

Mental Health Payment by Results Readiness Review



Working together

Mental Health Strategies (MHS) is a long-established, leading provider of support to organisations wishing to improve mental health services. They work across the health and social care continuum and actively engage with NHS providers and commissioners as well as the third and independent sectors.

The Mental Health Network was established as part of the NHS Confederation to provide a distinct voice for mental health and learning disability service providers. The Mental Health Network aims to improve the system for the public, patients and staff by raising the profile of mental health issues and increasing the influence of mental health and disability providers.

Strategic health authorities (SHAs) manage the NHS locally on behalf of the government and provide an important link between the Department of Health and the NHS. There are currently ten SHAs in England. Among other functions, the SHAs ensure that national priorities are integrated into local health service plans.

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Explanation of the structure of this report – read this first

This report has an unusual structure, arising from a rapidly developing sequence of events during the autumn of 2011. This section explains the structure we have decided to adopt.

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

Immediately after the completion of the review report, as promised in the “Dear colleague” letter from Bob Alexander and Bruce Calderwood of 6 June 2011, an early draft of the mental health PbR guidance for 2012/13 was published. This inevitably means that there has been progress in addressing some of the points raised in our report.

We therefore felt it important to present:

- the text of our September findings, and the recommendations arising from them. Given the time participants gave, and the interest expressed in this work, we wished to make available a clear presentation of the situation which pertained at that time. This material starts in section two, and forms the bulk of this report. Everything in that section should be understood as current as at September 2011
- a statement from the SHA mental health leads, current as at the date of this report, explaining both their response to the review findings, and policy expectations as to what should happen next. This statement forms Postscript One to this report and it can be found immediately following this section. It is the only element of this report which should be read as a policy statement
- a very brief response to Postscript One from Mental Health Strategies. This forms Postscript Two, and comments on the implications of the SHAs clarified expectations for our understanding of services’ readiness to implement PbR in mental health.

Postscript One. Strategic health authority mental health leads' response to review findings

Introduction

We very much welcome this readiness review into the implementation of PbR in mental health. With around 100 colleagues interviewed, it gives us a clear picture of the state of play at a specific point in time, and it elegantly describes a framework for complete readiness to implement PbR and for service users to be able to reap all the benefits which it will bring.

Not surprisingly, the review shows we are not completely ready yet. However, the immediate challenge is to make sure we are ready for the introductory year which begins on 1 April 2012. The headlines of what needs to be done for 1 April are below.

The readiness review was also overtaken by the DH Payment by Results Draft Guidance, which addresses a number of the issues raised in the paper.

Draft guidance

The Payment by Results Draft 2012/13 Mental Health Guidance clarifies a number of key points, outlined below.

It is clear that 2012/13 is the introductory year for PbR, following on from all service users being clustered by 31 December 2011. Local cluster cost information is very variable in terms of quality and quantity, and commissioners and providers are expected to work together to ensure there is an overall cost neutral impact in 2012/13. Careful monitoring of cost and prices will support building confidence.

There is ongoing work needed to improve accuracy and data quality, and the beginning of building in NICE and CQC standards. The work needs to support the adoption of best practice in delivering to the outcomes in *No health without mental health*. It is clear the clusters do not by

themselves define the appropriate interventions and treatments to meet an individual's characteristics. Many of these are already well defined by NICE/SCIE and professional guidelines.

There will need to be significant development around quality and outcomes in the coming years.

The guidance is available at:

www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130387.pdf

Action by 31 March 2012

In order to be ready for the introductory year, commissioners and providers together must:

- develop and use the Memorandum of Understanding to support joint working and risk sharing, and agree risk share for resources for 2012/13, which will have a cost neutral impact in 2012/13
- share cluster data, and develop and share a process for costing clusters and assessments based on the current version of the national PbR Guidance, and the cluster costing guidance
- agree a first cut version of the costs per cluster per day and how they will be used to set prices
- agree an activity plan that specifies the level of activity expected on a cluster basis
- agree a set of data to flow locally, and any use of MHMDSv4
- agree whether and how CQUIN will be linked into the currency model
- develop and share a set of discharge criteria
- confirm what is within and what is outside the clusters
- agree that during 2012/13 providers will work with commissioners to deliver the broader work programme that includes developing and testing more comprehensive currency models.

Providers must:

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

Commissioners must:

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

Conclusion

We need to have the key requirements in place for PbR from 1 April 2012, but much more challenging and of far greater interest to the people who use services will be the work required during 2012/13 and onwards to use the clusters to empower and enable service users, build recovery and outcomes into the journey, support for clinicians and a new dialogue between providers and commissioners.

Lawrence Moulin, Chair of the SHA Mental Health Leads Group
1 November 2011

Postscript Two. Mental Health Strategies' updated perspective on readiness

We welcome the SHA mental health leads' positive response to our report.

Our state of readiness review was carried out in September, prior to the publication of additional national guidance in October 2011. Our work was conducted in the context – shared by the overwhelming majority of our interviewees – that the expectation was for a substantially functioning PbR system to be in place by April 2012. Interviewees' comments, and their views as to the expectations being placed on them, should be read on that understanding. We are conscious their comments and views may already have changed in the light of the additional guidance.

We have subsequently reviewed the SHAs' list of actions dated 1 November 2011, which they require commissioners and providers to achieve by 31 March 2012. The findings in our report show that most areas are planning to operate the 2012/13 contract in shadow form with risk sharing mechanisms, although by September not all trusts and commissioners had jointly discussed what their plans were. Commissioners and trusts will welcome the message that 2012/13 is seen as an introductory year in which they can work together to develop and test more comprehensive currency models.

Commissioners and trusts are currently at very different stages of progress in implementing PbR across the country, and it is unlikely that all areas will meet all the detailed tasks now being spelled out by the SHAs by 31 March 2012. In particular, trusts have not made enough progress in costing clusters to use these to set local prices for next April.

Our review findings show, however, that the majority of trusts will have clustered all service users by 31 December 2011; and there are good grounds for optimism that the space offered by the introductory year will enable significant progress to be made over the coming year.

Report summary

The development of a Payment by Results (PbR) approach to provider reimbursement in mental health services has been going on for a number of years. It has been agreed that the Care Cluster model should form the mental health currency. The aim of our review was to provide an assessment of commissioners' and providers' readiness to deliver the Department of Health (DH) policy commitment that adult mental health PbR currencies should be used for commissioning and reimbursement purposes from April 2012.

The review was carried out by seeking the views of a widespread of people in mental health trusts, commissioners, local authorities and the independent sector, as well as national stakeholders. We spoke to over 100 people in 99 telephone interviews in September 2011. Interviewees were asked a number of questions based on a framework agreed with the SHA mental health leads, the NHS Confederation and the DH.

We developed a framework of what we think needs to be in place for a local health economy to be considered fully 'ready' to implement PbR in mental health. Our findings show that commissioners and providers will not be ready to use the care clusters as the contract currency for 2012/13 with local prices. This is not due to a disinclination to implement PbR. Most people we spoke to were enthusiastic about the clustering process, and could see real benefits in implementing PbR.

Although most trusts will have allocated users to clusters by December, poor data quality means that trusts will not have a robust currency by April 2012. The level of progress made in defining packages of care for each cluster is very mixed. Only a third of trusts interviewed had made considerable progress, and nearly half had not started.

Trusts have not made sufficient progress in costing clusters to have local tariffs for April 2012. While some trusts have carried out considerable work, some have not yet started. Barriers to meeting the deadline include concerns over the quality of cluster data, inadequate IT systems to collect the necessary clinical activity and the lack of trend data on clusters and associated interventions. Tariffs are not yet fit for purpose, due to a lack of national guidance on how to calculate them and limited understanding of the variation in care packages by cluster.

For the effective implementation of PbR, commissioners need to be at the centre of the process working closely with organisations that they contract with. This is often not the case, although we did find some examples of excellent joint working. The changing commissioner landscape has reduced commissioners' ability and capacity to focus on mental health.

We make 19 recommendations. Mental health contracts should contain risk sharing agreements until the market is confident that local tariffs are fit for purpose. Reviews should be undertaken to gain a greater understanding of consistency issues in clustering users, and the variation in care packages provided to users within one cluster.

Communication mechanisms should be strengthened to ensure momentum is maintained in implementing PbR and consistency of approach. There is a particular need to educate new commissioners about PbR. The establishment of a national website for the sharing of learning, tools and techniques would support local implementation.

We trust this report will prove informative and useful in enabling all the responsible agencies to consider the next steps in this implementation process.

Introduction

Objective of the review

The overall objective for this review was to provide an assessment of commissioners' and providers' readiness to deliver the Department of Health (DH) policy commitment that adult mental health Payment by Results (PbR) currencies will be used for commissioning and reimbursement purposes from April 2012.

