Developing an episodic payment approach for mental health

Detailed guidance

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How does this document support mental health payment development?

This document supports local payment development and implementation of new local pricing rules for mental healthcare. It is part a set of written guidance to support local efforts. We are also offering more direct engagement and advice via workshops and webinars. The figure below illustrates how this document (highlighted in green) sits within the context of the wider support package.

This document outlines high-level steps needed to develop an episodic payment approach for mental healthcare.

This document follows publication of the ‘short written guidance’ on episodic payment for mental healthcare in December 2015. The purpose of that publication and this one is to aid local discussions on developing a payment approach. It is part of a series to help the sector move forward with transparent payment approaches that are linked to outcomes. Although this document highlights some legal issues, it does not address all the legal issues that commissioners and providers will need to consider when adopting any new payment/contracting approach.
Summary

This document provides step-by-step guidance on developing an episodic payment approach for mental health for contracting, pricing and finance professionals. For 2017-19, NHS Improvement and NHS England have made changes to the local pricing rules to require providers and commissioners of adult and older adult mental healthcare to adopt either a capitated or episodic/year-of-care payment approach. In either approach, a proportion of prices must be linked to the achievement of locally agreed quality and outcome measures.

An episodic payment approach provides payments to a provider or group of providers for an individual patient’s episode of care. This payment will vary according to which of the national currencies for mental health services best describes the patient’s needs. The characteristics of people who access secondary mental health services will vary from year to year, as will the number of people who require care.

An episodic payment approach for mental health can help local health economies address the limitations of unaccountable block contracts, and help providers and commissioners better understand the care they provide and the resource used to deliver that care.

An episodic payment approach can also help better achieve the Five Year Forward View’s (5YFV) objectives for mental health: parity of esteem between mental and physical healthcare; more efficient and effective evidence-based care; and earlier intervention, prevention and improved patient outcomes.

Providers and commissioners should cover seven key elements when developing an episodic payment approach for mental health:

- determining and agreeing the active caseload
- identifying relative resource intensity (RRI) and cluster costs
- using RRI with the current contract value to develop local prices
- determining the costs of delivering NICE-concordant care
- agreeing a risk-sharing approach
- agreeing how quality and outcome measures are linked to payment
- agreeing an approach to data monitoring between and within organisations and feedback to clinicians and service users.

These elements do not have to be carried out sequentially. This document is intended to offer a pragmatic approach that mental health providers and commissioners can adopt using existing data flows.

1 Providers and commissioners can agree an alternative payment approach as long as it is consistent with Rule 4 of the local pricing rules. With any alternative payment approach, providers and commissioners must still link prices to outcome measures.
1. Introduction to the payment approach and currency model

The purpose of this document is to provide guidance to providers and commissioners to assist in the development of an episodic payment approach for mental health. Providers and commissioners across the country have different levels of data quality, technical capability, resources and IT infrastructure available to them. This document presents an approach that can be adopted by all providers and commissioners.

The national tariff documents have signalled the need for providers and commissioners to move away from unaccountable block contracts, which are not in the best interests of service users, since 2013. We also recognise that the kind of ‘activity-based’ payment approach used for much acute physical healthcare is not suitable for mental health services. Typically those needing secondary mental health services have a longer-term relationship with their provider, which is why one of the payment approaches required under the local pricing rules is a payment based on an episode of care.

The payment approach seeks to address the limitations of unaccountable block contracts and will:

- support providers in better understanding the care they provide to service users and the resources used to deliver that care, and help them be reimbursed appropriately for delivering that care
- provide data to enable commissioners and service users to compare provider organisations and what they are achieving for service users so they can make well-informed decisions about commissioning and choosing services
- support clinicians to deliver the best possible care by incentivising the delivery of good outcomes as a key part of the payment approach.

The units of healthcare used for the episodic payment approach are the mental health currencies which are mandated for use from April 2012. The currencies are known as care clusters and cover most mental health services for working-age adults and older people. There are 21 mental health currencies, illustrated in Figure 1. The currencies are needs-based but fall under three broad diagnostic categories: psychotic, non-psychotic and organic.

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Currencies are the unit of healthcare for which a payment is made, and can take a number of forms covering different periods from an outpatient attendance or a stay in hospital, to a year of care for a long-term condition. Tariffs are the set prices paid for each currency.
The most appropriate cluster is assigned to a person following a clinical assessment using the mental health clustering tool. The assessment must be regularly reviewed in line with the timing and protocols in the mental health clustering booklet. All providers are contractually obliged to assign the most appropriate cluster to each service user, and to report this information as part of the broader Mental Health Services Data Set (MHSDS) monthly submission requirements to NHS Digital, whether or not they have used the care clusters as the basis of payment. The mental health services that currently fall outside the scope of the currencies are described in Appendix 2 of this guidance.

