



# **Linking quality and outcome measures to payment for mental health**

## **Technical guidance**

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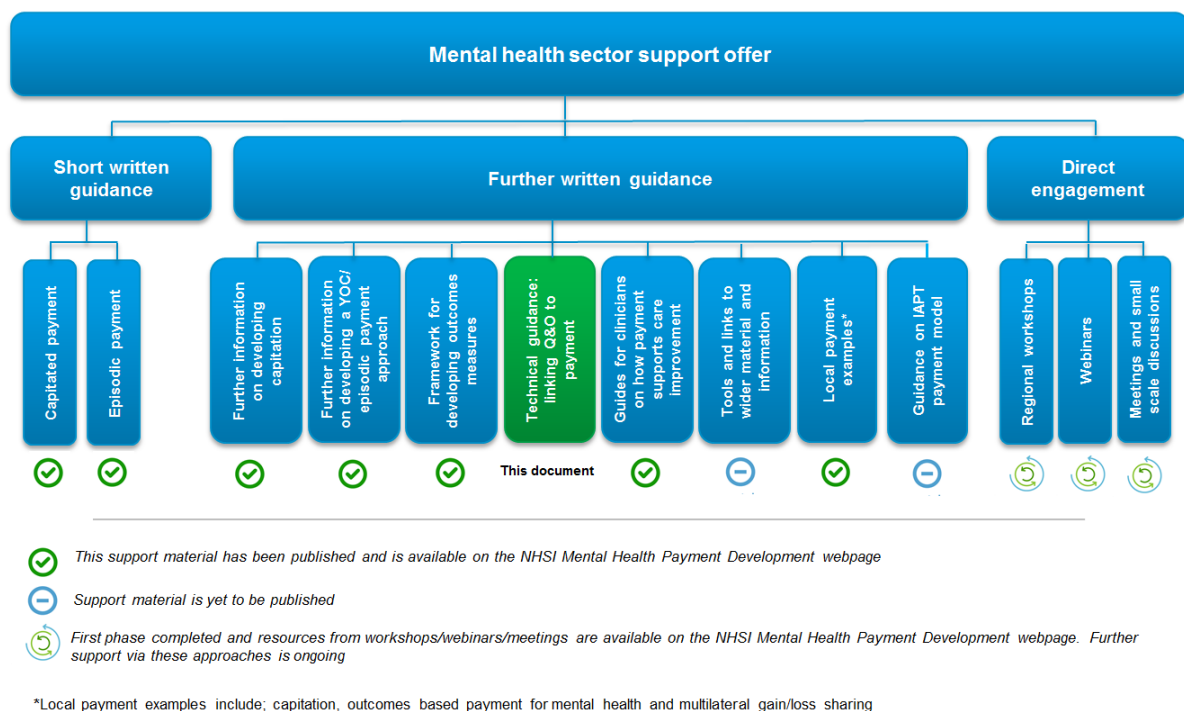
# 1. Purpose of this document

This document provides technical guidance on how providers and commissioners can link locally agreed quality and outcome measures to payment. It has been developed to support mental health providers and commissioners to implement the new requirements under the 2017-19 local pricing rules. It is aimed at all those professionals in provider and commissioner organisations who need to work together to successfully link quality and outcome measures to payment – this includes clinicians, finance and contracting professionals and senior management.

This document is part of a set of written guidance to support local work in payment development for mental healthcare. It should be used with the guidance on *Delivering the Five Year Forward View for mental health: developing quality and outcome measures*, published in July 2016. That provided a framework for providers and commissioners to develop and agree the quality and outcome measures. This document provides technical guidance on how and whether measures developed using this framework can be linked to payment for mental healthcare.

NHS Improvement and NHS England offer more support and advice via workshops and webinars as part of our sector support package. Figure 1 illustrates where this document sits within the context of the wider support package to implement the new local payment rules for 2017-19.

**Figure 1: Summary of mental health sector support offer**



## 2. Context for linking quality and outcome measures to payment

The *Five Year Forward View (5YFV) for mental health*<sup>1</sup> strongly called for new payment approaches for mental health and for both national and local outcome measures to be part of the approach. This is because payment for most mental healthcare services often does not have strong links to quality and outcome measures, and does not incentivise the delivery of timely or quality care. Nor does it support continuity of care or effective patient choice.

Explicitly linking a component of payment to achieving quality standards and outcomes offers a clear focus for providers, commissioners and the local system to work together to deliver safe and effective care in patients' best interests. In particular, it can:

- increase focus on a common vision of population needs, and provide a common language for describing them
- better meet the needs of the people who use services
- increase attention and incentives paid to early intervention and more patient-focused preventive care
- improve effectiveness and efficiency of care, ensuring value for money and best use of limited resources
- help mitigate some of the risks inherent in a local health economy.

