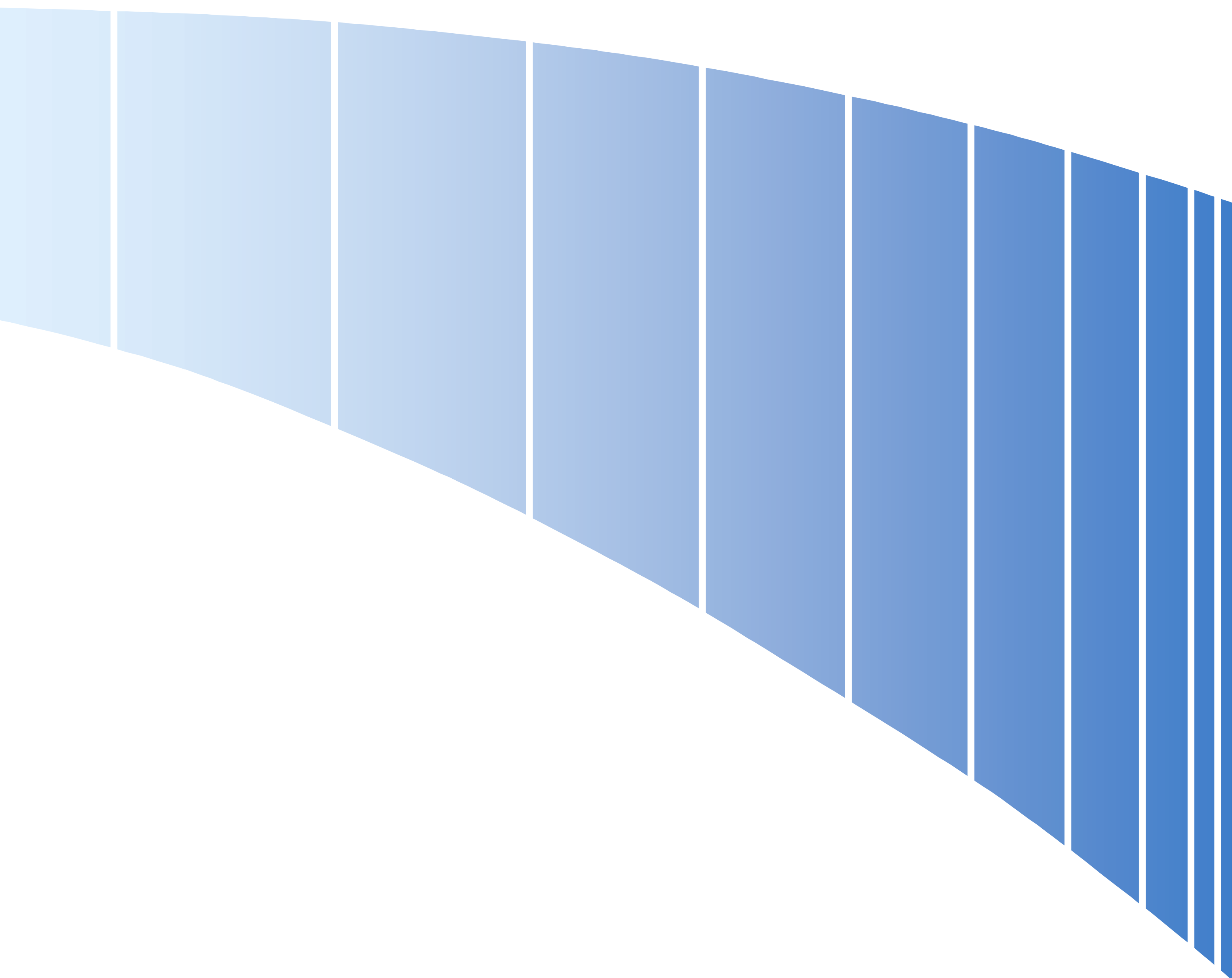
NHS

Key steps for successful implementation of Mental Health Payment by Results



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For Recipient's Use	

Introduction

1. This short guide has been prepared to help organisations understand the key steps that should be undertaken to continue with the implementation of Payment by Results (PbR) for Mental Health services in 2013-14. It is accompanied by a more detailed set of guidance for those who are responsible on a day-to-day basis with embedding the new approach in their organisations.

2. In 2012-13 the new mental health currencies for working age adults and older people were mandated. This means that they are required to be used by providers within their organisations, and by commissioners as the basis on which contracting for services is undertaken. The chosen currency units for mental health are clusters based on service user characteristics and their needs. There are 20 clusters in use, and a variance cluster, cluster 0. The clusters fit under three broad super clusters, non-psychotic, psychotic and organic.

3. This practical guide sets out a number of important areas of activity that need to occur locally to support the continued implementation of mental health PbR. The overall goal of these actions is to improve the way in which services are commissioned and are paid for, and most importantly to support improved outcomes for service users and delivery of the mental health strategy[1].

4. This guide is not exhaustive, but is a pointer to key considerations and areas for local discussion. As well as the actions, the guide contains a glossary (Annex A) to help ensure that everybody is using common terminology. The same terminology is used in the reference cost guidance for 2012-13.

