Payment by Results in mental health
A challenging journey worth taking

Payment by Results (PbR) for adult mental health services will be introduced in the NHS in 2012/13. While commissioners and providers broadly support this, they have identified significant challenges. An independent readiness review was commissioned by strategic health authority (SHA) mental health leads through the Mental Health Network.

Much needs to be done across the whole system in order to begin using PbR in the 2012/13 introductory year, and to develop the system during that time, and beyond. This Briefing summarises the key findings and recommendations of the readiness review.

Responding to questions as part of the independent readiness review, the majority of people interviewed felt that mental health PbR had the potential to offer:

- **service users** greater clarity on what to expect from services
- **clinicians and managers** a way to further reduce variation, support the continuing transformation of services and better understand how to achieve the best outcomes in the most efficient way
- **commissioners** a platform for services that better meet the needs of individuals, helping them to more clearly focus on outcomes and better understand what they get for the money they spend.

While it highlighted a real enthusiasm for implementing PbR, the review also exposed the need for clarity about who needs to do what, by when, in order to implement PbR. It also found that more support, particularly for commissioners, was needed if the potential benefits of PbR are to be realised and the risks that could result from the system not being ready are to be avoided.

**Key points**

- Commissioners and providers support the introduction of Payment by Results for adult mental health and believe it presents real opportunities for patients, clinicians, providers and commissioners.
- Without substantial support and a further injection of resources, commissioners and providers may not be ready to use care clusters for the implementation of Payment by Results in adult mental health by the April 2012 deadline.
- Most trusts will have allocated users to clusters by December 2011, but poor data quality means that trusts will not have a robust currency by April 2012.
- The recommendations of the independent report should be acted upon across the system to ensure Payment by Results is implemented within a demanding timeframe.
Background

The principles underlying a PbR approach to reimbursing mental health service providers have been under discussion for many years. They state that the system should:

- improve clarity for service users and carers about what they can expect from services and the outcomes they can achieve
- facilitate an understanding of clinical processes between commissioners and providers, and between clinicians and service managers
- incentivise both commissioners and providers to deliver effective, efficient and equitable models of treatment and care
- distribute the burden of financial risk fairly between commissioners and providers.

Several steps are needed for the PbR system to be put in place and to ensure it meets the above principles:

- **Identify a currency** – a unit of service activity that is both clinically meaningful and has relatively stable costs.
- **Identify a tariff** – a price for each unit of service activity.
- **Commissioners and providers agree to a contract structure** that includes service models, care pathways, volumes and performance incentives.

Equity and excellence: liberating the NHS made a commitment to introducing mental health care clusters as the currency for adult mental health services for 2012/13. Prices would be agreed between commissioners and providers and would not be set nationally.

The Department of Health (DH) issued draft mental health PbR guidance in October 2011, restating its intention to mandate the use of care clusters for contracting for adult mental health services from 1 April 2012. It also provided details of the care packages for each of the current 21 care pathways (clusters) nationally.

A letter accompanying the readiness review proposed that SHA mental health leads in each SHA cluster carry out a rapid assessment of readiness for each primary care trust (PCT) cluster and offer support to enable them to deliver within the timescale.

Summary of the review findings

Mental Health Strategies conducted the independent readiness review, which was commissioned by the SHA mental health leads through the Mental Health Network. The review involved speaking to more than 100 people from mental health trusts, commissioners, the independent sector, local authorities and national stakeholders in September 2011.

The reviewers developed a readiness framework, showing what would need to be in place for a local health economy to be considered ‘ready’ to implement PbR, against which to compare the review findings.

The review found a high state of readiness in terms of progress for defining care packages. Of 37 trusts responding to a question on progress, 17 had made no progress and a further nine were at the start of the process. Joint working between commissioners and trusts was also patchy.

Providers which had made more progress in clustering and had begun to analyse the data were particularly concerned that service users were not always allocated to the correct cluster and clusters may not be consistent within or between providers.

There was wide variation between trusts in terms of progress for defining care packages. Of 37 trusts responding to a question on progress, 17 had made no progress and a further nine were at the start of the process. Joint working between commissioners and trusts was also patchy.

All interviewees said a lack of robust data meant that the financial risks of implementing PbR live in 2012/13 were too great and as a result the recent DH guidance regarding an introductory year and risk sharing has been welcomed.