![Figure 1: Mental health currencies](image)

**Using the clusters for payment**

Each of the cluster currencies has a maximum review period. This means that a reassessment should have taken place at the end of the period to check whether the current cluster is still appropriate or whether a new cluster should be assigned.

In developing our thinking about the appropriate reimbursement period for each cluster, we have been guided by both the maximum review period and by the length of time that groups of service users with similar needs typically receive care for.

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This means that most of the clusters lend themselves to a year-of-care payment, and for the others we suggest that the maximum review period should be the indicative episode of care for payment. The approach is set out in Table 1.

**Table 1: Clusters**

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Cluster label</th>
<th>Max cluster review period</th>
<th>Suggested payment approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Variance group cluster allocation not initially possible</td>
<td>6 months</td>
<td>Episode</td>
</tr>
<tr>
<td>1</td>
<td>Common mental health problems (low severity)</td>
<td>12 weeks</td>
<td>Episode</td>
</tr>
<tr>
<td>2</td>
<td>Common mental health problems</td>
<td>15 weeks</td>
<td>Episode</td>
</tr>
<tr>
<td>3</td>
<td>Non-psychotic (moderate severity)</td>
<td>6 months</td>
<td>Episode</td>
</tr>
<tr>
<td>4</td>
<td>Non-psychotic (severe)</td>
<td>6 months</td>
<td>Year of care</td>
</tr>
<tr>
<td>5</td>
<td>Non-psychotic (very severe)</td>
<td>6 months</td>
<td>Year of care</td>
</tr>
<tr>
<td>6</td>
<td>Non-psychotic disorders of overvalued Ideas</td>
<td>6 months</td>
<td>Year of care</td>
</tr>
<tr>
<td>7</td>
<td>Enduring non-psychotic disorders (high disability)</td>
<td>Annual</td>
<td>Year of care</td>
</tr>
<tr>
<td>8</td>
<td>Non-psychotic chaotic and challenging disorders</td>
<td>Annual</td>
<td>Year of care</td>
</tr>
<tr>
<td>10</td>
<td>First episode in psychosis</td>
<td>Annual</td>
<td>Year of care</td>
</tr>
<tr>
<td>11</td>
<td>Ongoing recurrent psychosis (low symptoms)</td>
<td>Annual</td>
<td>Year of care</td>
</tr>
<tr>
<td>12</td>
<td>Ongoing or recurrent psychosis (high disability)</td>
<td>Annual</td>
<td>Year of care</td>
</tr>
<tr>
<td>13</td>
<td>Ongoing or recurrent psychosis (high symptoms and disability)</td>
<td>Annual</td>
<td>Year of care</td>
</tr>
<tr>
<td>14</td>
<td>Psychotic crisis</td>
<td>4 weeks</td>
<td>Cluster episode (at first presentation)</td>
</tr>
<tr>
<td>15</td>
<td>Severe psychotic depression</td>
<td>4 weeks</td>
<td>Cluster episode (at first presentation)</td>
</tr>
<tr>
<td>16</td>
<td>Dual diagnosis (substance abuse and mental illness)</td>
<td>6 months</td>
<td>Year of care</td>
</tr>
<tr>
<td>17</td>
<td>Psychosis and affective disorder difficult to engage</td>
<td>6 months</td>
<td>Year of care</td>
</tr>
<tr>
<td>18</td>
<td>Cognitive impairment (low need)</td>
<td>Annual</td>
<td>Year of care (annual review)</td>
</tr>
<tr>
<td>19</td>
<td>Cognitive impairment or dementia (moderate need)</td>
<td>6 months</td>
<td>Year of care (annual review)</td>
</tr>
<tr>
<td>20</td>
<td>Cognitive impairment or dementia (high need)</td>
<td>6 months</td>
<td>Year of care</td>
</tr>
<tr>
<td>21</td>
<td>Cognitive impairment or dementia (high physical need or engagement)</td>
<td>6 months</td>
<td>Year of care</td>
</tr>
</tbody>
</table>

All the currencies are independent of setting, and therefore there should be an incentive for providers to care for patients as close to home as possible, in the least restrictive and most cost-effective setting appropriate.