5. Many of the actions in this guide fall mainly on providers because they are allocating service users to clusters and ensuring the collection of the relevant information. However, the active involvement of commissioners is crucial (see action 2) and a checklist specifically for them has been included at Annex B.

Understanding the benefits

6. The Department of Health does not underestimate the amount of work that has already been undertaken by organisations to develop and introduce mental health PbR. From the provider perspective, it has involved a huge training programme so that clinicians are able to allocate service users to the clusters. It has involved looking at the way services are described and delivered, working with service-users, commissioners and other stakeholders, and making changes to IT and costing systems.

7. From the commissioner perspective, the ability to understand the information recorded in Mental Health Minimum Data Set (MHMDS) and

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1 http://www.dh.gov.uk/health/2011/07/mental-health-strategy/

to interrogate is now required. However, there are two over-arching benefits:

a. The opportunity to better understand the needs of service users and ensure that service responses to these needs are high quality (safe, effective and a positive experience) and good value (by being efficient and productive) and are delivering measurable improvements to the mental well-being of service-users.
b. The chance to make much better informed decisions about mental health services through better and more comprehensive data.

8. There are a number of other benefits for commissioners, providers and service users. These include:

    a. A commissioner can expect to have a clear understanding of the number and nature of service users being treated, a transparent framework on which to align outcome measures and the opportunity to have meaningful discussions with providers about the service response to each care cluster. A common language will be in use across all providers that a commissioner is contracting with. Because the clusters focus on individuals, they should also facilitate the coordination of multiple providers delivering different aspects of care, leading to integrated care plans for each service user.

    b. Providers will have a more detailed understanding of their business, including the costs of individual service users, the ability to reorganise service provision based on service user characteristics, and a transparent means of demonstrating their productivity and efficiency and achievement of outcomes through benchmarking with other providers.

    c. Service users should have well-defined responses to their individual care needs, with clarity over treatment and support options and expected pathway through the mental health system. The approach supports personalisation and the introduction of personal health budgets.

PbR and QIPP

9. The implementation of Payment by Results in Mental Health supports the QIPP (Quality, Innovation, Productivity and Prevention) agenda as it provides a framework to support each of the four elements. The design of care packages should embrace innovation, and quality metrics form an integral part of the clustering approach. Improved productivity will reduce costs per cluster. Finally, by linking payment to individual service users, there is an incentive to reduce the need for more specialist mental health care through preventative interventions.

The Clustering approach

10. The approach to currencies for mental health services was first developed by clinicians in Yorkshire, and then was taken forward by the regional Care Pathways and Package Project working with other parts of the country. This work resulted in the development and subsequent mandating of “clusters” as the Mental Health PbR currency. The cluster approach allocates service users to clusters. These are groupings based on common characteristics such as level of need, and requiring similar resources to meet those needs through the provision of packages of care. The tools that support allocation to the clusters are built on existing clinical tools. The clusters are detailed in the Mental Health Clustering Booklet (2013-14), which should be read in conjunction with this guide.

11. The methodology has two distinct parts – the clusters and the Mental Health Clustering Tool (MHCT) that facilitates mental health professionals allocating service users to the clusters. The MHCT contains the twelve standard HoNOS (Health of the Nation Outcome Scales) data items as well as six additional items to support cluster allocation.

12. We recognise that the mental health currencies, and hence the clusters and the assessment tool will develop over time. Whilst we need to have national consistency in the use of clusters and the clustering tool, the care package or pathway that follows the assessment and clustering process for each service user is not being nationally defined. A menu of care options must be developed locally which can be personalised to provide the best package for each service user. However, in developing the options we expect both providers and commissioners to be focused on care that meets relevant NICE guidance.

13. The rest of this guide considers the activities that are required to support the further implementation of mental health PbR.

Action 1: Ensure there is a senior PbR lead individual within your organisation that has responsibility for delivering this work and that they are supported by key stakeholders

14. Commissioners and providers should have a lead individual in post with responsibility for implementing mental health PbR in their organisation. This individual needs to have sufficient seniority to ensure that the activities required locally can be delivered. They should act as the voice for mental health PbR within the organisation.

15. For provider organisations in particular, there should be other identified leads or "champions" for PbR in specific areas. There will need to be a clinical lead who ensures frontline staff are communicated with and involved in the decision-making, ultimately overseeing the achievement of clinical buy-in to the approach of assessing, recording and then clustering individuals.

16. There will need to be a finance lead who can take responsibility for identifying the costs of providing care to individuals within the different clusters. Finance leads can get support for this work from the Healthcare Financial Management Association who have a buddying scheme in place. [2]

17. There will need to be an informatics lead who ensures the timely local capture of all the necessary information to allow the use of currencies, and the submission of the data to the Health and Social Care Information Centre through the monthly MHMDS uploads. The informatics lead should also work with the PbR lead to ensure that data reports are available for local management reports and to help put local audit and assurance processes in place.