If tariffs are not fit for purpose in time for implementation, the review saw a real danger that commissioners, guided by poor quality data, could make inappropriate decisions that could have a detrimental effect on mental health services.
Interviewees raised a number of questions about what constituted a local tariff and how it should be calculated. There was also anxiety about achieving a robust national tariff.

Linking quality and outcomes to the PbR clusters was seen as key for mental health. Although there is a programme of work around quality and outcomes, further progress needs to be made. Progress in the national quality and outcomes group was seen as important for this.

The review also found a general concern about the ability of IT systems across the country to support the implementation of PbR. Commissioners said they did not know which IT systems they needed to manage PbR, and while trusts had found varied solutions to capturing cluster data, they were finding it difficult to capture clinical activity.

**Commissioning**

The reorganisation of PCTs into cluster groups is affecting the ability of commissioners to focus on mental health PbR. The review found that it was not always clear who was commissioning mental health, and the lack of a stable commissioning environment was seen as a big barrier to implementation. As a result, support for incoming clinical commissioning needs to be put in place as soon as possible.

**Social care**

Overall, interviewees did not understand how to deal with social care in the context of mental health PbR. They felt that the links between health and social care had not been fully thought through. The review also found that significant further work is needed to ensure PbR appropriately interfaces with personalisation and emerging personal health budgets.

The report found that people were unsure about whether social care staff should be included in the tariff.

**Independent sector**

The independent sector felt there had been relatively little communication with them about PbR and there was general confusion about which services they provide would be covered by the mental health PbR. Issues included:

- who should they cluster with and will users come already clustered?
- how will the system deal with users who are in more than one service at one time?
- if tariffs are wrong, they could cause market instability.

Overall, the review identified a clear need for leadership at all levels of the system, better and more consistent communication and strategic direction to ensure PbR is implemented and to avoid the perception that it is too difficult and could never happen. Clearer national guidelines and answers to key questions were a common request.

**Timescales**

The Department of Health’s draft guidance set out the following timescales.

**By 31 December 2011:** All service users accessing mental healthcare (post GP or other referral pathway) that have traditionally been labelled working age adults, including early intervention in psychosis (EIP) services from age 14, and older people’s services, should have been allocated to a cluster.

**By 1 April 2012:** Providers should have agreed local prices with their commissioners for 2012/13, based on the cost of the care clusters. They should also have negotiated agreements for 2012/13 that include how any financial risks will be managed and shared to ensure that overall there is a cost-neutral impact for 2012/13.

**During 2012/13:** Providers and commissioners will need to carefully monitor the initial cluster costs and prices. Providers should work with all their commissioners to agree a single local trust price for each cluster for use in 2013/14. They will also need to make progress in other areas to ensure that the data to support mental health PbR in future years is as accurate as possible.

**Implementation actions**

In their postscript to the review, the SHA mental health leads outlined actions that are critical to ensure PbR is in place for adult mental health on 1 April 2012. To deliver the full benefits, further actions will be important for developing the system during the introductory year in 2012/13 and beyond.

The actions for providers, commissioners and national organisations for each stage of implementation are as follows.
Mission critical work for 1 April 2012

Commissioners and providers together should:

- develop and use the Memorandum of Understanding to support joint working and risk sharing
- agree risk share for resources for 2012/13, which will have a cost-neutral impact in 2012/13
- share cluster data, understanding that it is a first cut and cannot be used in immediate service changes, except those mutually agreed
- develop and share a process for costing clusters and assessments based on the current version of the national PbR guidance
- agree a first-cut version of the costs per cluster per day and how they will be used to set prices
- agree an activity plan that specifies the level of activity expected on a cluster basis
- agree a set of data to flow locally, and any use of the Mental Health Minimum Dataset (MHMDS) v4.0, that enables monitoring of:
  - numbers per cluster
  - average time spent in each cluster
  - per cent of reviews undertaken within expected timescales defined in the clustering booklet
  - collection of quality and outcomes metrics
- agree whether and how Commissioning for Quality and Innovation (CQUIN) will be linked into the currency model
- develop and share a set of discharge criteria
- confirm what is within and what is outside the clusters
- agree that during 2012/13 providers will work with commissioners to deliver the broader work programme that includes developing and testing more comprehensive currency models.

