complete. In addition, care planning can be poor if information about the client is not shared between the host referring agency and the new provider. Above all, a poor connection between those with responsibility for decision making and those with responsibility for managing the budget can lead to poor management of OATs spend.
- 46 At present, it is not possible to obtain accurate information from trust financial returns about OATs. Commissioners sometimes bear the costs of OATs and in some cases the MHT carries responsibility. Furthermore, only a proportion of OATs are reflected in the line in the trust annual accounts concerning spend on non-NHS providers. This fell by 7 per cent in 2004/05 although still accounted for over six times as much (3.3 per cent) in mental health as in the acute sector (0.5 per cent).
- 47 Some trusts have managed to reduce their OAT costs to zero whereas others spend a significant amount; nearly half of our respondents reported cost pressures of between £30,000 and £2.6 million. If those with responsibility for the budget do not directly manage the decision about referrals (for example, if clinicians in the MHT or the acute sector making the OAT decisions and managers with responsibility for the budget are not communicating appropriately, or if information is inadequate) costs can be difficult to control. Several actions are likely to improve practice where this occurs; better information and more effective financial governance is crucial. An example of good practice is provided by East Kent Partnership Trust (**Case study 3**).

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### Case study 3

#### East Kent NHS & Social Care Partnership Trust (now Kent & Medway NHS & Social Care Partnership Trust)

In East Kent, a mental health OATs panel was established, led by the clinical director of the Trust. The group considers non-emergency cases and supports decisions about referral to a specialist service provider. If the referral is refused, it goes back to the referrer with reasons and suggestions for how to source treatment locally. Emergency referrals (for example, out of hours or mother and baby referrals) are dealt with by the crisis assessment team who monitor performance. A risk-sharing

arrangement is also in place to share over- or under-spend on OATs and this has had the effect of increasing financial control and reducing costs.

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- 48 Ideally, no trust should be required to pay an OATs bill for a patient where the decision has been made by a third party unless clear, written protocols have been agreed between them and are widely shared. Each trust should also have clear protocols governing how decisions should be made by staff to authorise OATs and how the financial consequences should be recognised. OATs spend should be clearly identified as a line in the trust budget (separately identifying expenditure for PCTs and trusts) and monitored. OATs spend should also be disclosed in the notes of the trust accounts where they represent a material cost.

### Recommendation

**All trusts should have explicit, agreed and communicated agreements for purchasing OATs. No trust should be required to pay an OATs bill for a patient where the decision has been made by a third party unless clear, written protocols (including risk-sharing agreements) have been agreed between them and widely shared. Each trust should have clear protocols governing how decisions should be made by its own staff to authorise OATs and how the financial consequences are identified, recorded and monitored.**

- 49 There are also other benefits of improving information about OATs as the example from Lancashire Care Trust (**Case study 4**) illustrates. By providing better information, the Trust was able to generate additional income.

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## Case study 4

### Lancashire Care NHS Trust

Like many MHTs, Lancashire Care had suffered from an historic lack of information about the provision of treatment to patients from outside their catchment area. As a consequence, the Trust was not funded for work being undertaken. Once they implemented the new national care record service as part of the NHS Connecting for Health programme, they were able to secure additional income of around £300,000 in the first year.

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In addition to cost pressures, MHTs have significantly more provider partnerships than acute trusts and these bring particular challenges

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- 50 Partnerships with external providers are commonly developed to deliver services across the NHS, but mental health providers have almost six times as many as the acute sector, reflecting the long-term complex care needs of people with mental health problems. Partnerships are made with a variety of organisations: LAs, PCTs, other NHS providers, drug action teams, ambulance trusts and non-statutory charitable and private sector providers. Ten MHTs (18 per cent) reported between 6 and 11 significant commissioner/provider partnerships and 33 (62 per cent) reported between 1 and 5. Most partnerships (almost 80 per cent) are relatively small in financial terms, but the remainder (42 contracts or 21 per cent) each cover more than 1 per cent of the trust's turnover, and this represents a key financial risk if they are poorly managed.

The quality of the relationships between MHTs and their commissioners is variable and presents risks, although there are examples of good practice

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- 51 While relationships between commissioners and providers are an issue in general in the NHS, this is particularly true of mental health. Services are commissioned locally by one PCT taking lead responsibility. In some parts of the country, joint commissioning arrangements with LAs are in place although in others (care trusts) these arrangements are firmly embedded in the trusts' legal framework. In all cases, the quality of the relationship underpinning the partnership between parties is important. However, our fieldwork identified that the quality of relationships with commissioners is currently

variable. Almost half (47 per cent) of respondents said their commissioners failed to work in effective partnership with them. Eighteen (34 per cent) said commissioners failed to engage and 31 (59 per cent) said their commissioners failed to prioritise mental health services appropriately. By contrast, the majority of respondents (88 per cent) reported very good relationships and regular information exchange with their SHAs. PCTs explained that SHA requests for information carried more weight, which can often undermine local negotiations between providers and commissioners.

## Recommendation

**Joint commissioning arrangements between PCTs and LAs, through a joint commissioning team or partnership board should be strengthened to support:**

- planning for current and future mental health needs;
- commissioning through service specifications and SLAs;
- the monitoring and performance management of service suppliers around, for example, expenditure, demand, budgetary pressures, volume and quality of services;
- service development and improvement;
- the overcoming of barriers to effective financial management caused by different financial regimes, different information and systems for data collection; and
- the achievement of local and national targets.

**52** Commissioners we spoke to were often frustrated at not having regular routine information about activity: this has a serious impact on their ability to commission mental health services effectively. Two-thirds of our respondents admitted that the quality of their information reporting to PCTs was poor. Indeed, very few MHTs said they were excellent at any aspect of information provision for stakeholders. Some PCT commissioners are therefore starting to build new information requirements into their existing contracts. Others, however, said they are waiting for new commissioning arrangements within the NHS to be rolled out before they make any changes (**Ref. 23**). The quality of information flows has a further impact on provider/commissioner relationships.

## Recommendation

PCTs should ensure that their contracts with MHTs include the following specifications on information flows and performance monitoring:

- information provided quarterly to enable the commissioner to monitor both the activity level set out in the SLA and progress on mental health targets;
- timely, validated information, and details of any variations; and
- sanctions (for example, a financial penalty relating to the baseline contract value) in the event that timely and complete information fail to be provided.

- 53 We discuss examples of how to address issues relating to both partnerships and information in **Chapter 4**.

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The leading risks for the future are perceived by MHTs to be the implementation of PbR in the acute sector, development of PbR within mental health, the introduction of FTs and other aspects of NHS reorganisation, such as practice based commissioning (PBC)