18. These leads should form the nucleus of expertise within the organisation to drive forward local delivery of PbR.

19. Given the complexity of the task and the necessity for interactions across an organisation, it may also be beneficial to designate a dedicated project manager who has implementing the clustering approach as their primary responsibility.

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2 http://www.hfma.org.uk/faculties/mhfinance/

Action 2: Ensure that implementing mental health PbR is a joint project involving commissioners, providers, local authority partners and public health colleagues

20. To be successful, mental health PbR must meet the needs of local stakeholders. It cannot succeed if developed solely by a commissioner or provider, nor should it be seen as something to be done by the NHS without the involvement of social care.

21. For commissioners and providers it is recommended that PbR preparation be treated as a joint project. This is an excellent opportunity for partnership working on an important piece of work. Such an approach will also facilitate the development of agreed packages of care to be delivered as part of each cluster.

22. Clear terms of engagement around information sharing should be set out at the start and it is recommended that an open book relationship should be used wherever possible. This is particularly important while commissioners get up to speed with analysing the MHMDS.

23. PbR for mental health needs to be sufficiently flexible to recognise the varied levels of integration with social care that exist across the country. It also needs to support the personalisation agenda, which now relates to both health and social care. The best way of achieving this is a full discussion with local authority partners, so that the social care contribution to the cost of treating service users in particular clusters can be understood, and so that care packages can be formulated that are tailored to an individual's requirements.

24. There are a number of differing arrangements currently in place aimed at supporting integration of health and social care for people with mental health problems. These can include formal section 75 partnership agreements for provision and commissioning, and a range of informal agreements aimed at encouraging partnership, and the provision of seamless integrated care and treatment. The Monitor licence condition relating to integrated care will set the expectation that providers deliver services in an integrated way where this improves patient care.

25. The development of PbR for mental health is intended to continue to support that integration, and though the initial phases of currency development are focussed upon the establishment of local prices for the health funded elements of care, commissioners and providers should consider the impact the social care element has on the overall care package content and the resources and outcomes delivered as a result.

26. Commissioners need to be aware that the varied contributions of different local authorities can make it hard to make quick comparisons between providers about the costs and scope of services.

27. The clusters also provide an opportunity for greater involvement of public health professionals in mental health care. Local health and wellbeing boards will be keen to know that mental health care provided truly reflects the needs of local people.

Action 3: Agree local cluster prices for 2013-14, ensuring that finance colleagues engage with clinicians in developing prices that link to cluster packages of care.

28. The overall aim of the future mental health payment system is to understand the relationship between needs, price and outcomes, and make this transparent across local and national health economies. In introducing the PbR approach to paying for Mental Health services we are conscious of the need to provide stability over time and across organisations, whilst building in the right incentives for delivering good outcomes for service users. Payments should therefore be based on the **cluster review periods** which will allow alignment to the developing range of outcome measures.

29. To support local stability and the development of the currency model in 2013-14, pricing should be developed based on 2013-14 agreed contracting values. This will take existing contract values for services as described within local contract agreements at a Clinical Commissioning Group (CCG) level and rebase them against activity defined by the new currency.

30. Some providers have worked with their main commissioners and agreed as a group, a single set of cluster prices from 2013. We welcome this.

31. However, this has not yet been possible for most providers. So, for 2013-14, the majority of providers will need to take the contract values for services, as described within each local contract agreements at a CCG level, and rebase them against activity defined by the new currencies for 2013-14.

32. The currency unit on which to rebase contracts will be **cluster review periods**, as the quality metrics for **"review periods"** will be clinically validated against the maximum cluster period currently set out within the MH PbR clustering booklet. Rebasing current contract values against activity based on cluster periods will therefore, produce a **price per cluster period** for each CCG, with each of its providers. Therefore, at an organisational level a different price per cluster period (local current market price) would emerge within each contract and for the provider as a whole.

33. We will be asking for indicative prices to be submitted to DH in April 2013, and we will publish them alongside the indicative national cluster costs, based on information received in reference costs. As the first year of operation is intended to support transparency, understanding and efficacy of the emerging payment model, it is proposed that contract plans are re-based on a six monthly basis and re-submitted. We expect the quality of clustering to improve during 2013-14 and this would impact on the profile of cluster costs during the year.

34. It is also proposed that building on the Memorandum of Understanding and risk sharing agreements put in place for 2012-13 an Income

Guarantee is agreed at each CCG level, ensuring that financial stability is preserved. The final move to an activity-based funding model should not be taken before the impacts can be fully assessed from both a commissioner and provider perspective. This could be incorporated into the Memorandum of Understanding.

35. Working with the NHS, we will develop further business rules to support the new payment mechanism based on the learning we gain through 2013-14.

36. **To support the transition from cluster days to Cluster Review Periods** guidance is available on how to develop an activity schedule for 2013-14 using cluster review periods. This forms an annex to the full mental health PbR guidance. This will involve taking a snapshot of caseload and applying to this the maximum cluster review periods as described in the Transition Protocols set out in the Mental Health Clustering booklet.