Providers should:

- ensure all staff are trained and cluster all new and current service users
- ensure all staff apply the care transition protocols for all new referrals and reviews
- ensure staff record Mental Health Clustering Tool (MHCT) scores at discharge – but do not cluster.

Commissioners should:

- review and map service specifications to clusters and redraft if required, redefine quality standards and information flows
- clarify the models of commissioning
- confirm access and use of MHMDSv4.0.

The DH, the National Commissioning Board and Monitor should:

- reconfirm the timeframes and details of what must be delivered by 31 March 2012
- review national delivery and delivery of products
- coordinate and share sets of data on:
  - cluster assessment tools
  - costing models
  - contents of clusters
  - outcome measures
- strengthen routine information bulletins and create a database of frequently asked questions
- deliver a standard pack of sample service specification, quality standards and information items
- SHAs should enable or deliver to each PCT cluster a package of support to enable the delivery of the mission critical work and set the model for the development.

Delivery programme for 2012/13 and beyond

Commissioners and providers together should:

- jointly review the quality and outcome metrics collected, as recommended in the quality and outcomes reports and agree how these will be used locally as a measure of quality
- agree a data improvement plan for 2012/13 and onwards
- develop joint plans on how users and carers are involved in all the developing processes
- develop joint plans on how users and carers have a steady flow of information about menus and outcomes
• develop joint plans for building in loops to feed back on user and carer outcomes and experience
• assess current delivery against ideal delivery models
• develop a timed programme over three years to deliver full NICE guidance
• review service change processes, opportunities for innovation and creative plans in current services
• open up to new elements of delivery.

Providers should:

a) Implement the system
This involves:
• staff training and development
• getting IT systems to a place where they can record the cluster, ideally with allocation algorithm is within the IT system
• getting all service users clustered accurately and at appropriate times
• routine re-assessment embedded within routine practice
• developing systems to check robustness of allocation
• preparing to implement the new electronic algorithm in two years
• considering opportunities for innovation and planning creative developments.

b) Deliver services
This involves:
• developing systems to record what is delivered for each user
• demonstrating the content of care packages for each of the clusters that reflect evidence and best practice and support ongoing innovation and development
• building on NICE and other best practice guidance to create the menu for users
• delivering first user menu from October 2012.

c) Measure outcomes
This involves:
• using agreed common outcome measures for every user
• drawing together data into a clinical dashboard and feeding back to users, clinicians, and to commissioners
• producing reports on the completion of the quality and outcomes metrics recommended in the quality and outcomes report on a cluster basis
• producing performance/activity reports as agreed with commissioners
• evidencing validation of cluster accuracy – using an algorithm where possible, auditing clinical records, and/or reviewing other relevant data collected as part of the overall process.

d) Cost the framework
This involves:
• creating a framework for costing clusters (models for costing are already available) and running data
• sharing and ensuring buy-in for the costing system from commissioners
• developing costing information for separate assessment costing
• developing and testing a range of options for currency.

Commissioners, care cluster groups and local authorities should:

a) Consider the resource framework
This involves:
• looking at risk sharing up to 2014/15 through pooling resources and managing risks
• sharing data and building costing confidence from 2012 onwards
• reviewing any potential perverse incentives, developing and taking action to mitigate these
• beginning an analysis of population needs by cluster, building on the joint strategic needs assessment (JSNA) and working with the Health and Wellbeing Boards.

b) Rework contracting structures
This involves:
• leading a programme to develop service specifications for clusters and redrafting as require
• redefining quality standards and information flows.

c) Collect and analyse information, data and collaboration
This includes:
• the 2011/12 pattern of service use
• the number of people in each cluster
• developing current outcomes data
• user flows within services, and step up and down rates
• achievement of quality indicators and outcome measures, and test funding system based on outcomes
• ensuring data supplied by providers is reviewed and
analysed and used within the overall commissioning process

• developing benchmarking plans that enable the commencement of comparisons of cluster price, care package content, and achievement of quality indicators and outcome measures.

The DH, the National Commissioning Board and Monitor should:

• review outputs from the national work

• ensure SHAs continue to support PCT clusters and clinical commissioning groups to support further development of the system

• develop a single NHS and social care assessment structure which brings together the clustering tool and the social care assessment frameworks

• build recovery into the core of the clusters

• develop prevention and primary care into the cluster structure.

Mental Health Network viewpoint

Mental health providers and commissioners recognise that PbR provides an important building block to support the further improvement of mental health services across England and are keen to make progress.