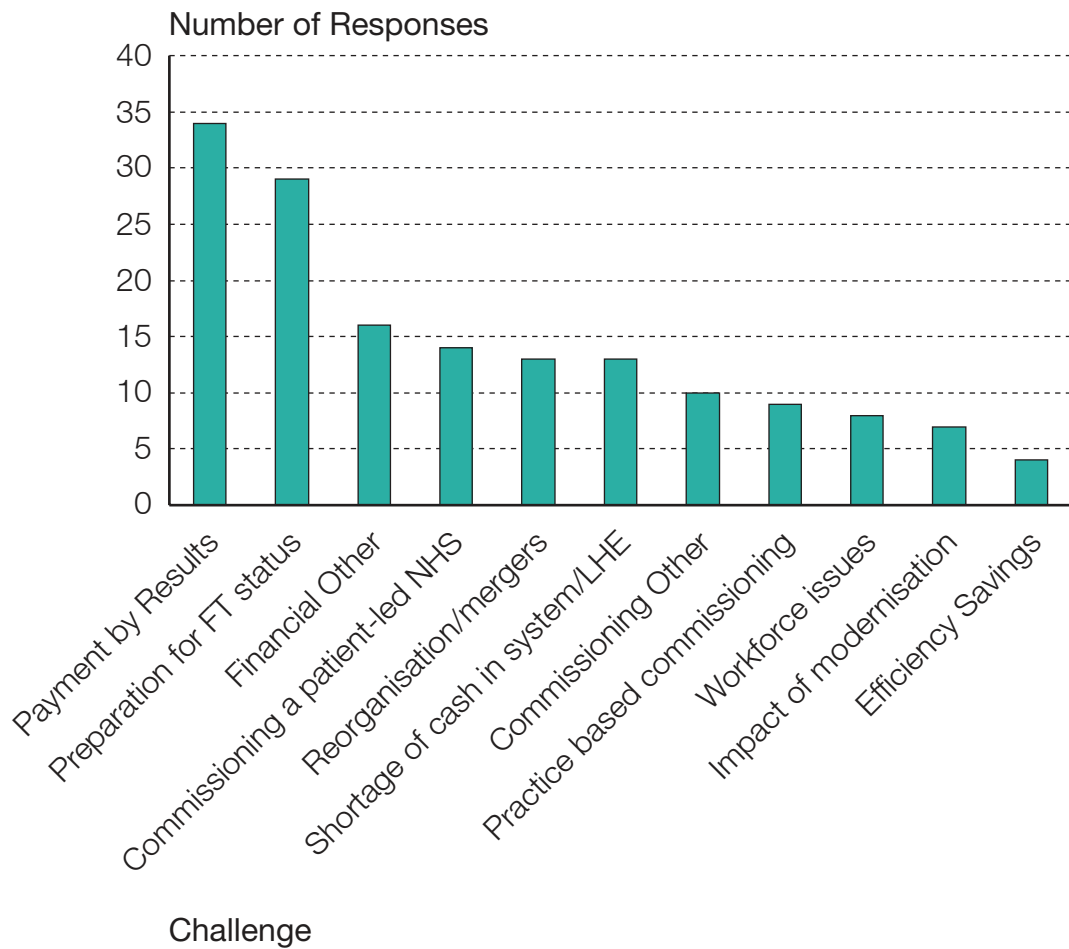
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- 54 We asked mental health providers about their leading cost pressures and future risks (**Figure 6**). PbR was identified as the leading risk by 64 per cent of respondents. Here, MHTs were concerned both about the absence of PbR in mental health and the impact upon them of its operation in the acute sector. This was closely followed by the challenge presented by making a FT application (55 per cent).

**Figure 6**

**Financial management challenges in mental health**

Payment by Results was identified as the leading risk by 64 per cent of respondents.



Source: Audit Commission

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Implementation of PbR in the acute sector is perceived as a threat to MHTs and has been identified as a leading risk

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- 55 Until PbR is introduced for mental health, it is difficult for MHTs to measure their performance, assess the efficiency of their services and deliver value for money across the sector. There is still uncertainty about what PbR will look like for mental health. The approach taken in the acute sector is not directly transferable. A sector-specific model that provides greater transparency and a clear link between activity and funding is being developed.
- 56 The DH has commissioned the HSCIC to develop currencies and casemix measures to inform and set the mental health tariff, building on care packages under the Care Programme Approach – the system used to outline secondary care for people with severe mental ill-health. This work is linked with a pilot of PbR being undertaken in trusts in the North East of England (**Case study 5**). Although the work shows promise, it is unlikely to be rolled out more widely before 2007/08 and PbR is unlikely to be implemented across the mental health sector before 2009.

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### Case study 5

#### Mental Health PbR Care Packages Research Project

This project is one strand of the work commissioned by the DH with the HSCIC, to develop currencies for mental health PbR. It is led by the National Institute for Mental Health (England) and North East Yorkshire Health. Seven trusts are involved:

- South West Yorkshire Mental Health NHS Trust
- Humber Mental Health Teaching NHS Trust
- Doncaster & South Humber Healthcare NHS Trust
- Tees & North East Yorkshire NHS Trust
- County Durham & Darlington Priority Services NHS Trust
- Leeds Mental Health Teaching NHS Trust
- Newcastle, Northumberland & North Tyneside Mental Health NHS Trust

The aim is to test a model, developed in South West Yorkshire Mental Health Trust, that groups service users of working age into 1 of 13 clusters to support development of a cost currency for mental health PbR. Participating trusts are collecting data that will be analysed to determine:

- if a needs assessment tool can be used across the seven trusts to place service users into a cluster;
- if the algorithm used to make cluster placement is reliable across the seven trusts; and
- how current activity compares to standardised packages of care.

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- 57 MHTs perceive earlier implementation of PbR in the acute sector as a threat to them. In the context of a local economy characterised by deficits, strong acute providers or weak commissioning, they fear that commissioners will fail to prioritise mental health interests, taking advantage of the opportunity presented by the absence of a national mental health tariff to make cost reductions or leave mental health until last in the queue. This is one reason that some trusts, like the Devon Partnership Trust (**Case study 6**), have made a start on preparing for PbR now.

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### Case study 6

#### Devon Partnership NHS Trust

Although PbR is not due to be implemented nationally before 2009, the Trust decided there would be value in making a start. Commissioners had expressed frustration at the lack of information available and it was clear that there were other benefits in terms of closer involvement in financial governance of clinicians and service managers. The Trust is operating a simple form of PbR for forensic services already and will include more services over the next two years.

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System reform and organisational change, including the development of FTs should, if managed well, drive improvement in relationships with commissioners, an area where many MHTs report a lack of engagement and interest

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- 58 All trusts, including MHTs, are expected to be in a position to apply for FT status by 2008. Preparation for FT status was identified by 55 per cent of our respondents as a leading risk. Monitor's authorisation process for the acute sector involves an assessment of financial position, recent performance, risk identification and forward planning. To assist MHTs in this process, the DH and Monitor have produced a guide, *NHS FT Whole Health Community Diagnostic Programme New Guidance*, and an adapted package of diagnostic tools for SHAs and MHTs to assist in the roll-out of the FT programme<sup>1</sup>.
- 59 In autumn 2005, representatives from acute, mental health and ambulance trusts were invited to attend one of five seminars held by the Audit Commission across England. Acute trusts described some of the advantages and challenges posed during the FT application process (summarised below).

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### Advantages of becoming a FT include:

- financial freedoms;
- increased board skills;
- improved commissioning;
- clearer partnerships;
- opportunities for innovation; and
- clarity in service provision.

**Source:** Audit Commission Autumn 2005 seminars

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<sup>1</sup> *NHS FT Whole Health Community Diagnostic Programme New Guidance*, DH & Monitor (May 2006) Gateway reference numbers: 6584 & 6582 date [www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/SecondaryCare/NHSFoundationTrust/NHSFoundationTrustBrowsableDocument/fs/en?CONTENT\\_ID=4124694&chk=hj3g%2BQ](http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/SecondaryCare/NHSFoundationTrust/NHSFoundationTrustBrowsableDocument/fs/en?CONTENT_ID=4124694&chk=hj3g%2BQ).

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### Challenges for MHTs of applying to become a FT include:

- maintaining a cash balance;
- establishing a secure business and financial plan;
- preparing the board;
- engaging all stakeholders;
- providing information to support forecasting, monitoring and reporting; and
- financial risk-sharing.