37. The maximum cluster review periods should be monitored against actual cluster review periods during 2013-14 to understand whether any modifications may be required, and to gain an understanding of the utility of cluster periods in developing a fully workable payment mechanism, and also to ensure robustness of local activity plans.

38. This approach will provide for the first time a transparent view of the relationship between needs and current market price. This transparency should enable discussions around priorities for improvement, and over time should encourage a convergence in the relationship between needs price and outcomes across organisations, with the key focus on delivering better service user outcomes with the resources available.

39. There will also be variations in market price that are driven purely by the lack of a historical relationship between local price and cost, but understanding this at a cluster level, alongside the relationship with outcomes, will also enable local negotiations between CCGs and providers to manage this variation from the system. ***It will be important that there is no move towards the lowest price and that pricing takes into account the relationship between needs, resources, outcomes, and sustained recovery or improvement.***

40. Underpinning developing cluster prices there needs to be good costing information. Organisations should use the Mental Health Costing Standards and consider how they are going to move to Patient Level Information and Costing Systems (PLICS) to support the capturing of information the activity and costs of care for individual service users. Monitor, as it develops its pricing strategy, has already signalled a preference for cost data based on PLICS.

41. Cluster prices do not include the cost of the initial assessment when someone is first referred to a secondary mental health provider and these should be costed separately. Experience suggests that an initial

assessment for the purposes of clustering can be completed in two contacts or two working days for in-patients.

Action 4: Confirm the packages of care to be provided to service users

42. In the mental health PbR guidance for 2012-13 we asked that commissioners and providers should work together to agree the packages of care that would be offered to service users in each cluster. There are some excellent examples of collaborative approaches that have been taken to developing these packages of care. For example, by holding workshops that bring together commissioners, providers, local authorities, service users and carers, GPs and the voluntary sector to get agreement on what will be provided.

43. Many organisations are looking at offering core interventions that are provided to everyone in a cluster, and a menu of other interventions that can be used to provide a personalised package of care that as appropriate incorporates NICE guidance. The revised mental health clustering booklet for 2013-14 references NICE guidance likely to be associated with each cluster.

44. It is important that this work is at an advanced stage to agree contracts for 2013-14. Resources to help organisations are available via the IMHSeC website[3] and through our QuickR site, a web-based collaborative tool which brings together those with particular interests. We invite all commissioners and providers to register and join. For further details e-mail pbrcomms@dh.gsi.gov.uk.

45. Providers and commissioners also need to be mindful of the continued roll-out of personal health budgets in 2013-14 which many service users who are entitled to continuing care may choose to use.

3 http://www.mednetconsult.co.uk/imhsec/

Action 5: Clinical engagement - continue to build-in sufficient training time for staff and broader clinical engagement

46. For provider organisations, all clinical staff need to be trained in the methodology that supports mental health PbR, especially the use of the MHCT, to support the allocation of service users to the 21 clusters. Use of the clustering tool and submission of the data is a mandatory part of the MHMDS. Whilst all relevant staff within providers should now have had their initial training, there will always be new clinicians involved in clustering for the first time who will require training, and there will need to be regular updates for existing staff. This refresh should be informed by analysis of the data that is being collected within an organisation. It is recommended that organisations develop a number of clinical experts in the use of the clusters who can cascade their expertise to other staff.

47. To facilitate training, the Royal College of Psychiatrists has developed a training programme which is available to providers across England. The training's broad scope is:
    - Introduction – Why are we doing this?
    - The assessment approach and when to assess
    - Clusters and cluster allocation
    - Local method for capturing the data
    - How data can be fed back to clinicians

48. To register interest in this training please contact Emma George, Training Programme Manager, Royal College of Psychiatrists Education and Training Centre on egeorge@rcpsych.ac.uk . There is a charge for the training.

49. A number of on-line tools are being developed. We will include links to these under action 9 as they become available. These however, should be seen as a supplement rather than a replacement for initial face-to-face training.

50. DH has also commissioned an algorithm which can be used as a decision support tool by clinicians. The algorithm consists of an Excel tool which can be incorporated into local systems, and associated written guidance. As the algorithm is new, 2013 will be a period of further road-testing during which we would welcome feedback on its utility and suggestions for how it might be improved. We recognise that there will be problems for organisations that are part of the National IT Programme, as we cannot start to mandate the algorithm for suppliers to add it to the front-end of systems until the road-testing is completed and any amendments are made. In the meantime, the Care Pathways & Packages Project (CPPP) is going to put an on-line version of the tool on their website[4], which can be used by all clinicians.

51. There is also a need to ensure that there is broad engagement with clinicians and other staff so that the benefits from having more information about the services that are being delivered, and the

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4 http://www.cppconsortium.nhs.uk/

outcomes that are being achieved are realised across the organisation. This engagement should also extend to other partner providers with whom shared care or patients transfers happen frequently. You should consider developing some local guidance, which operationalises the national PbR guidance for your own particular circumstances.

Action 6: Understand the data issues

52. Mental Health PbR is dependent on data. For this reason, Action 1 suggested each provider organisation identifies an informatics lead.