We want this payment approach to support early intervention and effective condition management, in particular when people are experiencing a psychotic crisis or severe psychotic depression, which may require inpatient care that can be expensive to provide.
The cost of supporting a patient in psychotic crisis or severe psychotic depression should be built into the value chain of care packages associated with clusters where evidence suggests crisis may occur. In light of this, we suggest that the cluster episode price for clusters 14 and 15 should normally only be paid in the case of a first presentation to mental health services but recognise that further work may be needed locally to:

- ensure local data flows exist to identify first presentations
- develop and implement reimbursement arrangements for patients who have a first or non-first presentation and who are not normally resident in your area.

Providers have told us that in some areas there is a particular issue with people being admitted repeatedly as the result of a psychotic crisis caused by taking legal highs. This group of people may have no history of mental illness or interact with mental health services otherwise. We suggest that commissioners should reimburse such episodes in full, but seek to work with the provider, public health teams, local authorities and other services in the area to look at ways to reduce the incidence of this type of crisis.

We are working with NHS Digital to look at how MHSDS reports can flag when a crisis is the first time that a patient is cared for by a service, and how the use of legal highs can be captured in the dataset. In the meantime, commissioners and providers may need to ensure local data flows exist to identify first presentations.

In all cases, providers should deliver an appropriate evidence-based package of care that at a minimum is NICE-concordant. This will need to be taken into account in agreeing local prices. The detail of an individual person’s package of care in any one cluster will of course vary according to diagnosis and their specific needs, requirements and personal goals.

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4 There will be legal issues to consider when agreeing prices or new arrangements – for example, those relating to procurement, consultation and competition.
2. Elements to developing an episodic payment approach

The task of establishing local prices and developing the local payment approach can be broken down into a number of elements. We do not expect they will all be carried out in sequence.

Figure 2: Elements to establishing an episodic payment approach

2.1 Determine and agree the active caseload

The starting point for developing prices for episodes of care is to understand the active caseload currently being cared for by the provider. The active caseload for any financial year is the number of service users by cluster who are receiving treatment or assessment. Providers must ensure that their patient data system only includes people currently being assessed or receiving treatment. The active caseload should be determined by taking an average over a 12-month period; if this is not possible then an average should be taken from three snapshots at agreed points in the year. The caseload should be broken down by cluster and those being assessed for the first time. The approach for establishing the active caseload should be agreed between commissioners and providers, and could depend on things such as whether there are any known seasonal fluctuations in activity. Monthly reports from NHS Digital include information on caseload, which could be used to inform this step.
Stakeholders have asked us about the treatment of patients recorded as being in cluster 99, ie those people who are recorded on systems as not being assessed or clustered. In some systems, patients are automatically moved into cluster 99 once the maximum review date has passed without a review taking place. In some organisations, people remain within their current cluster after the maximum review date has passed, but an agreed grace period for reassessment is in place, with a clear understanding that if this is passed there is no payment for people who are in cluster 99. The approach taken locally must be made transparent and agreed with commissioners.

It may be that there are changes anticipated to the caseload in the coming year, whether through planned changes in service delivery (for example, to meet the new access and waiting standards), or due to demographic changes. Data and evidence from the NHS Benchmarking Network, Public Health England, Office for National Statistics and NHS Atlas of Variation are among the data sources that may help to identify trends and likely changes. Any anticipated changes should be discussed and monitored on a quarterly basis.

2.2 Identifying relative resource intensity and cluster costs for current care

In this section, we use hypothetical information to explain the principles of how cluster and assessment prices can be determined through understanding the resources required for treating different groups of patients. In this example we use direct staffing costs as a proxy for the total resource intensity associated with any one patient.

Where providers have patient-level information costing systems (PLICs) it should be relatively straightforward to calculate the average cost of delivering care for patients in each cluster, which can inform a dialogue with commissioners about local prices. However, this approach may be useful where PLICS is not available.

An extract from the organisation’s patient administration system (PAS) should be written for a defined reporting period, such as the most recent financial year, which includes the following patient-level information:

- patient ID
- cluster allocated – where no cluster is allocated, the service user is assumed to be in the initial assessment phase
- length of time of appointment
- staff band
- number of days the service user has been allocated to the cluster for the period reported on. This should be from the day after a cluster is assigned.
Using this information and details of staff pay, it is possible to calculate a cost of the staffing resource used across the selected cluster. However, including a team and/or service in the extract from PAS would enable the production of weightings at team and/or service level.

