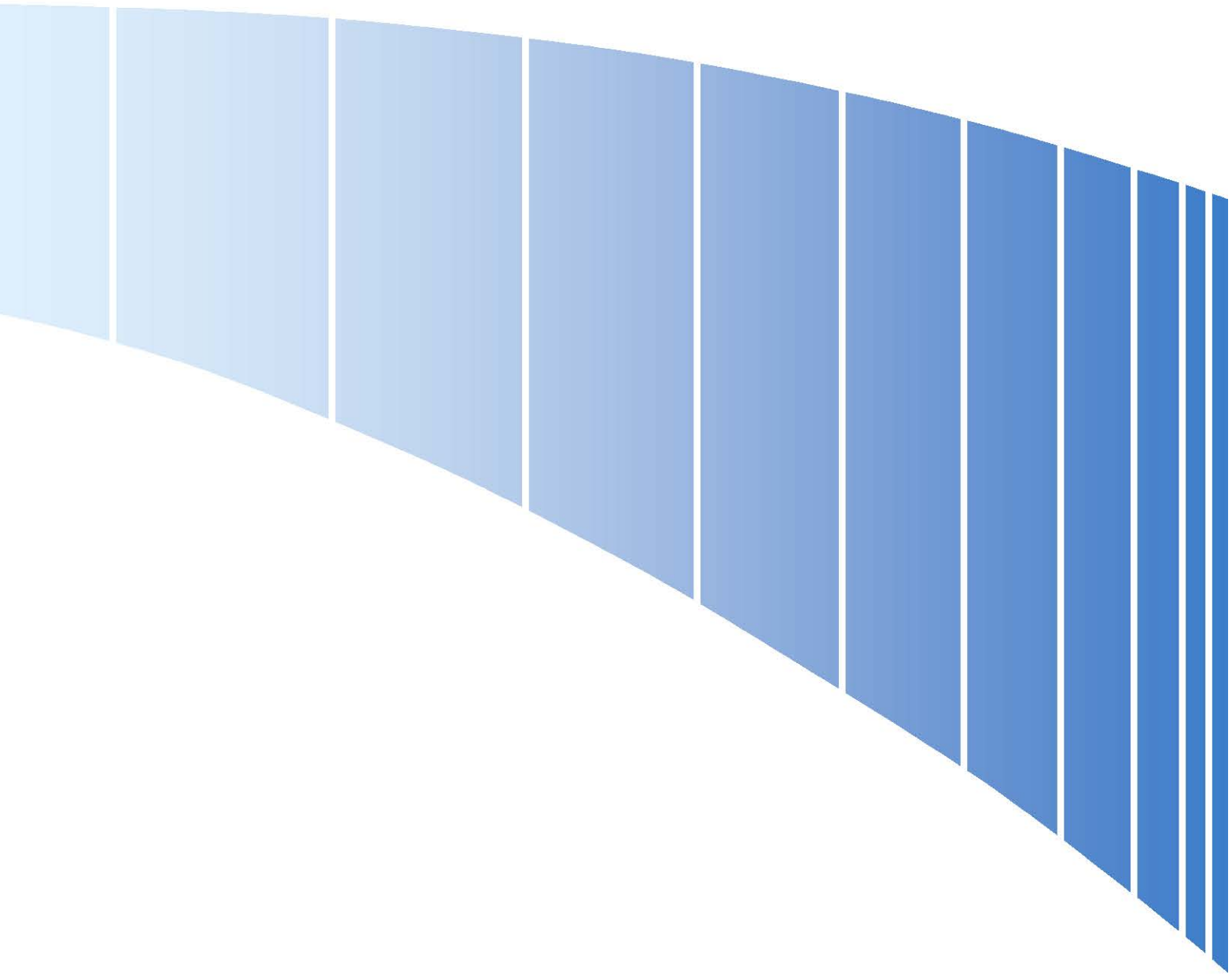
Mental Health Payment by Results Guidance for 2013-14



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1 Introduction

1.1 2012-13 was a major step forward in bringing mental health services within the scope of the Payment by Results (PbR)[1]. The mental health clusters was mandated for use from April 2012. The clusters are the currencies[2] for most mental health services for working age adults and older people. That means that service users have to be assessed and allocated to a cluster by their mental health provider, and that this assessment must be regularly reviewed in line with the timing and protocols set out in the mental health clustering booklet. It also means that the clusters must form the basis of the contracting arrangements between commissioners and providers.

1.2 We recognise that 2012-13 was just the starting point for services to get ready for any future introduction of a national tariff. National tariffs are seen as supporting the delivery of more consistent services. They should help to ensure that people coming into contact with all mental health providers will be offered the right package of care, based on best practice, but personalised to meet their individual needs, and focussed on supporting service users to move towards recovery.

1.3 The introduction of mental health PbR is a major organisational change for both providers and commissioners. For the first time clinicians will have a direct impact on the funding that their organisation receives through their work to deliver high quality care and to achieve better outcomes. Commissioners will start to understand in detail how the services they are purchasing meet the needs of individual people, and how this directly affects the prospects for patient recovery.

2 Moving forward in 2013-14

2.1 During 2012-13 we have looked at how mental health PbR is working in practice. We know that some providers have PbR firmly embedded into their internal processes and into their contracts. They have good IT systems in place that, in addition to capturing the Mental Health Minimum Data Set (MHMDS) and clustering decisions, provide added value to the organisation and to individual clinicians. They have worked with commissioners, service users and carers, local authorities and GPs to agree what services should be provided as part of each cluster and they have good costing systems in place. Others are less advanced. Commissioners too are at different stages of embedding mental health PbR into the way they work, and we have concluded that it is not yet possible to introduce a national tariff in 2013-14 without risks to both providers and commissioners. However, providers and commissioners will need to move forward during the next year in a number of ways.

[1] Payment by Results (PbR) is the transparent rules-based payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs.
[2] Currencies are the unit of healthcare for which a payment is made, and can take a number of forms covering different time periods from an outpatient attendance or a stay in hospital, to a year of care for a long term condition. Tariffs are the set prices paid for each currency.

2.2 Some providers have been able to agree a single local cluster price with their main commissioners. However, most providers have not been able to do this. As a minimum, all contracts for 2013-14 for working age adults and older people that fall within the scope of the mental health currencies should be agreed based on the clusters, and a price should be agreed for each cluster review period based on the current contract value. The cluster review period is the time between reassessments suggested in the clustering booklet. Further detail on how to develop a cluster price is contained in section 6 and Annex B.

2.3 For the moment, this means that many providers will have a different cluster price for each commissioner, and commissioners could have a range of prices for similar services from the organisations that they contract with. If providers are delivering a common set of services to every service user regardless of where they live, and there are a number of different cluster prices being agreed it may mean that there is currently some element of cross subsidisation taking place. Providers should be clear about the types of care interventions that they will offer service users in each cluster, basing these on National Institute for Clinical Excellence (NICE) guidance and other best practice. Payment should be made to providers on a monthly basis for each service user in scope of the clusters, with a quarterly reconciliation.

2.4 Within this guidance we are publishing a set of indicative cluster costs. These are based on the maximum cluster review period. The reason for taking a cluster review period is that the reassessment process provides a way of measuring whether there has been any improvement in a service user's mental well-being during a period of care. These indicative cluster costs should not be seen as a non-mandatory tariff, but we would like providers and commissioners to provide us with feedback on how these costs compare with local prices during 2013.

2.5 Initial quality and outcome measures were proposed for 2012-13. For 2013-14 we want all commissioners and providers to start to use some measures. More detail is set out later in the guidance.

2.6 A glossary of terms also forms part of this package, and is consistent with the Health and Social Care Information Centre's data dictionary. Its use will ensure that commissioners and providers use consistent language.

2.7 Before a national tariff could be introduced we recognise that there are a number of building blocks that need to be in place to ensure that there will be a smooth transition, and that any future tariff supports delivery of the mental health strategy with its focus on recovery.

3 Building blocks for mental health PbR

High quality data

3.1 It has been a mandatory requirement for all statutory NHS providers to flow data to the Mental Health Minimum Data Set (MHMDS) since 2003. Version 4 was mandated from April 2012. The requirement now covers all providers of NHS mental health services, not just NHS organisations. However, not all providers currently submit complete data records to the Health and Social Care Information Centre (HSCIC). Diagnosis is an area of MHMDS where there is currently great variability between the percentage recorded by providers. It is important that wherever possible, diagnosis is captured. The HSCIC will start publishing monthly reports in 2013-14 and this will highlight where providers are not submitting complete records.. Further details are set out in section 19.

3.2 It is of course not just submitting data that is important, but also the quality and accuracy of the information which is submitted. For PbR purposes, nowhere is this more important than in undertaking the clinical assessment of a service user and determining and recording which cluster each service user is assigned to. The mental health clustering booklet sets out how this should be done. Currently not all clinicians are recording every item in Health of the Nation Outcome Scales (HoNOS). It is very important that they do, as this data will be used when looking at whether particular outcomes have been achieved. We are publishing an algorithm which can be used as a clinical support tool to supplement use of the booklet. This is described in more detail later in this guidance.

3.3 The quality of data supplied to the Department of Health on the costs of providing health services is also very important. National tariffs are developed using the data that is submitted by providers about the costs of delivering the services they supply. If this data is not of good quality there is a danger that tariffs will be calculated that do not reflect the costs of the service provided.

3.4 Costing is an area that is underdeveloped in mental health services compared with the acute sector as few mental health providers have currently implemented Patient Level Information Systems. Monitor has indicated that in the future they will look to base tariffs on costs submitted by organisations that are using PLICS[3] systems. Use of the Healthcare Financial Management Association (HFMA) mental health clinical costing standards[4] is recommended as they are currently best practice. These will develop further in 2013, and will be incorporated into Monitor's Approved Costing Guidance.

3.5 The Audit Commission has commissioned Capita to work with NHS mental health trusts and their commissioners on the assurance of both costing and clustering data. Their final report will provide an overview of the methodology

[3] Patient Level Information and Costing System
[4] http://www.hfma.org.uk/NR/rdonlyres/1CF429F5-BC1C-4D79-8648-BEF384B8EA4D/0/MHstandards2012topresscrop2.pdf

used and identify the processes that organisations can put in place to measure how they are performing. The London Mental Health Project has developed a simple tool for providers to assess their organisational readiness for PbR, and this can be found at Annex A.