53. Locally, there are two big issues the informatics lead will need to address. First, there is the issue of ensuring the necessary information is routinely collected. To place individuals in clusters their assessment scores must be collected and submitted as part of MHMDS. Changes to the MHMDS to capture the clustering information have been through the Information Standards Board processes, and MHMDS 4 should now be implemented on all IT systems.

54. Secondly to maxmise the benefits internally of implementing mental health PbR informatics leads need to develop a range of internal reports from their information systems. These need to show clustering completion and reassessment rates, ideally on a team by team basis. These reports should be used at senior meetings such as Board meetings as part of compliance reporting, and should be used by teams.

55. As a minimum providers and commissioners should be carefully monitoring:
    - How long people actually stay in clusters.
    - When are reviews taking place.
    - Looking at the diagnosis of people within clusters.
    - Taking opportunities to look at benchmarking patterns across England.

56. Measuring quality and outcomes that are being achieved for service users is equally important. Further information about what is required as a minimum is set out under action 7.

57. Data assurance processes are also important. There are simple tools that can be used to assess the quality of the data which is being captured and put into the MHMDS and an organisations preparedness for PbR. An example from London is set out in <u>Annex C</u>.

58. The Audit Commission has asked Capita on its behalf to work with providers and commissioners on assurance processes. Their report will be published in early 2013 and will provide some useful ideas for further work on assurance.

59. We are also working with the Health and Social Care Information Centre (HSCIC) to develop a range of reports nationally from MHMDS, which will be of value to commissioners and providers and which ultimately could be used to support payment. These reports will also link measurement of the outcomes that are being achieved for service users through the care that is delivered.

Action 7: Implementing quality and outcomes measures

60. The National Q&O group are developing a range of quality indicators and outcome measures for testing during 2013-14 which are an integral part of the currency model. These include;

- The use of a range of existing metrics, collected routinely as part of the MHMDS, as an indicator of quality
- The use of MHCT/HoNOS ratings as a clinician rated outcome measure (CROM) as an indicator of clinical change on a cluster basis
- The use of a patient rated outcome measure (PROM) as an indicator of patient outcome on a cluster basis or super class level
- Establishing use of Patient Rated Experience Measures (PREMs) that can be utilised at either a cluster or super class level.

Use of Existing Metrics:

61. For each cluster it is expected that there will be a small number, 1-3, of recommended quality indicators currently collected as part of the MHMDS. These will be indicative of the quality of services and/or of service user outcomes.

62. Providers and commissioners should confirm their selection of at least 1 quality indicator for each cluster, monitor these indicators on a quarterly basis though 2013-14, and using a recommended methodology, assess on a shadow basis how these could be used as a part of the local tariff.

63. It is not expected that the indicators will have a direct financial impact during 2013-14, but preparation should be made for future financial linkage.

Use of CROMs

64. For each cluster it is expected that an assessment of statistical difference between referral and review (or discharge) will be established using the total and 4 factor scores for HoNOS. This will involve assessing the clinical significance of outcomes for each cluster by calculating the % of service users that meet the criteria for improvements or deterioration and reporting this on an organisational basis. Providers and commissioners will need to ensure the MHCT/HoNOS data submitted for each cluster is accurate, complete and of high quality. They may wish to consider the use of Commissioning for Quality and Innovation (CQUIN) to incentivise this improvement and the use of Patient Rated Outcome Measures (PROMs) to support the CROM data.

Use of PROMs

65. For all clusters it is expected that a PROM will be used. It has not been possible to identify one universal PROM that adequately reflects the priorities for all of the clusters. Taking a pragmatic approach, testing of the Warwick & Edinburgh Mental Health Well Being Scale (WEMWBS) is currently taking place. It is suggested that where no PROM is currently being used within an organisation, WEMWEBS should be the PROM of choice. Additional or different PROMs may also be used.

66. Commissioners and providers should ensure a PROM is introduced for all of the clusters during 2013-14 and that a quarterly review of the data relating to this should be undertaken.

Patient Experience

67. As with PROMs there is no universally or agreed way to assess and report patient experience. Consideration is currently being given to the use for the CQC service user survey as part of the PbR approach. Commissioners and providers should agree local methods of assessing and reporting patient experience on an organisational and cluster basis, and review these on a quarterly basis.

68. It is not expected that either PROMs or patient experience data will be linked to payment during 2013-14, but commissioners and providers should assess how this might be achieved in the future.

69. The following cluster quality metrics were developed to support Commissioning discussions for 2012-13, will also be mandated from April 2013. These quality metrics currently include:
    - Cluster caseloads (%age clustered)
    - Cluster caseloads (Client Numbers)
    - Adherence to cluster reviews periods
    - Adherence to Care Transition Protocols

70. Client numbers and cluster caseloads are currently being reported by the NHS SCIC as experimental analysis at provider and CCG level. Work will be undertaken to produce reports that show performance against cluster review periods and care transition protocols.

71. The above metrics should be collected and monitored during 2013-14 to inform the quality of the clustering data and to ensure that providers and commissioner understand the “active caseloads” which are representative of local populations and which inform activity demand plans.

