Monitor
Making the health sector work for patients

Improving payment for mental health services

This document gives answers to the questions Monitor and NHS England received during our two recent webinars.

The first webinar, on 2 December 2015, outlined our vision for mental health payment development. The second, on 4 December 2015, provided details on how to implement episode of treatment/year of care and capitated payment approaches.

You can view these webinars again and find out information on these payment approaches for mental health on our website.[1]

Consultation

What has been the initial response to Monitor and NHS England's consultation[2] proposing changes to the local payment rules covering mental health. When will this be shared?

We will summarise the response in our mental health guidance and s.118 consultation documents, due to be published by February.

Implementation, support and guidance

When will Monitor and NHS England publish new national guidance?

The guidance for mental health currency and payment will be published alongside the s.118 consultation document by February.

What levers do NHS England, Monitor and TDA possess to ensure the move away from block contracts?

All providers and commissioners must adhere to the local price setting rules and principles. These require local mental health payment to be in the best interest of patients, promote delivery of evidence-based care, including NICE-concordant care, drive transparency and accountability, and encourage the sharing of best practice. They also require providers and commissioners to engage constructively with each other to agree local payment approaches. Poorly specified and unaccountable block

[1] www.gov.uk/guidance/new-payment-approaches-for-mental-health-services
[2] https://www.gov.uk/guidance/new-payment-approaches-for-mental-health-services#proposed-changes-to-local-payment-rules-covering-mental-health-services

contracts – i.e. those that are not based on accurate data and information and do not meet the needs of patients and agreed quality and outcomes are not acceptable.

We will support the sector adhere to these rules by running workshops, engagement events and providing further guidance in from early 2016.

Further, Monitor has a number of enforcement powers that can be exercised to ensure sector adherence to the rules.

Will commissioners be required to move to contracts based on clusters rather than on bed days and contacts?

Please see our response below under 'Clusters and cluster days'.

What additional guidance will be developed to ensure consistent application of clusters across the country?

To ensure an organisation produces and uses consistent and good quality data, all its staff must be trained in the use of the cluster tool. The Royal College of Psychiatrists provides trainers and training materials[3].

Providers must also ensure:

- assurance processes are in place to review and ensure accuracy of data
- data from the Mental Health Services Data Set (MHSDS), as other sources (eg feedback to clinical, front-line staff and from patients) are analysed
- mechanisms are in place to use data is used to inform payment development and in making systematic improvements in the care delivered to patients.

At the national level, together with the Health & Social Care Information Centre, we are looking at how we can use the MHSDS to flag consistency issues that need to be addressed.

Will Monitor and NHS England take a role in sharing what has been learned by trusts that are making good progress in data collection and payment development?

Yes. We are seeking to identify what those trusts making good progress are doing and how they are overcoming any barriers.

Providers and commissioners can view our local payment examples. These give case studies and detailed guidance on the payment options that local health economies can adopt.[4]

[3] Available at: www.rcpsych.ac.uk/traininpsychiatry/conferencestraining/resources/mhct.aspx
[4] Available at: www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models

Some commissioners and providers have made less progress than others in collecting and using data as well as developing transparent payment approaches. What timescales are you expecting these trusts to achieve for adoption of the new payment approaches?

Consistent and high quality data are essential to understand the:

- profile of those who are accessing services
- services that are being delivered
- outcomes that are being achieved through the services provided.

It is already a regulatory and contractual requirement to submit data to the MHSDS.

Provider boards and their commissioners should be making it a top priority to put in place systems to capture and analyse data about the services they provide, if they have not done so already. Consistent with the local price setting rules and principles, transparent and evidence based payment approaches should already be in place.

How do we start work if we do not have an agreed option? Do we have to model both options? Have we got time?

Many providers and commissioners have already agreed and started to develop the payment approach that best meets the needs and desired outcomes of their local health economy.

Those that are not ready to implement a new approach in 2016/17 should use existing mental health data and information to select a payment option in the next few months, so that it can be developed, implemented and/or shadow tested in the 2016/17 financial year.