Defining the service to be delivered

3.6 We asked providers to complete work on defining the packages of care that would be associated with each cluster during 2012-13. These need to be clearly specified and agreed with commissioners and with service users. Whilst there is no prescription about which packages of care should be associated with each cluster, providers and commissioners are expected to work towards delivering care that meets any appropriate diagnosis specific NICE guidance and other best practice. The Industry & Mental Health Service Collaborative (IMHSeC) website[5] provides support to organisations for developing appropriate packages of care. Many organisations are taking the approach of defining a core set of interventions that are provided in each cluster, and a menu of interventions that will depend on the precise needs of the service user.

Quality of the service and outcomes achieved

3.7 Another key component of mental health PbR is being able to measure and understand the quality of the services that are being delivered and how service users are improving. This is important both from the perspective of individuals who are using mental health services, and from the point of view of the clinicians who are delivering the system. Commissioners will want to know that the services they are commissioning are delivering the best possible care and achieving real improvements in the mental wellbeing of those people who are using the services. More details about the measures that should be used are set out later in the guidance.

4 What is new for 2013-14?

4.1 Although we are not introducing a national tariff for mental health services, which will be a future decision for Monitor and the NHS Commissioning Board, we are for the first time publishing indicative cluster costs. These arebased on 2011-12 reference costs, and can be used as a comparator. They should not be used to set contract prices.

4.2 We are asking that all contracts are rebased on the basis of the mental health cluster and we provide a methodology which sets out an approach for how this can be done.

4.3 We are mandating the use of some quality and outcome measures in contracts. Details of these are set out in section 7.

[5] http://www.mednetconsult.co.uk/imhsec/

4.4 We are publishing an algorithm with this guidance which provides a decision support tool for clinicians. 2013 will be a year for testing the utility of the algorithm and to make any further amendments that are required.

5 Indicative cluster costs

5.1 The indicative costs for each cluster are based on the maximum duration of a cluster between each review as set out in the mental health clustering booklet which has been updated for 2013-14 and which accompanies this guidance.

Table 1: Mental health clusters

Cluster no.	Cluster label	Cluster review period (maximum)
0	Variance	6 months*
1	Common mental health problems (low severity)	12 weeks
2	Common mental health problems	15 weeks
3	Non-psychotic (moderate severity)	6 months
4	Non-psychotic (severe)	6 months
5	Non-psychotic (very severe)	6 months
6	Non-psychotic disorders of overvalued Ideas	6 months
7	Enduring non-psychotic disorders (high disability)	Annual
8	Non-psychotic chaotic and challenging disorders	Annual
9	Blank cluster	Not applicable
10	First episode in psychosis	Annual
11	Ongoing recurrent psychosis (low symptoms)	Annual
12	Ongoing or recurrent psychosis (high disability)	Annual
13	Ongoing or recurrent psychosis (high symptom and disability)	Annual
14	Psychotic crisis	4 weeks
15	Severe psychotic depression	4 weeks
16	Dual diagnosis (substance abuse and mental illness)	6 months
17	Psychosis and affective disorder difficult to engage	6 months
18	Cognitive impairment (low need)	12 months*
19	Cognitive impairment or dementia (moderate need)	6 months
20	Cognitive impairment or dementia (high need)	6 months
21	Cognitive impairment or dementia (high physical need or engagement)	6 months

* The proposal to change cluster 0 to 6 months and cluster 18 to annual is set out in the updated Mental Health Clustering Booklet. The changes have been made based on clinical feedback regarding custom and practice. Cluster 0 represents a diverse group of patients and hence the outer limit for the cluster review has been set through clinical consensus. It is therefore likely that the level of variation in actual review frequency will be greater for this cluster. The maximum review period for cluster 18 now aligns more closely with settings where this patient group are typically treated (e.g. memory clinics).

5.2 So for example, the indicative cost for cluster 1 covers all care that is required for the 12 weeks between reviews, and for cluster 16 it is six months. This

may include periods as an in-patient. The indicative cluster costs are derived from the costs reported in the 2011-12 Reference Costs return, excluding the costs of initial assessments. In the 2011-12 reference cost returns, the separate identification of initial assessment costs was not mandatory, and as such only 29 of the 60 trusts submitting cluster data were able to complete this. Therefore, the indicative costs use only the data from these 29 trusts to create a national average cost per maximum cluster review period. .

5.3 These costs have had the Market Forces Factor (MFF) stripped from them. The indicative costs have not been adjusted to account for any bias in using a sample of 29 out of the 60 Trusts, or what the total length of engagement of a service user in a cluster was in practice before a review was carried out.[6]

Table 2: Indicative cluster costs, derived from 2011-12 Reference Costs

Code	Cluster label	Maximum Cluster review period	Unit cost per day (£)	Unit cost per maximum cluster review period (£)
1	Common mental health problems (low severity)	12 weeks	9.25	777
2	Common mental health problems (low severity with greater need)	15 weeks	10.66	1,120
3	Non-psychotic (moderate severity)	6 months	11.41	2,076
4	Non-psychotic (severe)	6 months	16.69	3,037
5	Non-psychotic (very severe)	6 months	21.75	3,959
6	Non-psychotic disorders of over-valued ideas	6 months	18.50	3,367
7	Enduring non-psychotic disorders (high disability)	Annual	18.16	6,628
8	Non-psychotic chaotic and challenging disorders	Annual	23.92	8,731
10	First episode psychosis	Annual	29.06	10,606
11	Ongoing recurrent psychosis (low symptoms)	Annual	15.22	5,556
12	Ongoing or recurrent psychosis (high disability)	Annual	26.45	9,653
13	Ongoing or recurrent psychosis (high symptom and disability)	Annual	40.57	14,809
14	Psychotic crisis	4 weeks	86.23	2,415
15	Severe psychotic depression	4 weeks	46.56	1,304
16	Dual diagnosis	6 months	35.84	6,522
17	Psychosis and affective disorder (difficult to engage)	6 months	53.24	9,690
18	Cognitive impairment (low need)	6 months	5.75	1,046
19	Cognitive impairment or dementia (moderate need)	6 months	10.19	1,855
20	Cognitive impairment or dementia (high need)	6 months	22.30	4,059
21	Cognitive impairment or dementia (high physical or engagement)	6 months	23.58	4,291

Notes:

Only organisations submitting initial assessments data (29)
Excluding initial assessments costs
Costs are in 2011-12 price base.
Costs have not been adjusted to account for any bias in using a sample of 29 out of the 60 Trusts
Costs exclude MFF.
This table has not been amended to reflect the change in the proposed duration of cluster 18

5.4 How these indicative costs might relate to each provider will depend on the MFF of the organisation. NHS trusts will need to multiply the indicative costs by their own market forces factor to arrive at what they would receive for each service user if the indicative cluster costs were in fact national tariffs. Details

[6] The indicative costs can be compared to the national average unit costs per cluster from Table 2 on the 2011-12 Reference Cost Schedule sheet. These unit costs are a non-MFF adjusted version of the indicative costs. The MFF was used for the indicative costs to remove any location specific costs.

of the MFF, how it is calculated and the list of factors is set out in a separate publication.[7]

5.5 These indicative costs should **not** be used by commissioners as the starting point for agreeing cluster prices with their providers. However, we would like to receive feedback during 2013 about these indicative costs and what the impact of a tariff based on these costs might be for your organisation. You can e-mail us via pbrcomms@dh.gsi.gov.uk.

6 Agreeing local cluster prices

6.1 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 using the developing range of outcome measures many of which are derived from changes in the scores recorded at each re-assessment.

6.2 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. Some providers have worked with their main commissioners and agreed, as a group, a single set of cluster prices from April 2013. We welcome this, as this is a prerequisite for moving towards a national tariff. However, this has not yet been possible for most providers.

6.3 So, for 2013-14, the majority of providers, who have not agreed a single set of prices with all of their commissioners, will need to take the contract values for services, as described within each local contract agreements at a Clinical Commissioning Group (CCG) level, and rebase them against activity defined by the new currencies for 2013-14.

6.4 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 Mental Health 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. From the provider perspective, a different price per cluster period (local current market price) would emerge within each contract held between a provider and its various commissioners, and for the provider as a whole.

6.5 We would like the indicative cluster prices agreed between providers and commissioners to be submitted to DH by providers in April 2013, with the

[7] See *PbR Guidance for 2013-14* and *2013-14 tariff information spreadsheet*, at www.dh.gov.uk/pbr

intention of publishing them alongside reference costs in order to inform a national and local understanding of the relationship between cost and price. 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 be rebased on a six monthly basis and cluster prices re-submitted.

6.6 We will develop further business rules to support the new approach to payment based on the learning we gain through 2013-14.

6.7 **To support the transition from cluster days to Cluster Review Periods** Annex B shows how organisations can develop an activity plan for 2013-14 using cluster review periods. 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.

6.8 The maximum cluster review periods will 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 standard cluster periods in developing a fully workable payment mechanism, and also to ensure robustness of local activity plans. MHMDS data can be used for this.

6.9 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, resources and outcomes across organisations, and hence prices, with the key focus on delivering better service user outcomes with the resources available.

6.10 There will also be variations in market price that are driven purely by the lack of a historical relationship between local price and cost. Understanding this at a cluster level, alongside the relationship with outcomes, will also enable local negotiations between CCGs and providers to manage this variation and have better information to support the development of quality and outcome indicators. ***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.***

6.11 It is also proposed that building on the Memorandum of Understanding (MoU) 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 during 2013-14. 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 MoU. A sample of a possible MoU for 2013-14 is provided at Annex C. Providers and commissioners should also note that there is a national efficiency requirement for the NHS which is –4% and pay and price inflation is assessed at +2.7%. This gives an adjustment of –1.3% which should be the base assumption built into discussions on price for all non-tariff services.

7 Quality and outcome measures

7.1 In November 2011 the Department of Health published a report setting out a number of quality indicators that could be used to measure the service provided by Mental Health Trusts. Work continued during 2012 and the National Quality and Outcomes group is developing a range of quality indicators and outcome measures for testing during 2013-14. These are an integral part of the currency model to enable a better understanding of what a service is achieving, and eventually to enable some element of payment to be linked to quality. This work has resulted in:

- A set of quality indicators, reported via the MHMDS has been analysed and seven of recommended for use;
- The Clinician Rated Outcome Measure (CROM) based on MHCT/HoNOS[8] is now recommended for use;
- Good progress has been made on the development of a Patient Rated Outcome Measure (PROM), with testing of the Warwick Edinburgh Mental Well Being Scale (WEMWBS) receiving positive feedback from service users. Further testing of the short version of WEMWBS will take place;
- Further progress on developing Patient Rated Experience Measures (PREMs) and appropriate use of a "friends and family" question; and
- Completion of the IMHSEC website which provides guidance on the content of care packages for each of the clusters.