72. Commissioners could consider using CQUIN as an incentive to improve data quality which underpins all of these measures. Providers and Commissioners should agree jointly for 2013-14 a range of improvement outcomes associated with the national and locally agreed quality and outcome measures.

Action 8: Identify contractual issues

73. Providers and commissioners need to be aware that the 2013-14 contract, which has been produced by DH on behalf of the NHS Commissioning Board[5], looks and feels very different to previous standard contracts. It is simpler, more concise and easier to use.

74. A simplified three-part structure will replace the current five-part structure. The first section (the Particulars) will contain the details of the parties, the services being commissioned, and all locally-agreed matters in relation to those services, such as payment, quality and performance measures. The Particulars will function as the key contract creation and contract management tool for the parties to the contract.

75. The second section (the Service Conditions) will hold the generic, system-wide provisions governing the delivery of services and payment for them, from which commissioners will select those applicable to the package of services being commissioned and the provider that is to deliver them.

76. The third section (the General Conditions) will comprise all of the standard conditions that will apply to all services and all types of provider, including mechanisms for contract management, generic legal requirements and defined terms. These are not open to variation locally.

77. The existing contract process for payment (monthly payment based on one twelfth of Estimated Contract Value with monthly activity reviews and regular (quarterly) reconciliation plus an end of year reconciliation) will support contracting using the clusters. It is expected that the monthly reimbursement will be based on the agreed Income Guarantee between commissioners and providers, adjusted for any incentives and penalties agreed in the contract.

78. Monthly data flows to and reports from the IC from April 2013 will help support the reconciliation process.

79. Thought also needs to be given locally to how any sub-contracting arrangements will work. The currency model is focused on paying for individuals, not individual services. However, parts of an individual's care may be provided by different organisations e.g. voluntary and independent sector.

80. Commissioners may want to specify that particular providers offer some elements of care to an individual whose needs are principally being met by another provider. If they want to contract directly with a provider for just part of the care package (i.e a subset of the response to the total needs of an individual in a particular cluster) then that will be need to be factored into any locally established prices (see action 3).

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5 http://www.commissioningboard.nhs.uk/nhs-standard-contract/

Action 9: Make use of available resources on-line

81. All the intricacies of the currency methodology cannot be covered in this short practical guide. However, there is plenty of more detailed information on-line. First stop should be the Department of Health's Developing PbR for mental health services webpage.[10] Information includes:
    - Clustering Booklet – This explains the information that needs to be collected as part of the assessment process and then how this relates to allocation to clusters. This will be updated annually – the current version is for use in the 2013-14 financial year.
    - Care Transition Protocols – These protocols are designed to deal with the issue of clustering where service users are being reassessed and their needs have decreased, but only because of ongoing treatment. These now form part of the clustering booklet.
    - Mental health PbR Guidance 2013-14 – This covers in more details how the clusters are to be used and what aspects of mental health services do not currently form part of the care clusters.
    - Project Board and Expert Reference Panel minutes and terms of reference – The terms of reference cover the function of these two governance groups. Minutes are added as they are approved to make project deliberations and discussions as transparent as possible.

82. Other web-based resources include:

    - DH QuickR site – This secure web-based resource contains regular updates about meetings and the progress of mental health PbR. All meeting papers are stored on the site as well as documents that Trusts and Commissioners have been willing to share. It is also possible to start forums discussions on particular topics.
    - IMHSEC - This website is a developing site of resources designed to give a high level overview of good practice, evidence informed care pathways for each of the care clusters, to help localities plan how to efficiently, effectively and equitably operationalize services for high quality care. http://www.mednetconsult.co.uk/imhsec/
    - CPPP the Care Pathways and Packages Project was instrumental in developing the approach to mental health PbR. Their website contains many useful documents http://www.cppconsortium.nhs.uk/cppp.php

Next Steps: What will happen in 2013

83. Mental Health PbR is a developing piece of work that has been a major collaboration between the NHS and the Department of Health. Beyond 2013-14 the NHS Commissioning Board and Monitor will assume responsibility for the future developments in funding healthcare, Monitor for the price setting process including national tariffs, and the NHS Commissioning Board the scope of the tariff and developing new currencies. Therefore, any decision on moving to a national tariff for mental health services will fall to these organisations.

84. These organisations already sit on the Mental Health PbR Project Board and other mental health working groups such as the Mental Health PbR Product Review Group, the body that will considers in detail what elements of mental health PbR should be mandated nationally.

85. Work will continue in 2013 on:

- Quality and outcome measures
- Looking more closely at resource homogeneity, which will help to refine the clusters
- Further work on costing cluster review periods
- Reviewing the Mental Health Clustering Tool
- Testing and refining the algorithm through the use of live data and looking at the potential for the algorithm to support re-assessment of existing service users.

86. Other discrete pieces of work will look at issues such as the fit of specialist services with the clusters. Pilots are already underway to look at how best CAMHS services and secure and forensic services can be brought into the scope of PbR and integrate with the existing currencies. These are expected to conclude at the end of 2013-14.