It is important that the selected payment option meets the needs of patients and achieves the quality and outcome measures they value. Payment must be based on robust, up-to-date and evidence-based data and information. We will provide further details on the relevant data and information to help inform local payment development for mental health care in our mental health guidance document to be published in February 2016.

Is work towards the new local payment approaches being piloted? If so, how do I get involved?

We are not planning to run a formal pilot programme as the entire sector needs to develop these new approaches. However, as already mentioned, we are looking to work with sites that are making good progress in their area, so we can support their efforts, learn from challenges they are facing and share their experience more widely with the sector.

We are looking to hold workshops to support the early adopters and those able to implement these payment approaches in February and March 2016. We will provide further information on this, as it is available.

This is a substantial piece of work. Surely we need someone locally to drive it forward? Is there funding available to carry out this work? What steer can you give for the 2016/17 contract negotiation in terms of payment?

Every mental health provider should already have a payment lead. We suggest you establish an internal project group and a joint group with your main clinical commissioning groups (CCGs) to take mental health payment development forward locally.

Providers and commissioners should ensure that contracts are transparent and consistent with the local price setting rules and principles. As part of this contract development, the collection and use of relevant data should be viewed as 'business as usual'. This will help the local health economies understand whether resources are being used most effectively and whether the best care is being provided to those who need it.

Providers and commissioners may also look at our local payment examples,[5] which can also be adopted in different local areas – depending of local circumstances and patient need.

Will you protect mental health services from financial destabilisation by quickly undertaking a national rebasing exercise?

Prices for mental health are based on local negotiations between providers and commissioners. Where appropriate, and depending on local circumstances, some providers and commissioners could undertake a rebasing exercise.

We do not consider rebasing is necessary to support the local payment options outlined in the webinars. In most cases, these options will be informed by existing local spend and then adjusting this according to, for example, local care needs, changes to demand and efficiency levels.

Caps and collars and risk-sharing agreements can be used to manage change.

Mental health data

Will the intervention codes be reviewed to improve activity data and help cost cluster pathways?

[5] Available at: www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models

New interventions codes in the new MHSDS come on stream in January 2017. These should support improved costing. Further information on the MHSDS can be found on the HSCIC website.[6]

How will providers be incentivised to record accurate data in the MHSDS to inform both payment approaches?

The MHSDS is incredibly important as it is used to help inform the primary care budget allocation for mental health and should also be used to help inform provider payment. HSCIC publishes quality reports on data submitted by mental health providers to the MHSDS[5]. These should be used to support and encourage providers to improve the accuracy of the data they submit.

We know that data quality can be greatly improved if organisations use and analyse data to support and inform continued improvement in care – this includes use by front-line staff, managers, boards and others.

Monitor's Pricing Enforcement and Case Management Team will audit mental health providers in 2016. This will include audits for whether providers are adhering to the data reporting requirements outlined in the local price setting rules covering mental health.

Local authorities often hold data that are essential for understanding and meeting local needs and supporting patient recovery. What guidance can you provide to support local data sharing?

The vanguard sites have raised the need to share data across organisations in a local health economy and the practical challenges to achieving this. We plan to share guidance and support material that has been provided to vanguard sites on how to overcome this with the mental health sector.

Cluster and cluster days

Do you expect clusters rather than contacts and bed days to provide the basis for contracts?

Commissioners and providers were asked to stop paying for services on the basis of non-transparent block contracts from April 2014. The default position set out in the national rules is payment based on the currencies, the clusters. The payment period should be based on an episode of care, not contacts or bed days. This will best incentivise care that is focused on early intervention, recovery and condition management.

It is important that a component of payment is linked to achievement of agreed outcomes. Outcomes should represent key outcomes valued by patients and clinical staff, they may also represent high-level governance or process points that enable

[6] www.hscic.gov.uk/mhsds

desired outcomes to be achieved (e.g. support integration and coordination of patient care). It is appropriate to include outcomes linked to population-wide objectives (eg rates of employment or access to stable housing for those with mental ill health). Outcomes measures should not represent a single intervention or action undertaken.