**Source:** Audit Commission Autumn 2005 seminars

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- 60 Although MHTs demonstrate a good understanding of their local communities and their needs, which is a requirement for FT status, many will be severely challenged to demonstrate a clear relationship between their business and financial plans, costs and volumes of activity. An NHS FT's asset status is tested formally by Monitor and providers are required to make a list of their assets publicly available. One difference between the acute and mental health sectors concerns their asset base to turnover ratio. The acute sector has an 80–90 per cent ratio, whereas mental health providers have a ratio that varies between 15 and 92 per cent (**Ref. 24**). Some MHTs are concerned that the high cost of renting and maintaining buildings in a poor state of repair, coupled with their ownership of fewer capital assets, might restrict the strength of their applications.
- 61 Among the smaller risks identified by respondents, changes in commissioning were seen as both an opportunity and a challenge. PBC (**Ref. 25**) is designed to support GPs to improve referrals and treatment decisions that best fit patients' needs. It should also help to facilitate the efficient delivery of effective services across organisational boundaries. Mental health has not featured significantly in indicative budgets under PBC to date, nor was mental health often included in PBC's forerunner of GP fundholding and total purchasing pilots in the mid-1990s. There are benefits in commissioners and MHTs discussing the implications and opportunities, both clinically, and in terms of the financial arrangements of PBC (**Ref. 26**). Without dialogue, there is a risk of widening the functional and financial divide between primary mental health and secondary mental healthcare: an outcome that is unlikely to be consistent with the overall efficiency of the mental health sector, or in the interests of service users and carers who cross these boundaries frequently.

- 62 Other risks identified by our respondents include the impact of policy documents such as *Creating a Patient-led NHS (Ref. 27)* and *Commissioning a Patient-led NHS (Ref. 28)*, which set out plans for NHS organisational change. As a consequence, mergers between provider PCTs are now being planned and models for PBC are starting to emerge. Wellbeing, choice, independence and community services, traditionally the domain of primary care, were given a significant level of new priority in *Our Health, our Care, our Say (Ref. 29)*, which set a new direction for NHS and social care services.
- 63 In this chapter, we have summarised the cost pressures and risks reported by MHTs; it is clear from their responses that they are concerned about the future. Preparing for FT status, particularly in the context of poor information about activity, costs and outcomes, will be a challenge and health service reorganisation will make further demands. In this context, it will be important for MHTs to review and strengthen their existing financial management arrangements: this will be discussed further in the next chapter.

# 4

## Strengthening financial management arrangements

Drawing on findings from our review of financial standing, cost pressures and risks, this chapter looks in more detail at the financial management arrangements in place in MHTs and identifies areas for improvement. Having the right information infrastructure to support effective financial management is a critical part of this. Implementing these recommendations will help MHTs reduce the risks presented by NHS reorganisation and financial system reform and should help them prepare for FT applications.

- 64 Many NHS bodies need to improve their financial management arrangements (**Ref. 30**). PbR, growth in the use of independent healthcare providers, changes in commissioning and challenges posed by deficits within the NHS will intensify uncertainty about income and expenditure levels across the NHS.
- 65 For MHTs there are additional demands, despite their good financial standing. The nature and extent of their provider and commissioning partnerships, contract arrangements, and complex stakeholder relationships mean that financial management needs to be particularly robust, ideally moving towards the standards set out in *World Class Financial Management*. The nature of the current financial regime and delays in developing and implementing PbR present challenges to achieving these standards and making applications for FT status. A guide<sup>1</sup> to help MHTs achieve FT status published by DH and Monitor sets out the particular issues that MHTs face, such as financial stability and contracting, governance and partnerships.
- 66 We reviewed existing financial management arrangements in MHTs against the standards set out in *Achieving First Class Financial Management in the NHS* (**Ref. 21**) and *World Class Financial Management* (**Ref. 32**), and identified a number of areas that MHTs might focus on, drawing on the review of cost structures and pressures in the previous chapter. Many of the steps MHTs need to take are no different to the acute sector; however, there

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<sup>1</sup> *Applying for NHS Foundation Trust Status: Guide for Mental Health Trusts*, DH, April 2006. [www.dh.gov.uk/publications](http://www.dh.gov.uk/publications).

are some areas that are specific to mental health. The Audit Commission's new ALE framework, the results of which will be made available alongside the Healthcare Commission's annual health check, will also help assess weaknesses within financial management arrangements.

## Financial governance and leadership

- 67 Financial management is 'about managing performance and achieving an organisation's strategic objectives, as much as about managing money' (**Ref. 31**). The quality of a trust's overall financial culture, what is often termed 'the tone from the top', is a crucial starting point to ensure good financial management throughout the organisation. To become a FT, as well as achieve best practice in financial management, it is essential that there is good corporate leadership to drive the effective financial management arrangements.

**'Good governance leads to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes.'**

**Sir Alan Langlands, Chair of the Independent Commission on Good Governance in Public Services, January 2005**

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The development of financial skills within the trust and effective challenge on financial matters are key parts of financial governance and leadership

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- 68 Non-executive directors (NEDs), and clinicians and managers at all levels, need to understand the financial implications of policies, programmes and activities if they are to make effective, informed decisions based on evidence, and understand the trust's underlying cost profiles and cost drivers. The whole organisation should take collective responsibility for financial matters, not just the director of finance and the finance department.
- 69 Although auditors reported few concerns about members of the finance teams within MHTs, they reported that NEDs in 22 per cent of MHTs need to improve their financial skills, a finding supported by our respondents, only 34 per cent of whom felt that their NEDs were able to provide effective challenge of financial matters. To support members of boards, including NEDs, Somerset Partnership Trust has implemented a programme of training in financial management (**Case study 7**).

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## Case study 7

### Somerset Partnership NHS & Social Care Trust

Somerset Partnership Trust is implementing a programme of financial management training:

- To drive financial management up the agenda due to the nationwide financial problems.
- To encourage NEDs (often without a finance background) to challenge more at meetings, and provide more productive meetings, more debate and so on.
- To supplement the support provided centrally for non-executives which is rather acute orientated and therefore not so relevant to mental health.
- To raise awareness of other related issues (such as commissioning).

Benefits include:

- Much stronger debate and challenge on financial matters leading to more effective board meetings.
- Exploration of areas where there are cost pressures.
- Better information for everyone to support the development of solutions.

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- 70 All NHS bodies are required to have an audit committee to contribute independently to corporate governance, assure an effective framework of internal control and scrutinise financial information and systems on the board's behalf. South Essex Partnership NHS Foundation Trust has developed robust arrangements to oversee its capital expenditure and planning (**Case study 8**). They have also taken steps to provide training seminars for board members.

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## Case study 8

### South Essex Partnership NHS Foundation Trust

In South Essex Partnership NHS Foundation Trust, one of the first trusts to be authorised as a FT, significant time is devoted to financial matters at each board meeting and a series of separate seminars have been arranged to ensure that all board members fully understand the Trust's financial position and strategy. The Board

approves the financial plan at the start of the financial year and monthly financial reports to the Board are prepared. A Board sub-committee oversees the Trust's capital and non-recurrent expenditure programme and the Trust's Executive Team oversees the management of the recurrent revenue plan. A further sub-committee of the Executive Team, involving board members has responsibility for managing the Trust's approach to cost pressures, cash releasing efficiency savings (CRES) and the income generation programme.

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## Recommendation

To support applications for FT status, and ongoing management of the trust, MHTs should take early steps to appraise the general and financial management skills and competencies of board members and, if necessary, provide training on risk and financial management to enable them to take responsibility and provide effective financial challenge.