87. The approach we are taking for mental health PbR is one where we are keen to learn from developments that are occurring locally that can help to inform the national picture, so do please get in touch if you have details to share.

88. Similarly, please let us know if there is further information you require. In both instances, you can use the PbR mailbox. To join the mental health PbR QuickR site use the mailbox or email ewa.dziura@dh.gsi.gov.uk.

ANNEX A - Summary table of glossary terms

Type	Term	Description
Periods	Care Spell	This is an overarching and continuous period of time that a patient spends in the care of a single or multiple healthcare providers.
	Child and Adolescent Mental Health Care Spell	This is an overarching and continuous period of time that a patient spends in the care of a single healthcare provider of child and adolescent mental health services.
	Adult Mental Health Care Spell	This is an overarching and continuous period of time that a patient spends in the care of a single healthcare provider of adult mental health (including elderly) services.
	Hospital Provider Spell	A hospital provider spell is a continuous period of care including periods of leave of up to 28 days in an in-patient setting where a bed is occupied.
	Adult Mental Health Care Team Episode	The period of time a patient spends under the continuous care of a specialist Adult Mental Health Team within a healthcare provider. For the purposes of Mental Health Clustering, these teams may be in scope or out of scope for National MH PbR services. Adult Mental Health Care Team Episodes typically occur in community based teams. A patient can have multiple episodes within an Adult Mental Health Care spell and these episodes can be concurrent.
	Mental Health Care Cluster Assignment Period	The period of time that a PATIENT is assigned to a Mental Health Care Cluster during a Mental Health Care Spell.
	Cluster Review Period (Maximum, Actual, Average and Agreed)	A Cluster Review Period is the time between consecutive Mental Health Cluster Tool assessments within a Mental Health Care Cluster Assignment Period.
	Cluster Episode Period Duration	The number of days that a patient has remained on the same cluster regardless of whether MHCT assessment reviews have taken place.
Events	Start Date (Hospital Provider Spell)	This is more commonly known as Admission Date and is the event which triggers the start of a Hospital Provider Spell.
	Discharge Date (Hospital Provider Spell)	This is the event which triggers the end of a Hospital Provider Spell.
	Start Date (Adult Mental Health Care Spell)	definitions to be completed
	End Date (Adult	definitions to be completed

Type	Term	Description
	Mental Health Care Spell)	
	Initial Mental Health Clustering Tool Assessment	The first Mental Health Clustering Tool Assessment that occurs within a Mental Health Care Cluster Assignment Period should be the initial Mental Health Clustering Tool assessment. The Assessment Reason recorded at the time of this Assessment should be **"01 New Referral Request".**
	Mental Health Clustering Tool Assessment Review	Following the first Mental Health Clustering Tool Assessment that occurs within a Mental Health Care Cluster. Assignment Period any subsequent assessments occurring within the same Mental Health Care Cluster Assignment Period should be Mental Health Clustering Tool assessment reviews. The Assessment Reason recorded at the time of this Assessment should be **other than "01 New Referral Request".**
General Terms	Clusters	The 21 clusters are based on the characteristics of service users and group people with similar characteristics together, in a clinically meaningful way.
	Mental Health Clustering Tool	This tool includes the twelve standards items of the Health of the Nation Outcome Scores (HoNOS) rated on a current basis and six additional items, mostly rated on an historical basis. The 13 current items are labelled 1-13, the five historical items A-E.
	Currency	In PbR, a currency (sometimes called a secondary classification) is the unit for which a payment is made. For example, an outpatient attendance for a physical ailment is a currency. The clusters are the currency for mental health services.
	Activity Plan	A plan of chargeable activity for a given financial period based on agreed cluster review periods. I.e. Month, Quarter, Year.
	Active Caseloads	Patients with a current (not closed) mental health cluster assignment.
	Cluster Day	The shortest time period used to compare Mental Health Care Cluster assignment periods.
	MHCT Casemix	An aggregated profile (e.g. at Healthcare provider, ward, mental health team or individual practitioner caseload level) usually including active patients (but could be historic patients) broken down by the number in each MHCT cluster.
	Mental Health Care Cluster Super Class	The Mental Health Care Super Class enables the Mental Health Care Clusters to be narrowed down,

Type	Term	Description
		by deciding if the origin of the presenting condition is primarily non-psychotic, psychotic or organic.
	Care Packages	Care packages is the name given to the responses designed to meet the needs of individuals within the clusters. Care packages will not be nationally mandated as part of mental health PbR (although many will inevitably be based on NICE guidance) to allow flexibility in meeting people's needs.
	Care Pathways	The care packages an individual receives over a period of time could be described as their care pathway
	Tariff	In PbR terms, a tariff normally means a nationally set price for a given currency. We have not committed to a timescale for moving to,a national tariff for mental health services. This will be for Monitor and the NHS Commissioning Board to determine.
	Top-up payments	Some individuals in a cluster may be "outliers", having additional needs beyond the core ones associated with the cluster (e.g. substance misuse might be an issue for an individual in cluster 3, Non Psychotic (moderate severity)), or a service user may require a translator. These may need to be met through an additional top-up payments, which will need to be agreed by commissioners and providers.
	Unbundling	A term used in PbR to refer to the splitting up of a currency into smaller units. A cluster could be unbundled if multiple providers were commissioned to provide care e.g. a main provider offering the majority of care, and then a more specialist provider to provide part of the care pathway

ANNEX B - Specific actions for commissioners

1. Capacity and Capability - Does your CCG have a nominated senior lead, with responsibility for the implementation of MH-PbR, who has access to appropriate expert advice from other colleagues (Action 1)? The PbR lead should have access to colleagues within the CCG, with the appropriate clinical, informatics and financial skills.