**Table 2: PAS data**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Cluster</th>
<th>Appointment time (min)</th>
<th>Band</th>
<th>Staff rate per hour (£)</th>
<th>Cost of appointment (C*E) (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>W</td>
<td>Assessment</td>
<td>45</td>
<td>Band 7</td>
<td>21.75</td>
<td>16.31</td>
</tr>
<tr>
<td>W</td>
<td>1</td>
<td>60</td>
<td>Cons</td>
<td>65.4</td>
<td>65.4</td>
</tr>
<tr>
<td>W</td>
<td>1</td>
<td>30</td>
<td>Band 6</td>
<td>18.55</td>
<td>9.28</td>
</tr>
<tr>
<td>X</td>
<td>Assessment</td>
<td>45</td>
<td>Band 7</td>
<td>21.75</td>
<td>16.31</td>
</tr>
<tr>
<td>X</td>
<td>1</td>
<td>30</td>
<td>Band 6</td>
<td>18.55</td>
<td>9.28</td>
</tr>
<tr>
<td>X</td>
<td>Assessment</td>
<td>45</td>
<td>Band 7</td>
<td>21.75</td>
<td>16.31</td>
</tr>
<tr>
<td>X</td>
<td>3</td>
<td>30</td>
<td>Band 6</td>
<td>18.55</td>
<td>9.28</td>
</tr>
<tr>
<td>Y</td>
<td>2</td>
<td>60</td>
<td>Band 8a</td>
<td>27.72</td>
<td>27.72</td>
</tr>
<tr>
<td>Y</td>
<td>2</td>
<td>60</td>
<td>Band 8a</td>
<td>27.72</td>
<td>27.72</td>
</tr>
</tbody>
</table>

Using a report from the information collected through the healthcare team, and through PAS, we can obtain the total patient days (the total time patients have spent in each cluster – column H below). The cost of clinical staff time and the total patient days can be used to derive the average cost per patient day on each cluster (column I). These average costs are then converted into an RRI (column J), relative to the lowest cluster cost.

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5 All appointments before a service user has been assigned to a cluster are counted as initial assessment appointments. The appointment at which a cluster is allocated to the patient is counted as the final initial assessment appointment; all subsequent appointments are counted as treatment appointments against the allocated cluster(s).
Table 3: RRI calculation

<table>
<thead>
<tr>
<th>Cluster number</th>
<th>Total direct staff cost of cluster (£) (G)</th>
<th>Patient days for period (H)</th>
<th>Cost per patient day (G/H) (£) (I)</th>
<th>RRI (cluster cost (l)/ lowest cluster cost (l)) (J)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>129,938</td>
<td>15,750</td>
<td>8.25</td>
<td>1.65</td>
</tr>
<tr>
<td>1</td>
<td>38,750</td>
<td>7,750</td>
<td>5.00</td>
<td>1.00</td>
</tr>
<tr>
<td>2</td>
<td>227,125</td>
<td>39,500</td>
<td>5.75</td>
<td>1.15</td>
</tr>
<tr>
<td>3</td>
<td>485,850</td>
<td>79,000</td>
<td>6.15</td>
<td>1.23</td>
</tr>
<tr>
<td>4</td>
<td>711,000</td>
<td>79,000</td>
<td>9.00</td>
<td>1.80</td>
</tr>
<tr>
<td>5</td>
<td>279,063</td>
<td>23,750</td>
<td>11.75</td>
<td>2.35</td>
</tr>
<tr>
<td>6-21*</td>
<td>8,954,400</td>
<td>546,000</td>
<td>16.40</td>
<td>3.28</td>
</tr>
<tr>
<td>Assessment</td>
<td>515,964</td>
<td>39,538</td>
<td>13.05</td>
<td>2.61</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>11,342,089</strong></td>
<td><strong>830,288</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Clusters 6 to 21 need to be calculated separately.

RRI is an indication of the relative resource utilisation of a cluster. From Table 3 you can see that, on average, cluster 5 is 2.35 times more resource-intensive than cluster 1.

It should also be noted that this example does not include looking at inpatient costs. Providers will need to determine the costs associated with providing a bed for a patient, whether these vary by cluster, and typically what percentage of time in a cluster might be spent as an inpatient. This will then need to be factored into the resource relativity of each cluster.