Effective implementation of PbR represents a significant challenge for the whole mental health system and requires far more support if it is to be achieved and the risks associated with this complex task avoided.

We believe the following are essential next steps.

• The DH must further develop communications to ensure that organisations know who needs to do what by when. Ensuring that organisations can easily access up-to-date information on the DH website is essential.

• The DH, SHAs, commissioners and providers must work together to share good practice and support learning across the system.

• The DH and SHAs must develop a support programme to build the capacity and capability of commissioners as soon as possible.

• Commissioner and providers must focus on the consistent and effective implementation of the currencies to improve data quality and the development of outcomes associated with the clusters.

For more information on the issues covered in this Briefing, contact steve.shrubb@nhsconfed.org

Summary of the country’s state of readiness for PbR implementation

| State of readiness |
|-------------------|------------------|
| All service users accessing mental healthcare (post-GP or other referral) that have traditionally been labelled working age adults and older people’s services, are allocated to a cluster | High |
| Commissioners and providers are confident in the quality of cluster data | Low |
| Packages of care are defined for each cluster | Low |
| Clusters are costed | Low |
| Local tariffs are fit for purpose – stable, accurate, with acceptable variance | Low |
| Mental health contracts use the care clusters as the contract currency with local prices | Low |
| Process for validation of payments is in place | Low |
Mental Health Payments by Results Readiness Review – recommendations

The review made the following 19 recommendations.

1. There should be regular and comprehensive communication as to requirements in the implementation of mental health PbR. Information should include clarity on deadlines and what they mean, and progress reports on national development work. Briefings should be monthly so that the mental health system receives information in a timely fashion.

2. It should be ensured that there are sufficient resources, at all levels, to deliver the work required. Robust project management systems should be put in place to ensure deliverables are achieved and implementation risks highlighted at an early stage.

3. A formal FAQ system should be established so that timely answers are provided to commissioners’ and providers’ questions about implementation.

4. A programme of PbR training should be rolled out for new commissioners.

5. A national mental health PbR website should be established for the sharing of learning, techniques and tools. This would include investing in the development of tools which local organisations or regions have created, so that the tools can be shared nationally.

6. A review should be undertaken to understand why there appear to be inter-rater reliability issues in clustering users. This should include analysis of why clinicians are overriding the cluster tool in significant numbers. Depending on the outcome of this review, work may need to be commissioned to improve the clustering tool's inter-rater reliability.

7. Guidance should be published on how local tariffs should be calculated.

8. Social care staff should be included in the tariffs. Guidance should make clear how personal budgets fit into PbR.

9. A review should be undertaken to gain greater understanding of the variation in care packages provided to users within one cluster, and the impact this has on cluster costs and tariff. This should include looking at co-morbidities, thresholds and current commissioning patterns. Depending on the outcome of the review, action will need to be taken to address any unacceptable level of cost variance before the tariffs are fit for purpose.

10. Discussions should begin with independent providers to lead and guide the local process of PbR development.

11. A full assessment of the IT infrastructure required to fully implement PbR should be carried out.

12. Consideration should be given to what mechanisms should be put in place to encourage collaboration in implementing PbR with other areas.

13. All users of relevant services should be allocated to a cluster.

14. Mental health contracts for 2012/13 should contain risk sharing agreements to ensure financial stability during the transitional period.

Recommendations continued overleaf.
15. Work should be carried out to improve the quality of clustering data. This will include ensuring:

- users are allocated to the correct cluster
- users are reviewed regularly using the transition protocols.

16. Packages of care for each cluster should be determined.

17. Clusters should be costed.

18. Local tariffs should be developed. An assessment should be carried out to whether they are fit for purpose for 2013/14 contracts.

19. An administrative and clinical system for validating clusters for payment purposes should be developed.

Further information

The full report, Mental Health Payment by Results Readiness Review, is available at www.nhsconfed.org/publications

Mental Health Network

The Mental Health Network was established as part of the NHS Confederation to provide a distinct voice for mental health and learning and disability service providers.

We aim to improve the system for the public, patients and staff by raising the profile of mental health issues and increasing the influence of mental health and disability providers.

For further details about the work of the Mental Health Network, visit www.nhsconfed.org/mhn or email mentalhealthnetwork@nhsconfed.org