Structure of this report

In this introduction we explain the background to implementing mental health PbR and the DH implementation timetable. Following this introduction, the report is organised in three main sections:

Section 4 describes the methods adopted to carry out the assessment of the state of readiness.

Section 5 presents the findings of our interviews. These have been analysed into nine themes.

Section 6 summarises our judgements of how ready commissioners and providers are to deliver the DH policy commitment that adult mental health PbR currencies will be used for commissioning and reimbursement purposes from April 2012. We identify the barriers to implementation and recommend what else needs to be done.

Background

The principles underlying a PbR approach to provider reimbursement in mental health services have been under discussion for many years. The intention has been to develop a reimbursement system which:

- facilitates understanding of clinical processes between commissioners and providers, and between clinicians and service managers
- distributes the burden of financial risk fairly between commissioners and providers, including financial risks arising from demand for services, service activities, service quality, and service efficiency
- incentivises both commissioners and providers to deliver effective, efficient and equitable models of treatment and care.

Achievement of these principles requires a series of processes:

- identification of a **currency**: a unit of service activity which is recognised as both clinically meaningful, and exhibiting relatively low cost variance
- identification of a **tariff**: the price to be paid for each unit of service activity
- agreement of a **contract structure**, containing not only currencies and tariffs, but also specifications of service models, care pathways, volumes (and volume thresholds) and outcome/performance incentive arrangements.

Within the English NHS, work on a mental health currency has centred on the Care Cluster model, developed first in South West Yorkshire, but spread rapidly both regionally and nationally. This proposes a small series of clusters of needs, linked to which there are model structures of care pathways and care packages. The proposed unit of service activity would be the 'cluster episode' i.e. a period of care for an individual with needs in that cluster.

Work is now underway to address the remaining processes: to cost the delivery of services by cluster (and thereby to test more widely the currency's cost variance than has thus far been possible); to identify the consequent tariffs per cluster episode (initially locally, but possibly nationally in due course); to integrate this reimbursement system within the framework provided by the national standard contract structure for mental health services, including approaches to volumes and performance incentives.

The Department of Health's timetable for the implementation of mental health PbR

The Department of Health (DH) policy is for local providers and commissioners to move towards operational implementation of this approach to PbR by April 2012. There is clearly room for a measure of uncertainty as to what is meant by 'operational implementation.' The DH PbR guidance for 2011/12 (as current when this work was undertaken) stated:

"Mental health currencies – the care clusters – were made available for local use in 2010/11. Equity and Excellence: Liberating the NHS commits us to mandating these currencies for 2012/13 with local prices.

"2011/12 is therefore a crucial preparatory year. We expect that by the 31 December 2011 all service users accessing mental health care (post GP or other referral) that have traditionally been labelled working age (including early intervention services from age 14) and older people's services, should be allocated to a cluster.

"A second crucial task for 2011/12 will be for commissioners and providers to agree the prices to be used in 2012/13. This will require understanding of local costs per cluster."

Method

Interviews

The review aimed to seek the views of a wide range of people in mental health trusts, commissioners, local authorities, and the independent sector, as well as national stakeholders. We have spoken to over 100 people in 99 telephone interviews in September 2011. Within the tight timescales of the review we have achieved a reasonable spread across the country.

Table 1 shows the makeup of our sample. The HFMA has carried out surveys with finance staff in both mental health trusts and PCTs. We were therefore asked not to interview finance staff, although we did speak to a few involved in national work or where a trust chief executive delegated the interview to a finance director.

Table 1. Interviews

Commissioners	18
Chief executives of mental health trusts	17
Medical directors of mental health trusts	17
PbR project managers within mental health trusts	18
Independent sector providers	4
Local authority leads	4
Strategic health authority representatives	7
Individuals and agencies	14

A list of all those interviewed is included in Appendix A. As well as carrying out telephone interviews, we facilitated a session at the NHS Confederation Mental Health Network General Meeting in September 2011 to seek views of members.

Interview questions

Interviewees were asked a number of questions based on a framework agreed with the SHA mental health leads, the NHS Confederation and the DH. Copies of the interview frameworks are included in Appendix B.

Framework for measuring the state of readiness

In writing this report we have developed a framework of what we think needs to be in place for a local health economy to be considered fully 'ready' to implement PbR in mental health (Table 2). We compare our findings against this framework in section 4 below.

Table 2. Readiness framework

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

Findings

This section presents the findings of our interviews. The analysis is based on things which were said to us, organised into nine themes. The aim is to give a flavour of the nature of the opinion we experienced, and the balance of comments is intended to be typical of the balance of what we heard. The nine themes we have identified are:

- clustering service users
- defining packages of care associated with each cluster
- local tariffs
- contracting arrangements for 2012/13
- IT infrastructure
- commissioning
- social care
- independent sector
- support in implementing PbR.

Clustering service users

Meeting the deadline

Trusts vary widely in the progress made in clustering service users but virtually all those interviewed believe they will meet the December 2011 deadline. Service users on CPA are more likely to have been clustered than those not on CPA. Outpatients are seen as a particular problem, where users are not seen often and may not be seen in time for the December deadline.

32 trusts answered the question: "What progress have you made in clustering users to date?" Their responses were:

% clustered to date	Number of trusts
Less than 20%	2
20%–50%	3
51%–80%	13
More than 80%	14

35 trusts answered the question: "Do you think you will meet the December 2011 deadline for clustering all service users?" Only four trusts said they would not meet the deadline.

Those interviewed were generally very positive about the clustering process. For example, we heard that: the clustering data gives them new information about the people they are treating; it ensures there is some degree of consistency in assessment; it has provided them with information about caseloads for productivity and service redesign; it provides clinicians with a common language to see where quality and outcome improvements are needed; it provides a basis for discussion between commissioners and trusts.

"The PCT has just seen the cluster profiles for the first time. This is enormously helpful. It is the first time we have realised how many patients are on the books. In the past we have always counted activity not patients. It raises lots of questions about the different types of patients."

"People start to think more robustly about who are their patient groups, their needs and what are the appropriate interventions."

"We can design services around needs not historical resources, and improve the clarity for service users and staff about what is expected."

"We have used cluster data to project capacity requirements and remodel our workforce."

"We can design services around needs not historical resources, and improve the clarity for service users and staff about what is expected"

Most trusts felt that clinicians were generally supportive of the clustering process.

“Our clinicians are engaged. We have a clustering tool and recording system built into RiO which the clinicians use. We produce monthly reports for clinicians which show their individual cluster patterns compared with their team.”

“Clinician support has improved at the stage where they can see the links between clustering and care pathways. Initially clustering was linked to a CQUIN target, so people felt they were clustering to reach a target.”

“Clinicians get it generally. Most can see it doesn't take away their ability to diagnose and treat. When they understand that, they get behind it.”

Quality of clustering data

Significant concerns were raised about the quality of the clustering data, in particular by those trusts who have made more progress in clustering, and are now starting to analyse the data.

Service users are not always allocated to the correct cluster.

“One key issue is about new referrals to the service. When someone is referred to the service, they are clustered immediately – when they don't have enough information about the user to properly cluster. Two things can happen which can distort the cluster information. 1. Having been clustered, they may be discharged very quickly as secondary care is not required. 2. We find out later that they have been allocated to too low a cluster because they were clustered too early in the assessment process before enough was known about their needs. The impact of this is that it looks like the trust has large numbers in lower clusters, which can then cause confusion with commissioners.”

Service users may not be being clustered consistently within a trust or between trusts. Inter-rater reliability was raised as an issue as part of the national development work and has not been satisfactorily resolved.

“Consistency is an issue – if a person is categorised as cluster 9 in one trust would they be categorised as cluster 9 in another trust? Even within the trust this is not certain.”

Some trusts said that clinicians are often overriding the cluster tool decisions, while others do not have the tools to measure whether this is an issue or not. One trust had 50 per cent of cases where the clinicians disagreed with the clustering booklet decision; many reported lower, but nonetheless substantial, levels of override.

Trusts have generally focused on meeting the December 2011 deadline for the initial clustering of all users. There has been less focus on reviewing users at regular intervals using the transition protocols. This means that some users may not currently be in the correct cluster.

“Less attention has been paid to transition protocols, which means that some users are not on the right cluster any more. The focus has been on meeting the deadline – so people have not been reclustered, e.g. when they have been admitted to hospital. If you look at information reports, it looks like we have people on low clusters on wards, which is wrong – they should have been reclustered to a higher cluster number. The PCT wants to see PbR cluster data – we do not want to share it until we are confident that is correct.”

“Less attention has been paid to transition protocols, which means that some users are not on the right cluster any more”

Some trusts that have been clustering for a longer time are starting to address some of these issues.