2.3 Use RRI with the current contract value to develop local prices

Once RRI has been determined, it can be applied to the current annual contract value of services covered by the clusters to calculate indicative costs for each cluster, as shown in Table 4. The overall contract value will of course include all the other indirect costs, such as organisational overheads, co-ordination with colleagues and care professionals in other organisations, not just face-to-face contacts (direct costs).
Table 4: RRI and budget allocations to cluster

<table>
<thead>
<tr>
<th>Cluster number</th>
<th>RRI</th>
<th>Total annual expected patient days</th>
<th>Weighted treatment days (JxK)</th>
<th>Proportion of weighted treatment days per cluster</th>
<th>Overall contract value per cluster (contract value apportioned by weighted treatment days L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(J)</td>
<td>(K)</td>
<td>(L)</td>
<td>(M)</td>
<td>(N)</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>1.65</td>
<td>31,500</td>
<td>51,975</td>
<td>1.1</td>
<td>£481,285</td>
</tr>
<tr>
<td>1</td>
<td>1.00</td>
<td>15,500</td>
<td>15,500</td>
<td>0.3</td>
<td>£143,529</td>
</tr>
<tr>
<td>2</td>
<td>1.15</td>
<td>79,000</td>
<td>90,850</td>
<td>2.0</td>
<td>£845,265</td>
</tr>
<tr>
<td>3</td>
<td>1.23</td>
<td>158,000</td>
<td>194,340</td>
<td>4.3</td>
<td>£1,799,575</td>
</tr>
<tr>
<td>4</td>
<td>1.80</td>
<td>158,000</td>
<td>284,400</td>
<td>6.3</td>
<td>£2,633,524</td>
</tr>
<tr>
<td>5</td>
<td>2.35</td>
<td>47,500</td>
<td>111,625</td>
<td>2.5</td>
<td>£1,033,640</td>
</tr>
<tr>
<td>6-21*</td>
<td>3.28</td>
<td>1,092,000</td>
<td>3,581,760</td>
<td>78.9</td>
<td>£33,166,846</td>
</tr>
<tr>
<td>Assessment</td>
<td>2.61</td>
<td>79,075</td>
<td>206,386</td>
<td>4.6</td>
<td>£1,911,188</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>1,660,575</td>
<td>4,536,836</td>
<td>100</td>
<td>£42,010,781</td>
</tr>
</tbody>
</table>

In this example there is just a single RRI for assessment. This could be broken down further for each of the clusters.

The price for initial assessments is calculated by taking the overall contract value for initial assessments as calculated in Table 4 and dividing by the total number of assessments being contracted for (based on the agreed active case load). Using the example above:

Allocated contract value for assessment – £1,911,118 (from Table 4, column N)  
If 5,750 initial assessments have been contracted for then:

\[
\text{£1,911,118} \div 5,750 = £332 \text{ per completed initial assessment}
\]

The price per initial assessment is for an assessment irrespective of whether the patient is accepted for treatment. Providers tell us that in most cases an initial assessment for the purposes of cluster assignment will be completed after two contacts for non-admitted care or on admission for inpatients, but this will vary.
Cluster episodes

Providers and commissioners should develop cluster prices based on the schedule in Table 1 for episodes of care and year of care. Understanding the average cost of cluster days is a helpful starting point, but in developing the episode price, organisations should look at the average duration of a cluster locally.

If a patient is identified as needing to change cluster before the cluster episode is completed, commissioners need to be aware that in many cases the costs of delivering care may be front-loaded and it may be appropriate to pay most if not all of the agreed local cluster price.

For example, for a patient who is identified as being in cluster 18, ongoing care could be limited to attendance at a memory clinic once a year. So in that case, all the costs are incurred at the start of the episode. In some cases the patient could deteriorate rapidly during the year, be re-clustered and found to be in cluster 20, where a different and more expensive package of care will be required. It is entirely appropriate to pay the full price of cluster 18 as well as start to pay for cluster 20 during the same year.

In some cases patients typically remain in a cluster for several years after the initial cluster assignment. It may be the case that the first year is much more expensive than subsequent years in terms of the intensity of care required. Providers should use evidence from their patient systems to demonstrate whether this is the case and share their findings with commissioners to reach an agreement on whether year 1 for such patients should attract a higher price.

Whether care is usually delivered in an inpatient or community setting will affect costs. However, providers and commissioners need to be working towards delivering care in the least restrictive setting appropriate and – wherever possible and cost-effective – in the community.

Reference cost data can provide useful information for benchmarking purposes. However, commissioners and providers should bear in mind that the reported costs of each cluster may vary from provider to provider because of different service specifications, and different levels of investment into mental health.

