Developing a capitated payment approach for mental health

Detailed guidance

Published by NHS England and NHS Improvement

8 November 2016
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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 a capitated payment approach for mental healthcare. It also highlights information on potential data and tools, which can be used to help develop this payment approach.

This document follows publication of the ‘short written guidance’ on capitated 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. They will be followed by more detailed payment guidance as part of the wider sector support for developing new care models.
Summary

This document provides step-by-step guidance on developing a capitated 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.¹ In either approach, a proportion of prices must be linked to the achievement of locally agreed quality and outcome measures.

A capitated payment approach is a payment to a provider or group of providers to meet the local population’s healthcare needs. Payment can be based on different segments of the local population. It can be adjusted to reflect changes in the size and characteristics of these segments, as well as in other variables (e.g., patterns of care, efficiencies and investment). As costs and patterns of care may change over time, basing payment on accurate and robust information prevents providers and commissioners from being locked into payments that are based on outdated and incorrect assumptions.

A capitated payment approach can help providers and commissioners better achieve the Five Year Forward View’s (5YFV) objectives for mental health. In particular, it can help local health economies to offer more co-ordinated and integrated care to patients across physical health, social health, community and third party/voluntary sector organisations.

When developing a capitated payment approach for mental health, providers and commissioners need to:

- define the population scope covered by the payment approach
- define the service scope covered by the payment approach
- determine the contractual form and duration
- determine the payment amounts
- determine the provider-to-provider payment approach
- determine the gain/risk sharing arrangements
- link quality and outcome measures to payment.

Based on these elements, this document offers a pragmatic approach that all mental health providers and commissioners can adopt. To ensure payment for mental

¹ Providers and commissioners can agree an alternative payment approach, as long as this 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.
healthcare is transparent and evidence-based, we identify available data and information that can be used when applying the steps outlined in this document. The data and analytical examples offer local health economies a starting point for building understanding of patient need, population characteristics, resource utilisation, cost of delivering quality mental healthcare and how best to mitigate financial risk. Some examples of data and information identified include the Office for National Statistics (ONS), NHS Digital, Public Health England (PHE), NHS England and local datasets.

This document builds on the high-level guidance on developing capitated payment for mental healthcare, published in December 2015. Although it highlights some legal issues, this document does not address all the legal issues that commissioners and providers will need to consider when adopting any new payment/contracting approach.
1. Background

This document gives guidance to providers and commissioners on developing a capitated payment approach for mental health. Data are fundamental to understanding the local population’s needs and to developing a payment approach that can help meet them. This guidance illustrates how – regardless of where a local area is starting from – providers and commissioners can use readily available data and user-friendly analytical tools to inform payment development.

The examples outlined are simplified illustrations showing potential use of currently available data and resources. Providers and commissioners are encouraged to build on the data analysis outlined, and to complement it with other local and national data and tools.

1.1. Need for effective payment approaches in mental healthcare

The healthcare needs of people with mental ill health are generally complex and often require intervention/services from different health, community and social care providers and organisations. The Mental Health Taskforce confirmed that as a result of this, many people who use mental health services experience fragmented care that does not meet their needs or provide outcomes they value.

Payment is an important lever to help providers and commissioners improve and integrate care. A capitated payment approach for mental healthcare can align financial incentives and reduce financial barriers across organisations that can inhibit the provision of more co-ordinated, integrated and effective care that better meets patient needs and outcomes. In addition, it offers incentives for providers to prioritise early intervention and preventive care to the local population. This can help improve people’s health and wellbeing and reduce the risk of their developing physical health issues that can arise from untreated mental ill health. This may also lead to lower utilisation of secondary healthcare (eg via reduced hospitalisation) and increase the scope for efficiencies.

1.2. Principles and rules for local payment development

As stated in the 5YFV for mental health, providers and commissioners must use payment based on transparent and evidence-based contracts focused on achieving and incentivising the right outcomes for patients. Providers and commissioners need to work together\(^2\) to agree payment that:

- is in patients’ best interests

\(^2\) The 5YFV for mental health also advocates co-production of payment approaches with experts-by-experience, clinicians and relevant organisations. This needs to be consistent with any procurement and competition requirements that may apply.
• promotes delivery of evidence-based care (at a minimum this is NICE-concordant care)
• drives transparency and accountability
• encourages the sharing of best practice
• supports patient choice where appropriate in mental health.

For further information on the rules and principles relating to mental health local price setting, please see the national tariff document. The Taskforce report’s Annex A lists the Principles underpinning payment approaches in mental health, which providers and commissioners should also apply in payment development.