Do you expect cluster days to remain the currency for mental healthcare in both payment approaches?

Clusters, **not** cluster days, remain the mandated currency for adult and older people's mental healthcare. As with any currency set, the care clusters may evolve over time, as appropriate.

We recognise the sector has made a significant investment to report data on the basis of the mental healthcare clusters, and to use them for local payment arrangements. We know those who are using the care clusters correctly, find them useful in designing efficient and effective services and payment.

Please explain why you have ruled out 'cluster days' as a currency option.

Providers should be reimbursed on the basis of how well they do in delivering an evidence-based package of care. They cannot measure how well they do or be appropriately incentivised if payment is based on cluster days.

We want payment for mental health services to incentivise care focused on early intervention and recovery, as well as co-ordinated care across a range of care settings.

An episodic approach to payment is consistent with the approach taken in physical healthcare for people with other longer term conditions.

Outcomes

Service specifications are not necessarily based on care clusters. Will commissioners be required to move to service specifications based on clusters?

No. The mental healthcare clusters reflect groupings of people with similar need for mental health services and therefore whose average cost of care is similar. Variation in treatment packages and associated costs of care exists within each cluster, as will the vast majority of health care classifications, varies and the profile of this variation should be understood locally. The mental health care clusters do not represent the delivery of specific care activities or care pathways that are specific to each patient. As such, they can and should be used to inform the underlying population needs for mental healthcare (along with other population data and information e.g. ONS data). They can also inform how resources are used and how services can be developed to give the best value care for those with mental ill health.

Are outcomes payment methods different from CQUIN?

Commissioning for quality and innovation (CQUIN) has historically been used to incentivise the sector to make changes to improve care. This method is usually time limited.

By contrast, payment for outcomes can be an enduring approach that encourages continuous learning and improvement. An outcomes-based contract can incentivise the delivery of good outcomes through the payment from both clinical and patient perspectives.

Do you know of trusts that have implemented outcomes but have not been through a procurement process?

Both Oxford Health NHS Foundation Trust and Cheshire and Wirral Partnership NHS Foundation Trust have implemented an outcomes-based payment model. Further details of this can be found in our local payment example.[7] This payment approach has three components: a fixed core payment, a proportion of total payment based on outcomes and a mechanism for sharing gains or losses. Providers could use some of the outcomes measures described in this local payment example in their own local health economies.

It is essential that outcomes measures are co-produced with all key stakeholders. For example, providers should work with local populations to develop outcomes measures ensure they reflect population needs. They should also work with CCGs as CCGs are responsible for their population's health. CCGs need to make sure they have contracted the best providers to deliver mental healthcare in their area.

Episode of treatment/year of care

How do you envisage the year of care payment model will maintain cash flow to providers?

Providers would be paid on account for their anticipated work, with a quarterly reconciliation process for actual activity.

If you are calculating year of care activity by taking caseload by cluster on a monthly basis, how does this differ materially from cluster days?

Establishing the active caseload is the starting point for negotiations between providers and commissioners. To do this you may need to look at activity over a period to see if it varies across the year or between years, which may need to be taken in to account.

[7] Available at: www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models#outcomes-based-payment-for-mental-healthcare

It is also important to look at likely levels of unmet need in the population, not just historical activity.

The figures and methodology used must be agreed between providers and commissioners.

Capitated payments

How would a capitated payment reflect changes in activity?

This depends on whether you want to reflect activity changes on a daily, monthly or annual basis to reflect changes in activity that arises due to certain factors (eg due to increase in population). Daily and monthly (ie cyclical) changes in activity should already be reflected in the historical, patient level data that should be used to calculate the capitated budget. This data will provide an indication of the likely healthcare needs of the target population for capitation. It is important that providers and commissioners use data to identify patient need (both unmet and met) and also how current and future patient use of services may change. This will help ensure that changes in activity can be appropriately estimated and captured within the capitated payment approach.

