21/10/2015

Gateway Reference number: 04148

Dear colleague,

Consultation on payment proposals for mental health services for adults and older people commissioned by CCGs in 2016/17

This letter sets out proposed changes to the Local Payment Rules covering mental health care.[1] In order to increase equity of access to evidence based services and reward quality and outcomes, we are considering requiring commissioners and providers of adult and older people's mental healthcare to adopt either:

- a payment approach based on year of care or episode of treatment, or
- a payment approach based on capitation.

With both payment approaches it would be important to maintain focus on delivery of clinically appropriate care and the outcomes patients need. Therefore, we propose a proportion of payment is linked to achievement of agreed quality and outcomes standards.

Under the proposed Local Payment Rules it would still be possible for commissioners and providers to agree an alternative payment approach, as long as that approach is consistent with the current arrangements for agreeing a price without using a national currency.

We seek your views on these proposals. In particular, we would like your feedback on four questions:

- Given a choice of a year of care/episodic payment approach or a capitated payment approach, which option would you most likely adopt in 2016/17?
- What do you think would be the key challenges of implementing one of these two payment approaches in 2016/17?
- In light of these challenges, what support would you need to develop and implement the proposed payment approaches for mental healthcare, including delivering the quality and outcomes element of payment?
- Do you have any concerns about the potential requirement to use one of these options?

This letter has been sent to providers and commissioners of mental healthcare as well as voluntary organisations with an interest in the mental health payment system.

[1] For reference, current requirements are set out in Section 7 of the National Tariff Payment System 2014/15 (Rules 8-10), and associated National Tariff Explanatory Notes: Mental Health - National tariff payment system 2014/15, Rules and Statutory Guidance, available, https://www.gov.uk/government/collections/the-nhs-payment-system-regulating-prices-for-nhs-funded-healthcare#2014-15-payment-system .

It is easiest to respond via our electronic survey details available on Monitor's website; alternatively you can respond via e-mail to pricing@monitor.gov.uk.

Please provide your response by 5pm on 19 November 2015. Your feedback will help inform proposals for the Local Payment Rules in the statutory consultation on the 2016/17 national tariff, to be published in early 2016. It will also inform the nature and content of material to support local development and implementation of proposed payment approaches.

Context

The Five Year Forward View stated the need for service transformation across the health system. The Mental Health Taskforce has been asked to recommend steps the sector should take to meet the objectives of the Five Year Forward View – namely patient-centred care with greater integration of mental, physical and community health. Preliminary feedback from the Taskforce notes a need for:

- improved access to and quality of care
- a focus on prevention
- greater integration of care.[2]

Local health economies will need to collect and use data on costs, activity and quality to inform service delivery and develop the right local payment approach. The use of quality and outcome data will also give assurance to the clinical leadership and professional bodies that the proposed payment system will enable clinicians to deliver care that is in line with their duty of care and professional standards, including those set out by the National Quality Board (NQB)[3] and NHS constitution e.g. performance on meeting access and waits standards.

Health and care professionals already make use of a range of indicators including clinical effectiveness, safety and patient experience, and NICE Clinical Guidelines and Quality Standards, going beyond what is required in the Mental Health and Learning Disabilities Dataset. More active use of such data enables clinical staff to improve the care they provide. It also enables a better understanding of local mental healthcare needs, development of local care models and helps ensure providers deliver evidence based effective care.

Some local health economies are using mental healthcare cluster data as a payment currency, with payment based on cluster days or episode of care. However, we believe that payment based on cluster days does not best incentivise early intervention and recovery-focused care. Using an episode of care approach, where appropriate, would provide better incentives, and we believe the sector is capable of implementing this type of payment approach in 2016/17.

A few areas have models of care offering integrated mental healthcare, or fully integrated care across mental, physical and community healthcare. They have used care cluster data to understand primary mental health need and to determine their service design. This data has then been used to develop payment arrangements based on capitation, with a component of payment linked to quality and outcomes.

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[2] Update on engagement with the Mental Health Taskforce, NHS England https://www.england.nhs.uk/2015/06/04/paul-farmer-2/

[3] Final report *Quality in the new health system: maintaining and improving quality*, National Quality Board, January 2013 www.gov.uk/government/uploads/system/uploads/attachment_data/file/213304/Final-NQB-report-v4-160113.pdf

This approach to service design and payment development, with a clear focus on outcomes, ensures this form of capitated payment offers transparency and accountability.