Consistent with the recommendations in the 5YFV for mental health, the 2017-19 local pricing rules for mental health now require commissioners and providers to link prices to locally agreed quality and outcome measures and achieving access and waiting-time standards. This document has been developed to support mental health providers and commissioners to implement these requirements.

### 2.1. Framework for developing quality and outcome measures

The quality and outcome measures need to be locally developed and agreed. The 5YFV for mental health recommends both national and local outcome measures should be part of the payment approach. It calls for indicators that are:

- clinically relevant
- co-produced with experts-by-experience
- measurable

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<sup>1</sup> <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

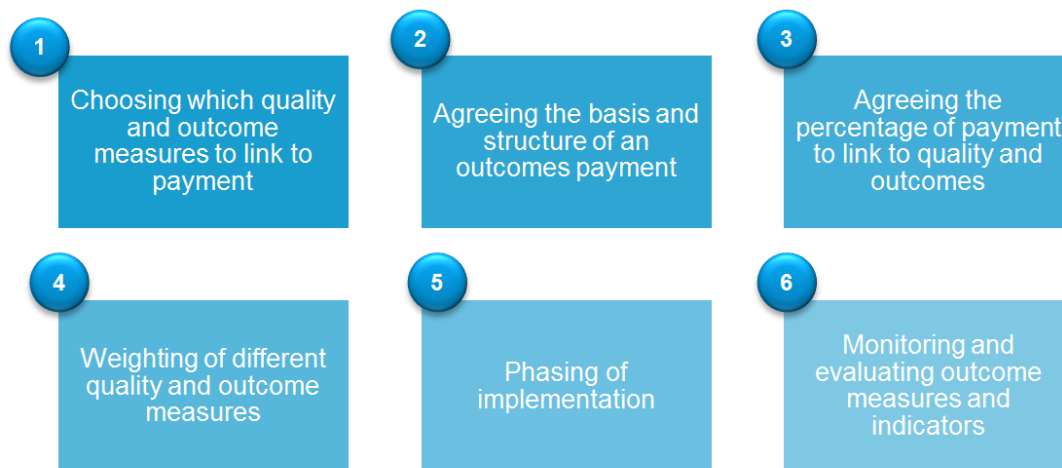
- aligned with system-wide objectives – including, for example, the objectives outlined in the 5YFV for mental health, sustainability and transformation plans, the Carter Review and local Joint Strategic Needs Assessments.

When developing local quality and outcome measures, local health economies should refer to the document *Delivering the Five Year Forward View for mental health: developing quality and outcome measures*.<sup>2</sup> This provides a framework for local quality and outcomes development.

### 3. Implementing quality and outcome measures for payment

Providers and commissioners should consider six elements shown in Figure 2 when linking quality and outcome measures to payment.

**Figure 2: Six elements for linking quality and outcomes measures to payment**



Both the quality and outcome measures, and the mechanism for linking them to payment, should be agreed among providers, commissioners, experts-by-experience and the wider local health economy. This should also inform any procurement exercise led by commissioners. This mechanism should promote and support a culture of continual improvement and development in localities to deliver the local priorities that support the 5YFV objectives. Commissioners should not use outcomes-based payment to penalise providers, nor should providers use it to recover core revenue for delivery of services. Providers and commissioners may wish to agree a memorandum of understanding to ensure a constructive and collaborative approach to using outcome measures to support care improvement.

The six key elements outlined in Figure 2 may vary according to local circumstances and through further testing and analysis in this area. Further information on these key elements is discussed in the sections below.

<sup>2</sup> <https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/mh-quality-outcome.pdf>

### 3.1. Starting expectations for linking quality and outcomes to payment

Quality and outcome measures must be a core component of the payment approach used in the local health economy. When choosing quality and outcome measures to use for payment, and when determining how they are linked to payment, local health economies should already have an agreed view of:

- **Population needs:** It is important to use available data and information to get a sense of the need for relevant care within the area. This should include feedback from patients and carers, local health and care activity data, Public Health England's fingertips tools, and non-health data to understand unmet need (demographic data from the Office for National Statistics and data from police and other emergency services).
- **The mental health care model:** Chosen quality and outcome measures and payment should support the agreed care model to meet local healthcare needs.
- **The payment approach:** In accordance with the 2017-19 local pricing rules, NHS Improvement and NHS England require the use of a capitated or episodic payment for mental health, where quality and outcome measures must be linked to prices with any payment approach that is chosen locally.<sup>3</sup> Further guidance on payment for mental healthcare can be found on NHS Improvement's [mental health payment development webpage](#).<sup>4</sup>
- **Locally agreed quality and outcome measures to choose from:** Locally agreed quality and outcome measures support patient-centred care and those objectives outlined in the 5YFV for mental health by the Mental Health Task Force. Locally agreed quality and outcome measures need to include access and waiting-time standards as part of the holistic suite of measures selected. Further guidance and information on the local framework for outcomes development is outlined in the document: [Delivering the Five Year Forward View for mental health: developing quality and outcome measures](#).