Proposed changes to the local pricing rules for mental health

From 2017/18, NHS Improvement and NHS England have changed 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. We have outlined these changes in the 2017/19 National Tariff Payment System document. These changes to the local pricing rules for mental health align with the 5YFV objectives to offer more transparent and effective payment approaches that better meet the needs of people who use services. Providers and commissioners may agree an alternative payment approach, as long as it is evidence-based and transparent about quality, outcomes and how payment supports patient needs.

Building blocks for payment development

Providers and commissioners need to have building blocks in place if they are to implement robust local payment approaches. These include but are not limited to:

• Robust collection and use of evidence and data: Data must be accurate and robust as they are used to understand the population’s needs. In particular, this should continue to include the robust collection and reporting of the mental health care cluster data and when available, patient-level information costing systems (PLICS). In addition, other national and local data, including on outcomes, activity and finance, can be used to inform payment and continued improvement.

• Development of quality and outcomes measures: Quality and outcomes measures must be co-produced, with experts-by-experience taking a leading role; payment must be linked to achieving these measures. Further

4 Mental Health Taskforce report: www.england.nhs.uk/mentalhealth/taskforce/
information on how these can be developed is given in *Developing quality and outcomes measures* support material and technical guidance document on *Linking quality and outcome measures to payment for mental health*.

- **Transparent and strong governance**: Clear and accountable governance structures are needed to ensure development and implementation of effective service delivery models and payment. Providers and commissioners need to ensure there are strong local relationships and appropriate collaboration in developing payment. This includes working with the third sector, local authorities, voluntary sector, local communities, mutual aid groups and all segments of the local population – including black, Asian and minority ethnic populations and people with comorbidities. Further information on building blocks can be found on the mental health payment development webpage.

We have produced a companion document on how to develop an episodic/year-of-care payment approach for mental health. High-level information on capitation for mental health, published in December 2015, can be found in our *Short guide on developing a capitated payment approach for mental health*. Providers and commissioners can also refer to the forthcoming *Whole population based handbook*, which will provide further information on the payment approach, including calculating and agreeing gain/loss sharing agreements and determining payment amounts. This will be available on our mental health payment development webpage when published later this year.

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5 [https://improvement.nhs.uk/resources/new-payment-approaches/](https://improvement.nhs.uk/resources/new-payment-approaches/)

6 Care must be taken to ensure these arrangements comply with procurement and competition rules and that appropriate consultation/engagement is carried out as required.

7 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.

8 [https://improvement.nhs.uk/resources/new-payment-approaches/](https://improvement.nhs.uk/resources/new-payment-approaches/)

9 Further information on developing an episodic/year-of-care payment approach for mental health can be found on our website: [https://improvement.nhs.uk/resources/new-payment-approaches/](https://improvement.nhs.uk/resources/new-payment-approaches/)

10 Short guide on capitation for mental health can be found [here](https://improvement.nhs.uk/resources/new-payment-approaches/).
2. Elements to developing a capitated payment approach

Providers and commissioners should complete the seven elements in Figure 1. We do not expect that they will necessarily be carried out in sequence. However, it is important that all seven elements are in place when developing this payment approach.

![Figure 1: Elements to developing capitation for mental health](image)

**2.1. Define the population covered by the payment approach**

The local commissioning strategy and the clinical care model that will integrate or co-ordinate care across existing boundaries will determine the target population to be covered by the payment approach.

The capitated payment approach should cover a relatively large population as this will mean providers (and any subcontractors) can benefit from the greater efficiencies of operating at scale. In addition, it will mean providers and commissioners can more easily absorb variations in patient costs and volatility risk of service utilisation. On the other hand, a relatively small population scope for payment may make it easier for the local health economies to build capability and test the effectiveness of the payment approach locally. Providers and commissioners should consider whether there are safeguards to address patients with complex healthcare needs.

The capitated payment should at a minimum include care for adult and older people who are covered by the mental health care clusters. Local providers and commissioners may agree to include other population cohorts, such as children and young people. GP registration lists should be used as the primary basis to define the population scope for capitation. Secondary mental health data can then be used to help provide further granularity and information that is not covered by GP registration.
list data. The absolute size of the target population will vary depending on the individual local health economy, including providers’ ability and willingness to carry utilisation risk.

- **GP registration lists**: If these lists are sufficiently large (or combined with other registration lists), providers and commissioners can better identify and manage risks caused by random variations in service use/cost by patients. In addition, as GP registration lists are likely to include people who are not already known to secondary mental healthcare services, they may capture unmet need. This wide population scope also offers greater incentives for early intervention and preventive mental healthcare.

- **Secondary mental healthcare referral data**: These offer detailed data on population characteristics, flows and activity, and as such can help identify the core mental health population that may need care, eg the number of people in scope for services in the different care clusters, and identify types of mental healthcare needs/population size in a particular local area.

Figure 2 gives examples of data and analytical tools that can be used to define the population covered by the capitated payment.