“At the start data quality was not brilliant. People are now getting better at it. There are some inter-rater reliability issues, which take time to improve. The solution is to improve this through caseload supervision. You have to get team leaders properly trained and they then become the local clinical experts.”

“We are confident in our data quality. The resulting information is well used by clinicians – more than any other data report. It’s available to clinicians on an individual patient basis also for caseload management and looking at HoNoS scores. Service users are clustered using a team approach – i.e. the team agree the cluster. Evidence indicates that this is the most effective method.”

Validating clusters for payment purposes

A number of commissioners and providers raised the issue of how clusters would be validated for payment purposes. Clinicians and commissioners stated that it would be easy to escalate a cluster. There were concerns about how easy it would be to validate clustering, particularly as the transition protocols allowed for considerable personal judgement.

“How do you audit PbR. Shadow assessment? Commissioners are not clinicians. Other than checking documentation, does look right, are they reviewed? What else can you do?”

“You have to get team leaders properly trained and they then become the local clinical experts”

Defining packages of care associated with each cluster

Progress made

The level of progress made in defining packages of care is very mixed. Some areas have yet to start, some have made significant progress, but very few areas have completed this task.

37 trusts answered the question: “What progress have you made in defining packages of care for clusters?” 17 trusts reported having made no progress, a further nine had started the process, while 11 had made considerable progress.

“There has been a lot of work on determining the packages of care associated with a cluster. Most clusters now have a clear description of the package of care which includes core and optional elements.”

“The trust has made good progress in determining packages of care for each cluster. The next stage is to compare the care packages with current provision and assess whether services can deliver the new care packages within the resources available. This will not be implemented by April.”

Joint working

The level of engagement between commissioners and trusts in defining appropriate care packages varies. While commissioners and providers are working on the task together in some areas, this is not the case everywhere. Some commissioners are struggling to engage with their local providers.

“The PCT is struggling to influence how PbR is developed e.g. the trust won’t engage in defining care packages. CCGs need to be involved in discussing clinical pathways – this is not happening. The process is largely being driven by providers – commissioners would like more engagement and collaboration.”

There are also areas, where providers have wanted to engage with commissioners, but they have not been able to get commissioners on board.

Variation in care packages provided within a cluster

There is limited understanding of the variation in care packages provided to users within one cluster, and the impact this will have on cluster costs and tariff. Most people interviewed do not yet know whether users in one cluster will receive similar packages of care, or whether there may be significant variation.

“Our pilot showed that clusters are not iso-resourced – there was wide variation.”

“The reference cost work showed a three to four-fold variation.”

People mentioned a number of reasons why there is likely to be variation in care packages with a cluster. These included:

Co-morbidity

People with complex additional needs are likely to have more expensive care packages than ‘standard’ people. These additional needs may be mental or physical.

“Acute PbR has a list of co-morbidity codes, where the tariff is increased for certain items. There should be a national steer on this for mental health. Without this, local agreements will mean that it will not be possible to compare price between trusts.”

“Our pilot showed that clusters are not iso-resourced – there was wide variation”

Thresholds between clusters

Some of the people we spoke to felt strongly that thresholds between clusters are not the same between trusts. Clinicians are likely to allocate users to clusters grounded in their understanding of their local area, but areas have different levels of morbidity. The threshold between general adult mental health and forensic services varies between trusts. If the threshold for access to forensic services is low, unit costs in both adult mental health and forensic services could look low. If the threshold is very high, unit costs will look very high.

“The key issue is that local context varies – even across the local area our three PCTs have historically had different levels of funding and set up different services”

Some trusts have several commissioners who spend different amounts on mental health. The content of care packages can also vary due to different commissioning decisions. Different shared care arrangements will also have an impact on the care package provide by the secondary care provider.

“The key issue is that local context varies – even across the local area our three PCTs have historically had different levels of funding and set up different services.”

“The PCT in one of our boroughs pays us to provide welfare benefit advice as this service is not provided by anyone else, and it was seen as a positive part of the care package. The PCT in another of our boroughs does not provide this. Patients in the same cluster in the two boroughs will therefore have different costs.”

Local tariffs

Costing

Trusts have not made enough progress in costing clusters to have robust local tariffs for next April. Some trusts have not started to cost clusters, while others have carried out considerable work.

Some trusts are waiting for more guidance before starting.

"We have done nothing. Until there is a definitive approach/clarity/clear definition of the currency to costing a cluster episode then this won't be done i.e. what is an episode or spell for a cluster group? Is it a year?"

Trusts who have started the process are discovering that the pace is too fast for implementation.

"How quickly can accountants do patient level costing which is meaningful? Can resources be properly allocated to appropriate clusters rather than spread out as average?"

"It is not possible to develop robust costs by cluster in time for 2012/13 contracts due to data quality issues around cluster data, finalising care packages, and the fact that people have not been in clusters for long enough. The trust would prefer to have an activity plan for 2012/13, and then fully implement the tariff in 2013/14."

"The deadlines are incompatible i.e. 100 per cent clustered by December and then local tariff for April. It is impossible to calculate a tariff on 2011/12 data if the trust has only just met the cluster deadline. Our region is ahead of the game, but there is so much checking still to do."

"It is at a very early stage for costing even for those organisations who have been looking at it for five to six years. The tariff will have to develop over years and become more sophisticated so that there is fair reimbursement."

"How quickly can accountants do patient level costing which is meaningful? Can resources be properly allocated to appropriate clusters rather than spread out as average?"

Some interviewees asked why the process for developing tariffs in mental health was different from in the acute sector.

"With HRG development, it is a two to three year process to establish prices – they need two years stable financial data before looking at HRG costing. This approach does not seem to be being adopted in mental health."

Moving to a local tariff

The issues around cluster data quality, defining care packages and costing mean that organisations will not have developed robust local tariffs by April 2012.

People interviewed raised a number of points about the local tariff:

What will price be?

"If costs have to equal price, there will have to be a fudge factor, i.e. price is equal to block contract less % efficiency savings."

Should a local tariff be based on current service models or on newly specified care packages?

"Indicative costs have been calculated for clusters prior to care pathways being developed, using existing activity data."

What is the local tariff? Is it the trust price, the borough price or the CCG price? Some trusts have historic funding and different services in place for each of their PCTs.

"We don't want a different tariff for each of our PCTs, otherwise it's likely to be a block contract with increased transaction costs."

What is the local tariff for the independent sector?

National tariff

Some people felt that the current approach to implementing PbR meant that it would be hard to achieve a robust national tariff.

"The DH has asked local health economies to contract on 2012/13 with clusters with little practical guidance. This would be less of an issue if there were no plans to move to a national tariff. Stronger central guidance would ensure greater consistency in what people do, and would then make it easier to move to a national tariff."

"When services are redesigned this will change costs that go into tariff. Not a problem at a local level, but will be when there is national tariff. Timing of efficiency savings has an impact on local tariff."

"I am anxious about the national tariff – Monitor does not understand mental health. DH has not resourced the central team adequately."

Outcomes

A quality and outcomes framework is recognised to be a key element of developing a robust PbR system for mental health. Limited work has been carried out in developing outcomes for the clusters across the country. Many are waiting to find out what progress the national quality and outcomes group has made.

"I am anxious about the national tariff – Monitor does not understand mental health"

Contracting arrangements for 2012/13

All those interviewed said that the financial risks are too great for implementing PbR live in 2012/13 due to the lack of robust data. In describing their contracting arrangements for next year, most described operating the 2012/13 contract in shadow form with risk sharing mechanisms. Not all trusts and commissioners have jointly discussed what their plans are.

"It really is a challenge to use PbR in contracts. We need to gain confidence and understanding in currency, and describe it in a care package, then cost – and then understand what it means for the contract. There is no culture of using information and sharing with commissioners. trusts are concerned that they will use it for easy pickings to save money. Commissioners are coming to the table saying they don't have capacity or knowledge to do anything with it. It's about contracting not commissioning mental health services."

"We will have a local tariff for 2012/13, but it won't be robust. The contract will have lots of safeguards in for the trust and PCTs. I can guarantee that the local tariff will be wrong in the first year."

"We have agreed to keep contract value at the same level for 2012/13 and use local PbR tariffs in shadow form."

"These are really tight deadlines for commissioners. Three months to nail a contract with probably only one month's fully clustered data to do this with."

"The key issue is how 2012/13 is handled. It needs to be a shadow year, otherwise commissioners could be making decisions on the basis of incorrect incomplete data."

IT infrastructure

There is general concern about the strength of IT systems across the country to support what is required to fully implement PbR. While trusts have come up with varied solutions to capturing cluster data, capturing clinical activity is more problematic.

"We need a good IT system. Staff are clustering service users on paper."