7.2 There remain challenges in moving towards a system where some element of payment can be linked to delivering particular outcomes. Further work will be carried out over the next year to strengthen the quality and outcomes framework and its component parts. More detail is provided in the following paragraphs on how to use the measures in 2013-14.

Quality indicators

7.3 For each cluster a small number of quality indicators, between 1 and 3, should be agreed. These should use data already collected as part of the MHMDS. They will be indicative of the quality of services and/or of service user outcomes. Indicators analysed and recommended for 2013-14 are:

- The proportion of users on CPA with a crisis plan in place
- The accommodation status of all users (as measured by an indicator of settled status and an indicator of accommodation problems)
- The intensity of care (bed days as a proportion of care days)
- The completeness of ethnicity recording
- The proportion of users in each cluster who are on CPA

[8] Health of the Nation Outcome Scales © Royal College of Psychiatrists 1996

- The proportion of users on CPA who have had a review in the last twelve months
- The proportion of users who have a valid ICD10 recorded.

7.4 Providers and commissioners should confirm their selection of at least one quality indicator for each cluster, monitor these indicators on a quarterly basis though 2013-14, and using a recommended methodology[9], assess on a shadow basis how these could be used as a part of the local tariff.

7.5 It is not expected that any indicators will have a direct financial impact during 2013-14, but preparation should be made for understanding how this could work in the future.

Use of CROMs

7.6 A four-factor model of HoNOS has been developed and is due to be tested on national data from MHMDS submissions during 2013. It is expected that the statistical significance of average changes observed in the HoNOS total and four factor scores could be used to evaluate outcomes in each PbR cluster. The clinical significance of changes observed in the HoNOS totals scores, which involves calculating the percentage of service users that meet the criteria for reliable improvement or deterioration, could also be used to evaluate outcomes in each PbR cluster. The results could be reported by cluster for each organisation/service provider.

7.7 At this stage providers and commissioners will need to assure themselves that the Mental Health Clustering Tool (MHCT) data (from which HoNOS can be derived) submitted for each cluster is accurate, complete and of high quality. This will require providers to ensure all MHCT items are recorded accurately and completely from April 2013 onwards at the required points in the service user journey, at initial referral assessment, routine review, significant change in presenting needs, and at discharge.

7.8 From April 2013 every MHCT item score will form part of the baseline for the future outcome measure, hence the need for accurate rating. Due to variability of the quality of scoring, data recorded from April 2013 will be disregarded for outcome measurement.

7.9 A user guide that provides further instructions on how this can be calculated locally will be made available on the Care Pathways and Packages Project (CPPP) website [10], and the DH QuickR site in March 2013.

Use of PROMs

7.10 It has not been possible to identify a single PROM that adequately reflects the priorities for all of the clusters. Taking a pragmatic approach, testing of the

[9] http://www.cppconsortium.nhs.uk/qualityAndOutcomes.php
[10] http://www.cppconsortium.nhs.uk/docs.php

Warwick & Edinburgh Mental Health Well Being Scale (WEMWBS) is currently taking place[11] As a result of this, further testing of the shortened version of WEMWBS will take place in 2013. It is suggested that where no PROM is currently being used within an organisation, consideration should be given to using the shorter 7 item version of WEMWBS (known as SWEMWBS) as the PROM of choice. Additional or different PROMs may also be used.

7.11 Commissioners and providers should ensure a PROM is being used for all of the clusters, and tie-in using the PROM with use of the MHCT. A quarterly review of the data relating to this should be undertaken.

Patient Experience

7.12 As with PROMs there is no universally or agreed way to assess and report patient experience. Consideration is currently being given to the use of the Care Quality Commission (CQC) service user survey as part of the PbR approach. We have provided at the end of this document at Annex D a list of the top 12 questions from the CQC survey as rated by service users as an example of what could be used at a local level.

7.13 Commissioners and providers should agree local activity to assess patient experience. Consideration should also be given to the appropriate use of a friends and family question: *How likely are you to recommend our services to friends and family if they needed similar care or treatment?*

7.14 The scale below should be used to answer the question:

1 Extremely likely
2 Likely
3 Neither likely or unlikely
4 Unlikely
5 Extremely unlikely
6 Don't know

7.15 .As with a PROM, a PREM should be collected in line with the MHCT, ie on completion of initial assessment, at routine review, significant change in presenting needs, and at discharge. A quarterly review of the data should be undertaken by commissioners and providers.

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

[11] http://www.healthscotland.com/documents/1467.aspx

Developing the framework further in 2013-14

7.17 In 2013-14 the focus will be on refining the framework further, testing the measures in practice and developing further recommendations on how the indicators and outcome measures can be used to incentivise high quality care.

7.18 Key objectives include:

- Testing the CROM on National Data from MHMDS and making progress on integrating PROMS and PREMS into future versions of MHMDS;
- Further analysis of indicators and measures, including assessment of quality indicator data to establish what good looks like and how it can be measured;
- Further testing of PROMs and PREMs to establish suitability as part of the framework;
- Ongoing stakeholder engagement, including service users; and
- Looking at how outcomes could be linked to payment in the future.

Data quality

7.19 The following cluster data quality metrics developed to support commissioning discussions for 2012-13, should be used from April 2013:

- Cluster caseloads (% clustered)
- Cluster caseloads (Client Numbers)
- Adherence to cluster reviews periods
- Adherence to Care Transition Protocols

7.20 The above metrics will 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.

7.21 Commissioners may wish to consider the use of Commissioning for Quality and Innovation (CQUIN) payment framework to incentivise data quality improvements and the outcomes measures outlined above. In any case, 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.

7.22 Client numbers and cluster caseloads are currently being reported by the HSCIC 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.

7.23 We recognise that this is very challenging work for both commissioners and providers, but would encourage them to work together to make as much progress as possible in 2013-14.

8 Algorithm

8.1 A set of algorithms has been developed for the Department to provide an additional tool to support clinicians with their clustering decisions at the point of a person coming to a mental health provider following an **initial** referral. The algorithms identify the most likely clusters for every service user at their initial assessment, based on the scoring arrived at through use of the mental health clustering booklet, and the comparison of an individual's MCHT ratings to the normal profile for each cluster. Their use is primarily as a decision support tool, to indicate how well the MCHT ratings fit with the clinician's choice of cluster. At the organisational level, commissioners may wish to apply the algorithms retrospectively to compare the decisions made by different providers at the first assessment. At the provider level the tool can look at the variation in clustering decisions made by different clinicians or service lines. It is not appropriate to use the algorithm to question variance at the individual patient level.

8.2 The algorithm is published with accompanying guidance alongside this document. We are proposing that during 2013 we have a period of road-testing so that we can see whether any further refinements are required before we apply to incorporate the tool into national IT systems. We recognise that this may make it difficult for some people to fully use and test the tool. However, there is an online version available on the Care Pathways & Packages Project (CPPP) website.[12]

9 Using the mental health currencies

9.1 The currencies for mental health differ from those in the acute sector. Unlike acute PbR, mental health PbR does not use the ICD-10 or OPCS-4 classification systems. They are based on a period of care, which may last for up to twelve months before a review takes place, depending on the needs of the person under the care of a specialist mental health provider.

9.2 The currencies are known as care clusters, and are based primarily on the characteristics of a service user, rather than on their diagnosis alone. Mental health professionals rate service users using the MHCT[13]. This tool has 18 scales (e.g. depressed mood, problems with activities of daily living), the first 12 of which are HoNOS. Each scale is given a rating from 0 (no problem) to 4 (severe to very severe problem). The additional six scales were taken from a previous iteration of the clustering tool known as SARN (Summary Assessment of Risk and Need) and these take into account historical information. In the MHMDS they are called the SAC (Summary Assessment of Characteristics).

[12] http://www.cppconsortium.nhs.uk/algorithm/

[13] The complete Mental Health Clustering Tool and the Care Clusters descriptions can be found in the *Mental Health Clustering Booklet 2013-14.*

9.3 The mental health clustering booklet helps clinicians to decide which cluster someone should be allocated to, and sets out a number of diagnoses that are usually associated with each cluster. However, the same diagnosis may be associated with several clusters, as the clusters reflect the assessed level of need. For the majority of service users diagnosis via MHMDS is routinely recorded only following an in-patient spell. However there are providers who do provide an ICD-10 diagnosis for the majority of their service users. We would encourage this to be done wherever possible.

9.4 Using the booklet and the ratings scales, mental health professionals can identify the cluster profile which most closely matches that of the service user being assessed. The care clusters are numbered 0-21, although cluster 9 is now a blank cluster.[14] We are future-proofing the cluster numbering system, so that any new clusters and subdivisions of clusters can be added in a logical fashion.

9.5 If no match to cluster is possible, but the service user requires treatment from an in-scope mental health service (typically non-severe autism or learning disability), then a variance cluster (cluster 0) can be used, but the reasons for selecting this must be recorded along with the characteristics of the service user. An average price for the variance cluster will need to be agreed. Where cluster 0 is being used because of co-morbidities, it may be helpful to use a "best-fit" approach and focus on the main problem at the time of clustering.

9.6 The use of cluster 0 should be reducing over time as clinicians gain more confidence in clustering, and the clustering tool is further developed to take account of less frequently encountered complex needs. Further analysis of cluster 0 will be undertaken during 2013-14 to potentially inform guidance for 2014-15.

9.7 The clusters are mutually exclusive, and a service user can only be allocated to one cluster at a time – if they transfer to a new cluster following a reassessment, the previous cluster episode ends.

9.8 The clusters are designed to be setting independent, on the premise that people should be treated in the least restrictive care setting possible. Inevitably, in a number of the clusters some people will need to be treated as admitted patients for a period. We are checking that the currencies do not create perverse incentives with regard to the minority of mental health service users who do require admitted patient care.

9.9 The final decision on which cluster to allocate a service user to rests with the mental health professional. Because clustering is linked to payment, the Department of Health is working with the Audit Commission, and their agents Capita, as part of the PbR data assurance framework. During the latter part of 2012 Capita worked with nine providers and their commissioners. Capita will review the key costing processes, selected costing data, and the accuracy

[14] Cluster 9 originally related to substance misuse and identified those service users who did not have a primary mental health need. They would be treated by substance misuse services, which have different commissioning routes and information systems from mainstream mental health services.

of the key data that underpins a selection of the new currencies. Capita will examine the arrangements the commissioners of the nine mental health trusts have in place to ensure data from mental health providers is of good quality.