6 The clustering booklet provides information on likely duration of care.
2.4 Determine the costs of delivering NICE-concordant care

Providers and commissioners should identify whether what is currently offered delivers appropriate NICE-concordant packages of care, or whether changes are required to deliver these. The Mental Health Task Force has made it clear that, as a minimum, patients should expect to receive care that meets this standard. Where this is identified as not the case, it may impact not only on the resource relativities between the mental health clusters but on the absolute funding that should be invested in mental health services.

The exact package of care should wherever possible be agreed with each patient, and should reflect their personal aspirations and goals in accordance with the empowerment and involvement principle in the Mental Health Act 1983 code of practice. Some providers have developed a menu-based approach whereby there is a core package of care offered to all service users, and other interventions are linked to a person’s diagnosis and their individual preferences. In designing care packages it is good practice for commissioners and providers to involve experts-by-experience, carer groups and GPs. The Industry and Mental Health Services Collaborative (IMHSeC) website provides a useful resource for developing care packages. Publications from the Joint Commissioning Panel for Mental Health can help to inform commissioners about the principles for effective commissioning of mental health services.

The quality of costing is very important. NHS Improvement’s costing transformation programme will mandate the use of new costing standards, including mental health providers, to deliver a step change in the quality and use of patient-level costing information. In the meantime, use of the Healthcare Financial Management Association’s (HFMA) mental health clinical costing standards is recommended, as they reflect current best practice.

2.5 Agree a gain/loss sharing approach

Gain and loss sharing mechanisms help support provider sustainability while services undergo redesign. They can also help local health economies align the

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9 If provision of care will be changed, there are likely to be consultation/engagement obligations with service users under Section 14Z2 and Section 242 of the NHS Act 2006. In addition, in some cases commissioners may need to consider whether the requirement for an equality impact assessment is met, particularly where there are likely to be service delivery changes that will affect different patient groups in different ways.
10 http://www.mednetconsult.co.uk/imhsec/
11 http://www.jcpmh.info/resource/guidance-for-commissioning-public-mental-health-services/
12 https://improvement.nhs.uk/resources/transforming-patient-level-costing/
13 https://www.gov.uk/government/publications/approved-costing-guidance
incentives of individual organisations and systems, and allocate risk associated with service changes. Gain and loss sharing is the sharing of savings (gains) or overspends (losses) generated through lower or higher than expected utilisation of services covered by the episodic payment approach.

Providers and commissioners should agree gain and loss sharing arrangements as part of this payment approach. Gain and loss sharing mechanisms can be agreed between one or multiple providers and commissioners.¹⁴ When developing a gain and loss sharing mechanism, a number of design elements should be considered. These include, but are not limited to:

- **Principles and objective of mechanism**: providers and commissioners have an agreed view of the principles and objectives for the gain and loss sharing. This may reflect local circumstances and priorities.

- **Scope of activities and stakeholders involved**: providers and commissioners should determine and clearly specify which activity or activities, and associated utilisation risk, should form the basis of any gain and loss sharing arrangement.

- **Duration of agreement**: this will depend on the chosen care model and the expected impact of services on the local health economy.

- **Calculating the outputs of the mechanism**: the gains or loss can be calculated as the difference between the baseline (calculated and agreed prospectively as per the payment approach) and the outturn to the providers(s) delivering care.

- **Operational considerations regarding reporting and invoicing**: there should be regular reporting and invoicing that clearly outline key changes, with information that can be used to calculate gains or losses, identify financial risk, sustainability issues and performance.

- **How to share the outturn gains and losses across providers and between providers and commissioners**: this will depend on the arrangement agreed between stakeholders in the local health economy – which must be consistent with relevant rules and regulations.

Providers and commissioners should ensure that gain/loss sharing arrangements are consistent with the local pricing rules and principles outlined in the National Tariff Payment System document. Further detailed information on gain and loss sharing arrangements will be provided as part of the new care models work programme.

¹⁴ The parties will need to consider relevant legal duties. These can include, for example, those relating to procurement and competition.
Commissioners should be aware of potential procurement issues when making substantial amendments to contracts already in place. To this end, commissioners should look at the guidance note on amendments to contracts during their term issued by the Crown Commercial Service. They (and providers) will also need to consider legal duties in relation to consultation and engagement, and should take care to ensure compliance with competition rules, particularly in relation to collating and sharing sensitive cost data.