"We have built a cluster allocation tool outside RiO. We are now building a link from the allocation tool to RiO, where there is a care plan library."

"RiO does not provide what we need – very cumbersome – makes it very hard for clinicians to input data, so we decided to use standalone tool which everyone has access to."

"The accuracy of costs depends on improving activity data. At best trusts in this area are collecting 50 per cent of clinical time, and they do not have the information systems to do this."

Commissioners do not know what IT systems they need to manage PbR, and many have not considered it at all.

"We have not done anything yet. We would need to be looking at a complex coding/invoice validation system to match patient level data on SUS. We won't support PbR until we have a full battery of tools to validate."

"We have built a cluster allocation tool outside RiO. We are now building a link from the allocation tool to RiO, where there is a care plan library"

Commissioning

The lack of a stable commissioning environment is seen as a barrier to the delivery of the policy. The reorganisation of PCTs to clusters and clinical commissioning groups (CCGs) is having an impact on commissioners' capacity to focus on mental health PbR. Reorganisation means that it is not always clear who is commissioning mental health.

"PCT reorganisation has led to a loss of key staff. There has been a hole in mental health commissioning which has contributed to not having made enough progress in developing a tariff. There are no plans in place for how they will develop a tariff."

"There is chaos in commissioning moving from three PCTs to nine CCGs."

"We are not sure whether mental health sits in the PCT clusters or in the emerging clinical commissioning groups."

"For a while mental health providers did not have anyone to talk to at the PCTs."

The lack of engagement and communication nationally and regionally with commissioners has not helped them to become stronger commissioners.

"We need regular updates from the Centre that say what is expected of commissioners. It would be helpful if someone was saying that by now you should have got this far. We are having to take what providers say at face value. Give us something against which we can appraise the progress of our providers."

"We need help and support to deliver service specifications i.e. national service specifications which we can then tailor locally. We don't have the time to do this, or to challenge providers – and providers want to drive the process. Providers get away with things because of weak commissioners."

There is a mixed picture of **the level of engagement by commissioners** in PbR. In some areas trusts said that their commissioners were not engaged in PbR at all. *'It's not on the PCT chief executive's agenda'. 'Some PCTs are interested in mental health, but for a lot of them it is not an area they focus on.'* In other areas commissioners have been on the local PbR project board from the outset including local authority commissioners.

"We need a clear signal that PbR will happen come hell or high water, and commissioners must work with trusts. They need waking up."

The changing commissioner landscape means that **commissioners' knowledge and understanding** of the complexities of mental health PbR are patchy. Particular concerns were raised about how much GPs understood.

"GPs locally are not knowledgeable about PbR. We are struggling to educate them about community mental health services, never mind the intricacies of PbR."

"A very big issue is the need for training and education of CCG leaders so that they understand the complexities and risks. Lots of GPs read the guidance and think that there will be a local tariff next year – they don't understand the complexities."

The **commissioners' capacity** to implement PbR was raised as an issue by a number of PCTs.

"The reduction in staff means that there is not enough time to develop service specifications for all the clusters."

"We are not ready – it is a massive piece of work to go from a block contract to 20 different sets of specifications for care pathways."

It has felt from many of our interviews that the **commissioners are not in the driving seat** for implementing PbR. A number of PCTs expressed

frustration that trusts were not willing to work with them.

"A key issue is the lack of reported information from the trust on numbers in clusters, number of reviews etc. We are not prepared for a local tariff due to information not being provided by the trust. We want data that shows that the provider has met the requirements of the care pathway."

Social care

The general sense from interviews was that the links between health and social care had not been fully thought through.

"Social care appears to be nationally too difficult. How am I meant to understand how to deal with it?"

Personal budgets

People felt it was unclear how PbR fitted with the personalisation agenda. Concerns were raised about PbR perpetuating a medical model rather than taking account of the range of social care outcomes.

"Personalisation is a big problem. We have a number of pathways that work in social care. We need to unbundle the tariff to make personal budgets work in mental health. It is hard to get money out of the system."

Developing the tariff

There is wide confusion on whether social care staff should be included in the tariff.

"Currently social care staff are included in our costing – the commissioner needs to decide whether they want to do it this way, but the commissioner is waiting to hear from the DH. The pilot excluded social care and this distorted the picture, because in integrated teams the care co-ordinator may be a social worker. The trust view is that social care staff should be included."

"A local decision has been taken not to include social care costs."

"There is no clear guidance what to do with social care. It can be quite variable e.g. we have four boroughs who invest different amounts in mental health. This has an effect on care pathways."

"Social care integration is far more complex than the DH thinks. There are loads of models across the country, some formal some informal. Price is impossible to determine until there is consistency – with social care included or not. With formal section 75 or not. This needs cleaning up."

Independent sector

Although we are aware that there is an independent sector representative on the main mental health PbR board nationally, there has been little communication with the independent sector around mental health PbR from the centre or locally. Concerns raised by this group include:

Mental health is not ready for implementing PbR.

"It is clear that the sector is not yet ready for PbR, there is still a lot to clarify and adjust if it is to be meaningful."

"A lot of stuff is laudable, but the devil is in detail. There need to be simple rules as to how to do it."

There is confusion about which services provided by the independent sector are covered by mental health PbR.

They have not been involved in the pilot work.

"The independent sector feels excluded."

There are differing views on who they will need to cluster, and which users will arrive at their services already clustered.

There are questions about how PbR will take account of users being in more than one service at a time.

"There is an assumption that people in a pathway use only one service at a time. This is not the case – people use NHS services and others simultaneously, so don't assume a straightforward NHS pathway."

There are issues about supply chain management.

"How do all organisations that contribute to the outcome become part of the contract, for example social care enables outcomes. We would hate to see a system where social care can only be subcontractors."

What does a tariff mean for a non NHS provider? There is a need for illustrative examples of how tariffs are being tested. If the tariffs are wrong, this could cause market instability.

"We are concerned because we don't know what we are signing up to."

"How will tariffs take account of additional costs incurred by people with specialist needs, for example acquired brain injury, deaf?"

They have not agreed with commissioners how PbR will be used in contracts for 2012/13.

PCTs recognise the need to educate and engage with this sector.

"The private providers have not done anything yet. I have presented to them – they had no prior knowledge of PbR."

"No progress yet. The commissioners have identified that there are key voluntary sector providers that will be part of some pathways of care. They have identified the need to engage with these providers so they understand and use clustering."

"The voluntary sector are seen as a useful part of the recovery model. As most of the resources are tied up in the FT, we need to work in collaboration with the FT to make this happen."

Support in implementing PbR

We asked people for their views on the national and regional support for implementing PbR, and whether there were other things they would find useful.

There was a clear message from many people interviewed that they wanted clearer **leadership and strategic direction** from the Department of Health to ensure a consistent approach to the implementation of PbR.

"Without national leadership this isn't going to happen, and there will be no consistency of approach. I haven't heard PbR mentioned much recently. Has the steam gone out of it? Who is the national lead? There is a PbR bulletin on the website, but David Nicholson doesn't draw attention to it in weekly bulletins, there are only a couple of sentences in the Operating Framework. The project team has gone and the website is lacking material."

"Clear commitment nationally about mental health having a national tariff, with the same drive as they had for acute tariff."

"The trust would welcome clearer national direction so that PbR is implemented more consistently across the country."

Many people asked for clearer **national guidance and answers to key questions**.

"The lack of national lead leads to lack of consistency of business rules. This reduces the chance of introducing a national tariff."

"The lack of national guidance on key questions means that trusts will construct their tariffs differently. If trusts all do it differently, how can

commissioning occur as tariffs will be different due to varying ways they have been constructed."

"Answers to our questions! For example, what to do with cross-boundary referrals, A&E psychiatric liaison. Questions seem to go into a black hole."

"There has been a big gap in national guidance and direction from the centre – there has been a vacuum for the past year."

"We need more guidance for commissioners especially for CCGs."

People also want better **communication** about what is going on nationally.

"It's been very quiet for long time. No news on algorithm or outcomes for months. It would be useful to have regular updates on when we can expect to receive information."

"With a change programme you need to over inform – this does not appear to have happened. If you want to carry people with you, you need to over inform."

Some stakeholders see themselves as having been less well communicated with than others, for example commissioners and the independent sector.

Some people commented on the **limited resources at the DH** for leading the PbR programme, and compared this with the level of resources allocated to acute PbR. While there is recognition that some of the SHAs have played a key role in supporting national development work, they won't be able to do this in future once they have been abolished. Project management of PbR was described as 'light touch' which has meant that some parts of the project plan have not happened.

"Feels like the process hasn't been driven – always a work in progress."

“We need a properly resourced project team at DH to run and drive the project. Naïve to think you can rely on the goodwill of a few alone.”