A number of key enablers and building blocks should be considered when locally linking quality and outcome measures to payment. Key building blocks include, for example, putting in place clear governance processes and mutually agreed objectives. In addition, a fundamental and operationally important component is to ensure robust collection, reporting, flow and use of data on outcome measures and indicators. Access to periodic data and information on the outcome measures linked to payment can:

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<sup>3</sup> Local pricing rules permit use of an alternative payment approach (local variation) if this is consistent with local pricing rules and principles.

<sup>4</sup> <https://improvement.nhs.uk/resources/new-payment-approaches/>

- allow providers and commissioners to assess how well they are doing within year and contract
- ensure any operational, safety and financial risks can be identified early and addressed.

To further support providers and commissioners to link outcomes to payment using data, localities should make use of wider data and information collected and reported via NHS Digital, which can improve local insights and reduce data burdens.<sup>5</sup>

In addition, key enablers can further support local health economies. These include, for example, investing in local efforts to seek board-level commitment, developing good local leadership for working with partners and service users, and embedding and promoting a culture of continual improvement.

These building blocks and enablers are essential for successfully developing and implementing payment linked to quality and outcome measures. They do not add additional burdens from the payment requirements or those that are needed for sustainability and transformation plans and the Carter Review.

## **3.2. Choosing which quality and outcome measures to link to payment**

### **3.2.1 Number of outcome measures and indicators for payment**

We suggest that in total a limited set of three to seven outcome measures with between six and 15 indicators are used to link to payment for mental healthcare at the contract level. These should be clearly defined, but still offer clinicians freedom to innovate and improve care delivery.

Linking a limited set of measures to payment can allow local health economies to focus on priority areas of development and achieve realistic improvements. Selecting a small number of measures can also help effectively engage clinicians and focus attention on key objectives, particularly from system-wide partners in the local health economy. These outcomes and indicators may capture all or some of the service lines. This means that not all quality and outcome measures should be linked to payment. The box below shows examples of the number of quality and outcome measures selected for payment in the NHS.

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<sup>5</sup> The Mental Health Services Data Set (MHSDS) can be accessed via the NHS Digital webpage here: <http://content.digital.nhs.uk/mhldsreports> Further data and information can be requested by providers and commissioners via the NHS Digital Data Assess Service: <http://content.digital.nhs.uk/dars>

## Examples from the sector

**Oxfordshire Clinical Commissioning Group (CCG) and Oxford Health NHS Foundation Trust** have developed an outcomes-based commissioning model for adult mental healthcare. Outcome measures were co-developed with experts-by-experience and third sector partners (Mind, Restore, Response, Elmore and ConnectionFS). The model includes seven outcome measures with 14 indicators. Further information on this can be found in the published [local payment example](#).

**Camden and Islington NHS Foundation Trust** has worked with CCGs, clinicians across acute and community providers, experts-by-experience and patients to locally agree seven outcome measures and 17 indicators for payment purposes. Outcome focused on three key areas: (i) wellbeing status – independence, wellbeing and health outcomes (ii) process of care – right care and right time, right place (iii) sustainability of services – cost, staff, learning organisation.

### 3.2.2 Criteria to consider when choosing outcomes for payment

In line with the 5YFV recommendations, we suggest linking different types of measures to payment for mental healthcare services. These could include, for example, process, activity, patient outcome and patient experience measures. Providers and commissioners also need to ensure that the [mental health access and waiting-time standards](#)<sup>6</sup> are included in any suite of locally determined quality and outcome measures linked to payment, where this applies to services. This is consistent with the requirements in the 2017-19 local pricing rules for mental health.

The measures selected for payment need not be limited to mental healthcare providers but can include other organisations covered by the service delivery. This may include, for example, acute providers, community providers, local authorities and third party/voluntary sector organisations.