10 When should clustering take place?

10.1 Mental health clustering should occur at three points:

(a) On completion of the initial assessment (typically within two contacts);
(b) scheduled reassessments; and
(c) any reassessment following a significant change in need that cannot be met by the continuation of the current cluster care package[15].

10.2 In addition, at discharge the MHCT scores must be recorded and entered into the HoNOS fields in the MHMDS, but service users should **not** be re-clustered. Scoring service users at discharge will help build information for the implementation of Clinician Rated Outcome Measures.

10.3 When reviewing a service user who has already been allocated to a cluster, upon reassessment using the MHCT, he or she may have a lower score because they are receiving effective treatment. However, if this treatment were to be stopped, due to allocation to a lower cluster or discharge, their needs would increase again. Therefore, to avoid such perversities, the *Mental Health Clustering Booklet 2013-14* includes guidance on points to consider in re-assessment, known as care transition protocols. The protocols should be used before applying the MHCT and reviewing the care cluster scores.

10.4 This approach of using the care clusters as currency and use of the MHCT does not obviate the need for good clinical diagnosis and psychological formulation, which remain key to the management of an individual service-user's care, and in selecting the most appropriate package of interventions to address their mental health needs.

10.5 The clusters are very different from most currencies currently in use in acute physical PbR in that they cover more extended periods of time, and will typically contain multiple different interactions with a range of clinicians, and different types of interventions. For instance, whilst in cluster 4 – non-psychotic (severe) – a service user might have several sessions of psychological therapies, contacts with a care coordinator and other types of interventions.

10.6 The amount of time that a service user will remain in a cluster will vary. The total time in the cluster will represent the cluster episode period duration. Depending of the needs of the individual, each cluster episode may be made up of several cluster review periods. The cluster period itself represents the interval between reviews of care.

[15] A note should be made of the number and percentage of unplanned reassessments, and why these are taking place. Development work should help to identify what percentage of re-assessments will normally be unplanned.

10.7 Table 1 sets out for each cluster the expected review interval. These have been developed through a review of best practice and represent the maximum intervals between care reviews. They vary considerably between clusters as some relate to short episodes of mental illness, and others to where the mental illness needs to be monitored and reviewed over a longer period. The Care Programme Approach (CPA) review period is annual. Commissioners should monitor that the reviews are taking place as scheduled, noting when the reason a review has not taken place is due to the service user not attending.

11 Mental health assessments for clustering

11.1 Development of the mental health care clusters has brought into focus the issue of how the initial assessment of an individual for clustering purposes should be reported, costed and reimbursed, what outcomes can be delivered, whether or not they are allocated to a cluster. This section relates to new referrals and 'one-off' assessment services, rather than to re-assessments or internal transfers between services of existing service users.

Initial assessments

11.2 The initial assessment can be triggered in a number of ways, as part of a GP or mental health practitioner referral, in response to a specific request by an organisation such as the police or social services, or through self-referral.[16] These initial assessments can be classified in three ways, according to how the assessment was initiated and whether an individual is allocated to a care cluster or not:

(a) Assessed, not clustered and discharged

In this classification, an individual may be referred by their GP or through other routes to a mental health provider for an initial assessment. On assessment, the mental health professional establishes that it is not appropriate for the individual to be offered specialist mental health care and hence the individual may be referred back to the GP by the mental health professional for other diagnosis or treatment, or signposted to other services. An example of this might be referral to non-mental health related substance misuse services.

(b) Assessed, clustered, and accepted for treatment

As before, an individual may be referred by their GP or through other routes to the mental health provider for an initial assessment. The assessment process establishes that the individual needs to be allocated to a care cluster. In some cases, the assessment may take place over more than a single visit. The individual then comes under the care of the

[16] An assessment may include electronic solutions such as telephone consultations and telemedicine, in addition to a face-to face meeting.

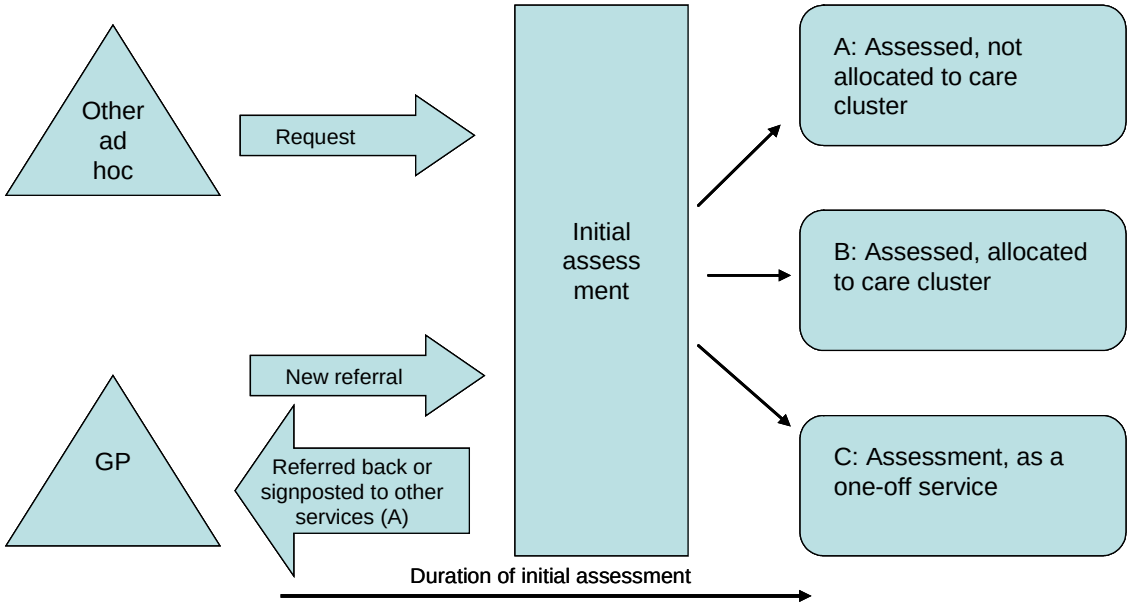
mental health service provider, and the model of service and package of care to deliver effective interventions are discussed and agreed with the service user.

(c) Assessment 'service'

This classification differs from the previous two in that it tends to be more intermittent, covering the one-off provision of mental health services, for example, providing clarification to a GP about the mental health of an individual and any further treatment that will need to be delivered by the GP, or assessments at memory clinics.

11.3 It is difficult to specify the frequency with which the assessment 'service' will be utilised, the circumstances in which assessment services will apply must be agreed with commissioners**.** The risk of assessment services becoming an uncontrolled activity payment will be minimised if all parties understand what will be, and what will not be, covered within service contracts. Figure 1 illustrates the three types of initial assessment.

Figure 1 Initial assessment classifications



Duration of initial assessments for clustering

11.4 The assessment period begins when the mental health provider receives a new referral from a GP or elsewhere. Where the assessment is to determine whether someone will be clustered, experience to date suggests that this should normally be completed within two contacts in a community setting or two working days/bed nights in an in-patient setting. Providers have advised us that these assessments may often be completed in a single session or day,

for example one-off assessment services such as memory clinics. The assessment is completed when the individual is either allocated to a cluster, not allocated, or the provision of the one-off service has concluded.

Funding initial assessments for clustering

11.5 The initial assessment of an individual will be funded as a separate activity. This is because the initial assessment and subsequent clustering of an individual by a mental health provider can be an intensive process, requiring significant professional resource. However, as described earlier, some individuals are referred and assessed, and then found not to need specialist mental health services, so are not allocated to a care cluster. If payment was only linked to allocation to a care cluster then the assessment of these individuals would not be reimbursed unless the costs of their initial assessments were included as an overhead in the payment for service users who are clustered.

11.6 This does not seem satisfactory and would provide an incentive to reduce thresholds and allocate people to clusters inappropriately. It would also distort the cost of care clusters if the costs of initial assessment for people who are allocated were included. Diagnostic tests undertaken as part of the initial assessment may need to be included in the initial assessment price where these are not separately funded by commissioners.

Pricing assessments for clustering

11.7 Commissioners and providers will need to negotiate local prices for initial assessments. Some assessments will be more complex than others, requiring more resources, including the involvement of several professionals. A process for pricing assessment activity for 2013-14 is included in the finance and activity schedule at Annex B. More detailed analysis of assessments will be undertaken to help inform any arrangements for future years.

Re-assessment of existing service users

11.8 The previous section only covers new referrals and the provision of initial assessment ‘services’. Mental health providers will re-assess and re-cluster existing service users at pre-determined and agreed intervals. To facilitate this, care transition protocols have been developed which map an individual’s progress, and propose movement through the care clusters as an individual responds to the package of care that they receive. The costs of re-assessments are to be included in the costs of the current cluster at the point of re-assessment, as all service users will be reassessed at various points for the purpose of re-clustering, and as part of monitoring on-going care.

12 Cluster periods as contract currency

12.1 The cluster periods are the contract currency used in the NHS Standard Contract for all service-users falling within the scope of the clusters. This means that commissioners will be paying providers on the basis of x people in cluster 1, y people in cluster 2 and so on at any one time.

12.2 We expect all providers to ensure that by the end of 2012-13 they have specified the care packages that will be available for each care cluster. The IMHSeC website tool[17] has been developed to provide a resource for providers and commissioners. It draws together existing best practice associated with the clusters.

12.3 As usual, commissioners may choose to commission and/or contract through collaborative arrangements using the Health Act Flexibilities to jointly or lead commission. When contracting using the new contract currencies commissioners have a number of options, they could:

a. contract a lead provider to be both a clinical and contractual pathway provider, where all local health services within the cluster are either provided by or subcontracted by the lead provider. This may include the need to move patients out of area to another provider on a temporary basis, for example for a period of intensive care. In all cases the lead provider will also be responsible for managing and improving the quality, outcomes, innovation, productivity, and improving prevention along the whole pathway.

b. contract a principal provider to be a clinical pathway provider. Other local providers of services within the pathway remain contracted directly from the commissioner but are specified within the care pathway. The principal provider is only responsible for improvements within their part of the pathway. Commissioners would then retain responsibility for ensuring a smooth interface between providers, and for monitoring the quality of service of all of the providers. Commissioners should involve the principle provider in discussions with other providers to ensure maximum productivity, smooth transitions, and high quality along the whole pathway.

12.4 With a principal provider model, if there were multiple providers within the care pathway, this in effect means the tariff would be unbundled. This could lead to paying more on a fee for service basis, which may encourage providers to do more activity rather than providing holistic care over a period of time.

12.5 Where there are multiple providers delivering part of the care for a cluster it is important that all relevant data is transferred from one provider to another. This of course includes cluster information. This principle applies equally to NHS organisations and to independent and third sector providers.