However, some mental health providers are still reimbursed through block contracts, where payment is based on historic budgets rather than an assessment of population needs. Block contracts do not incentivise delivery of the objectives in the Five Year Forward View. They do not facilitate access to timely evidence based care such as those set out in the new mental health access standards.

Proposed approach to payment for adult and older people mental health services commissioned by CCGs in 2016/17

For adult and older people's mental healthcare covered by the mental healthcare clusters we propose that commissioners and providers should adopt one of two payment models in 2016/17:

- **A payment approach based on year of care or episode of treatment**, as appropriate to each of the mental healthcare clusters.
- **A payment approach based on capitation**, informed by care cluster data and other evidence required to understand population needs and what it costs to meet these needs efficiently.

Under both approaches, an element of payment should be linked to the achievement of agreed quality and outcomes measures. These should include measures of patient experience, achievement of mental health access and waiting time standards (including those mandated for 2016/17: early intervention in psychosis and IAPT), and measures that support delivery of NICE concordant care in line with the principles set out by the NQB.

Agreeing a gain and loss share arrangement would help to limit providers' and commissioners' financial risk due to any unanticipated changes in demand, whichever payment option is chosen. This would also allow both commissioners and providers to benefit from any efficiencies achieved.

Local areas could also agree to move part of their contracts to year of care/episodic payment, and part to capitation based payment.

As provided by Rule 4 of the current national tariff, and proposed for the 2016/17 National Tariff[4], providers and commissioners would still be able to agree an alternative payment approach to the options proposed. Alternative payment approaches would need to be consistent with the principles for locally determined prices, and in particular will need to:

- be in the best interest of patients
- promote transparency to improve accountability and encourage the sharing of best practice

[4] Where there is a national currency specified for a service, but the commissioner and provider of that service wish to move away from using the national currency, the commissioner and provider may agree a price without using the national currency. When doing so providers and commissioners must reflect arrangements in their contract, use Monitor templates to document and publish a written statement of agreement, and submit this to Monitor. Further, all arrangements must be consistent with Principles for all locally determined prices (outlined in this letter). For details see: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300547/2014-15_National_Tariff_Payment_System_-Revised_26_Feb_14.pdf (page 153)

- be agreed through a constructive engagement process.

Local commissioners (CCGs) should engage with providers to identify which of the approaches is most appropriate for their local health economy. Commissioners and providers should then agree this approach. Where one provider has contracts with a number of CCGs, it may be advantageous for the CCGs to work together to align their preferred payment designs.

In the annex to this letter, we offer further detail on the two payment approaches described. Work on the payment approach for IAPT services is ongoing, and although we will be offering a model for local adoption, we plan to further test our proposed payment approach in 2016/17. CAMHS and secure and forensic mental health services are also excluded from these proposals and will be covered by separate arrangements.

Next steps

Subject to the outcomes of this consultation and further policy development, we may include proposals for mental health payment in the statutory consultation. In any event, we propose to provide written guidance and practical support[5] outlining how these payment approaches could be developed and implemented locally. We will be publishing revised *Guidance for Mental Health Payment* in line with the statutory consultation notice. Where available, we will also signpost existing support material, such as the Local Payment Examples[6]. Further, we will work with representatives from the sector and the Health and Social Care Information Centre (HSCIC) to improve the way analysis and comparisons based on the national dataset are presented to the sector.

To support our work to develop national outcomes measures we are holding a stakeholder event in London on 4 November 2015. This will bring together a number of existing workstreams on mental health outcomes indicators and consider what type of measures may be appropriate to link to payment. If your organisation has not received an invitation for this event and would like to be involved, please contact NHS England via email to england.paymentsystem@nhs.net.

We welcome your responses to the draft proposals in this letter. Please contact us on pricing@monitor.gov.uk before 5pm 19 November 2015. Your feedback will help us to further develop our proposals for mental health payment in the statutory consultation notice on the 2016/17 national tariff. In particular, we would like your views on the following questions.