“It would have been more helpful to have a more structured implementation, similar to the implementation of PbR in the acute sector. Mental Health PbR feels like it has much less attention, interest or investment compared to acute PbR.”

A number of people commented that **national tools were being delivered late**. This was seen as one of the barriers to meeting the national deadlines for implementation.

“The project time line for trusts to deliver is faster than the infrastructure to support it e.g. the electronic clustering tool was late and it doesn’t work. The outcomes framework has been delayed. trusts are not allowed to miss a deadline, but national support does!”

The overwhelming majority of interviewees asked for more opportunities to **learn from others and for a more coordinated approach**. Some regions and some individual organisations have developed local tools for implementing PbR, and they could see benefits in these being more widely available for others to use e.g. tools for electronic clustering, workforce and costing.

“Lots of different groups are putting effort into this and working separately, so there is duplication of effort and activity. It would have been better to have had a coordinated approach rather than everybody doing their own thing. This trust has lots of areas to focus on and figuring out PbR is not such a priority compared to other initiatives that need to be delivered.”

“A national database which told you what other trusts were doing/had problems with so that we can benefit from shared learning without having to attend national events.”

There has been significant variation in the **regional support structures** for the implementation of PbR, which has had an impact on how ready organisations are. Areas where there has been more support for a longer time tend to be more advanced, although there are examples of organisations in other regions who are also more advanced. Concerns were raised about how regional support would be provided once the SHAs went in their current form.

“We need a properly resourced project team at DH to run and drive the project. Naïve to think you can rely on the goodwill of a few alone”

Discussion and recommendations

Introduction

The previous section presented our findings from interviewing a wide range of stakeholders. This section assesses how ready commissioners and providers are to deliver the DH policy commitment that adult mental health PbR currencies will be used for commissioning and reimbursement purposes from April 2012. We have used the framework outlined in section 2.3 to summarise our judgements. We also consider what else is required to support the implementation of the policy.

Discussion

Table 3 provides an overall summary of the country's state of readiness for implementing PbR, using the framework we outlined at the beginning of the report. We have measured readiness as 'low', 'medium' or 'high'. We then describe how we have come to this judgement.

All service users accessing mental healthcare (post-GP or other referral) that have traditionally been labelled working age adults and older people's services, are allocated to a cluster.

Commissioners and providers are confident in the quality of cluster data

Although most trusts will have allocated users to a cluster by December, poor data quality means that trusts will not have a robust currency for commissioning and reimbursement purposes from April 2012.

Nearly all mental health trusts think they will have allocated all users to a cluster by December 2011. However, meeting this target does not necessarily mean that the cluster data is fit for purpose to use as a currency. There are significant concerns about the quality of the clustering data, with particular issues about the correct allocation of users to clusters, consistency in cluster allocation and the use of transition protocols. Few trusts feel confident that their cluster data is good enough to use as a currency from April 2012.

Table 3. Summary of the country's state of readiness for PbR implementation

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

Packages of care are defined for each cluster

Insufficient progress has been made in defining care packages, which creates delays in costing clusters

The level of progress in defining packages of care is very mixed. Only a third of trusts interviewed had made considerable progress, and nearly half had not started.

More work needs to be done on understanding how social care is dealt with in PbR. There is uncertainty about whether social care staff should be included within care packages, and it is unclear how PbR sits with the personalisation agenda. Social care is concerned about whether PbR perpetuates a medical model rather than taking account of social care outcomes. Views in a recent ADASS paper *Recovery and payment by results in mental health August 2011* note that HoNoS measures mental health and social functioning but does not directly measure recovery, nor recovery focused upon social inclusion.

Clusters are costed

Trusts have not made sufficient progress in costing clusters to have local tariffs for next April

Some trusts have not yet started to cost clusters, while others have carried out considerable work. There are a number of barriers to meeting the deadline. There are concerns over the quality of the cluster data, which forms the basis of costing. Few trusts have finalised their packages of care by cluster. Many trusts do not have adequate IT systems to collect the necessary clinical activity, and those that do have not collected it for long enough to have sufficient trend data on clusters and associated interventions. National guidance on costing clusters has yet to be published.

Local tariffs are fit for purpose – stable, accurate, with acceptable variance

Commissioners and providers will not have local tariffs fit for purpose by April 2012

For local tariffs to be fit for purpose, commissioners need to be able to compare prices and outcomes

between different organisations and be confident that they are comparing like with like. This will not be the case by April 2012. The current lack of confidence in the cluster data quality, together with the lack of progress in defining care packages and costing clusters, means that there is a considerable way to go before robust local tariffs are developed.

The lack of national guidance on how to calculate local tariffs means that organisations are unlikely to calculate tariffs in a consistent manner, for example should they be based on current service provision or new care packages, should they include social care costs, does local mean by trust or commissioner?

Even once local tariffs are developed, the limited understanding of the variation in care packages provided to users within one cluster, and the impact this will have on cluster costs and tariff, means that there is a danger that local tariffs could destabilise the market until this is worked through.

There is also considerable work required to develop a quality and outcomes framework for the clusters.

Mental health contracts use the care clusters as the contract currency with local prices

The market is not ready to fully implement mental health PbR in April 2012

For the reasons outlined above, the financial risks for implementing PbR live in 2012/13 are too great. Most areas are planning to operate their 2012/13 contract in shadow form with risk sharing mechanisms.

For the effective implementation of PbR, it is essential that commissioners are at the centre of the process working closely with the organisations that they contract with. This is often not the case, although we did find some examples of excellent joint working between trusts and PCTs. There are a number of reasons why this is so. The lack of a stable commissioning environment has reduced

commissioners' ability and capacity to focus on mental health. This has been compounded by the fact that support for the implementation of PbR for commissioners has not been strong. The focus nationally and regionally has been more with the NHS trusts, with little specific engagement or communication with commissioners. Commissioners are less knowledgeable about mental health PbR, and are not always clear what is expected of them.

The lack of engagement with the independent sector means that this sector is unclear about what they should be doing to prepare for PbR, and what impact the implementation of PbR will have on them.

Process for validation of payments is in place

There is no process for validating payments under mental health PbR

Commissioners have not considered their IT requirements for the implementation of PbR, and people do not know how they can validate currency for payment. There are concerns about how easy it would be to escalate clusters to increase income levels.

Summary

Our review has found that commissioners and providers are not ready to use the care clusters as the contract currency for 2012/13 with local prices. This is not due to a disinclination to implement PbR. There is recognition that the current block contracts for mental health expose providers to financial pressures. The introduction of mental health PbR brings a level of transparency to commissioning decisions. Government health reforms mean that commissioning will be increasingly important for the performance management of providers. Commissioners need to have a language to be able to specify what they want. Evidence-based practice and pathways are of critical importance in delivering the Government's mental health strategy and future quality objectives from the NHS Commissioning Board.

Most people we spoke to were enthusiastic about clustering users, and could see real benefits in implementing PbR. PbR is seen to be a useful tool for improving both quality and value for money, as well as a more transparent way of commissioning mental health.

One reason why the system is not ready is one of pace. Even trusts who have been clustering users for some years are not yet confident in the quality of their clustering data. This then causes delays in costing clusters, and developing local tariffs.

There has been a feeling in some areas that mental health PbR would never happen. A lack of strong national leadership and strategic direction has contributed to some commissioners and trusts not having started to implement PbR sooner. Many commissioners are not properly engaged in the process. Greater communication with NHS providers, and in particular commissioners and the independent sector, is needed. More opportunities to learn from others and the sharing of locally developed tools would also support the implementation process.

Implementation has in part been delayed through a lack of national guidance on some topics, for example there is a need for a national steer on how social care is dealt with in PbR, and how local tariffs should be calculated. The late delivery of promised national tools has caused additional delays.

England is trying to achieve something which has not been achieved anywhere in the world i.e. develop a robust currency for mental health. It is essential that tariffs are fit for purpose before they are implemented 'live'. There is a danger otherwise that the mental health market is destabilised: commissioners could inappropriately reduce investment on the basis of poor quality information; and perverse incentives could lead to poorer quality in care.

Recommendations

In preparing this report, our principal task was to present a clear and accurate picture of the current state of readiness to implement PbR. We hope that we have done that above. We were in addition asked briefly to recommend the actions which, in our opinion, could arise from our findings.

Both commissioners and providers need to be fully engaged in mental health PbR implementation. This includes having a good understanding of mental health PbR and what it means for them as commissioners and providers. Attention should be given to PbR at board level, and organisations need to ensure they have staff with the relevant skill and knowledge to implement PbR. SHA clusters should consider how they can support local commissioners and providers with the implementation process, and the DH should ensure that it provides the necessary leadership for the process.