[17] http://www.mednetconsult.co.uk /imhsec/

12.6 Many services are commissioned using both health and social care funds. It is for commissioners to make a judgement on whether such provision is considered health care, and hence part of MH PbR, or social care, and hence part of a personal budget for social care outside of the cluster tariff. However, in doing so they must follow national guidance in assessing whether an individual has a primary health need or otherwise[18].

12.7 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.

12.8 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.

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

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

12.11 By allowing classification and benchmarking, 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.

12.12 The cluster currencies should, as with PbR more generally, apply regardless of where and who delivers the care, so will also be applicable to the third sector and the independent sector as well as the NHS. We recognise that the independent sector often has a particular focus on some of the more specialist mental health care, much of which is not in scope of the current clusters.

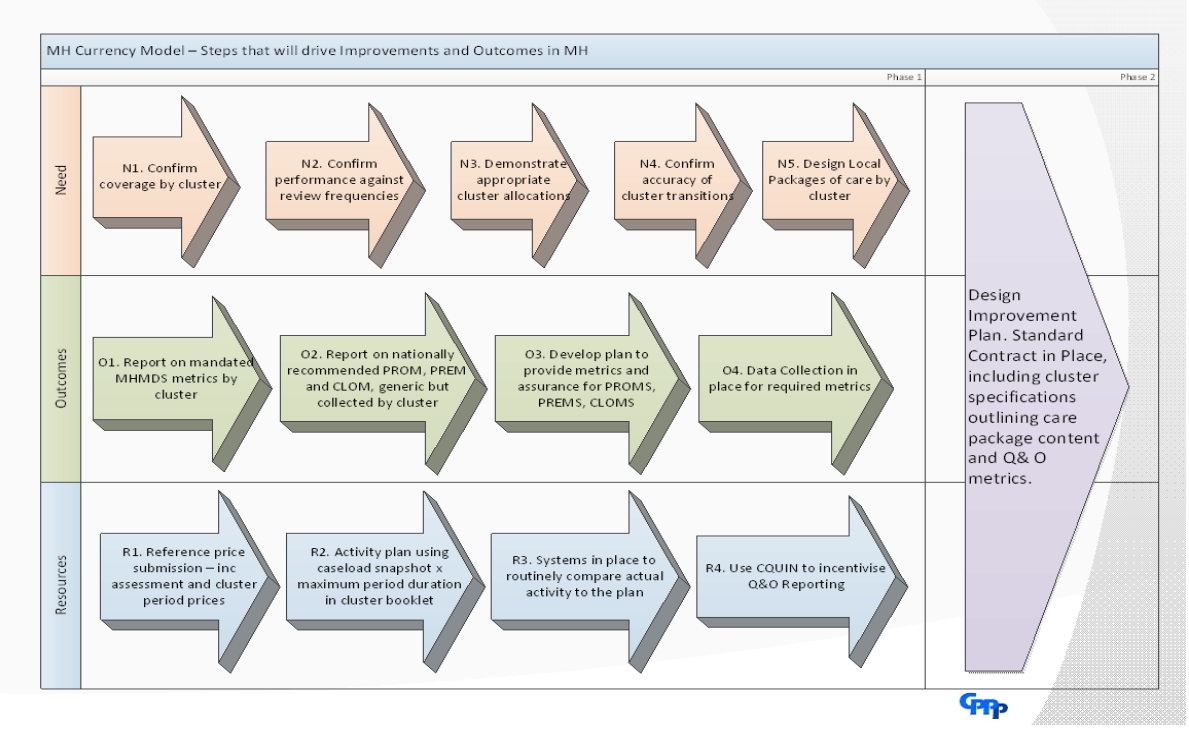
[18] https://www.wp.dh.gov.uk/publications/files/2012/11/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf

12.13 The payment for each care cluster will inevitably be an average payment. Commissioners and providers should be cognisant of groups of individuals who may add significant additional costs to the average service user within a cluster, for example service users with communication difficulties may have a requirement for a translator or a signer. It may be appropriate to agree additional top-up payments or alternative funding arrangements, in addition to the core cluster payment, to ensure the cost of these additional services is recognised. Over time, the currency model will be expanded to include other specialised services, subject to the future work programme of Monitor and the NHS Commissioning Board.

13 Overall currency development

13.1 The following diagram summarise the stages of development for the currency model, and the main required actions for 2013-14.

Figure 2



14 Interaction between the mental health clusters and Improving Access to Psychological Therapies (IAPT)

14.1 Where secondary care services offer combined treatments, which include a component of NICE approved Psychological Therapies for anxiety and depression, service users will be clustered in the normal way. These clusters will be used as the currency for payment. Subject to local agreement, the payment for the IAPT component of care may be unbundled and paid

separately. If the IAPT care is paid for separately, this could be via a block, or cost & volume contract basis. A component of the payment may be based on outcomes.

14.2 Where service users receive **only** the IAPT treatments that NICE guidelines recommend, providers are exempt from the mandatory requirement to cluster all service users in 2013-14. However, for consistency, providers may choose to cluster service users upon admission to these services. Payments for discrete IAPT services will be made according to locally agreed contracts. These can include payment for activity and a component based on outcomes measures.

14.3 A feasibility study for an outcomes based PbR currency model for IAPT services has been undertaken during 2012-13. . Data from 22 IAPT pilot sites has been submitted each month. An extended pilot is planned for 2013-14. Further details about the feasibility study, including detail of the outcomes based model may be found on the IAPT web site[19].

15 Personal health budgets - how will they interact with mental health PbR?

15.1 The Government has made clear that individual choice and control in public services is a priority. Personal health budgets, which were piloted in the NHS from 2009 to 12, are one of the ways of achieving this, enabling individuals to better manage their physical and mental health.

15.2 On 30 November 2012, Ministers announced that based on the positive evidence in the independent evaluation[20] of the pilot programme, the use of personal health budgets would be rolled out more widely across the NHS. The evaluation showed that the groups who benefited most from personal health budgets during the pilot were those with higher levels of need, including individuals in receipt of NHS Continuing Healthcare and those with mental health needs.

15.3 A practical 'Toolkit'[21] is available online to support implementation and will evolve as more is learned about personal health budgets during the early stages of rollout. This will include further information about implementing personal health budgets in mental health.

15.4 Goods and services purchased by personal health budgets have so far generally replaced community or mental health services, so, the mental health currencies and tariffs are expected to be helpful in setting personal health budgets and identifying how much money should come out of existing contracts.

[19] www.iapt.nhs.uk/pbr
[20] http://www.personalhealthbudgets.dh.gov.uk/Topics/latest/Resource/?cid=8603
[21] www.personalhealthbudgets.dh.gov.uk/Toolkit

16 Exclusions

16.1 The clusters cover the mental health care delivered by a secondary provider for services that have traditionally been labelled working age (including early intervention services) and older people's services. As early intervention services are included this means that there will be some children who are allocated to a cluster.

16.2 Table 3 lists the service areas not covered by the clusters. This list included all areas which will be commissioned directly by the NHS Commissioning Board from April 2013. More detailed descriptions of the services can be found on the Department's website.[22]

Table 3: Mental health services areas excluded from the clusters

Specialist Commissioned Services excluded from PbR
Child and adolescent mental health services (CAMHS) Pilot work is taking place with CAMHS providers over the next eighteen months to develop a suitable approach for PbR for CAMHS.
Forensic and secure services Adult Secure Mental Health Services will include high, medium and low secure in-patient care and associated non-admitted care including outreach when delivered as part of a provider network.
Perinatal psychiatric services (mother and baby units) Specialist Perinatal Mental Health Services are provided by specialist mother and baby units. Services will include in-patients and associated non-admitted care, including outreach provided by these units when delivered as part of a provider network. This applies to provision in adults and young people.
Tertiary eating disorders Adult Specialist Eating Disorder Services will include in-patients and bespoke packages of care for intensive day care (as an alternative to admission) services provided by Specialist Adult Eating Disorder Centres. The service will include associated non-admitted care including outreach when delivered as part of a provider network.
Gender dysmorphia Gender Identity Disorder Services will include specialist assessment, non-surgical care packages, transgender surgery and associated after care provided by Specialist Gender Identity Disorder Centres. This applies to provision in adults and children.

[22] http://www.dh.gov.uk/health/2012/09/cagreport/

Specialist Commissioned Services excluded from PbR
Specialist mental health services for deaf people Specialist Mental Health Services for Deaf Adults will include in-patient and non-admitted care including assessment and treatment services for deaf people provided by Specialist Centres. In addition, the service will include advice to general mental health services on the management and treatment of the deaf person's mental illness.
Severe obsessive compulsive disorder and body dysmorphic services Include services provided by Highly Specialist Severe Obsessive Compulsive Disorder and Body Dysmorphic Disorder centres. This applies to provision in adults and adolescents.
Specialist Services for Severe Personality Disorder in Adults Specialist Services for Severe Personality Disorder in Adults will include in-patients and bespoke packages of care for intensive day care services (as an alternative to admission) provided by Specialist Centres. In addition, the service will include associated non-admitted care including out-reach when delivered as part of a provider network.

Other services currently excluded from mental health PbR
Discrete IAPT Services
Specialised addiction services. These services are being commissioned by Local Authorities from April 2013[23]
Specialist Psychological Therapies – admitted patients and specialised out-patients[24]
Learning disability services for non-mental health needs .
Acquired brain injury
Complex and/or treatment resistant disorders in tertiary settings
Specialist services for autism and Asperger's
Liaison psychological medicine – work will be undertaken during 2013 to identify how this area might be brought within the PbR approach

[23] Substance misuse is often a complicating factor for a mental health problem. This is included in the clustering tool.

[24] Specialist Psychological Therapies are those therapies that are delivered, usually over a longer duration, by expert clinicians, qualified in particular therapeutic modalities. Patients who require specialist psychotherapies usually present with the most complex and severe mental health problems for whom primary care services and standard secondary mental health services, e.g. input via recovery teams, have either not been effective or have been unsuitable.

16.3 Locally, there may be other specialised non-standard services that both providers and commissioners agree fall outside of those included in the clusters.

16.4 Work is in progress to develop PbR currencies for forensic and secure services, and CAMHS services, with pilots underway that are due to report towards the end of 2013-14. We are also looking at whether there is a need for additional clusters for people with learning disabilities with specific mental health conditions. The timetable for bringing any other services into the scope of PbR will be confirmed by the NHS Commissioning Board and Monitor in due course.