- 71 Auditors highlighted concerns in just over a quarter of both mental health and acute trusts about clinicians' financial management capabilities, implying they may need support and training. Just over half of our survey respondents had positive comments to make about engaging clinicians in the financial management process, but this should be systematic. This is particularly relevant around the OATs agenda, as identified in **Chapter 3**. It will require a new mindset and culture within the organisation and it is only likely to occur if boards give it priority.
- 72 Morecambe Bay PCT (**Case study 9**) developed a forum to discuss financial management issues – an example of one way to mainstream financial management.

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## Case study 9

### Morecambe Bay PCT

This PCT provider of mental health services is a large organisation (with an annual budget of around £400 million and 2,500 whole-time equivalent staff) spread over a wide geographical area of approx 900 square miles. As well as commissioning services, the PCT is also a significant provider with a budget of over £70 million, covering areas such as primary care, learning disabilities, young people and mental health. To improve communications, particularly on key issues like finance, the PCT introduced the PCT Forum, which meets three or four times per year. It consists of about 100 clinical and non-clinical managers, including some GPs. The Director of Finance has a regular item on the agenda to update all members with financial planning issues. This has been especially important over the last two years as the PCT has been implementing a substantial financial recovery plan, affecting all services (£5 million in 2004/05 and £8 million in 2005/06). The Forum has been instrumental in engaging staff and managers who are able to raise questions and gain a greater understanding of their role in all aspects of planning and financial management. The Forum played an important part in helping the PCT to meet its financial targets in 2004/05.

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Engaging MHT staff in financial management processes; finance and information should be everybody's business

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- 73 It is important that clinical and managerial staff at all levels of the organisation are involved in the trust's financial management processes. Mersey Care NHS Trust (**Case study 10**) is working to ensure effective involvement of staff in financial management.
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## Case study 10

### Mersey Care NHS Trust

Mersey Care NHS Trust faced a number of challenges in relation to financial management, including issues relating to financial stability, balance, and costing. A Finance Committee was formally established as a Board sub-committee to enable the full Board to focus on the key financial management areas. Chaired by the Trust Chairman, membership consists of the Trust Chief Executive and Deputy, the Director

of Finance, the Director of Human Resources, two NEDs and a mental health service user/carer. Senior members of the finance department are required to attend and present reports on their areas of responsibility. The impact has been significant in terms of the quality of discussion and decision making about the Financial Strategy and the Financial Plan for 2006/07. Board members have been able to engage with senior finance professionals and improve their knowledge and competence in relation to financial matters. The Board now has greater assurance in respect of the Trust's current and future financial position.

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- 74 Doncaster and South Humber Healthcare NHS Trust (**Case study 11**) have developed an approach (a budget book) for all wards and departments within each directorate to ensure that clinical staff, as well as managers, are well informed and fully engaged in financial issues.

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### Case study 11

#### Doncaster and South Humber Healthcare NHS Trust

The Trust has developed an approach to engaging wards and departments within a directorate. A budget book is produced annually before the start of each financial year, setting out details of the budgets for each ward and department alongside directorate income. It outlines assumptions made at budget setting and contains details of directors with responsibility. It shows how inflation rates are applied, as well as the CRES required by each directorate. It is adjusted in-year once contract variations are agreed with commissioners. Budgets are then fed into the finance ledger system to control income and expenditure. The book gives a clear indication to directors and ward managers about the action they need to take and helps the Trust to monitor income and expenditure trends throughout the year.

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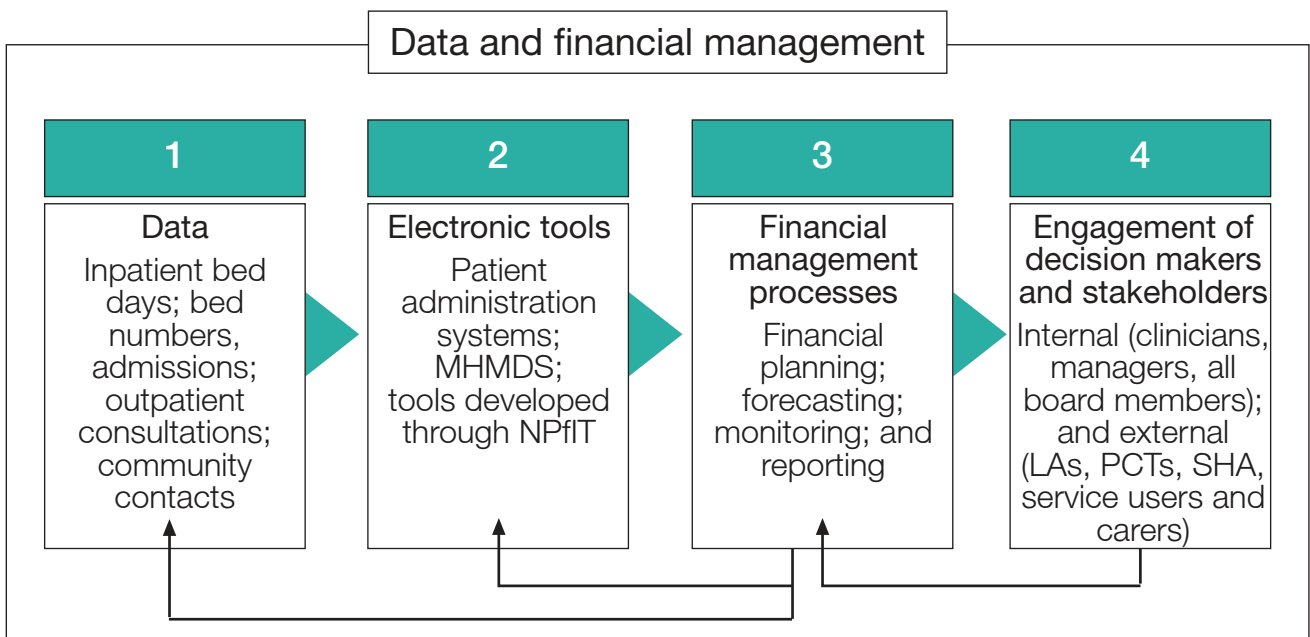
## Information for decision making

**75 Figure 7** illustrates the critical importance of data and information systems in supporting financial management and stakeholder engagement. Accurate, reliable data (point 1) should be integrated into meaningful information (point 2) to inform the trust’s financial management processes (point 3). Together, these components support effective decision making by internal partners such as board members (including NEDs), clinicians and managers (point 4), as well as the effective engagement of external stakeholders such as mental health commissioners, provider partners, service users and carers.

**Figure 7**

### Data and financial management

Data and information systems are critically important in supporting financial management and stakeholder engagement.



**Source:** Audit Commission

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Reliable and good-quality information is often difficult to obtain due to the complexities in the mental health sector, but there are steps MHTs can take to address this

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- 76** Without accurate data about costs, activity or outputs and outcomes (that are then related to one another), it is difficult for information systems underpinning financial management to operate effectively. It is vital that the development of good-quality data, that is, consistent, accurate and timely, is prioritised. Locally this is important for effective decision making. It also supports benchmarking across the NHS. Benchmarking is not widespread in mental health: only one MHT is currently a member of the NHS Benchmarking Club, despite several respondents saying how much they would value benchmarking data.