The various parts of the mental health system will need to work together to achieve the following, and each agency should consider carefully the particular contribution it could make. Responsibilities and time scales need to be clear at local and national levels.

“There should be regular and comprehensive communication as to requirements in the implementation of mental health PbR”

1. There should be regular and comprehensive communication as to requirements in the implementation of mental health PbR. Information should include clarity on deadlines and what they mean, and progress reports on national development work. Briefings should be monthly, so that the mental health system receives information in a timely fashion.
2. It should be ensured that there are sufficient resources, at all levels, to deliver the work required. Robust project management systems should be put in place to ensure deliverables are achieved, and implementation risks highlighted at an early stage.
3. A formal FAQ system should be established so that timely answers are provided to commissioners' and providers' questions about implementation.
4. A programme of PbR training should be rolled out for new commissioners.
5. A national mental health PbR website should be established for the sharing of learning, techniques and tools. This would include investing in the development of tools which local organisations or regions have created, so that the tools can be shared nationally.
6. A review should be undertaken to understand why there appear to be inter-rater reliability issues in clustering users. This should include analysis of why clinicians are overriding the cluster tool in significant numbers. Depending on the outcome of this review, work may need to be commissioned to improve the clustering tool's inter-rater reliability.

7. Guidance should be published on how local tariffs should be calculated.
8. Social care staff should be included in the tariffs. Guidance should make clear how personal budgets fit into PbR.
9. A review should be undertaken to gain greater understanding of the variation in care packages provided to users within one cluster, and the impact this has on cluster costs and tariff. This should include looking at co-morbidities, thresholds and current commissioning patterns. Depending on the outcome of the review, action will need to be taken to address any unacceptable level of cost variance before the tariffs are fit for purpose.
10. Discussions should begin with independent providers to lead and guide the local process of PbR development.
11. A full assessment of the IT infrastructure requirements to fully implement PbR should be carried out.
12. Consideration should be given to what mechanisms should be put in place to encourage collaboration in implementing PbR with other areas.
13. All users of relevant services should be allocated to a cluster.
14. Mental health contracts for 2012/13 should contain risk sharing agreements to ensure financial stability during the transitional period.
15. Work should be carried out to improve the quality of clustering data. This will include ensuring:
 - users are allocated to the correct cluster
 - users are reviewed regularly using the transition protocols.
16. Packages of care for each cluster should be determined.
17. Clusters should be costed.
18. Local tariffs should be developed. An assessment should be carried out to whether they are fit for purpose for 2013/14 contracts.
19. An administrative and clinical system for validating clusters for payment purposes should be developed.

Appendix A. Interviewees

ORGANISATION	NAME
Individuals and agencies	
Association of Directors of Adult Social Services Mental Health Group	Terry Dafter
Care Pathways and Packages Project	Carole Green
Chair of Mental Health PbR Costing Group	Letsie Tilley
Chair of Mental Health PbR Expert Reference Panel	Stuart Bell
Department of Health	Bruce Calderwood
Department of Health	Martin Campbell
Department of Health	Hugh Griffiths
Foundation Trust Network	Paul Betts
Monitor	George Batchelor
NHS Confederation Mental Health Network	Steve Shrubb
NHS Confederation Primary Care Trust Network	David Stout
NHS Information Centre	Netta Hollins
Royal College of Psychiatrists	Bohdan Solomka
University of Southampton	David Kingdon
Commissioners	
NHS Derby/Derbyshire Cluster	Miles Scott
Nene Commissioning	Richard Alsop
NHS Black Country Cluster	Lesley Brougham
NHS Bedfordshire	Howard Shoebridge
NHS County Durham and Darlington	Dean Cuthbert
NHS County Durham and Darlington	Richard Lilly
NHS Dorset/Poole and Dorset Cluster	Rosemary Shaylor
NHS Hull	Keith Baulcombe
NHS Kent and Medway Cluster	Lauretta Kavanagh, Phil McSweeney, Joanne Ross
NHS Knowsley	Colin Vose
NHS Lincolnshire	Alan Kitt
NHS Mid Essex	Nicola Colston
NHS Nottingham City	Naomi Roose

ORGANISATION	NAME
NHS North Somerset	Julie Kell
NHS South Tyneside	Ian Holliday
NHS Outer North East London Cluster	Christopher Soltysiak
NHS West Sussex	Tom Insley
NHS Wolverhampton City	Lucy Heath
Local authorities	
Brent Council	Alison Elliot
Stockport Metropolitan Borough Council	Nick Dixon
Worcestershire County Council	Susan Harris
Worcestershire County Council	David Hitchen
Chief executives of mental health trusts (or nominated representative indicated by a *)	
2gether NHS FT	Sandra Betney*
5 Boroughs Partnership NHS FT	Gail Briers *
Birmingham and Solihull Mental Health NHS FT	Georgina Dean*
Coventry and Warwickshire Partnership NHS Trust	Rachel Newson
Cumbria Partnership NHS FT	Sarah Senior *
Hertfordshire Partnership NHS FT	Stanley Riseborough*
Leicester Partnership NHS Trust	Sue Hitchenor* and Sab Bhaumik*
Manchester Mental Health and Social Care Trust	Tracy Ellery*
Norfolk and Waveney Mental Health NHS FT	Aidan Thomas
Northamptonshire Healthcare NHS FT	Brendan Hayes*
North Staffordshire Combined Healthcare NHS Trust	Fiona Myers
Northumberland Tyne and Wear NHS FT	James Duncan*
North Essex Partnership NHS FT	Andrew Geldard
Southern Health NHS FT	Helen DeVal* and Chris Woodfine*
South Staffordshire and Shropshire Healthcare NHS FT	Jayne Deaville*
South West London and St George's Mental Health NHS Trust	Mike Naylor*
South West Yorkshire Partnership NHS FT	Steven Michael

ORGANISATION	NAME
Medical directors of mental health trusts	
Barnet Enfield and Haringey Mental Health NHS Trust	Peter Sudbury
Cambridge and Peterborough NHS FT	Tom Dening
Camden and Islington NHS FT	Sylvia Tang
Cheshire and Wirral Partnership NHS FT	Andy Cotgrove
Cornwall Partnership NHS FT	Ellen Wilkinson
Derbyshire Healthcare NHS FT	John Sykes
Humber NHS FT	Douglas Gee
Lancashire Care NHS FT	Max Marshall
Manchester Mental Health and Social Care Trust	Sean Lennon
North East London NHS FT	Alex Horne
Nottinghamshire Healthcare NHS Trust	Peter Miller
Pennine Care NHS FT	Henry Ticehurst
South Essex Partnership University NHS FT	Llew Lewis (PbR clinical lead)
Surrey and Borders Partnership NHS FT	Rachel Hennessey and Clive Field
Tees Esk and Wear Valleys NHS FT	Nick Land
West London Mental Health NHS Trust	Nick Broughton
Worcestershire Health and Care NHS Trust	Bill Creaney
PbR project leads of mental health trusts	
Avon and Wiltshire Mental Health Partnership NHS Trust	Patrick McKee
Black Country Partnership NHS FT	Paul Stefanoski
Bradford District Care Trust	Malcolm Braim
Central and North West London NHS FT	Sarah Rushton
Derbyshire Healthcare NHS FT	Helen Spencer
Devon Partnership NHS Trust	Simon Polak
Dorset Healthcare University NHS FT	Olivia Hamilton
Dudley and Walsall Mental Health Partnership NHS Trust	Philip Hogarth
Leicester Partnership NHS Trust	Bernie O'Hare
NHS Isle of Wight	Jo Blackley

ORGANISATION	NAME
NHS Plymouth	David McAuley
Nottinghamshire Healthcare NHS Trust	Chris Ashwell
Northamptonshire Healthcare NHS FT	Andrew Northall
Oxleas NHS FT	Sophie Donellan
Rotherham Doncaster and South Humber NHS FT	Karen Cvijetic
Somerset Partnership NHS FT	James Marriott
Sussex Partnership NHS FT	Kay McDonald
Tees Esk and Wear Valleys NHS FT	Bob Craig
SHA representatives	
NHS London	Geraldine Strathdee
NHS London	Mo Zoha
NHS London	Pratima Singh
NHS South Central	Chris Gill and Julie Kerry
NHS South East Coast	Wayland Lousley
NHS West Midlands	Laurence Moulin
NHS Yorkshire and the Humber	Heather Raistrick
Independent sector providers	
Cygnet Health Care	John Hoar
Priory Group	Chris Thompson
St Andrews Healthcare	Russell Jones
Together	Liz Felton

Appendix B. Interview frameworks

Mental Health Payment by Results readiness review

The purpose of the review is to assess all aspects of readiness to implement current policy. It is **not** the purpose of the review to decide whether the current policy is the right one. If interviewees raise comments of this nature, we should note their views quickly, but ensure that the interview remains focused on the review's purpose.