Providers and commissioners should consider whether measures that are linked to payment meet these criteria:

1. **Achievable yet stretching:** Quality and outcome measures should be achievable by the providers/organisations responsible for meeting the measures. Quality and outcome measures should incentivise continuous improvement in services and patient care. It is important that targets are realistic and help promote and encourage quality in the local health economy.
2. **Timely:** Different measures may be observable at different points in time. The outcome measures selected for payment should be aligned with the contract

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<sup>6</sup> <https://www.england.nhs.uk/mentalhealth/resources/access-waiting-time/>



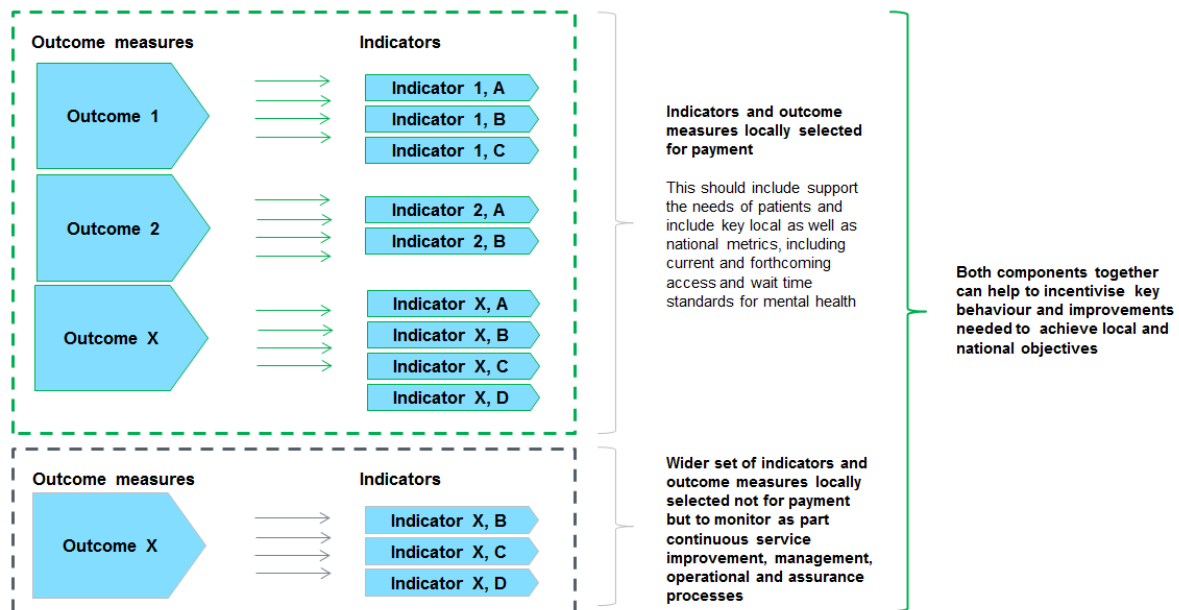
duration. Where outcome measures fall beyond the contract duration, it may still help to monitor them as part of the wider set of measures not linked to payment.

3. **Meaningful:** Providers and commissioners should ensure that measures linked to payments are meaningful. They should resonate with a wide range of service users, experts-by-experience, clinical, finance and operations teams and other local partners (eg third sector, local government). They should not be subject to material volatility, so that observed changes in them reflect changes in performance and not random variation.
4. **Clearly defined:** Quality and outcome measures and indicators must be clearly defined and measurable. Local health economies should have a clear view of the indicators and corresponding units in which the metrics will be measured. These must be relevant definitions in the context of clinical, finance and operations teams.
5. **Meet local and national priorities:** Quality and outcome measures must align with local commissioning objectives and those in the 5YFV for mental health, including the access and waiting-time standards for mental healthcare.
6. **Relevant to target population:** Providers and commissioners should consider whether the measures selected capture the target population covered by the service delivery model and payment approach. Quality and outcome measures selected for payment should at a minimum cover a subset of the population covered by the payment approach. Experts-by-experience and service users have a role in developing outcome measures, as well as in helping providers and commissioners prioritise and select the outcome measures for payment.
7. **No double incentives:** Providers and commissioners need to identify current incentives explicitly covered under any contractual or payment arrangement (eg CQUIN), and consider whether there would be a 'double payment' for any new outcomes locally selected for payment. There must not be a double incentive for achieving metrics. Measures selected for payment must not already be the basis of any other incentive or contractual penalty arrangement.

### **3.2.3 Wider use of outcomes beyond payment purposes**

Providers and commissioners may wish to select wider measures (including clinical measures) not for payment purposes but to monitor as part of continuous service improvement, management and operational processes, shown in Figure 3. It is important that wider measures selected for monitoring and continuous improvement are not arbitrary and do not increase undue burden on local health economies. These measures should be informed by clinicians and experts-by-experience.