### Recommendation

**The DH has a key role in encouraging and supporting improvements in data quality through the national performance management framework. In partnership with the HSCIC and the Care Services Improvement Partnership, DH should support the development of a more transparent system for tracking expenditure and measuring activity and outcomes so services can be more closely related to need. This should permit measurement of the impact of change, benchmarking of performance, and support effective financial management by providers and PCTs.**

- 77** As we identified in **Chapter 1**, the availability and quality of mental health data is generally poor. Previous Audit Commission reports on reference costs, waiting lists, and data quality (**Refs. 17, 18 and 19**) all highlight local limitations in mental health data quality, over and above those applying in the acute sector. For example, bed numbers, bed occupancy, re-admission rates and average lengths of stay, as commonly quoted in mental health reports, reflect only a very limited proportion of mental health activity. Community or home-based care has at least as much significance in policy and clinical terms although data and information relating to these activities are much more limited. Although this area is just as important at the commissioning level, the focus of this report is on improving information to support decision making at the secondary care level.

- 78 The MHMDS was developed to provide local clinicians and managers with better quality information for clinical audit, and service planning and management. In 2003 completion became mandatory for mental health service providers; it was hoped that central collection would provide improved national information (to help monitor patterns of services provision as a basis for allocation of resources, for example), facilitate feedback to trusts and help set benchmarks.
- 79 Work undertaken by the Audit Commission (2004/05) on behalf of the Healthcare Commission (**Ref. 32**) identified significant weaknesses in relation to the MHMDS as well as records of ethnicity. The engagement of staff in the task of recording information was reported to be variable. This finding was consistent with feedback from our respondents, 12 (23 per cent) of whom said they did not routinely collect any information for the MHMDS or use this to inform any other pieces of work. Although completion of the MHMDS is mandatory, the information it provides is rarely used internally, if at all. This may be due to perceived inadequacies of the MHMDS, both in terms of data fields and the reliability of completion. In addition, the MHMDS does not cover social care, or treatment provided by the non-statutory sector.
- 80 In time, it is expected that MHMDS implementation and Care Programme Approach data, integrated with a trust's electronic information system, will produce more robust information on patient demographics, clinical effectiveness, activity and overall performance. We therefore recommend that MHTs collect valid data against all key data items in the core MHMDS and use this to inform their work and reports to the board.

## Recommendation

**Good financial management is only possible when financial planning and budget setting are developed alongside service strategies and linked to service activity and outcomes. In this way, financial and operational plans can be linked. MHTs should therefore:**

- collect valid data against all key data items in the core MHMDS;
- collect Mental Health Act-related activity;
- work with their local implementation team to collect data for effective financial mapping<sup>1</sup>; and
- collect information about outcomes.

<sup>1</sup> Adult Mental Health Service Mapping, Durham University [www.dur.ac.uk/service.mapping/amh](http://www.dur.ac.uk/service.mapping/amh).

- 81 Information about the provision of care that crosses health and social care sector boundaries is also problematic. MHTs and commissioners reported that it is unreliable, difficult to enter at local level across multiple sites and/or difficult to access. Data about other important elements of spend is also commonly missing or difficult to identify. Many MHTs acknowledge the difficulty within mental health of capturing accurate information about the effectiveness of, and outcome from, treatment and care. Gaps in this area affect capital as well as revenue planning. Clinically relevant measures of performance (metrics) have been developed by national clinical directors and their colleagues working with the DH<sup>1</sup> that could helpfully be implemented more widely to inform discussion of outcome, which has an important place in the overall assessment of local value for money.
- 82 These issues will be important as MHTs start to consider their applications for FT status. The business case, or service development strategy, that applicant FTs need to develop must demonstrate a connection between costs, activity, outputs and outcomes.
- 83 South Essex Partnership NHS Foundation Trust (**Case study 12**), one of the first trusts to be authorised as a FT, has taken steps to strengthen the reliability and validity of data and the decision making processes that rely on it. The Trust has also engaged clinicians in the process.

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## Case study 12

### South Essex Partnership NHS Foundation Trust

The Trust has taken a number of positive steps to rationalise and improve its information management and technology (IM&T). The Trust's IM&T infrastructure is clear and well integrated. For example, an integrated web-based database accessible via the Trust's intranet is available for clinicians and managers to use when making decisions about admitting a patient to a bed. Clinicians are able to locate patient records and obtain ready access to detailed history, including outpatient appointments and waiting times and any community treatments or contact the patient may have had previously. Clinical staff also participate as members of service boards, with finance and information representatives also in attendance. An audit committee carries overall responsibility for integrating governance of finance, information and service plans.

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<sup>1</sup> The *Better Metrics Project*, 2006. [www.osha.nhs.uk](http://www.osha.nhs.uk).

## Recommendation

**Effective financial management depends on good-quality data. The trust board should adopt a data quality strategy, setting out the priorities for the organisation, and how information will be integrated into the trust's operational, performance management and governance arrangements. It should cover:**

- the relevance of data quality to business objectives;
- the corporate data quality requirements;
- compliance with external standards; and
- security of data.

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Effective information systems or tools should be developed to integrate accurate and reliable data about activity, costs and outcomes

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- 84** Without good information systems, MHTs cannot operate effectively as an organisation. MHTs cannot defend their position in relation to productivity and efficiency gains or changes in the volume of service to be commissioned. MHTs need to address this as a priority in consultation with their commissioners.
- 85** Effective information and tools support clinical and management decision making as well as effective planning, monitoring and reporting. They should facilitate:
- greater ease of patient follow-up after discharge from hospital;
  - better management of waiting lists;
  - clearer and quicker information about bed availability;
  - more effective performance monitoring; and
  - greater safety when access to information is needed in an emergency.

Information from these systems should enable managers to address variances and to support decisions about the use of resources. Again, there are particular issues for mental health in this area.

- 86 Problems associated with incompatibilities between the national patient record systems, electronic records for the Care Programme Approach and the MHMDS are not likely to be resolved until NHS Connecting for Health is fully rolled out (expected in 2010). It is not yet possible to aggregate information about all the complexities in the sector, including the large number of cross-sector arrangements, community provision, and care packages for people with multiple, long-term needs. Some trusts (like the Somerset Partnership Trust, **Case study 13**) have therefore developed bespoke local information systems.

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### Case study 13

#### Somerset Partnership NHS & Social Care Trust

Somerset Partnership Trust has replaced its historic paper-based system for patient records with a fully functioning electronic system for administrative, clinical and patient records. Although NHS Connecting for Health will deliver something similar in due course, the Trust has found it of great value to make a start sooner. Although formal financial savings are difficult to identify, there have been clear benefits in terms of efficiency and effectiveness of communications. The Trust is already able to collect the information likely to be needed as PbR is implemented.

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- 87 Berkshire Healthcare NHS Trust has taken steps to improve data collection and information processes (**Case study 14**).

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### Case study 14

#### Berkshire Healthcare NHS Trust

The Trust identified various issues around data quantity and quality:

- not all clinical data was being accurately collected;
- there were concerns about the future impact of PbR and the need to provide appropriate data to generate the required future cashflows;
- they were keen to exploit information to improve efficiency and effectiveness; and
- they wished to engage more effectively with commissioners by providing better-detailed information regarding services received.

The Trust therefore developed an information recovery plan that included:

- promotion of clinical and managerial ownership of data within each directorate/locality;
- clear protocols/procedures for reporting of monthly activity information and monitoring of all key actions at both a local and executive level;
- a clean up of the database by ensuring that only current patients were open on the information system;
- provision of benchmarking information based on both internal and external data;
- close working with commissioners to understand and meet their information requirements; and
- informal involvement with DH teams to understand and inform the implementation of PbR within mental health.