**Figure 2: Data to help define the population covered by the payment approach**

Appendix 1 lists some of the data and tools, highlighted below, that can be used to define the population covered by the capitated payment approach.

- **Data on GP registration lists**: NHS Digital provides data on GP registration lists by clinical commissioning group (CCG), local area, region and GP practice. It also includes mapping codes to allow data linkages.

- **Mental Health Population Calculator**: This is produced by the NHS Benchmarking Network and draws on NHS Digital data on weighted mental health GP registration lists for local areas.

- **NHS Digital Mental Health Services Data Set (MHSDS)**: This includes data on secondary mental health activity, outcomes and finance. This can be used to understand the specific care needs of the local population.

- **NHS Digital Mental Health Bulletin Annual Report 2014-15**: This provides analysis and commentary, using annual data from MHSDS.
2.2. Define the service scope covered by the payment approach

To determine the appropriate service scope, providers and commissioners must understand the whole population’s needs. This will allow a service scope for capitation to be developed that meets those local needs.

Local demographic data, as well as data from the police (and other emergency services), can inform an understanding of need, in particular unmet patient need. For example, higher levels of unmet need are generally greater in areas with high socio-economic deprivation, long-term unemployment, drug and alcohol abuse, homelessness, debt issues and crime rates. Data on all these areas are available via NHS Digital, PHE, local authority databases and ONS. In the context of this document, these data can also be used to inform the capitated payment and reflect different population needs. Further information on these data sources are outlined in Appendix 1.

**Define the service scope that meets the needs of the whole population**

The service scope included in a capitated payment approach will vary depending on the local health economy’s objectives and population needs. Commissioners should ensure the service scope supports patient outcomes and system-wide objectives, which it is expected are aligned with the 5YFV.

It is important to note that the service scope need not be limited to mental healthcare services – it can also include\(^\text{11}\) aspects of primary, social and community healthcare services. The 5YFV for mental health advocates that where care is integrated, the payment system should also be integrated. Figure 3 shows the potential service span for a population segment with psychosis. It illustrates how patient needs can cut across different care settings and providers/organisations.

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\(^{11}\) This may be subject to legal requirements around procurement rules or other requirements – which must also be considered.
It may be appropriate to offer additional care or interventions to specific subsets of the target population covered by the capitated payment approach. In some circumstances, it may be appropriate to exclude certain services from the capitated in-scope services: for example, services that are needed by the target population but which are highly specialised, expensive and/or infrequent. Where services are excluded from the scope of the capitated payment approach, providers and commissioners must consider:

- **Impact on patient outcomes, experience and need**: Any service(s) defined as out of scope must not adversely affect patient experience, outcomes or result in unmet need.

- **Risk of cost shifting to or from other care providers**: Exclusion of any service(s) must not result in a provider inappropriately shifting or transferring patients (and thus costs) to other providers. For example, providers and commissioners should ensure service scope and outcome measures focus on delivering recovery-focused care in the right setting for each patient, which can reduce the likelihood that patients are shifted to, or kept in specialised care settings unnecessarily. It is therefore important that the service specification and operational plans clearly identify care provided and how any risk of cost shifting will be minimised in the local health economy.

- **Local health economy’s ability to reasonably control and influence costs, and efficient allocation and utilisation of resources**: Providers should have a reasonable degree of influence to manage and/or control the costs associated with the in-scope service(s). This helps improve accountability and aligns incentives.
Providers and commissioners should engage with charities, third sector organisations, experts-by-experience, carers, emergency services and local authorities to help inform this step. In particular, service scope should support the chosen care model and evidence-based care, which is at a minimum NICE-concordant.\textsuperscript{12}

\textbf{2.3. Determine the contractual form and duration}

Providers and commissioners should agree the upfront duration of the capitated contract.\textsuperscript{13} Contract duration should be long enough that the benefits of the capitated payment approach materialise.

For example, a capitated payment approach incentivises providers and commissioners to deliver more early intervention and prevention. Some investment may be required to embed these programmes in the local health economy – this should be consistent with locally agreed investment levels on mental health.\textsuperscript{14} As such, when determining the contractual duration, local health economies may want to consider the investments made and the duration needed to yield maximum benefits to patients. Shorter contract duration (eg equal to or less than one year) is unlikely to be long enough to realise the benefits to patients or wider local health economy.

The NHS Standard Contract supports longer-term agreements. Commissioners will need to consider their procurement obligations under both the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013\textsuperscript{15} and the Public Contracts Regulations 2015\textsuperscript{16} when putting in a capitated payment arrangement. Additionally, where existing contracts are being amended, the commissioners will need to consider whether such amendments are a substantial change and, if so, what risks that presents. Consideration should be given to guidance issued by the Crown Commercial Service on this topic.\textsuperscript{17}

\textsuperscript{12} 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

\textsuperscript{13} This should be part of the procurement process.