16.5 Although commissioning for alcohol misuse services will move to Local Authorities for 2013-14, currencies are being explored for these services based on recent pilots. The currencies for alcohol misuse services will not be mandated at any point, but may be useful in the future for both providers and commissioners as a service improvement initiative.

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17 Non-contract activity

17.1 The longer-term duration of mental illness means that a service-user may present for urgent treatment from a provider in another part of the country. For instance, a service user is being treated by one mental health provider, but then has an incidence of mental illness elsewhere in the country that leads to their being admitted (for example under section 136 of the Mental Health Act), or needs other urgent treatment. This will need to be paid for separately by the commissioner located in the area where the service user normally resides. If a national tariff is introduced, cross-charging between providers may need to be introduced, which will require commissioner budgets for NCA activity to be devolved to the main provider. Further consideration will be given to guidance on this subject during 2013-14.

18 Interaction between care cluster and acute Healthcare Resource Groups

18.1 The care clusters are not mutually exclusive with acute physical healthcare HRGs. This is because a mental health service user may well need surgery or other treatment that is not related to their mental health problem, and this will be provided by an acute provider rather than a mental health service.

18.2 Many HRGs identify mental health problems as complicating factors in care. For instance, dementia is deemed a complicating factor in orthopaedic procedures. Consequently an HRG is generated which has a higher level of

complexity and the acute provider receives a higher payment. For instance an ICD-10 code of F001, Dementia in Alzheimer's disease with late onset, would result in the generation of HRG HB23B Intermediate knee procedures for non trauma with CC[25] rather than HRG HB23C Intermediate knee procedures for non trauma without CC. HB23B has a higher tariff than its counterpart without complications or co-morbidities**.**

18.3 Therefore, identification of mental health problems (eg through an assessment of mental state) and any additional costs in treating the primary physical condition, which result from the mental health problem, are included in the tariff price for the HRG. Treatment specifically for the mental health problem itself is not included in the HRG. Support for dealing with mental health issues in an acute setting is dealt with differently in different organisations.

18.4 In some areas, liaison mental health services are in place. These currently fall outside of the scope of the mental health PbR project and are subject to separate commissioning arrangements. In other areas, there may be no formal arrangements and a local mental health provider will be called in on an ad hoc basis to deal with any issues. In the case where a patient is not currently under a mental health provider, commissioners will need to ensure that the provider who is giving this service is appropriately reimbursed. Where a patient in an acute hospital is already under the care of a mental health provider, commissioners will need to ensure that they are not paying twice.

18.5 Conversely, mental health providers often provide physical healthcare to patients on an ongoing basis, for example for service-users with long-term conditions. The treatment may be carried out by paying for primary care services or by qualified ward staff. This work is not reimbursed through reference to HRGs, but the physical co-morbidities can be recorded in the MHMDS. Commissioners will need to agree with providers how to fund this care, either through embedding it into the price of clusters or through a separate payment for physical healthcare. The price paid must be transparent, fair and representative of the actual costs incurred.

18.6 One area that we will give further consideration to is who should fund admissions and treatment in acute physical healthcare that are primarily driven by an underlying mental health problem, eg self-harm presentations at A&E, or re-feeding and managing physical health in anorexia nervosa. Current funding arrangements continue for now, and this activity is for the moment outside of the scope of Mental Health PbR.

[25] Complications and comorbidities

19 Data analysis and sources of information for commissioners and providers

Mental Health Minimum Dataset (MHMDS) for commissioners

19.1 Record level MHMDS extracts are available for commissioners to download from the Open Exeter Bureau Service Portal (BSP). Extracts include MHMDS records for those patients for whom each organisation is the commissioner. Providers currently submit data once a quarter, but from April 2013 data will be submitted – and be available - once a month. Summary reports on clusters will be available on the BSP with the monthly data next year. Commissioners' record level MHMDS does not currently include NHS number – however, each record includes a Spell ID which is common to the extracts received by providers and can support investigation of individual records.

19.2 Providers make a primary submission soon after the end of the period and have the option of replacing this data with a 'refresh' submission at the next deadline. Patient records are filtered for each commissioner extract by the 'Org Code (code of commissioner)' entered by the provider in each patient record.

19.3 Commissioners are advised to discuss with the organisations from whom they commission services which code should be used. For further information about this important issue at a time of organisational change, please see the HSCIC web site: http://www.ic.nhs.uk/article/2196/Mental-Health-Information-Update---September-2012

19.4 Extracts have been available since April 2012 although many commissioners have not yet downloaded them. A specification for the commissioner extracts can be found on the HSCIC web site here: http://www.ic.nhs.uk/CHttpHandler.ashx?id=1697&p=0

19.5 If you have not already registered for access to MHMDS on the Bureau Service Portal you need to complete an application. If your organisation already has access to Open Exeter you can omit steps 1 and 2 below.

1. Go to https://nww.openexeter.nhs.uk/nhsia/index.jsp and click on the blue box at the bottom that says Caldicott Guardian. Register and check that the correct name is given for the Caldicott Guardian of your organisation.

2. If the name is incorrect or missing, download and complete the http://www.connectingforhealth.nhs.uk/systemsandservices/ssd/prodserv/caldicottcert.pdf form to register the correct Caldicott Guardian and send this back to the address on the form.

3. If the name of your organisation's Caldicott Guardian is correct then just complete the following form http://www.connectingforhealth.nhs.uk/systemsandservices/ssd/prodserv/bsp

ducform.doc to request access to Open Exeter for MHMDS v 4 and send it to the address on the form (Note: the addresses for the two forms are different).

19.6 Please note that once issued, accounts must be activated within a short period of time. Instructions on how to get a user login are on the IC website and in the MHMDS User Guidance. www.ic.nhs.uk/services/mhmds/spec (Section 8). For further help please contact the Information Centre via: exeter.helpdesk@nhs.net

MHMDS for providers

19.7 Providers who submit MHMDS have access to an extract in the same format as the commissioners receive (except it includes patient identifiable items) and a range of validation reports at the point of submission. For submissions from April 2013 these will include some additional warnings and diagnostic reports, including counts relating to clusters, as provided to commissioners. The MHMDS submission will be made once a month (for a monthly reporting period) starting with April 2013 submission.

19.8 It is important that providers discuss with their commissioners what Org Code (code of commissioner) should be used during the organisation changes over the next year. Please see the HSCIC website for further details: http://www.ic.nhs.uk/article/2196/Mental-Health-Information-Update---September-2012

19.9 In order for accurate data to flow to commissioners providers must ensure they are meeting the submission requirements described in the MHMDS User Guidance (http://www.ic.nhs.uk/services/mhmds/spec). It is important that they submit full, accurate and timely data in Tables 26 and 27 of the submission database. Providers need to ensure that all Episode End Dates (including PbR Cluster episode End Dates) are submitted when required (see http://www.ic.nhs.uk/article/2217/Mental-Health-Information-Update---October-2012)

19.10 Please note that once issued, accounts must be activated within a short period of time. Instructions on how to get a user login are on the IC website and in the MHMDS User Guidance. www.ic.nhs.uk/services/mhmds/spec (Section 8). For further help please contact the Information Centre via: exeter.helpdesk@nhs.net

20 Further information

20.1 A glossary of terms has been developed, and is attached at Annex H. This includes general terms as well as terms from the data dictionary. Further information to support preparations for mental health PbR can be found on the DH website,[26] but is also available via on the mental health QuickR sites, a

[26] http://www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/DH_4137762

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

ANNEX A - 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	

ANNEX B - Developing a finance and activity schedule for 2013-14

This annex sets out a methodology that organisations can use for developing a finance and activity schedule based on the mental health clusters, for use with commissioners in contracting negotiations for 2013-14. It moves providers away from the existing currency methodology based on bed days and contacts. Here the activity schedule is based on delivering care for service users in each cluster for the period of time between reviews and reassessment which is set out in the mental health clustering booklet.

For 2013-14, organisations will be rebasing payment for the activity carried out in each cluster on the basis of their current contract values, and the approach explains how to develop cluster period activity plans to support the development of the cluster prices. This requires an assessment of the relative resource intensity involved in the delivery of services at a cluster level, and using a snapshot of caseload to develop a standardised activity plan. For most providers, developing the contract for 2013-14 will involve rebasing the contract with each commissioner. A few providers have been able to agree with all their commissioners that they will have an organisation wide set of cluster prices. The same methodology can be used in both cases.

It should be noted that steps 1 and 2 **only** apply to organisations that are able to undertake patient level costing, or an alternative bottom up approach. However, Monitor has already signalled that this is the direction that they would like to see all providers moving in. Steps 3 and 4 will be relevant to **all** organisations whether a top down or bottom-up approach is used.

The methodology does not cover pricing for in-patients as at this stage of development there is assumed to be no variation in resource intensity associated with being an in-patient in any particular cluster. This will be subject to further analysis and consideration through 2013-14. Organisations will though need to look at the average amount of in-patient activity in each cluster to identify a cluster period price. Further details are set out later in this note.

The tables included with this note are illustrative only and are **not** meant to be used for comparison with your own organisation. You will need to work through the methodology by inputting your own data.

Approach for costing and development of finance and activity schedule for contracting 2013-14

Development of fully absorbed costs at a cluster level

This approach is based on a calculation of the direct costs of interventions, which are then used to determine the relative resource intensity of care provided across the clusters. The approach therefore recognises the resources employed in different cluster treatments. A cost per day is first calculated and used to allocate the full costs to take account of the relative difference in resource utilisation across the clusters. The full cost is then applied to the duration of care between reviews to give a cost per cluster review period.

Calculation of fully absorbed non in-patient cost per cluster

Stage 1: Collate the cost of Clinical time at a cluster level

From the data collected through the Mental Health Clustering tool (MHCT) run a report at a patient level for the given reporting period providing: -

- the length of time of the appointment
- cluster allocated (where no cluster is allocated, the patient is assumed to be in the assessment phase)
- band of staff – (individual staff details if available)
- number of days the patient has been in the cluster

Using this information, calculate a cost of the staffing resource utilised across these patients (the figures included in all the examples below are included to be used to illustrate the calculations, they do not relate to any specific services, however by the inclusion of team and/or service it would facilitate the extract of weightings at team and/or service level):

Patient ***(A)***	***Cluster*** ***(B)***	***Appointment Time*** ***(C)***	***Band*** ***(D)***	***Staff rate per Hr*** ***(E)*** ***£***	***Cost of Appointment*** *(C*E)* ***(F)*** ***£***
W	Assessment	45 mins	Band 7	£21.75	£16.31
X	1	30 mins	Band 6	£18.55	£9.28
Y	2	60 mins	Band 8a	£27.72	£27.72
Z	3	60 mins	Cons	£65.40	£65.40

As a standard all appointments before a cluster has been allocated to a patient should be counted as initial assessment appointments. The appointment at which the patient is clustered is counted as the final initial assessment appointment, following that all subsequent appointments are counted as treatment appointments against the allocated cluster (s). Stage 4 of this document provides further detail on the assessment methodology.