2.6 Agreeing an outcomes framework

It is important that in agreeing and monitoring the contract, use is made of the quality and outcomes framework. The framework is described in a companion publication from NHS England and NHS Improvement, which also includes a how-to-do-it guide for local implementation. Determining local metrics in addition to those which will be collected nationally should be done through joint working with experts-by-experience, carers, clinical staff and commissioners.

Information on how quality and outcomes are already being linked to payment is also available in the local payment example on outcomes-based payment for mental healthcare and the technical guidance document on Linking quality and outcome measures to payment for mental health.

2.7 Data monitoring and feedback

It is important that the payment approach continues to be informed by robust, timely data. This means that providers and commissioners must monitor actual activity against planned activity, the distribution of service users across the currencies, and actual against anticipated episode duration. The outcomes framework will become an increasingly important part of the payment system, and all agreed local metrics will need to be monitored. Much of the data required is included in NHS Digital's Mental Health Services Dataset. It is also important that investment is made in information systems locally. This will enable information to be fed back to clinicians in near real time and shared with patients. Being able to monitor the impacts of interventions will lead to informed decisions about the types of care that are offered.

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17 It may be appropriate to consult/seek wider engagement on such local metrics, and commissioners/providers will need to consider whether such consultation/engagement is required.
18 https://www.gov.uk/government/publications/local-payment-example-outcomes-based-payment-for-mental-healthcare
19 https://improvement.nhs.uk/resources/new-payment-approaches/
3. Next steps

It is important that all providers and commissioners develop transparent and evidence-based payment approaches that meet the needs and outcomes of their local population. Providers and commissioners also need to put in place the building blocks for payment development. This includes robust data collection and use, transparent governance arrangements, collaborative local relationships and local development, and use of outcomes measures and currencies. They must also meet access and waiting-time standards, and ensure local alignment with the objectives in the 5YFV for mental health.

The guidance in this document offers providers and commissioners a pragmatic approach to developing an episodic payment approach for mental health. The cited data resources are examples only. Providers and commissioners should use them as a starting point and apply them and similar tools to inform local analysis and payment development.

Providers and commissioners are responsible for leading local payment development for mental health. The sector should utilise local peer-to-peer networks, which may include other providers, commissioners, experts-by-experience, charities, local authorities and wider communities. These networks can help solve local challenges, and inform well-developed and robust payment approaches for mental health. Some useful sources of data are described in Appendix 1.

To help local health economies implement either a capitated or year-of-care/episodic payment approach, we will continue to deliver our sector support offer. This includes providing direct support, publishing practical guidance, workshops, webinars and sector engagement. Further information on our sector support offer and guidance material can be found on our mental health payment development webpage. We welcome suggestions on additional material that would support local payment development.

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20 Consideration also needs to be given to duties relating to procurement and competition.
21 Note that there may also be a requirement to formally engage or consult with such stakeholders on the proposals as a result of section 242 and/or section 14Z2 of the NHS Act 2006
22 https://improvement.nhs.uk/resources/new-payment-approaches/
Appendix 1: Data sources

Mental Health Services Data Set (MHSDS)

These data are publicly available and can be accessed by both providers and commissioners via the NHS Digital website.

Further information: This dataset includes patient-level information on the number of people who have been in contact with secondary mental health services and associated activity data. Providers and commissioners can use this dataset in addition to the GP registration lists and other data (e.g., ONS data) to help identify the target population. While this dataset is helpful in providing more granular information on patients who are in direct contact with secondary mental health services, providers and commissioners should take due regard of people who may need care but are not known to, or in contact with, any secondary mental healthcare providers.

Figures A1.1, A1.2, A1.3 and A1.4 show analysis and output that can be generated using these data.
Figure A1.1

MHSDS includes data on the number of people who are in contact with secondary mental health services as well as the number who have had clusters assigned to them. These data are published on both a periodic and annual basis. Providers and commissioners can use these data to understand the general flow and patient characteristics.

Figure A1.2

This shows the number of people assigned to the care clusters (in Q1 of 2014). Providers and commissioners can use annual data to understand the general distribution of needs/resource use that may be expected from the local population.

Figure A1.3

This shows the proportion of people in scope for clusters (cluster eligibility). This can help segment the population and help identify the broad categories that may need care in the local health economy.

Figure A1.4

This shows the number of people who have had clusters assigned (actual). This can also help identify the population scope and the relative level of needs associated with the care clusters.