2.4. Determine the payment amount(s)

Providers and commissioners should calculate the unit cost of delivering the in-scope services for the target population over the specified contract period. Further information on how to determine the payment amounts will be outlined in the forthcoming Whole population budget handbook.18

The capitated payment amount(s) should be based on forward-looking costs. It should be calculated for the defined whole population covered by the payment approach.

To inform service design, effective use of resources and local agreements about payment and investment in mental healthcare, providers and commissioners will need to understand different patient needs, characteristics and cost profiles. Providers and commissioners should use data and information to understand this for the whole population, population segment or individual patient level.

Providers and commissioner can determine the capitated payment amount(s) by following these broad steps:

I. establishing the baseline cost of services

II. forecasting changes to the baseline costs

III. adjusting capitated payment to reflect changes in in-scope population and, potentially, new data on forecast assumptions.

I. Establishing the baseline cost of services

Providers and commissioners need to identify the actual cost of providing in-scope services. Local health economies are responsible for ensuring that their baseline costs reflect evidence-based NICE-concordant care. They should also reflect accurate estimation of the population size, needs and an understanding of the expected patient casemix profile. Ideally, providers and commissioners should use patient-level costs for this step, using PLICS where available, adjusted for efficiency requirements.

Where patient-level costs are not available, current commissioner spend is a pragmatic starting point to establish the baseline amount. Commissioner spend can, for example, be allocated to different population segments and activity, or to GP registered lists where these lists have been used to define the population scope. Other data and evidence, e.g. benchmarking data and reference costs, can be used to support this analysis. Further information related to this is included in the Whole population budget handbook.

Providers and commissioners should review the *Mental health clinical costing standards* and other relevant national standards\textsuperscript{19} for any information that helps with understanding and allocating costs. To help understand the baseline cost of services, providers and commissioners can use a range of different resources (see Figure 4).

II. **Forecasting changes to the baseline costs**

Providers and commissioners can forecast variable changes to the baseline cost of providing care to the target population covered by capitation. Commissioner allocations for mental health services may provide a good starting point if the population and service scope of the provider under contract both match the level at which commissioner allocations are set. NHS England’s planning guidance for 2016/17 to 2020/21 states that commissioners must increase investment in mental health services each year at a level which at least matches their overall expenditure increase. This information should be taken into account and reflected transparently. However, there should not be a direct read-across from commissioner allocation growth to forecast capitation payment amounts without considering the expected external cost and demand pressures on the provider, including costs to provide NICE-concordant care, for the specific set of services and population in scope of the payment.

For the contract’s duration, it is important that payment is based on robust and transparent assumptions, evidence and information. Consider factors including:

- **Different pattern of care:** New data, evidence and technology are constantly emerging to improve care and efficient delivery of services. The 5YFV for mental health proposed a pathway and infrastructure development programme, outlining a timetable for developing the referral-to-treatment and recovery pathways, based on mental health conditions. These will be framed in line with NICE guidelines and quality standards, ensuring that more people get timely access to the full range of NICE-concordant care. The capitated payment should accurately reflect new patterns of care and service delivery models, particularly as they change, including the latest evidence and research published by NICE.

Providers and commissioners should also consider the positive impact of early intervention and prevention in the local area. One way to understand the effectiveness of services and identify where actual and/or potential savings can be made is by looking at service design and patient utilisation data – this may include, for example, using data from MHSDS and using influence/logic flow diagrams of the service. Summary information on some data sources are outlined in Appendix 3.

\textsuperscript{19} https://www.gov.uk/government/publications/approved-costing-guidance
• **Population size and demographics:** Over the duration of the capitated contract, the overall population size, as well as the distribution and characteristics of population covered by capitation, may change. These changes can have a material impact on the care needs of the population within the scope of the payment approach. Local health economies should therefore use current evidence, data and information to assess how the population, its needs and/or characteristics may change over time. Providers and commissioners can use a variety of information to inform this, which may include data from NHS Digital, PHE and the NHS Better Care Network. Summary information on these data sources is outlined in Figure 6 and Appendix 4.

• **Efficiency:** Providers and commissioners should use available data and information to ensure expected and actual efficiency over the duration of the capitated contract is accurately calculated and reflected in payment. It is important to consider how resources can be used more efficiently in existing care settings, as well as opportunities for altering the care model to provide more efficient and effective care. This must not result in care not being safe and NICE-concordant. Providers and commissioners should ensure that safeguards are in place to protect quality and quantity of care.

• **Inflation:** Providers and commissioners need to have regard to inflation data and information when developing and implementing payment for mental health.