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- 88 In a period of reorganisation, for example during mergers, effective information systems can be difficult to maintain. Most MHT respondents (68 per cent) reported participating in a recent major reorganisation (over 80 per cent since 2001), and more mergers are planned. In fact, a quarter of respondents identified MHT mergers and reorganisation as a financial challenge. Merging trusts commonly have incompatible financial and information systems which will therefore need to be integrated. The Audit Commission mergers tool can help to manage the risks during transition arrangements to help trusts overcome these issues. Northumberland, Tyne and Wear NHS Trust found the tool most useful during its merger with two other trusts, where challenges include two PFI schemes, a major P21 scheme, planned re-provision of services, multiple and complex commissioning and provider partnerships as well as the task of integrating separate data and information systems.
- 89 Doncaster and South Humber Healthcare NHS Trust have also found a way of reviewing systems and tools to integrating information following a transfer of services **(Case study 15)**.

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## Case study 15

### Doncaster and South Humber Healthcare NHS Trust

The Trust needed to review its identity and corporate arrangements following a transfer of mental health services from North and North East Lincolnshire, and a recent Healthcare Commission Review. The Next Steps Programme Board was established by the Senior Management Team in December 2004 to oversee the work. A single director-level post to manage all clinical and social care services (Director of Operations) was appointed and a trust-wide model for clinical and social care services management was developed, based on clinical groups. Clinical and professional leadership were explicitly promoted and an associated leadership network put in place. The identification of a social care lead for the Trust and development of a social care leadership network were also key components of the strategy. Led by Dr Gillian Fairfield, Chief Executive, revised management arrangements were effectively implemented by July 2005.

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## Financial planning, forecasting, monitoring and reporting to support decision making

Planning, forecasting and budgeting should be well integrated at all levels within the organisation

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- 90 Financial planning and budgeting should be linked directly to the trust's strategic and corporate planning processes, and must involve the whole organisation and not just finance staff. Most MHTs reported having established strategic or corporate plans, and 72 per cent (or 38 trusts) were in the process of preparing or reviewing these, some with future FT applications in mind. In approximately one-third of cases plans were between one and two years old and in 19 per cent (ten trusts) plans were between two and five years old. One trust said their plan was over five years old and two had no plan at all.
- 91 The majority of respondents (70 per cent) said they were 'satisfactory' or 'good' at developing an effective finance strategy, connected to an operational plan that was reviewed regularly. Furthermore, most respondents (60 per cent) believed the links

between their financial and strategic planning were effective although six (11 per cent) highlighted difficulties linking business and manpower planning.

- 92 *World Class Financial Management (Ref. 31)* highlights that financial planning and forecasting should not just be based on historical data, but should also consider future projections. Three-quarters of respondents report that revenue budgets are set on the basis of informed decisions and are agreed by their board. Best practice suggests that revenue budgets should be set according to activity undertaken, and set on a zero basis at the start of the financial year. They should include rolling forecasts reflecting patterns of expenditure, and include finance as well as non-finance information. However, almost half (45 per cent) of MHTs currently fail to meet these standards, that is, they only roll forward the previous year's budget, which is considered to be poor practice. This is a key area for improvement and a particular focus for trusts aiming for FT status. A simple system of indicators, linked to systems for financial forecasting and budget updates, could help to address this. **Case study 16** shows how Mersey Care NHS Trust has made progress in this area.

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## Case study 16

### Mersey Care NHS Trust

A zero-based budgetary approach was adopted for the first time in 2005/06. A detailed budget guidance pack is produced which integrates guidance on the business planning and local delivery plan. Directorates are given a total budget rolled forward from the previous year, minus CRES, reversals and non-recurrent adjustments plus any new development funding and growth. A finance manager works with the directorate to cost the staff and non-pay required to deliver commissioning targets, Trust objectives and required service levels. If costs exceed the available budget, plans are established to bring the service costs back into line. Budgets are reviewed annually. The system encourages more efficient use of resources and enables the finance team to work closely with directorates to achieve a balanced financial plan.

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- 93 Having effective, long-term financial plans in place, informed by strategic objectives, should mean that short-term fixes are not required. Plans should include not just income and expenditure forecasts, but also, importantly, the projected balance sheet and cashflow statements used to inform trust budgets and any major capital and revenue investment decisions. In fact, 94 per cent of respondents reported having effective mechanisms in place to review how they internally prioritise the allocation of capital.
- 94 In order to become a FT, MHTs must, like trusts in the acute sector, show that they are a financial going concern. This means they must demonstrate that they are financially viable and robust in the medium term. Stakeholder engagement, transparency of information, robust planning and firm financial arrangements must be well established in order to achieve this. The service development strategy that applicant FTs need to develop must be supported by a robust financial plan to show sufficient working capital and cash management.
- 95 The challenge of implementing PbR in mental health has implications for financial planning in MHTs. Although PbR will not be implemented for some time, MHTs can learn from the experience of the acute sector, and take early steps to prepare themselves. Acute trusts and commissioners have welcomed the better basis for planning and managing their business that PbR provides. However, the ease with which they have adapted to the new system has depended on their financial stability, their preparedness for implementation, and the complexity of the commissioning environment (**Refs. 20 and 33**). Health bodies that took early steps to strengthen their financial management and information systems in preparation have found implementation of PbR more straightforward. Organisations with weak strategic and financial planning arrangements have had the most difficulty. This has implications for the mental health sector, where commissioning arrangements are relatively complex and information systems and robust planning are a challenge, primarily due to the nature of the current financial regime.

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### Effective reporting is a critical process to aid decision making

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- 96 Unless decision makers are aware of, and involved in, the financial consequences of their decisions, it is difficult to maintain effective control and management of resources. Informed decisions cannot be taken in the absence of effective reporting. Information systems must be flexible enough to support the production of specialist internal reports, as well as reports for commissioners and external stakeholders. Ideally, internal and external reports should contain the same set of financial and non-financial information, covering all the primary financial statements.

- 97 MHTs are already quite good at providing reports for their boards. Auditors report far fewer concerns about MHTs than acute trusts in this regard, a finding supported by feedback from our respondents. Auditors' findings confirm that they are also less concerned about the quality of financial information provided to the board<sup>1</sup> in MHTs compared with acute trusts.
- 98 We examined how effectively MHTs reported on their financial management arrangements. Almost three-quarters of respondents said their board reports included monthly budget monitoring information on an accruals basis, containing both financial and non-financial information. However, we identified that quarterly balance sheets were not often produced, which is of concern.
- 99 In North Cumbria, a more effective and targeted approach to the reporting of financial information helped the Trust as a whole to engage with actions needed to deliver a cost improvement programme (CIP) and make financial savings (**Case study 17**).

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### Case study 17

#### North Cumbria Mental Health and Learning Disabilities NHS Trust

The Trust was facing a significant CIP as a result of a need to modernise services in a health economy in deficit. To improve ownership of the CIP, the Director of Finance developed more detailed finance reports that were presented to the Corporate Improvement Group (executives/senior managers) and to the clinical directors' meeting. The Audit Committee receives a hybrid of Board and executive reports that enable them to review operational issues as well as overall financial performance.

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<sup>1</sup> *The Intelligent Board*, Dr Foster Intelligence (February 2006).

- 100** Acute trusts that have become FTs<sup>1</sup> have highlighted the importance of planning, forecasting and reporting for successful transition. To be successful in their applications, MHTs must develop:
- short- and long-term financial viability;
  - working capital and cash management;
  - good financial control systems;
  - board and senior management skills;
  - cost control and CIPs;
  - effective risk management processes;
  - effective performance management; and
  - robust business planning.