This patient level data is then consolidated for the appointments identified as initial assessment and at the individual cluster levels to obtain a total direct staffing cost per cluster for this period.

Using a report from the information collected through the MHCT, we can then obtain the total patient days (the total time that patients have spent in each cluster column H below).

Cluster Number	***Total of Cluster***	***Patient Days***	***Cost Per Patient Day***	***Weightings***
			(G/H)	*(Cluster No Cost (I)/Lowest Cluster No Cost (I))*
	(G) **£**	***(H)***	***(I)*** **£**	***(J)***
0	126,879	36,716	3.46	1.14
1	75,895	25,134	3.02	1.00
2	177,565	32,368	5.49	1.82
3	129,228	18,017	7.17	2.38
4	226,998	34,864	6.51	2.16
5	158,458	21,085	7.52	2.49
6-21*	2,722,744	250,062	10.89	3.61
Assessment	460,073	58,475	7.87	2.61
TOTAL	**4,077,840**	**476,721**		

*Lines 6 – 21 need to be calculated separately.

The cost of clinical staff time is the cost driver being used to identify the relative resource intensity between the clusters. Those weightings are based on a calculated direct cost per patient day (column I). The weighting column above (column J) shows a Relative Value Unit of each cluster.

The Relative Value provides an indication of the relative resource utilisation of the clusters. From the example in the table above we can see Cluster 5 is shown to be 2.49 times more resource intensive than cluster 1.

Ideally this stage is completed utilising 12 months of data from the MHCT. There is a clear understanding that organisations are at different stages of collecting activity by cluster so where there is a limited level of data available, a sample will be more appropriate.

The above calculation can be applied at an organisation, directorate and or team level to develop benchmarking. As accuracy improves, the data collected will lead to developing bottom-up costing at team levels.

Stage 2: Calculate fully absorbed costs at a cluster level

Each organisation has a fully absorbed cost for patient services from their existing costing model that has been previously calculated to support the reference costs submission, applying standards contained within the HFMA Clinical Costing Standards and National Costing Guidance. Using costs from stage 1 for each patient service area the fully absorbed cost can be apportioned across the clusters using weighted patient days.

Using the patient days and weightings from stage 1, calculate weighted patient days per cluster. This can then be used to apportion costs from the fully absorbed cost of the service to each individual cluster, giving a fully apportioned cost by cluster (see below).

Cluster Number	***Costed Patient level Data*** *(from stage 1)* ***(G)*** ***£***	***Patient Days*** *(from Stage 1)* ***(H)***	***Weighting*** *(from stage 1)* ***(J)***	***Weighted Patient Days*** *(H*J)* ***(K)***	***Apportioned Full Cost*** *(Full cost *K/Total of K)* ***(L)*** ***£***
0	126,879	36,716	1.14	41,856	141,111
1	75,895	25,134	1.00	25,134	84,735
2	177,565	32,368	1.82	58,910	198,604
3	129,228	18,017	2.38	42,880	144,564
4	226,998	34,864	2.16	75,306	253,881
5	158,458	21,085	2.49	52,502	177,000
6-21	2,722,744	250,062	3.61	902,724	3,043,371
Assessment	460,073	58,475	2.61	152,620	514,530
TOTAL	**4,077,840**	**476,721**		**1,351,932**	**4,557,796***

*Full cost of the service, which is aggregated team data from costing model, and is apportioned using weighted patient days from column K in column L. The weighted patient days should ideally be based upon aggregated team activity. Having developed a fully absorbed cost per cluster for the service, a report should be run of activity by cluster. This can be by cluster day, or cluster review period, based on actual or standard periods of treatment. The methodology can be further developed to support patient level costing.

Through costing based on primary data collected at a patient level, organisations are better placed to fully understand resource utilisation, productivity and opportunities for improvement.

Development of finance and activity schedule for contracting in 2013-14

Stage 3 :Development of Activity schedule based on Cluster Review Periods

To support the 2013-14 shadow contracting arrangements the maximum cluster review period frequencies (as per DH guidance) are used to define cluster review periods for the purposes of contracting in 2013-14. The activity plan will be calculated by applying these standard cluster periods to an organisation's caseload by cluster. The caseload information should be obtained from the information held by cluster within an organisation's Patient Administration System. Caseload information can be taken as a snap shot or an average through the year, depending on local

agreement with commissioners and the quality of information that is available. It is important that during 2013-14 providers and commissioners robustly monitor and refine activity plans based on cluster review periods to ensure actual activity reflects active caseload.

Once caseload is known, each caseload by cluster is then multiplied by 365 to obtain a total number of days available by cluster for the year. The total days are then divided by the maximum review period frequencies per cluster to obtain the number of planned cluster periods for the year. A worked example of this is shown below.

Cluster Number	***Total Clients per cluster*** ***(O)***	***Total Expected Days*** ***(P)***	***Normalised Period Duration*** *Days* ***(Q)***	***Expected Cluster Period (Reviews)*** *(P / Q)* ***(R)***
0	87	31,653	365	87
1	43	15,826	84	188
2	217	79,132	105	754
3	434	158,264	183	865
4	434	158,264	183	865
5	130	47,479	183	259
6 - 21	2,991	1,092,022	365	2992
Contract Value-Treatment	**4,336**	**1,582,640**		**6,010**

The total MHCT data relating to assessment is used to calculate the price of an assessment. The denominator for this exercise is the number of newly referred clients. This can be done at various levels of assessment or for assessment as an overall service.

It is recognised that this approach represents an approach to price based on standardised activity, which will not reflect actual activity through the year due to variation in caseloads and variation in cluster periods. By taking a standardised approach to developing the contract plan and measuring and analysing actual activity against this standard, we can better understand levels and sources of variation to inform development of the approach for 2014-15. Within the confines of a memorandum of understanding and income guarantee, this enables both commissioners and providers to better understand the information and inform the development of the approach without financial risk.

Stage 4: Developing an indicative unit price

For 2013-14, the indicative unit price at a Clinical Commissioning Group (CCG) level will be based on 2013-14 agreed overall contract value, rebased according to the activity schedule calculated above. By taking contract value at a CCG level and

dividing by cluster period activity, an indicative price per cluster period for each CCG can be obtained.

The example below shows both the calculation for a indicative cluster period price for treatment and then assessment, the maximum cluster review period frequency of 365 on cluster 6 – 21 line is for illustrative purposes, the DH guidance cluster period varies across these clusters:

The first stage is to split this to the proportion that relates to initial assessment and that which relates to treatments. In the costing calculation the assessments appointments are calculated as a separate price. The proportion of the costs relating to initial assessment against the costs allocated to treatment is used to split the contract value.

From the example in the costing calculation above £514,223 / £4,557,796 = 11.2%

For the purpose of this example if the contract value is £4,700,000 the split would be:

Initial Assessment	- £530,267
Treatment	- £4,169,733

Total overall clients 5,816 (split 4,336 within treatment and 1,480 in assessment)

Total Clients 4,336

Treatment

The value of the contract is allocated across the clusters using weighted treatment days. Treatment days are weighted using relative values units, which identify the relative resource intensity across each cluster (at a team or service level). For those organisations using the CPPP methodology, or patient level systems, the RVU will be available, for those not using these methodologies, reference costs per day can be used as a proxy for RVU in the interim, while costing methodologies are developed through 2013/14. Once the contract value per cluster has been calculated, the price per cluster period can be attained by dividing the contract value by the number of cluster periods as calculated in stage 3 above.

Cluster Number	***RVU*** ***(J)***	***Total Expected Days*** ***(P)***	***Expected Cluster Period*** *Reviews* ***(R)***	***Weighted Treatment Days*** *(J * P)* ***(S)*** ***Days***	***Overall Contract value per cluster*** ***(T)*** **£**	***Indicative price per cluster period*** *(T / R)* ***(U)*** **£**
0	1.14	31,653	87	36,084	30,244	347.63
1	1.00	15,826	188	15,826	13,265	70.56
2	1.82	79,132	754	144,020	120,712	160.10
3	2.38	158,264	865	376,668	315,708	364.98
4	2.16	158,264	865	341,850	286,525	331.24
5	2.49	47,479	259	118,223	99,090	382.59
6 - 21	3.61	1,092,022	2992	3,942,199	3,304,190	1,104.34
Contract Value - Treatment		**1,582,640**	**6,010**	**4,974,870**	**4,169,733**	

Initial Assessment

It is necessary at this stage to separate out the price for initial assessment, which is the process by which someone is allocated to a cluster or signposted to alternative services. Initial assessments are assumed to be the average of the number of contacts prior to clustering. This is expected to be 2-3 contacts, and will be validated through 2013-14, along with refining our understanding of the need for a separate assessment price. For 2013-14 a single average price across all initial assessments is proposed. Therefore the price per initial assessment would be for an assessment irrespective of whether the patient is accepted for treatment.

Having identified above the element of the contract value relevant for assessment (£530,267 as seen above) this is simply divided by the number of clients assessed (1,480 as seen above) providing a price per assessment (£530,267 / 1,480 = £358)

During 2013-14 further development of the initial assessment methodology will look to further explore options to best capture the resource utilised in initial assessment and treatment. This will include comparison and review of the various assessment models in place across the country, and to determine for example if there is sufficient variation to warrant a different assessment tariff, by cluster team type (i.e. Crisis / SPA / Community) or significant co-morbidities, or if an overall assessment price would suffice. It is important to stress the difference between initial assessment and the further clinical assessment that takes place within cluster. This methodology will enable transparency nationally in determining the resources utilised before the cluster is applied, irrespective of where the individual goes on to receive treatment. Clinical assessment within cluster is part of the treatment price.

Calculation of in-patient indicative price per day

The current proposal to calculate an inpatient price per cluster assumes a relative value unit of 1 for all clusters. (ie current reference cost methodology).

Work should continue during 2013-14 in collecting and reviewing close observation data to determine if there is a correlation between the levels of close observations prescribed within the inpatient settings and a patient's cluster. Development of activity recording on clinical reporting systems should also be considered.