III. **Adjustments based on population changes**

Adjustments ensure that the payment arrangement continues to reflect population by reflecting changes in costs that are beyond provider ability to manage and/or control.

An example of an adjustment may be where new patients enter or exit the population part-way through the contract period. This may require a part-payment wash-up or claw-back. If there are changes to the population size or mental health needs profile, the capitated payment amount needs to be updated to reflect the differences from the assumptions made during the initial baseline and forecast calculations.

Providers and commissioners should work together to agree a mechanism for any adjustments within the term of the contract. It is recognised that forecasts are likely to include a degree of statistical error and that actual outturn may be (immaterially) different from forecast. As such, providers and commissioners should agree upfront any upper/lower boundaries beyond which adjustments are made to the capitated payment.
Providers and commissioners can use tools to help establish a baseline of the cost of services, and understand different cost types and trends (e.g., population forecast). This can also inform any adjustments to the capitated payment amount(s). These tools/data include:

**NHS Improvement Care Spend Estimation Tool:** This tool allows users to input local data to produce a rough estimate of how the local health economy spends its budget across different population segments. The output can be used to inform the setting of the baseline spend for different population segments.

**NHS Benchmarking Network:** This includes a host of benchmarking tools on areas including costs, workforce, activity, outcomes, and inputs used for service delivery. Resources from this network can be used to understand patient needs and costs, which can inform the development of the capitated payment amount(s).

**Influence diagrams (logic flows) – Joint Commissioning Panel for Mental Health:** This outlines different impact, risk, and scenarios that providers and commissioners may want to consider when looking at different service designs that can affect payment. It can help identify the risk and flow of patients associated with different scenarios, e.g., care model designed to reduce inpatient stay.

**Mental Health Services Data Set:** This includes patient activity data, which can help identify general patient flows, interaction with services, and patient outcomes. It can inform how patients are using the services and the impact on patients and costs. A full description of these data and tools is given in Appendix 3.
2.5. Determine the provider-to-provider payment approach

Where a provider subcontracts the delivery of care to other providers, it is important to agree a clear and robust provider-to-provider payment mechanism. In a capitated payment focused on mental healthcare provision, payment could be made to a lead/accountable provider that may then arrange to subcontract to other providers of mental healthcare and related services. The subcontracted payment arrangements would vary depending on the incentives that the lead provider needs to create, as well as the contract’s nature and duration. Other contractual forms may also be considered.

When designing provider-to-provider payment arrangements, providers and commissioners should consider:

- **Timing of payments and liquidity of providers**: Providers and commissioners should consider the timing of any payments to the lead providers, as well as to other subcontracted providers. Providers and commissioners should consider the cost of transactions/invoicing and also the liquidity and cash flow of providers and organisations involved in the capitated payment approach.
• **Payment infrastructure:** Providers and commissioners should ensure that appropriate IT and financial systems are in place to manage, process and validate payment.

• **Allocation of costs, efficiency and gain/loss share between providers:** Where care is provided by multiple providers, particular consideration must be given to appropriate and fair apportionment of financial gain/loss and efficiency targets between all involved providers.

• **Quality and assurance process:** This is required to ensure accurate and timely provider-to-provider payments. There should be sufficient levels of governance and monitoring to ensure the payment system’s accountability and robustness.

### 2.6. Agree gain and loss sharing arrangements

Gain and loss sharing mechanisms help support provider sustainability while services undergo redesign. They can also help local health economies to align the incentives of individual organisations and systems, and allocate risk associated with service changes. Gain/loss sharing is the sharing of savings (gains) or overspends (losses) generated through lower or higher than expected utilisation of services.

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.\(^{20}\) When developing a gain/loss sharing mechanism, a number of design elements should be considered. This includes, but is not limited to:

- **Principles and objective of the mechanism:** providers and commissioners should have an agreed view of the principles and objectives for gain/loss sharing. This may reflect local circumstances and priorities – but aligned with the core objective of this mechanism, as described above.

- **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/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 losses can be calculated as the difference between the baseline (calculated and agreed prospectively as per the payment approach) and the outturn to the provider(s) delivering care.

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\(^{20}\) The parties will need to consider relevant legal duties. These can include, for example, those relating to procurement and competition.
• **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, which will be available later this year.

Commissioners should be aware of potential procurement issues when making substantial amendments to contracts that are 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 relating to consultation and engagement, and should take care to ensure compliance with competition rules, particularly relating to collating and sharing sensitive cost data.

**2.7. Link agreed quality and outcomes measures to payment**

Quality and outcomes measures must be linked to payment for mental health services. This ensures providers and commissioners are clear about expectations for care quality and care objectives. Outcomes measures should reflect what local health economies want to achieve across biopsychosocial domains, as well as care quality standards. They should also reflect the needs of the whole local population and existing legal requirements, including equality legislation.