The interview schedules highlight the main questions in bold, with a number of subsidiary questions to prompt further questioning of a main issue.

For all areas, try to find out:

- progress made
- levers and barriers to progress
- benefits accrued so far
- impact of current state of readiness on meeting DH implementation deadlines
- further actions required to achieve DH implementation deadlines.

Questions for NHS trusts and commissioners

Theme	NHS trust chief executives	NHS trust medical directors	NHS trust PbR project managers	Commissioners
The processes for developing standard and costable care packages for each of the clusters				
<i>Allocating users to clusters</i>	How much progress has your trust made in clustering users? Do you expect to meet the December 2011 deadline?	How much progress has your trust made in clustering users? Do you expect to meet the December 2011 deadline?	How much progress has your trust made in clustering users? Do you expect to meet the December 2011 deadline?	How much progress has your main provider trust made in clustering users? Do you expect them to meet the December 2011 deadline?
	If you do not expect to meet the December 2011 deadline: What impact will this have on implementing MH PbR in 2012/13? What are the barriers to meeting the December 2011 deadline? When do you expect to complete clustering?	If you do not expect to meet the December 2011 deadline: What impact will this have on implementing MH PbR in 2012/13? What are the barriers to meeting the December 2011 deadline? When do you expect to complete clustering?	If you do not expect to meet the December 2011 deadline: What impact will this have on implementing MH PbR in 2012/13? What are the barriers to meeting the December 2011 deadline? When do you expect to complete clustering?	If you do not expect to meet the December 2011 deadline: What impact will this have on implementing MH PbR in 2012/13? What are the barriers to meeting the December 2011 deadline? When do you expect clustering to be complete?
	Are clinicians generally supportive of the process?	Are clinicians generally supportive of the process?	Are clinicians generally supportive of the process?	
	What has your organisation done to ensure that all your clinicians are fully trained to cluster?	What has your organisation done to ensure that all your clinicians are fully trained to cluster?	What has your organisation done to ensure that all your clinicians are fully trained to cluster?	What investment have your providers made in ensuring that all their clinicians are fully trained to cluster?
	What have been the benefits so far of allocating users to clusters?	What have been the benefits so far of allocating users to clusters?	What have been the benefits so far of allocating users to clusters?	What have been the benefits so far of allocating users to clusters?

Theme	NHS trust chief executives	NHS trust medical directors	NHS trust PbR project managers	Commissioners
<i>Defining packages of care associated with each cluster and developing indicative costs to use in 2012/13 contracting round</i>	<p>What progress have you made in determining packages of care associated with each cluster and developing indicative costs to use in the 2012/13 contracting round?</p> <p>What have been the greatest challenges/ major barriers to progress?</p> <p>What have been the benefits accrued so far?</p>	<p>What progress have you made in determining packages of care associated with each cluster and developing indicative costs to use in the 2012/13 contracting round?</p> <p>What have been the greatest challenges/ major barriers to progress?</p> <p>What have been the benefits accrued so far?</p>	<p>What progress have you made in determining packages of care associated with each cluster and developing indicative costs to use in the 2012/13 contracting round?</p> <p>What have been the greatest challenges/ major barriers to progress?</p> <p>What have been the benefits accrued so far?</p>	<p>What discussions have you had with your main provider about using care packages and cluster costs for the 2012/13 contracting round?</p> <p>What have been the greatest challenges/ major barriers to progress?</p> <p>What have been the benefits accrued so far?</p>
<i>Defining packages of care</i>	Has your organisation defined the packages of care that will be associated with each cluster?	Has your organisation defined the packages of care that will be associated with each cluster?	Has your organisation defined the packages of care that will be associated with each cluster?	Has your trust defined the packages of care that will be associated with each cluster?
		What involvement have you and clinical colleagues had in this process?		Has the trust involved you in determining the packages of care for each cluster?
	<p>If no, what are the barriers?</p> <p>What action needs to take place to be able to define packages of care for each cluster?</p>	<p>If no, what are the barriers?</p> <p>What action needs to take place to be able to define packages of care for each cluster?</p>	<p>If no, what are the barriers?</p> <p>What action needs to take place to be able to define packages of care for each cluster?</p>	<p>If no, what are the barriers?</p> <p>What action needs to take place to be able to define packages of care for each cluster?</p>
	Do you expect users in one cluster to all being receiving similar packages of care? If not, why not? Are you able to quantify the level of variation? Is there greater variation in some clusters than others?	Do you expect users in one cluster to all being receiving similar packages of care? If not, why not? Are you able to quantify the level of variation? Is there greater variation in some clusters than others?	Do you expect users in one cluster to all being receiving similar packages of care? If not, why not? Are you able to quantify the level of variation? Is there greater variation in some clusters than others?	Do you expect users in one cluster to all being receiving similar packages of care? If not, why not? Are you able to quantify the level of variation? Is there greater variation in some clusters than others?

Theme	NHS trust chief executives	NHS trust medical directors	NHS trust PbR project managers	Commissioners
<i>Setting a local tariff</i>	How prepared is the trust for using a national currency for 2012/13 contracts?	How prepared is the trust for using a national currency for 2012/13 contracts?	How prepared is the trust for using a national currency for 2012/13 contracts?	How prepared is the commissioner for using a national currency for 2012/13 contracts?
	What are the main challenges?	What are the main challenges?	What are the main challenges?	What are the main challenges?
	Have you costed the clusters? How?	Have you costed the clusters? How?	Have you costed the clusters? How?	Has your local trust costed the clusters? How?
	For those who have started costing clusters, what are the emerging issues?	For those who have started costing clusters, what are the emerging issues?	For those who have started costing clusters, what are the emerging issues?	For those who have started costing clusters, what are the emerging issues?
	How have you decided how to take account of social care staff who are part of integrated mental health teams?		How have you decided how to take account of social care staff who are part of integrated mental health teams?	How have you decided how to take account of social care staff who are part of integrated mental health teams?
	What progress have you made in agreeing a local tariff? (i.e. moving from cost to price)	What progress have you made in agreeing a local tariff? (i.e. moving from cost to price)	What progress have you made in agreeing a local tariff? (i.e. moving from cost to price)	What progress have you made in agreeing a local tariff? (i.e. moving from cost to price)
				What progress are your private providers making in clustering and costing? What have been the greatest challenges/major barriers to progress?

Theme	NHS trust chief executives	NHS trust medical directors	NHS trust PbR project managers	Commissioners
Data quality and data gathering processes	How confident are you in the quality of your cluster data?	How confident are you in the quality of your cluster data?	How confident are you in the quality of your cluster data?	How confident are you in the quality of the cluster data?
	What work has the trust done to ensure users are being clustered consistently and appropriately? Are you confident that service users are being allocated to clusters consistently within your trust and between trusts?	What work has the trust done to ensure users are being clustered consistently and appropriately? Are you confident that service users are being allocated to clusters consistently within your trust and between trusts?	What work has the trust done to ensure users are being clustered consistently and appropriately? Are you confident that service users are being allocated to clusters consistently within your trust and between trusts?	What work have you done to ensure users are being clustered consistently and appropriately? Are you confident that service users are being allocated to clusters consistently within your local trust and between trusts?
	What steps have you taken to ensure that you have the necessary IT infrastructure for implementing MH PbR?	What steps have you taken to ensure that you have the necessary IT infrastructure for implementing MH PbR?	What steps have you taken to ensure that you have the necessary IT infrastructure for implementing MH PbR?	What steps have you taken to ensure that you have the necessary IT infrastructure for implementing MH PbR?
	Depending on the answers: what else need to happen to ensure that data quality and data gathering processes do not hamper the successful implementation of MH PbR in 2012/13?	Depending on the answers: what else need to happen to ensure that data quality and data gathering processes do not hamper the successful implementation of MH PbR in 2012/13?	Depending on the answers: what else need to happen to ensure that data quality and data gathering processes do not hamper the successful implementation of MH PbR in 2012/13?	Depending on the answers: what else need to happen to ensure that data quality and data gathering processes do not hamper the successful implementation of MH PbR in 2012/13?
Financial risk assessment and risk distribution	What do you perceive to be the financial risks to your organisation from the implementation of MH PbR?	What do you perceive to be the financial risks to your organisation from the implementation of MH PbR?	What do you perceive to be the financial risks to your organisation from the implementation of MH PbR?	What do you perceive to be the financial risks to your organisation from the implementation of MH PbR?
	Do you have a sense of the level of financial risk faced by your organisation? How do you expect to manage this risk?		Do you have a sense of the level of financial risk faced by your organisation? How do you expect to manage this risk?	Do you have a sense of the level of financial risk faced by your organisation? How do you expect to manage this risk?