Where there is a shared commissioning arrangement, the Lead CCG should identify across the other CCGs, and Commissioning Support Unit, the resources to support MH-PbR implementation.

Where there is no shared commissioning arrangement, but a shared main Provider, is there a Coordinating CCG to lead the MH-PbR negotiations?

2. Leadership – Has your CCG set up a Joint Project Board for the delivery of MH-PbR (Action 2)? OR are you already part of a wider locality Joint Project Board?

If yes see 3-10

3. Have you agreed a PbR implementation plan, in line with national assumptions?

4. Is there a clear communications strategy in place that keeps staff up to date and informed?

5. Have you a good understanding of the information issues? Have you ensured that you can access, understands and interrogate MHMDS via the Health and Social Care Information Centre? Have you thought about the reports that you will need? Have you agreed with your providers what additional information may be required that you cannot access yourself?

6. Does the Joint Project Board have a clinical engagement plan, involving both primary and secondary care clinicians, and those working in third sector settings?

7. Have you started a process to align the development of outcome measures (see Action 7)? For example, are there agreed outcomes linked to movement between clusters or discharge from service?

8. Does the Joint Project Board have a training plan for key staff groups? (Action 5)?

9. Have you started a process to identify contractual issues (Action 8)? For example, agreeing specifications and how these link to the packages of care that are delivered to service-users in each cluster; sub-contracting and 'unbundling' the care clusters.

10. Have you started a process for local costing to determine prices (Action 9)?

11. Are you engaging properly with the independent sector and third sector so that they understand the requirements of introducing PbR into mental health services.

12. Are you engaging with your Health and Wellbeing Board?

ANNEX C - Organisational Readiness Self Assessment for Mental Health PbR for General Mental Health Services for working age adults 18 and over

Section 1: Organisation			
	1.1	Name of organisation:	
	1.2	Types of services provided: Adult services Inpatient Community Older adults	 Y/N Y/N Y/N Y/N

Section 2: Executive Lead for PbR			
	2.1	Has an executive lead been identified as accountable for ensuring implementation of PbR in the organisation? If the answer is no, at what level of the organisation is PbR being taken forward? If no, how are the executive team being informed of progress?	Y/N
	2.2	If yes, is the Executive Director supported in this task through regular reports on progress?	Y/N

Section 3: Organisation PbR strategy and implementation plan		
3.1	Does the organisation have an implementation strategy for PbR? **To answer yes the following needs to be in place.** **THE ORGANISATION HAS:** 1. Identified the training needs for Operational Managers on PbR and MHCT. 2. Identified the training and ongoing support needs for clinicians on PbR and MHCT 3. Identified the support needed by Informatics to manage this new data set and the requirement to report to the Information Centre 4. Identified the "AS IS" position regarding interventions offered per care cluster 5. Identified a process to cost interventions per care cluster 6. Identified processes to share cluster data with commissioners (at this stage the focus is on process rather than content) – e.g. via TSG or similar working group 7 Is aware of the key messages it needs to report to staff on their role in implementing PbR 8. Is aware of the MOU and identified a process to implement this **If the answer is no, which of the above steps are not in place? State numbers (1-8**) Will these steps all be in place within the next 3 months? If yes outline detail below in 3.2. What are the significant blocks in achieving the above?	Y/N
3.2	The organisation is in the process of implementing (outline detail from 3.1 here): 1. 2. 3. 4.	Y/N

3.3	Is the organisation reporting progress to the Executive or delegated lead on 3.1 and 3.2 above?	Y/N

Section 4: Organisational governance		
4.1	Is there a system in place for monitoring data quality? **To answer yes the following needs to be in place:** 1. Clustering data is monitored for compliance against national guidance on the MHCT. 2. Informatics processes are able to identify poor compliance and or quality. 3. Breaches are identified. 4. Breaches are reported to managers/clinicians. 5. There is a process to address poor data quality. 6. The Trust Governance Committee or equivalent receives a report on PbR data quality. **If the answer is no which of the above steps is missing? State numbers 1-6.** Will these steps be in place in the next 3 months? If yes outline detail below in 4.2. What are the significant blocks to implementing the above?	Y/N
4.2	The organisation is in the process of implementing (outline detail from 4.1 here): 1. 2. 3. 4. 5. 6.	Y/N

4.3	Other	