NHS Improvement and NHS England are supporting the development and use of outcomes measures for mental healthcare, and have published *Developing quality and outcomes measures.* This guidance offers a framework for local health economies to develop and select quality and outcomes measures. It should be read alongside the NHS Improvement and NHS England technical guidance on *Linking quality and outcome measures to payment for mental health.* This can be downloaded from the mental health payment development webpage.

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22 [https://improvement.nhs.uk/resources/new-payment-approaches/](https://improvement.nhs.uk/resources/new-payment-approaches/)
23 [https://improvement.nhs.uk/resources/new-payment-approaches/](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 their local population’s needs and outcomes. Providers and commissioners also need to put in place the building blocks for payment development. This includes:24

- robust data collection and use
- transparent governance arrangements
- collaborative local relationships and local development
- use of outcomes measures and currencies.

They must also meet access and waiting-time standards, and ensure local alignment with the objectives of the 5YFV for mental health.

Providers and commissioners are responsible for leading local payment development for mental health. The sector should use 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.25

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.26 We welcome suggestions on additional material that would support local payment development.

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24 You also need to consider duties relating to procurement and competition.
25 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.
26 https://improvement.nhs.uk/resources/new-payment-approaches/
Appendix 1: Examples of data and analysis to help define the population covered by the payment approach

Data on GP registration lists

NHS Digital data on GP registration lists are publicly available and can be accessed by both providers and commissioners. The data are updated quarterly and can be accessed via the NHS Digital website.

This dataset includes data on the number of people registered with GP practices in England. The dataset includes mapping codes:

- ONS and NHS England community region code
- ONS and NHS England region code
- ONS and NHS England CCG code
- GP practice code and practice postcode
- ONS CCG code
- CCG code (as used in the NHS)
- NHS England area team code.

These mapping codes allow providers and commissioners to link the target mental health population data with other relevant data published by ONS, NHS England, NHS Digital and other organisations (eg PHE and NHS Benchmarking Network) that also use these standardised data mapping codes. This can offer valuable information to providers and commissioners on patient needs, characteristics, costs and outcomes. Where more sophisticated IT and linked patient-level information systems are available, they should be used to link and integrate relevant local and national data.

It may be helpful to note that this NHS Digital data extract does not consolidate the different codes into one Excel sheet. Nor does it provide the GP or CCG name (only the respective code). For ease of access and analysis, providers and commissioners can use the consolidated list of mapping codes and respective CCG and GP practice name from the NHS England CCG budget allocation\(^27\) spreadsheet, and use this as a data template to update the latest population data from NHS Digital.

Mental Health Services Data Set (MHDS)

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

\(^{27}\) [https://www.england.nhs.uk/2014/03/allocations-tech-guide/](https://www.england.nhs.uk/2014/03/allocations-tech-guide/)
associated activity data. Providers and commissioners can use this dataset in addition to the GP registration lists and other data (eg 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.

**A1.1**

MHSDS includes data on the number of people 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.

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**Figure A1.1**

MHSDS includes data on the number of people 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

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.

Mental Health Population Calculator

This tool is available to all providers and commissioners that are members of the NHS Benchmarking Network. It can be accessed via the NHS Benchmarking Network website: www.nhsbenchmarking.nhs.uk/index.php

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To access these data, visit the NHS Digital website: http://www.hscic.gov.uk/catalogue/PUB18808
Further information: The Mental Health Population Calculator offers easy access to GP registration list data that are both weighted and unweighted by the estimated mental health population. Providers and commissioners may also use this tool to look at the population data in neighbouring areas. This may be important to understand as patients may move across payment/commissioning boundaries, which will need to be taken into account when looking at service configuration, provider-to-provider payment and patient flows. Similar to the data published by NHS Digital, the mental health population calculator presents the data in terms of:

- total registered (to GP practices)
- registrations weighted by mental health population
- age groups from 0-85+ years
- gender
- CCG group
- GP practice
- CCG area.

Figures A1.5, A1.6 and A1.7 below present extracts from the population calculator tool and high-level data analysis that can be used to understand the trends, characteristics and distribution of the population.

The population calculator offers local health economies a simple, easy-to-use tool to download and analyse information that all stakeholders of all technical abilities should be able to utilise. For example, providers and commissioners may use the calculator to identify the number of people in the local health economy, in particular

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29 To access this calculator, please login to your NHS Benchmarking Network portal. This is available under ‘Mental Health’ > ‘Combined Inpatient / Community’ > ‘View outputs’ > 2015, ‘MH Population Calculator’. http://www.nhsbenchmarking.nhs.uk/index.php
those aged over 64. These data can also be linked to other datasets (eg ONS data) that use the standardised codes.