- **Given a choice of a year of care/episodic payment approach or a capitated payment approach, which option would you most likely adopt in 2016/17?**

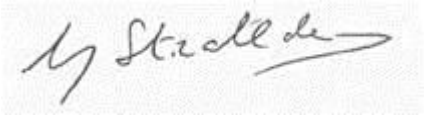
[5] We issued a mental health payment survey in September 2015. This provides critical evidence to help Monitor and NHS England establish a baseline of current payment arrangements for mental health. It will also inform the content and format for updated guidance and other material to support implementation of the proposed local payment approaches. Your feedback will also inform the development of support material.

[6] *Different approaches to support new care models*, Monitor August 2015 https://www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models

- **What do you think would be the key challenges of implementing one of these two payment approaches in 2016/17?**
- **In light of these challenges, what support would you need to develop and implement the proposed payment approaches for mental healthcare, including delivering the quality and outcomes element of payment?**
- **Do you have any concerns about the potential requirement to use one of these options?**

Yours sincerely,

Adrian Masters
Managing Director of Sector Development
Monitor



Dr Geraldine Strathdee
National Clinical Director Mental Health
NHS England

Paul Baumann
Chief Finance Officer
NHS England

Annex 1 – High level summary of proposed payment options

Year of care or episodic payment

A year of care or episodic payment approach means payment based on a price for each unit of activity. In the context of mental healthcare, this would mean payment was linked to the mental healthcare clusters and would cover care provided to someone in any given cluster for the duration of the payment period. This approach can make it easier for patients to choose their provider for an episode of treatment.

This payment approach can draw on existing data flows, provided existing data is of sufficient quality.[7] Introducing a year of care or episodic approach to payment builds on what is already being implemented or shadowed in many areas: payment based on mental health cluster currencies. Quality and outcome measures should also be agreed, along with agreement on data reporting, and how agreed quality and outcomes measures will be linked to payment. Caps and collars and risk sharing could be used to aid transition to this payment approach, particularly where untested assumptions have been made about demand or expected costs.

We suggest a year of care payment could be used for most currencies, but where care is expected to be shorter in duration, the episode should reflect the maximum cluster review period. The table below shows the suggested payment period.

Cluster no.	Cluster label	Max cluster review period	Suggested payment approach
0	Variance group cluster allocation not initially possible	6 months	Episode
1	Common mental health problems (low severity)	12 weeks	Episode
2	Common mental health problems	15 weeks	Episode
3	Non-psychotic (moderate severity)	6 months	Episode
4	Non-psychotic (severe)	6 months	Year of care
5	Non-psychotic (very severe)	6 months	Year of care
6	Non-psychotic disorders of overvalued Ideas	6 months	Year of care
7	Enduring non-psychotic disorders (high disability)	Annual	Year of care
8	Non-psychotic chaotic and challenging disorders	Annual	Year of care
10	First episode in psychosis	Annual	Year of care
11	Ongoing recurrent psychosis (low symptoms)	Annual	Year of care
12	Ongoing or recurrent psychosis (high disability)	Annual	Year of care
13	Ongoing or recurrent psychosis (high symptom and disability)	Annual	Year of care
14	Psychotic crisis	4 weeks	Cluster Episode (when first presentation)
15	Severe psychotic depression	4 weeks	Cluster Episode (when first presentation)
16	Dual diagnosis (substance abuse and mental illness)	6 months	Year of care
17	Psychosis and affective disorder difficult to engage	6 months	Year of care
18	Cognitive impairment (low need)	12 months	Year of care (annual

[7] Mental Health Dataset submissions are already made on the basis of the currencies and there are a number of metrics reported by HSCIC on a cluster basis per provider. All mental health providers already return reference costs for the services they provide to working age adults and older people based on these currencies. Currently this information is submitted in two forms: (i) a per diem basis; and (ii) maximum review period for each of the currencies.

			review)
19	Cognitive impairment or dementia (moderate need)	6 months	Year of care (annual review)
20	Cognitive impairment or dementia (high need)	6 months	Year of care
21	Cognitive impairment or dementia (high physical need or engagement)	6 months	Year of care

Notes on cluster assignment:

- The initial cluster assessment of service users when they are referred to secondary mental health providers is paid for separately, recognising that some people will not be assessed as needing treatment or are referred on to other providers. These costs are already collected separately.
- Cluster 0 reflects a group of service users where assignment to a cluster has initially not been possible.