## Working with commissioners

- 101** Mental health commissioners are arguably one of the most important external stakeholders in the mental health field, yet as we have identified, the information currently provided within block contracts is poor and gives little indication of how money is being invested and what is being delivered. This is an area of concern for many commissioners. MHTs should take early steps to develop their relationships with their new commissioners and ensure that robust arrangements are in place to underpin commissioning contracts.
- 102** Commissioners currently report finding it more difficult to obtain good-quality information to support their contracts with MHTs than the acute sector. Only a quarter of respondents reported that their organisations' financial information systems have flexible reporting tools to enable specialist reports for commissioners to be designed. This is important to enable effective commissioning and to promote value for money, and will become even more important as commissioning and contracting arrangements change.

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<sup>1</sup> Feedback from Audit Commission Autumn 2005 seminars for aspirant FTs in the acute and mental health sectors.

## Recommendation

MHTs should provide high-quality, contextualised finance and activity information to their PCT on at least a quarterly basis, so that commissioners are able to link activity to their expenditure and can question any changes. Such information should include the delivery of services by partner organisations on behalf of the MHT.

- 103** Ensuring effective contracting is also an issue for FTs. Contracts between FTs and their commissioners (whether NHS or not) are legally binding and should therefore include specifications to a much higher level of detail, including information about the cost and volume of service provision.
- 104** We identified a number of good-practice examples in our workshops with PCT commissioners. Five PCTs in Leeds are developing shadow cost and volume SLAs with their local MHT which incorporates a penalty for failing to deliver quarterly activity reports. In addition, Leeds Mental Health Teaching NHS Trust has worked with the commissioners to design a template of data fields to collect across both adult and older people's services to support performance monitoring of the contract (**Case study 18**).

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### Case study 18

#### Leeds Mental Health Teaching NHS Trust and Leeds PCTs

Leeds Mental Health Teaching Trust and the five Leeds PCTs are in the process of developing a SLA for their block contract for the provision of mental health and learning disabilities services. The SLA will operate on a shadow service-specific activity-based format, and will represent the first year of a shadow cost and volume agreement to provide a basis for the future development of choice and PbR within mental health services. The implementation and collection of the MHMDS provides the foundation with service activity information, supported by a Care Programme Approach integrated with the Trust's electronic information system. The Trust has worked with commissioners since 2003/04 to design a template of data fields to collect across both adult and older people's services. The aim is to provide information on patient demographics, clinical effectiveness and support activity-based commissioning.

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## Recommendation

PCTs, in their contracts and SLAs with providers, should include detailed service specifications about the mental health activity to be provided. This is particularly important where the range of services is commissioned using a block contract: the DH model contract provides an effective framework for this.

- 105 We also found some examples of good partnership working. In East Kent, a joint commissioning board and performance sub-committee have been established to ensure full and effective communication and decision making about matters that affect all provider partners (**Case study 19**). Here agreement has been reached concerning local performance indicators to support local service and financial planning.

### Case study 19

#### East Kent PCTs, Kent & Medway SHA, Health & Social Care Trust & County Council

A joint commissioning board, accountable to the four East Kent PCTs and Kent County Council, has been established to improve the healthcare and social care services provided for individuals with mental health problems. Effective partnership working is being achieved across the statutory and non-statutory sector, and service users and carers are included in commissioning and decision making. A joint performance management sub-group has been established to receive monthly performance monitoring reports and to monitor progress against financial balance action plans. Local indicators of performance including, for example, access to crisis services, systems to support choose and book, Care Programme Approach, MHMDS implementation and cleanliness have been agreed, based on national standards and reports. Other broad objectives, such as improvements in joint working between NHS and LA services, preparation for moving toward FT status, and robust business processes in SLA negotiation to avoid arbitration are also discussed in these forums.

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## Recommendation

PCT commissioners in consultation with stakeholders and providers should collaborate in the development of a set of key mental health performance indicators. These can be used to support local service and financial planning, improve joint working between NHS and LA services, and help MHTs to prepare for FT. The indicators would ideally include:

- access to crisis services;
- systems to support choose and book;
- care programme approach; and
- MHMDS implementation.

106 In such cases, formal risk-sharing arrangements are critical to effective partnerships, as Barnet, Enfield and Haringey MHT illustrates (**Case study 20**).

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### Case study 20

#### Barnet, Enfield and Haringey Mental Health NHS Trust

This Trust developed a plan to engage partners in effective risk-sharing arrangements. A three-borough devolved baseline budget was based on the 2003/04 outturn. The aim was to share cost risks in a proportionate way with the PCT, reflecting the amount of control the Trust had over costs. For CAMHS highly specialised (Tier 4) referrals, a significant source of overspending (just under £1 million), the arrangements were as follows:

- Risks of changes to average length of stay to be shared 80:20 between the MHT and the PCT, since the MHT has greater control over/ability to reduce it.
- Risks of varying patient numbers to be shared 20:80 because most referrals come from primary care.
- Risks of price variations to be split equally.

The arrangement is subject to annual reviews of baseline budget and the risk-share elements. The Trust expects to achieve significant reductions in expenditure which will be re-invested in CAMHS community provision in the interests of reducing dependence upon inpatient treatment.

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## Engagement of all MHT partners

- 107** One of the key objectives of FT status is that trusts establish stronger connections with their local communities in order to shape the healthcare services to better reflect local needs and priorities. NHS bodies will play a leading role in the development of a patient-led NHS, delivering an improved quality of service for patients and value for money for the taxpayer within the national framework of standards and inspection. Many MHTs find innovative and effective ways to engage service users<sup>1</sup> and carers in the management of their business. In particular, many engage service users in regular review meetings to discuss clinical and service delivery issues (see **Case study 3** for East Kent in **Chapter 3**). However, although the approach to include service users in financial matters has worked well where it has been implemented, it has been undertaken by very few MHTs.
- 108** Contract arrangements with partners for the provision of services vary in their quality as well as their type. Although MHTs reported that the larger contracts are well managed, they admitted that up to 10 per cent of the smaller contracts with LAs, PCTs and charities are of a poor quality.
- 109** Pooled budgets, using the flexibilities available under the Health Act 1999, are used to meet the needs of services users across health and social care boundaries, allowing for the development and management of joint services. Auditors found that pooled budgets are used particularly in the mental health sector (by 32 per cent of MHTs as opposed to 5 per cent of acute trusts) to, for example, improve the management of salaries in teams containing health as well as social care staff. They may also help MHTs and PCTs to

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<sup>1</sup> *Together: Working for Wellbeing*. A good-practice guide to valuing, respecting and supporting service-user activity. May 2006, 82a Wick Street, Littlehampton, West Sussex, BN17 7JS, tel 01903 733443, email [serviceuser-involvement@together-uk.org](mailto:serviceuser-involvement@together-uk.org)

overcome problems that would otherwise be posed by their partners' different financial regimes, different budget setting practices and reporting cycles. Where pooled budgets are used, partnership agreements need to be in place. This is likely to prove a challenge for MHTs, as well as having implications for PCTs in the new NHS environment, and therefore requires early preparation.

- 110 Good practice requires that there is a signed comprehensive partnership agreement in place setting out governance and risk-sharing arrangements. In 2004/05, however, two-thirds of MHTs, compared with 5 per cent in the acute sector, failed to have signed agreements in place. This is an important area for MHTs to strengthen. Guidance<sup>1</sup> in the form of a mental health model contract, including guidance on Section 31 agreements under the Health Act 1999, is now available from the DH to help MHTs to strengthen their contracts and secondary commissioning arrangements.
- 111 MHTs should also build more effective partnerships and arrangements for information sharing with LAs as joint commissioning with PCTs develops. At present, only seven respondents extend their review of financial performance and service outcome against budgets through to partnership level and both share and act upon the results. Further work on this will be needed as the proposals in *Our Health, our Care, our Say* (Ref.29) are implemented and arrangements are made to improve access to employment, housing and other services to reduce social exclusion. The Office of the Deputy Prime Minister's (ODPM) report *Mental Health and Social Exclusion* (Ref. 5) sets out a number of helpful recommendations to focus discussions with LAs.