**Figure A1.5**

This shows the basic population data output from the population calculator tool. Data is presented both in terms of weighted and unweighted mental health population.

**Figure A1.6**

This further breaks down the local population cohort. This example shows a breakdown of the population by age bands.

**Figure A1.7**

Building on Figure A1.6, this shows a further breakdown of the population data. This example shows age groups for females over 65 in the local area. These data can be used to inform more detailed risk analysis and help to more accurately identify patient need. For example, certain population segments may be associated with higher demand/need for certain services – therefore, these data can help providers and commissioners start to identify those needs.

More granular analysis of the population cohort can be undertaken to better understand the population and their needs. For example, the female population over 65 can be broken down into further age bands and by CCG/provider. The bar charts presented in Figures A1.6 and A1.7 were created using Microsoft Excel and are not an automatic output feature.
Appendix 2: Examples of data and analysis to help determine the payment amount(s) – establishing baseline of costs

1. NHS Improvement care spend estimation tool

This tool is publicly available on NHS Improvement’s website.³⁰

Figure A2.1: Care spend estimation tool

Figure A2.1 shows the Excel interface and some of the key outputs from the care spend estimation tool.

Where providers and/or commissioners have some cost and activity data available to them, providers may use the care spend estimation tool to estimate how the local care economy spends its budget. The tool allows providers to estimate cost of services through various prisms – eg age group, patient group and care settings. It also allows input of assumptions to explore how costs may evolve over time. This tool can be used as the starting base to undertake further local analysis to support the development of a capitated payment approach.

2. Mental health reference cost data and local costing data

Reference cost data are available for all mental healthcare services, including both cluster and non-cluster services (e.g. secure mental healthcare services). They can be accessed via NHS Improvement’s webpage.

3. **NHS Benchmarking Network – mental health toolkits**

The NHS Benchmarking Network offers a range of data, information and tools on mental health and other areas, including acute and community services. Tools and data cover areas such as costing information, workforce data, activity analysis and outcomes, which can be benchmarked across different organisations.
Appendix 3: Examples of data and analysis to help understand savings and effectiveness of different patterns of care, which can be reflected into the capitated baseline forecast

1. Influence diagrams (logic flows)

When developing the service delivery models, providers and commissioners should understand existing incentives and those they would like to promote in future via payment: eg greater patient access to evidence-based care.

One way to consider the implications of a particular service configuration, policy or payment approach is to develop ‘influence diagrams’ (see Figure A3.1). Examples of mental health influence diagrams are available from the Joint Commissioning Panel for Mental Health. Influence diagrams can, for example, be used to help localities understand the impact of certain services’ scope for payment. They can also:

- highlight potential risks associated with the service delivery model
- help identify wider impact on the local health economy
- help align local changes to the objectives set out in the 5YFV/Task Force.

Figure A3.1: Influence diagrams

Local health economies could use the logic underpinning the influence diagrams as the basis for developing more sophisticated models/analysis. This could include overlaying the analysis with provider-level activity and/or cost data to understand the financial impact of certain scenarios.

31 http://www.jcpmh.info/.
2. 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 in Figures A3.2, A3.3 and A3.4 use data from the Mental Health Services Dataset. They illustrate the aggregate cluster transitions that resulted from reviews (Figures A3.2 and A3.3) and also the cluster transition at the individual cluster level (Figure A3.4). 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 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 4: Examples of data and analysis to help understand patient need, size and demographic changes

By understanding the whole population’s needs, providers and commissioners are better able to deliver more co-ordinated, integrated and effective services that meet local mental healthcare, physical healthcare and social care needs.

This information and data can also be used to inform the payment approach. The capitated payment can be adjusted to reflect the different needs, characteristics and risks associated with different population segments/patients in the local health economy.

When looking at data and information to understand patient need, it is important that providers and commissioners identify and understand any unmet patient need in the local health economy. Broadly this covers patients in these categories:

- **Insufficient access to appropriate care**: those segments of the local population recognised by services as needing mental healthcare, but which get no or insufficient access to it. This may be a result of long waiting lists and/or limited beds or appropriate services in the local area.

- **Identified but misdiagnosed/untreated**: those segments of the local population that may be in contact with some health and/or support services, but may be misdiagnosed and/or not receiving care that meets their needs.

- **Unidentified and undiagnosed**: those segments of the local population that need mental healthcare but are not known or identified by any local services. This may be due to low patient activation levels and may include patients who are not registered with GPs.

Providers and commissioners can use various analytical tools and data to understand patient need, including:

- PHE system-profiling tools
- NHS Atlas of Variation
- NHS Digital iView tool.

**Public Health England system-profiling tools**

PHE data and analytical tools are publicly available and can be accessed by both providers and commissioners on the PHE website.³²

PHE provides interactive analytical and system-profiling tools for mental health.