In our short paper on capitation[8], we note that providers and commissioners may make annual adjustments to the payments if the outturn population size and/or needs are significantly than initial forecast.

Can you base a budget on the superclusters and derive the financial amount from last year's activity? How do you account for change in activity shifts? Do you pay monthly?

Capitation should be for the whole population. However, should be informed by an understanding of patient needs, appropriate service configuration(s) and resources needed to deliver care. Commissioners and providers may deem it appropriate to target certain care/intervention to given cohorts in the sub-population. In this example, this could include those patient characterised by the mental health superclusters.

We describe capitation as a forward looking payment based on average long run costs. The actual amount that is to be paid is determined upfront and this can be paid all at once or in monthly instalments, depending on the local health economy needs and agreed payment arrangement. Where there is a shift in activity, we expect adjustments to be made as part of any year-on-year adjustments in the contract – subject to agreed adjustment policy.

[8] https://www.gov.uk/guidance/new-payment-approaches-for-mental-health-services?utm_campaign=942458_MH%20Payments&utm_medium=email&utm_source=Monitor&utm_orgtype=Regulator&dm_t=0,0,0,0,0#payment-approaches-for-mental-health-services

How can the transition to provider-to-provider payments be smoothed as they may create significant income instability initially?

The use of good quality data can help to mitigate this risk by providing a useful baseline of expected population need and care provision. In addition, a component of payment should be linked to the achievement of agreed outcomes.

Gain and loss sharing arrangements may also be used to mitigate and up and downside risk to commissioners, lead providers and/or sub-contracted providers.

Miscellaneous

Will assessments need to be separately costed?

The initial cluster assessment when people are first referred to a secondary mental health provider should be paid for separately. This recognises that some people will be assessed as not requiring specialist mental health treatment, or will be referred to other services.

These costs are already collected separately in the reference costs collection.

Many initial assessments are completed in primary care, particularly those for the less complex care clusters. Assessments for the more complex care clusters take place in secondary care. How will this be reflected in the payment approaches?

It is unlikely that a cluster assignment will be made in primary care for services delivered in secondary care as such an assessment needs to be made by mental health clinicians. Prices for assessment may vary on a cluster-by-cluster basis.

Social care can have a profound effect on well being and recovery. How is the cost of social care being factored into the new payment approaches? Relevant data are likely to be held by local authorities.

Investment in mental health services by social care varies around the country. This is one reason why it is hard to establish national prices for mental health services. Some providers are taking control of the wider care agenda by partnering with the voluntary sector to deliver a more holistic package of care. Similarly wider capitated payment that covers a range of health and government provided care and services may be another way to coordinate care and funding at a local level.

How would a service user be captured if they are on the caseload for more than one team providing care?

A service user can only be in one cluster and recorded once on the dataset.

Can you clarify how cluster 14 and 15 episodes that are not first presentations are treated in calculating the costs?

We know from reference costs data that the cost of treating those in psychotic crisis is high. However, we do not want the new payment system to introduce perverse financial incentives by rewarding providers when patients are in crisis, instead of rewarding them for helping people to manage their condition, so that crisis is avoided.

To help avoid perverse incentives, our current thinking is that a separate payment can be made for up to four weeks of care for anyone accessing mental health services for the **first time**. Otherwise payment for crisis should form part of the prices agreed for the psychotic clusters.

What if local commissioners are more interested in taking funding out of the system rather than recognising the changing population needs population (growth and complexity)?

Commissioners' main obligation under the 'Procurement, patient choice and competition regulations' is to ensure the needs of patients in their area are met. Patient need should drive commissioner behaviour. Increased transparency and effective use and analysis of data and other evidence are key to ensuring both commissioners and providers understand the mental health care needs of their population, and therefore what care models and service provision will meet those needs in an efficient and effective way.