To develop a price per cluster at CCG level, contracts for inpatients should first be re-based, where this is not already the case, to determine a single bed price for each inpatients setting (PICU, Assessment & Treatment, Rehabilitation, etc). Activity within each inpatient setting should then be analysed by cluster to give a total price for all cluster activity for each inpatient setting. By aggregating price and activity for each cluster across all inpatient settings, an overall price per cluster for inpatient services will be attained at a CCG level, which reflects the relative intensity of care provided in each setting.

Indicative Aggregate Price per cluster

An aggregate price per cluster can be obtained by totalling community treatment price per cluster and in-patient price per cluster and dividing by total activity. This price will be reflective of relative intensity of treatments in meeting needs for patients within the cluster. Using this methodology an indicative Trust-wide aggregate price per cluster can also be determined. For collection of indicative prices the submission will include prices for assessment, community treatment, in-patient and aggregate prices per cluster at a CCG level.

ANNEX C – Sample Memorandum of Understanding

Memorandum of Understanding

This Memorandum of Understanding ("MoU") is made on ____ of _____ 2013 between **……..** CCG on behalf of the CCGs listed below and **.....** CSU ("The CSU") as authorised representative of the commissioning CCGs on the one hand (collectively referred to as "the Commissioners"), and **……**Trust ("the Provider").

The commissioning CCGs to which this MoU relates and which are bound by its provisions are (……Name each CCG……)

This MoU is authorised on behalf of all the named organizations (collectively referred to as "the Parties") by the named contacts, as noted below.

This MoU sets out the guidelines concerning how arrangements will practically function in the implementation and management of Mental Health PbR as defined by the David Flory letter ***Payment by Results gateway ref 17973 annex B.*** The MoU will be amended to incorporate any additional changes identified in the impending road test package and guidance. However it is anticipated these will changes will be minimal (if any).

This MoU will be effective for the period commencing on _____ and ending on _____ and it will be reviewed and renegotiated in December 2013 for contract negotiations for the financial year 2014-15.

The guidelines set out in this MoU may be strengthened by incorporating it into subsequent contracts drawn up between any of the Parties to this MoU.

Names and contact details

…….. CCG

Name	
Position	
Address	
Telephone	
E-mail	

Name	
Position	
Address	
Telephone	
E-mail	

…….. Trust

Name	
Position	
Address	
Telephone	
E-mail	

Name	
Position	
Address	
Telephone	
E-mail	

…… CSU

Name	
Position	
Address	
Telephone	
E-mail	

Name	
Position	
Address	
Telephone	
E-mail	

Terminology

For the avoidance of doubt, all terminology used in this MoU will have the same meaning as commonly adopted throughout the NHS, unless an alternative meaning is provided. In particular, the use of the terms “local” and “locally’” will refer to the Parties to this MoU and not to any other organizations.

Agreement

The Commissioners and Provider agree to work together in order to:

- Ensure that the implementation of national Mental Health (MH) Payment by Results (PbR) policy is effectively managed locally and via agreed structures (CCG / CSU) to maximise London influence over the development of national policy and ensure effective management of the policy during transition.
- Minimise the financial risk associated with the implementation of MH PbR for both the Commissioners and the Provider whilst achieving accurate prices and accurate activity data for each care cluster.
- Improve the accuracy, quality and data completeness of both the clustering and financial information to ensure a full and accurate picture of MH PbR is built up locally.

- Reach agreement on (notional) prices and activities (using the negotiated and agreed London template (report 1).

In order to achieve the above:

- Nothing will be implemented on the basis of information shared unless the underpinning data quality has been assured by all Parties or it has been nationally mandated. To this end the Provider agrees to use the clustering readiness template to record and share its assessment of its clustering quality with the Commissioners.
- There will be no change to existing contracting arrangements unless agreed by all parties or directed by national policy or outlined in guidance for 2013/14.
- Any mechanisms for the implementation and management of contracting for the new currency, including the Mental Health Minimum Dataset (MHMDS), will be jointly agreed prior to implementation using the agreed activity and finance reports.
- Any strategic commissioning intentions based on the currency model will be shared openly between all parties on a confidential basis and will be for the sole use of MH PbR development unless agreed otherwise by all parties.
- The parties to this MoU will work to make transparent any approaches or agreements to mitigate inappropriate or unnecessary financial pressures upon mental health services resulting from the implementation of MH PbR.
- The Provider will produce reference costs in keeping with national costing requirements and PbR guidance, as a basis of negotiating cluster prices, and will share and agree with the Commissioners overriding principles for the division of costs between PbR and non-PbR services. The Provider and Commissioners will also agree any variations to reference costs that are considered appropriate to achieve realistic prices, including any 'top-up' prices for cluster based services that may not be provided to all commissioners with whom the Provider contracts.
- The Provider and Commissioners will agree separate contracting arrangements and prices for services that are excluded from MH PbR, as set out below.

Specifically:

The Commissioners will:

- Be open and explicit about transitional arrangements to achieve "a single cluster price per provider" as outlined in David Flory's letter of 20 September 2012 (Gateway ref: 17973) if this is agreed as the way forward.
- Agree Provider income will be maintained at the level of the block contracts agreed for 2012/13, subject to DH required funding changes between 2012/13 and 2013/14 and any agreed service changes and QIPP plans.

The Provider will:

- Supply the Commissioner with activity and price information on the basis of clusters within the MH PbR based services by dates to be agreed)
- In the event that it is not possible to agree a 'single trust pricing/tariff' between all the Commissioners and the Provider, agree the 2013/14 local prices based on the PCT / Commissioner contract value. The Provider will then also develop a single

Trust price to enable a gap analysis to be made of the impact of the move to contracting on the basis of a "single cluster price per provider".

- Ensure that the key steps in the pathway process (assessment, cluster, review, (re-cluster), and discharge) are transparent and that cluster review intervals are applied as set out in *Appendix 1* to this MoU and in the clustering booklet.

The Parties will:

- As clustering quality and pricing improves, agree to model activity and contract price as though the system were live. It is expected that the local price per cluster will be refined through 2013/14 as clustering quality improves.
- As a minimum, work together to agree sub-super cluster based service specifications with notional costs to be used as part of the mental health contract, as an interim step towards full cluster-based commissioning.
- Work together to agree the activity and performance reporting requirements. A basic set of reports will be in place for 1st April 2013 and be reported against as per the locally agreed schedule. This will require refinement and development throughout the year as experience of contracting with the new system grows and data quality improves.
- Treat any information exchanged between the Provider and any CCG as confidential and agree that it remains the joint property of the Provider and that CCG. Information will not be shared with other CCGs or 3rd parties without the express permission of all parties to this MoU.
- Agree that, once the underpinning data quality has been assured by all Parties or it has been nationally mandated, data may be shared anonymously between all Parties for the purpose of benchmarking performance with the objective of improving the quality of patient care. The CSU, as the Commissioners' representative will obtain the agreement of all Parties to the sharing of each specific benchmarking indicator before it is shared.
- Incorporate outcome reports as they are developed and mandated nationally and incorporate any additional reports that may be agreed locally.
- Jointly develop a long term goal of seeking opportunities to develop a local Payment by Recovery approach which engages with patients and carers.

PbR Exclusions in 2013-14

Areas of mental health care that are currently **excluded from the currency / care clusters** and which will be dealt with under separate contracting arrangements are:

Services subject to Specialist Commissioning arrangements:

- Child and adolescent mental health services (CAMHS)
- Forensic and secure services
- Perinatal psychiatric services (mother and baby units)
- Tertiary Eating Disorders
- Gender Dysmorphia
- Specialist mental health services for deaf people
- Severe obsessive compulsive disorder and body dysmorphic services
- Specialist Services for Severe Personality Disorder in Adults

Other services currently excluded from mental health PbR

- Discrete IAPT services
- Specialised addiction services
- Specialised Psychological Therapies – admitted patients and specialised out-patients
- Learning disability services for non-mental health needs
- Acquired brain injury
- Complex and/or treatment resistant disorders in tertiary settings
- Specialist services for autism and Asperger's
- Liaison Psychiatry
- Mental Health services under a GP contract

Other locally agreed exclusions
(Any other services that the Parties agree between themselves, or are agreed between the Provider and any commissioning CCG, should be treated as outside the scope of MH PbR for 2013-14 should be listed here.)

Signed on behalf of the Commissioners by:

……

……

Date; ……

Signed on behalf of the CSU by:

……

……

Date; ……

Signed on behalf of the Provider by:

……

……

Date; ……

APPENDIX 1

Table 1 below sets out for each cluster the expected review interval. They vary considerably between clusters, as some relate to short episodes of mental illness and others to where mental illness is a long-term condition. The maximum review interval is annual, in line with the Care Programme Approach (CPA) guidance that says reviews should take place at least once a year. Commissioners may wish to consider how they monitor that the reviews are taking place as scheduled. (Incentives could be built into contracts through quality accounts, contracted audits against standards, or CQUIN payments).

Table 1: Mental health clusters

Cluster no.	Cluster label	Cluster review interval (maximum)
0	Variance	6 months
1	Common mental health problems (low severity)	12 weeks
2	Common mental health problems	15 weeks
3	Non-psychotic (moderate severity)	6 months
4	Non-psychotic (severe)	6 months
5	Non-psychotic (very severe)	6 months
6	Non-psychotic disorders of overvalued Ideas	6 months
7	Enduring non-psychotic disorders (high disability)	Annual
8	Non-psychotic chaotic and challenging disorders	Annual
9	Blank cluster	Not applicable
10	First episode in psychosis	Annual
11	Ongoing recurrent psychosis (low symptoms)	Annual
12	Ongoing or recurrent psychosis (high disability)	Annual
13	Ongoing or recurrent psychosis (high symptom and disability)	Annual
14	Psychotic crisis	4 weeks
15	Severe psychotic depression	4 weeks
16	Dual diagnosis (substance abuse and mental illness)	6 months
17	Psychosis and affective disorder difficult to engage	6 months
18	Cognitive impairment (low need)	Annual
19	Cognitive impairment or dementia (moderate need)	6 months
20	Cognitive impairment or dementia (high need)	6 months
21	Cognitive impairment or dementia (high physical or engagement)	6 months

ANNEX D – Top 12 questions from Care Quality Commission survey from a service user perspective

1. Did the person listen to you carefully?

2. Did you understand your care plan?

3. Did you have contact for crisis out of hours?

4. Have you discussed talking therapy?

5. Were your views taken into account when considering medication?

6. Were your views taken into account when your care plan was written?

7. Have you had a care review meeting?

8. Overall rating?

9. When was the last time you saw someone from the mental health service?

10. Were your views taken into account?

11. Did you have trust and confidence in the person seeing you?

12. Has your NHS worker checked how you are getting on with your medication?