³² [http://fingertips.phe.org.uk/profile-group/mental-health](http://fingertips.phe.org.uk/profile-group/mental-health)
These include data and analysis on activity, finance, outcomes, prevalence and risk factors relating to mental health, covering:

- children’s and young people’s mental health
- co-existing substance misuse and mental health issues
- common mental health disorder
- community mental health profiles
- severe mental illness profiles
- dementia profiles
- suicide prevention profiles.

The information derived from these tools can be used to better understand the needs, activity, prevalence of conditions and risk associated with the population for capitation.

**Understanding different segments of the population:** A range of data and evidence is available to help understand the population, its needs and also the characteristics of population segments. Where granular patient-level data and information are not available, providers and commissioners can adjust payment to reflect different segments of the local population.
Figure A4.1 illustrates the data output from the mental health population calculator that has been transferred into a simple Excel graph (data shown below is from a randomly selected CCG). Based on analysis of this and other data from NHS Digital, ONS and PHE, providers and commissioners, in this example, identify that they have an above average number of people aged over 65. Providers and commissioners may therefore delve further into the dataset to better understand this segment of the target population to ensure the service delivery model and payment approach help support their needs.

Figure A4.2 offers further analysis. It illustrates the age profile of the target population of people aged over 65, as shown by the bar chart. Certain age (and gender) cohorts may have different needs: payment and service provision could therefore be adjusted to reflect this. This bar chart, in addition to other data and evidence, can help providers and commissioners identify these needs.

Providers and commissioners can use additional data and information (e.g. as shown in Figures A4.3 and A4.4: PHE common mental health disorders fingertips tool) to develop a holistic understanding of more detailed information on specific segments of the population. This may include data on population risk profiles, need, cost and resource utilisation.

A capitated payment approach for mental health must reflect the different needs of the population covered. This can help better identify costs and resource utilisation, and inform service design and payment.

**Figure A4.5: Common mental health disorders PHE system-profiling tool**
Based on the common mental health disorders PHE system-profiling tool (see Figure A4.5), providers and commissioners can gather a range of information on their local health economy and target population. Additional fingertips tools, data and evidence should also be used.

The PHE profiling tool also includes other demographic data that can be used to inform the capitated payment – particularly within the context of forecasting population changes over the duration of the capitated contract: see Figure A4.6.

**Figure A4.6: Population turnover**

Figure A4.6 shows the population turnover (rate per 1,000 resident population) for a particular geographical area. These data can be compared against other local or national baselines. The tool also offers other information on the local population:

- turnover (internal migration): rate per 1,000 population
- migrant GP registrations: rate per 1,000 population
- % who identify their ethnicity as British, Irish or other
- % who identify their ethnicity as mixed or multiple groups
- % who identify their ethnicity as Asian or Asian British.
NHS Atlas of Variation

This information is available to the public as well as all providers and commissioners. It can be accessed via the NHS Right Care website33 where hard copies can be requested: http://www.rightcare.nhs.uk/index.php/nhs-atlas/

Further information: The atlas provides information on absolute and relative levels of investment, activity and outcome covering different local areas. This also includes access to an ‘opportunity locator’, which shows how local authorities and CCGs are grouped according to their local boundary and demographic peers. This resource can help identify current gaps in investment, service and outcomes – which can be addressed through appropriate development of service scope.

NHS Digital iView tool

This offers providers and commissioners information on both population and demographic estimates. It includes forecasts up to 25 years and by age and gender. This can be used to adjust the payment amounts for different local health economies and population segments in the capitated payment approach.

Defining the service scope that meets whole-population needs

1. National Institute for Health and Care Excellence (NICE) guidance34

This guidance is publicly available from NICE’s website: https://www.nice.org.uk/

Further information: Detailed guidance is available from NICE on effective and efficient evidence-based care. Providers and commissioners should use this to help identify the services that may be needed. NICE offers mental healthcare pathway mapping, as well as case studies and shared learning resources.

2. Joint Commissioning Panel for Mental Health (JCPMH) guidance

This guidance is publicly available from JCPMH’s website: http://www.jcpmh.info/

Further information: JCPMH is co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists. Others with an interest in mental health, addictions and learning disabilities are also involved. JCPMH provides practical guidance and a framework for developing mental health commissioning that is based on evidence-based care. It provides case examples and service model specification for a range of services and patient cohorts. Providers and commissioners can use these examples to help develop their own service delivery model. JCPMH has produced over 15 guidance documents on, for example, primary mental healthcare services, liaison mental health services to acute hospitals, rehabilitation services and services for people from Black and minority ethnic groups.

33 http://www.rightcare.nhs.uk/
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NHS Improvement (November 2016)   Publication code: CG 28/16