Mental Health Bulletin Annual Report 2014-15

This information is publicly available and can be accessed by both providers and commissioners via the NHS Digital website. It is updated annually.

Further information: As part of NHS Digital's annual report on mental health, it offers consolidated annual data on the number of people using NHS-funded secondary mental health and learning disability services by mental health provider. Providers and commissioners can use this analysis to provide an initial high-level snapshot of the local health economy. This can be used to focus and aid initial discussions, while further analysis is undertaken with more granular data and evidence.

Activity data from the Mental Health Services Dataset

This can help identify how patients are using the services. It can help providers and commissioners understand, for example, how patients are moving within/out of the clusters.

The pie charts and bar charts use data from the Mental Health Services Dataset. They illustrate the aggregate cluster transitions that resulted from reviews (Figures A1.4 and A1.5) and also the cluster transition at the individual cluster level (Figure A1.6). This analysis uses aggregate data, but can be replicated using trust or CCG-level data.

This can help providers and commissioners understand patient flow and highlight where services/care can be improved to ensure the patient cluster transitions are consistent with the desired outcomes. Providers and commissioners can track this over time and assess, for example, how patient discharges from certain clusters change as a result of certain service provision/intervention offered to patients.
Appendix 2: Mental health services that currently fall outside the scope of the currencies

The table below lists service areas not covered by the mental health care clusters, including all services for adult mental healthcare commissioned directly by NHS England.

<table>
<thead>
<tr>
<th>Specialist commissioned services – commissioned by NHS England</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Forensic and secure services</strong></td>
</tr>
<tr>
<td>Adult secure mental health services include high, medium and low secure inpatient care and associated non-admitted care, including outreach when delivered as part of a provider network.</td>
</tr>
<tr>
<td><strong>Perinatal psychiatric services (mother and baby units)</strong></td>
</tr>
<tr>
<td>Specialist perinatal mental health services are provided by specialist mother and baby units. Services include inpatients and associated non-admitted care, including outreach provided by these units when delivered as part of a provider network. This applies to provision for adults and young people.</td>
</tr>
<tr>
<td><strong>Tertiary eating disorders</strong></td>
</tr>
<tr>
<td>Includes inpatients and bespoke packages for intensive day care services (as an alternative to admission) provided by specialist adult eating disorder centres. The service includes associated non-admitted care, including outreach when delivered as part of a provider network.</td>
</tr>
<tr>
<td><strong>Gender dysmorphia</strong></td>
</tr>
<tr>
<td>Includes specialist assessment, non-surgical care packages, transgender surgery and associated after care provided by specialist gender identity disorder centres. This applies to provision for adults and children.</td>
</tr>
<tr>
<td><strong>Specialist mental health services for deaf people</strong></td>
</tr>
<tr>
<td>Includes inpatient and non-admitted care, including assessment and treatment services for deaf people provided by specialist centres. In addition, the service includes advice to general mental health services on the management and treatment of the deaf person’s mental illness.</td>
</tr>
</tbody>
</table>

**Severe obsessive compulsive disorder and body dysmorphic services**

Includes services provided by highly specialist severe obsessive compulsive disorder and body dysmorphic disorder centres. This applies to provision for adults and adolescents.
Specialist services for severe personality disorder in adults

Includes inpatients and bespoke packages of care for intensive day care services (as an alternative to admission) provided by specialist centres. In addition, the service will include associated non-admitted care, including outreach when delivered as part of a provider network.

Several other services are not currently covered by the care cluster currency model, some of which offer service models or payment approaches with an increased focus on:

- co-ordination of mental and physical as well as community care
- patient outcomes.

Other services falling outside the mental health cluster currency model are:

- discrete IAPT services
- specialised addiction services\(^{24}\)
- specialist psychological therapies – admitted patients and specialist outpatients\(^{25}\)
- learning disability services for non-mental health needs
- acquired brain injury
- complex and/or treatment-resistant disorders in tertiary settings
- specialist services for autism and Asperger’s syndrome
- liaison psychiatry
- mental health services under a GP contract.

\(^{24}\) Addiction services are now being commissioned by local authorities. Substance misuse may be a complicating factor for a mental health problem.

\(^{25}\) Specialist psychological therapies are delivered, usually over a longer duration, by expert clinicians, qualified in particular therapeutic modalities. Patients who require specialist psychotherapies usually present with the most complex and severe mental health problems for which primary care services and standard secondary mental health services, eg input via recovery teams, have either not been effective or have been unsuitable.
NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

This publication can be made available in a number of other formats on request.

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