Theme	NHS trust chief executives	NHS trust medical directors	NHS trust PbR project managers	Commissioners
	What about high cost patients – how will you treat outliers from cluster average costs?		What about high cost patients – how will you treat outliers from cluster average costs?	What about high cost patients – how will you treat outliers from cluster average costs?
Performance management and incentivising effective care	What opportunities does the currency provide you to improve quality, efficiency and effectiveness?	What opportunities does the currency provide you to improve quality, efficiency and effectiveness?	What opportunities does the currency provide you to improve quality, efficiency and effectiveness?	What opportunities does the currency provide you to improve quality, efficiency and effectiveness?
	Describe progress so far	Describe progress so far	Describe progress so far	Describe progress so far
	Describe any work that has been done on defining outcomes for clusters	Describe any work that has been done on defining outcomes for clusters	Describe any work that has been done on defining outcomes for clusters	Describe any work that has been done on defining outcomes for clusters
	Have contract service specifications been aligned with clusters?	Have contract service specifications been aligned with clusters?	Have contract service specifications been aligned with clusters?	Have contract service specifications been aligned with clusters?
	Have you used the introduction of PbR to bring in other service redesigns into your organisation?	Have you used the introduction of PbR to bring in other service redesigns into your organisation?	Have you used the introduction of PbR to bring in other service redesigns into your organisation?	Have you used PbR to work with your providers to redesign service provision in your area?
Local and regional implementation and support structures	What local and regional support has there been for the implementation of MH PbR?	What local and regional support has there been for the implementation of MH PbR?	What local and regional support has there been for the implementation of MH PbR?	What local and regional support has there been for the implementation of MH PbR?
	What has been most useful?	What has been most useful?	What has been most useful?	What has been most useful?
	What else is needed?	What else is needed?	What else is needed?	What else is needed?
National implementation and support structures	What national support has there been for the implementation of MH PbR?	What national support has there been for the implementation of MH PbR?	What national support has there been for the implementation of MH PbR?	What national support has there been for the implementation of MH PbR?
	What has been most useful?	What has been most useful?	What has been most useful?	What has been most useful?
	What else is needed?	What else is needed?	What else is needed?	What else is needed?

Theme	NHS trust chief executives	NHS trust medical directors	NHS trust PbR project managers	Commissioners
Good practice	Across the work you're doing on mental health PbR, are there things you're doing which feel like good practice, that you'd recommend others to adopt or follow?	Across the work you're doing on mental health PbR, are there things you're doing which feel like good practice, that you'd recommend others to adopt or follow?	Across the work you're doing on mental health PbR, are there things you're doing which feel like good practice, that you'd recommend others to adopt or follow?	Across the work you're doing on mental health PbR, are there things you're doing which feel like good practice, that you'd recommend others to adopt or follow?
Benefits of implementing MH PbR	What are the benefits of implementing MH PbR?	What are the benefits of implementing MH PbR?	What are the benefits of implementing MH PbR?	What are the benefits of implementing MH PbR?
	What are the benefits for service users?	What are the benefits for service users?	What are the benefits for service users?	What are the benefits for service users?
	How does it support closer engagement with social care? e.g. personal budgets	How does it support closer engagement with social care? e.g. personal budgets	How does it support closer engagement with social care? e.g. personal budgets	How does it support closer engagement with social care? e.g. personal budgets
'Desert island' question	If you could have just one thing to help you to implement mental health PbR, what would it be?	If you could have just one thing to help you to implement mental health PbR, what would it be?	If you could have just one thing to help you to implement mental health PbR, what would it be?	If you could have just one thing to help you to implement mental health PbR, what would it be?
Any other comments?	Do you have any further comments?	Do you have any further comments?	Do you have any further comments?	Do you have any further comments?

Questions for independent sector providers

What services do you provide to the NHS?

Which of these do you expect to be covered by PbR?

What is your understanding of the implications of PbR for your organisation?

What are the major barriers you are facing in meeting the deadlines?

- Clarity of application to your services
- Clarity of guidance
- Training
- Engagement of clinicians
- Technical – IT systems, local or national problems

What are the opportunities which MH PbR creates?

Across the work you're doing on mental health PbR, are there things you're doing which feel like good practice, that you'd recommend others to adopt or follow? How have you thought about new ways of working? Have you used clusters to understand how people enter and leave services?

Have you agreed with your commissioners how PbR will be used in contracts for 2012/13?

How do you plan to realise the benefits for people who use services?

If you could have just one thing to help you to implement mental health PbR, what would it be?

Any other comments?

Questions for local authority leads

What is your understanding of the implications of PbR for your organisation?

Have you received adequate guidance and support on the implementation of MH PbR?

Have you discussed the implementation of MH PbR with your local trust and local NHS commissioners?

What do you perceive to be the key challenges of implementing MH PbR from a local authority perspective?

What are the opportunities which MH PbR creates?

Are social care staff within integrated MH teams being included in the costing of clusters?

Are you looking at merging care clusters, the RAS and Care Funding Calculator?

How do you plan to realise the benefits for people who use services?

Across the work you're doing on mental health PbR, are there things you're doing which feel like good practice, that you'd recommend others to adopt or follow?

If you could have just one thing to help you to implement mental health PbR, what would it be?

Any other comments?

Questions for SHA mental health leads

Interviews will be constructed around the questions outlined for trusts and commissioners

Questions for ADASS

What's your overall perspective on the progress being made with mental health PbR?

- How well prepared is the MH system for meeting the DH deadlines for implementing MH PbR?
- What are the key challenges?
- What are the key opportunities?
- What actions are required (locally and nationally) to ensure the deadlines are met?

Interview will then be constructed around the questions outlined for local authorities

Questions for individuals and agencies

Theme	Question
Overall	What's your/your organisation's overall perspective on the progress being made with mental health PbR?
	How well prepared is the MH system for meeting the DH deadlines for implementing MH PbR?
	What are the key challenges?
	What actions are required (locally and nationally) to ensure the deadlines are met?
The processes for developing standard and costable care packages for each of the clusters	<p><i>Allocating users to clusters</i></p> <p>Will most trusts meet the December 2011 deadline?</p> <p>If you do not expect all trusts to meet the deadline:</p> <ul style="list-style-type: none"> • What impact will this have on implementing MH PbR in 2012/13? • What are the barriers to meeting the December 2011 deadline?
	Are clinicians generally supportive of the process?
	<p><i>Defining packages of care associated with each cluster and developing indicative costs to use in 2012/13 contracting round</i></p> <p>What progress has been made in determining packages of care associated with each cluster and developing indicative costs to use in the 2012/13 contracting round?</p> <p>What have been the greatest challenges/major barriers to progress?</p> <p>What have been the benefits accrued so far?</p>
	Do you expect users in one cluster to all being receiving similar packages of care? If not, why not? Are you able to quantify the level of variation? Is there greater variation in some clusters than others?
	How prepared are trusts and commissioners for using a national currency for 2012/13 contracts?
	What are the main challenges?
	For those who have started costing clusters, what are the emerging issues?
	What progress has been made in agreeing a local tariff? (i.e. moving from cost to price)

Theme	Question
Data quality and data gathering processes	<p>What are your views on the quality of cluster data?</p> <p>Are you confident that service users are being allocated to clusters consistently within and between trusts?</p>
	Do trusts and commissioners have the necessary IT infrastructure for implementing MH PbR?
	Depending on the answers: what else need to happen to ensure that data quality and data gathering processes do not hamper the successful implementation of MH PbR in 2012/13?
Financial risk assessment and risk distribution	<p>What do you perceive to be the financial risks from the implementation of MH PbR?</p> <p>How will risk be managed?</p>
Performance management and incentivising effective care	What opportunities does the currency provide to improve quality, efficiency and effectiveness?
Support structures for implementation – local, regional & national	<p>What support has there been for the implementation of MH PbR?</p> <p>What else is needed?</p>
Benefits of implementing MH PbR	<p>What are the benefits?</p> <p>What are the benefits for service users?</p> <p>How does it support closer engagement with social care? e.g. personal budgets</p>
Additional comments	Do you have any further comments?

Mental Health Payment by Results Readiness Review

The development of a Payment by Results approach to provider reimbursement in mental health services has been going on for a number of years. The aim of this review was to provide an assessment of commissioners' and providers' readiness to deliver the Department of Health policy commitment that adult mental health Payment by Results currencies should be used for commissioning and reimbursement purposes from April 2012.

The review was carried out by seeking the views of a wide spread of people in mental health trusts, commissioners, local authorities and the independent sector, as well as national stakeholders.

We trust this report will prove informative and useful in enabling all the responsible agencies to consider the next steps in this implementation process.

Further copies or alternative formats can be requested from:

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