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<sup>1</sup> *The Model Contract for Mental Health Trusts*, DH, April 2006 [www.dh.gov.uk/publications](http://www.dh.gov.uk/publications).

## Recommendation

**As a minimum, there should be a partnership agreement between MHTs and their partners, which:**

- is signed by all partners in a timely manner, to ensure compliance with Section 31 of the Health Act 1999;
- provides clarity about ownership;
- sets out arrangements for governance and accountability for all provider contracts;
- sets out how risk management and conflict resolution arrangements, including how to re-allocate resources back to partners should the arrangement break down;
- clearly identifies how pooled budget expenditure, MHT income and assets are accounted for; and
- establishes an effective performance management system to enable partners to assess achievement against agreed targets and to evaluate pooled budget arrangements.

**112** In this chapter we have argued that MHTs must embed all the components of financial management at all levels within their organisation. This cannot happen without leadership from the top. MHTs need the right financial information to run their organisations effectively and efficiently. Over and above this, they must be able to communicate and relate this information to an external audience. This is not possible to achieve without effective governance and leadership, reliable and valid data, information systems used to inform financial management processes and improved communication and contracting with all key partners.

**113** MHTs should take early steps to strengthen all the components of effective financial management. This will help them to prepare for NHS reorganisation and financial system reform and their applications for becoming a FT. It will support their capability to operate in a financial environment significantly different from that of other NHS trusts where they will have the freedoms to borrow and invest. However, it is clear that there is a significant amount of work to be done across the mental health sector as a whole if the government is to meet its target to have all trusts as FTs by 2008.

# 5

## Conclusions

- 114** This report examines the financial management arrangements in MHTs, their financial standing and financial performance in the context of significant cost pressures within the NHS as a whole. Our recommendations concern the means to strengthen financial planning and decision making for all the key players and stakeholders, based on the principles set out in *Achieving First-class Financial Management in the NHS (Ref. 21)* and the standards set out in *World Class Financial Management (Ref. 31)*. Where possible, recommendations incorporating the broad principles of financial management have been provided to enable MHTs to improve their service delivery and provision.
- 115** While the financial standing of MHTs is significantly better than acute trusts, there are clearly a number of challenges ahead. First is the need to strengthen the quality of data about mental health activity, costs and, where possible, outcomes. Second, improvements are needed in the tools used within and outside MHTs to relate high-quality and timely data to inform decisions on service monitoring, budgeting, finance monitoring and performance management. There are significant gaps in data, and shortcomings in the capability of MHTs to provide relevant and timely information to both decision makers within their trusts and their commissioners in the wider health economy, particularly in terms of activity.
- 116** The landscape of the NHS is changing and action to address these areas is vital. Block contracts to underpin commissioning will be replaced by cost and volume contracts, which will shift the locus of decisions about service from MHTs to PCTs. There is also widespread variation in spend between PCTs currently commissioning services, although PCT mergers will address some of these concerns, as well as bring about other changes to commissioning arrangements. The NHS is becoming a more commercial environment and MHTs need to rise to this challenge. The future implementation of PbR for mental health in 2009, alternative independent providers of healthcare, and a new financial regime operated within FTs provide significant challenges for MHTs as their current arrangements will not be adequate to take them forward.

- 117 The DH and Monitor are setting exacting standards for applicants seeking to achieve FT status. Becoming a FT gives trusts wide-ranging freedoms, including opportunities for service development, new borrowing powers, freedoms to make decisions on capital investment and new governance arrangements. A FT can retain and invest surpluses but is exposed to commercial pressures not faced before.
- 118 The recommendations in this report are aimed at tackling some of the weaknesses in financial management in the mental health sector and enabling it more readily to face the challenges of the future.

# Appendix 1

## Methodology

**Table 3**  
**Mental health providers in England (as of November 2005)**

Type of provider	
Care trust	5
Partnership trust and/or mental health and social care trusts	27
Mental health trust	29
Multi-service provider (Isle of Wight Healthcare NHS Trust)	1
PCT provider of secondary mental healthcare services	19
<b>Total</b>	<b>81</b>

The methodology involved a combination of primary and secondary research methods.

Semi-structured scoping interviews were undertaken at six sites (including two PCTs) to identify qualitative information around the issues and problems facing mental health providers and commissioners and how some of these were being addressed. This was used to provide general information for the direction of the study and to help populate fields for the questionnaire. A questionnaire was then developed to quantify this information, based around the key lines of enquiry from ALE. Five sites were visited to serve as pilots to validate the questionnaire for its usability and accuracy. The sites selected represented current diversity of financial management arrangements in mental health.

Questionnaires were sent by email to directors of finance of all mental health provider PCTs and trusts in England to obtain more detailed information on mental health bodies' financial management arrangements. The questionnaires were based on the 'characteristics of good financial management' as proposed in *Achieving First-class Financial Management in the NHS* (Ref. 21) and probed the trusts' existing, and barriers to improved, financial management arrangements. The questionnaires covered MHT general financial management arrangements, partnership arrangements, risk management arrangements, clinical engagement in the financial management process, availability and quality of information and examples of notable practice. The Commission received replies from 53 respondents (a response rate of 65 per cent). The breakdown of

identifiable respondents was: 9 PCTs, 3 care trusts, 40 mental health (including partnership) trusts and 1 multi-service trust.

Following the return and analysis of the questionnaires, 28 respondents were contacted to provide case studies to highlight examples of notable practice. The 20 case studies selected represent 14 trusts (including a PCT provider and a FT) across England and reflect the diversity of methods implemented to address challenges and risk to, and thereby improve the management of, their financial management arrangements.

Two workshops were carried out with a sample of five mental health commissioners (PCTs) from across the country, representing 18 PCTs. We assessed their views, and identified obstacles and challenges to the maintenance of effective systems to underpin the delivery of their business. Participants discussed their views about the quality of data and the systems such as contracting, partnership arrangements, performance management, and information that underpin commissioning, as well as their opinions about the risks facing MHTs in the near future.

The report also both draws upon and supports Audit Commission audit work around mental health. Data returns from 2004/05 audit work, audited accounts and other existing mental health data were analysed to establish a national picture, further informed by overall data quality findings.

The analysis of both the questionnaire completed by the Audit Commission's appointed auditors for every NHS body (2004/05) and trust account returns included 63 MHTs (not including PCT providers or the Isle of Wight Healthcare NHS Trust).

The analysis of the questionnaire completed by the Audit Commission's appointed auditors for every NHS body (2004/05) included 145 trusts: 131 acute trusts (including multi-service and teaching trusts, and excluding the Isle of Wight Healthcare NHS Trust) and 14 part-year FTs.

The analysis of the trust account returns included 154 trusts: 131 acute trusts (including multi-service and teaching trusts, and excluding the Isle of Wight Healthcare NHS Trust) and 23 FTs (9 full-year and 14 part-year FTs).

The two FTs excluded from the analysis are specialist trusts. Trusts that provide only learning disability services (Oxfordshire Learning Disabilities NHS Trust, Caldertstones NHS Trust and Northgate & Prudhoe NHS Trust) were excluded from all the analyses, and therefore the report.

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