Developing this payment approach locally

Commissioners and providers should carry out a bottom up costing exercise to look at how much NICE compliant care actually costs to deliver. This should include an appropriate focus on prevention and early intervention to ensure that good patient outcomes are delivered, and that resources are used in the most efficient and effective way. We propose to update our guidance and tools to support implementation. This includes noting how 2014 guidance on calculating relative resource intensity can inform a year of care or episodic payment approach.

People who are in crisis should be helped to stabilise within a short period. We do not want to incentivise paying for poor outcomes. Consideration could be given to paying separately for clusters 14 and 15 only when a service user is experiencing their first contact with a secondary mental health provider. A crisis will often be resource intensive for a limited time, after which an evidence based package of care should be in put in place.

Capitated payment approach

A capitated payment approach is intended to enable delivery of coordinated care by providing a per head payment for a specified scope of services for a defined population over a set period of time. This allows providers to plan and deliver care in a way that can be tailored to individual and local population needs, while also incentivising early intervention, prevention and recovery. A brief outline of what capitation may look like in practice is below. For further details see the Local Payment Examples published by Monitor and NHS England.[8]

Different capitated payment approaches may be appropriate depending on local factors, including:

- the vision for the local health economy and the degree of coordination between relevant services, including social care and housing
- the accuracy and availability of data to inform the capitated budget.

All capitated payment approaches should include a component linked to quality and outcomes to ensure that providers have financial incentive to maintain access to services elsewhere under cost pressure. In addition it may be desirable to include a mechanism that allows for some sharing of financial gains or losses between commissioners and providers, to facilitate changes in demand and data quality.

Developing this payment approach locally
When developing local capitated payment models, the CCG and the capitated budget holder (e.g. a lead accountable provider) must agree the scope of services and how payment will be calculated. If the budget holder is not the provider of all services, it will also need to agree payment arrangements with any sub-contracted providers of care. This could include NHS and community providers and the voluntary sector.

Key elements to consider when designing the capitated budget include:[9]

- **Specifying the population and scope of services**: the population could be based on GP registration lists or users referred to secondary mental health services. The scope of services included in the capitated budget will depend on local need, it could be limited to care provided predominantly in a mental healthcare setting, or include all healthcare services as well as aspects of social care. It may also be appropriate to exclude some services (eg services commissioned by NHS England as specialised services).

[8] Available by clicking, here.

[9] For more details see the local payment examples on Capitation, Outcomes based payment for mental healthcare and our animation on capitation.

- **Establishing the unit price (per person per year)**: this should be based on evidence of the costs to meet mental healthcare needs, using mental healthcare clusters as well as other data and information. The unit price should include adjustments to reflect the financial impact of:
    - expected annual changes in the population
    - meeting currently unmet demand, including those assessed and on waiting lists, as well as those whose need is still to be identified
    - delivering (new) clinical models to meet the needs of the population – which include NICE compliant care – and adjustments to demand (and spend) in other areas of care that this may create
    - opportunities to transition to more efficient models of care, including the use of digital technology or reduced use of inpatient beds.

In developing any capitated payment approach, providers and commissioners should ensure appropriate data infrastructure and internal practices are in place to support accurate and consistent data collection, reporting and analysis. It is also important that front line staff, boards and all levels of management in between have visibility of key data outputs to understand what drives quality and value for patients. Where patient care is provided across different providers or care settings, it may also be appropriate to arrange data sharing agreements and to link person level data. Data from a wide range of sources, including provider's data systems, Public Health England, the Office for National Statistics, emergency services (police/fire services) and the HSCIC can be used to develop a capitated payment approach.[10]

Capitation and patient choice can work together to deliver better outcomes for patients and the system as a whole. To achieve this, specific safeguards must be established to ensure that patient choice, as required within the NHS Constitution, is available. This includes ensuring that patients can exercise choice at a meaningful point in the pathway, such as after a mental health assessment rather than only at the point of GP referral. In addition, agreements may be put in place so the capitated budget holder pays if a service user chooses care that is outside of their service offering. Commissioners should also continue to consider if they can improve services for patients by enabling them to choose between different providers, for example, by creating additional local choices where the quality of services is not as good as patients have the right to expect.

[10] Further information on data use and tools will be published in the guidance document for mental health. Some of the current risk stratification and mental health data sources include: PHE fingertips tools and the mental health learning disabilities data set.