**Figure 3: Outcome measures for payment and use for continuous improvement**



### 3.3. Agreeing the basis and structure of an outcomes payment

When linking quality and outcomes to payment for mental healthcare, providers and commissioners should consider how the outcomes payment will be structured. There are two general options:

- a bonus on top of a payment that reimburses for efficient costs of providing the services
- withholding part of a payment that reimburses for efficient costs until required outcomes are met.

Further information on this is outlined below.

#### 3.3.1 Calculating outcomes payment

The quality and outcomes payment to providers should only be paid if agreed standards are met. An outcomes payment should be locally developed after considering key factors, including:

- **Establishing a baseline:** This should be for all indicators selected for payment and based on robust local and national data and information. Regard should be given to whether the baseline is stable over a defined payment period.
- **Quality and outcome standard/target:** This needs to be agreed prospectively by providers and commissioners and informed by stakeholders from the wider local health economy.

- **Appropriate adjustments:** In some instances, actual performance may be materially different to the established baseline. This may be due to, for example, unforeseen changes in the local health economy. Therefore, in some instances, it may be appropriate to correct the baselines to reflect the most up-to-date data and information. Providers and commissioners should prospectively agree 'trigger points' for such corrections.

### **3.3.2 Structuring outcomes payment**

A quality and outcome payment would ideally comprise a small proportion of the total payment to an organisation. Quality and outcome payments are usually most effective as a bonus over and above payment for efficient cost recovery of services. A small bonus would not undermine financial viability, but can help marshal support and leadership to meet stated objectives.

If outcomes payments are not a bonus but withheld from funds allocated to the recovery of efficient costs before demonstration of meeting outcomes, it risks:

- withdrawing or withholding critical operating funding needed for delivering services, which can further demotivate struggling providers, making it more challenging for them to improve performance
- creating an adversarial relationship between providers and commissioners, undermining collaborative working.

The payment design needs to take account of the local health economy's financial health and sustainability. Where organisations are in deficit, quality and outcome payments may cease to be a 'bonus' and the signal may be distorted or lost. Within the context of the local health economy's financial health, the expected achievable payment would include the payment for efficient costs plus quality and outcome payment. In this context, the quality and outcome payment could reflect two features:

- an earn-back element of the outcomes payment, based on a small proportion of the total efficient costs, to ensure delivery of core objectives
- a bonus element from anticipated efficiency savings in physical, mental and community healthcare settings due to more effective, efficient and co-ordinated payment, service and care delivery models in the local health economy.

### **3.3.3 Timing of the outcomes payment**

In addition to agreeing the structure for outcomes payment, providers and commissioners should consider the timing of such payments. Payments to providers do not need to be at the end of the year or at the end of the contract. They can be on a monthly or other periodic basis. More frequent payment has these benefits:

- reinforcement of positive behaviour; payment when quality and outcome measures have been achieved reinforces positive behaviour in the local health economy
- smoother cash-flow for continuous development and improvement. It is important that quality and outcome payments do not present a risk to operating the service or patient safety. This is particularly important if proportion of payment linked to quality and outcome measures is large.

Commissioners should decide how any unpaid quality and outcome payments are spent in the local health economy. They should be transparently spent on the target population covered by the payment approach, within the duration of the contract (which may fall over several financial years).

### **3.4. Agreeing the percentage of payment to link to quality and outcome measures**

In line with the 2017-19 local pricing rules for mental health, providers and commissioners need to agree the size of the contract value to link to locally selected quality and outcome measures. This will largely depend on local circumstances and context.

The percentage of the contract value linked to quality and outcome measures should be large enough to be meaningful to providers, commissioners and other organisations involved in the local service delivery model and payment approach.

The contract value linked to outcome measures should not be so large that organisations become reliant on it to cover efficient costs – which could lead to financial destabilisation in the local health economy. In addition, if too large a proportion of payment is linked to achieving outcomes, outcomes objectives are likely to be set at too conservative levels. This could lead to reduced innovation and improvement due to risk-averse behaviour.

We suggest that linking about 2% to 4% of the total financial contract value to incentives may be sufficient for the desired effect. Relatively small financial rewards should not threaten an organisation's viability and can provide an added incentive (and therefore internal/management support) to meet given objectives. Based on evidence,<sup>7</sup> small financial rewards can drive innovations when they are clearly aligned with system-wide objectives.

### **3.5. Weighting quality and outcomes metrics**

Providers and commissioners should agree the weighting of each outcome measure and indicator selected for payment. These weightings will represent the amount of

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<sup>7</sup>[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/381930/FinanciaNonFinancialIncentives.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/381930/FinanciaNonFinancialIncentives.pdf)

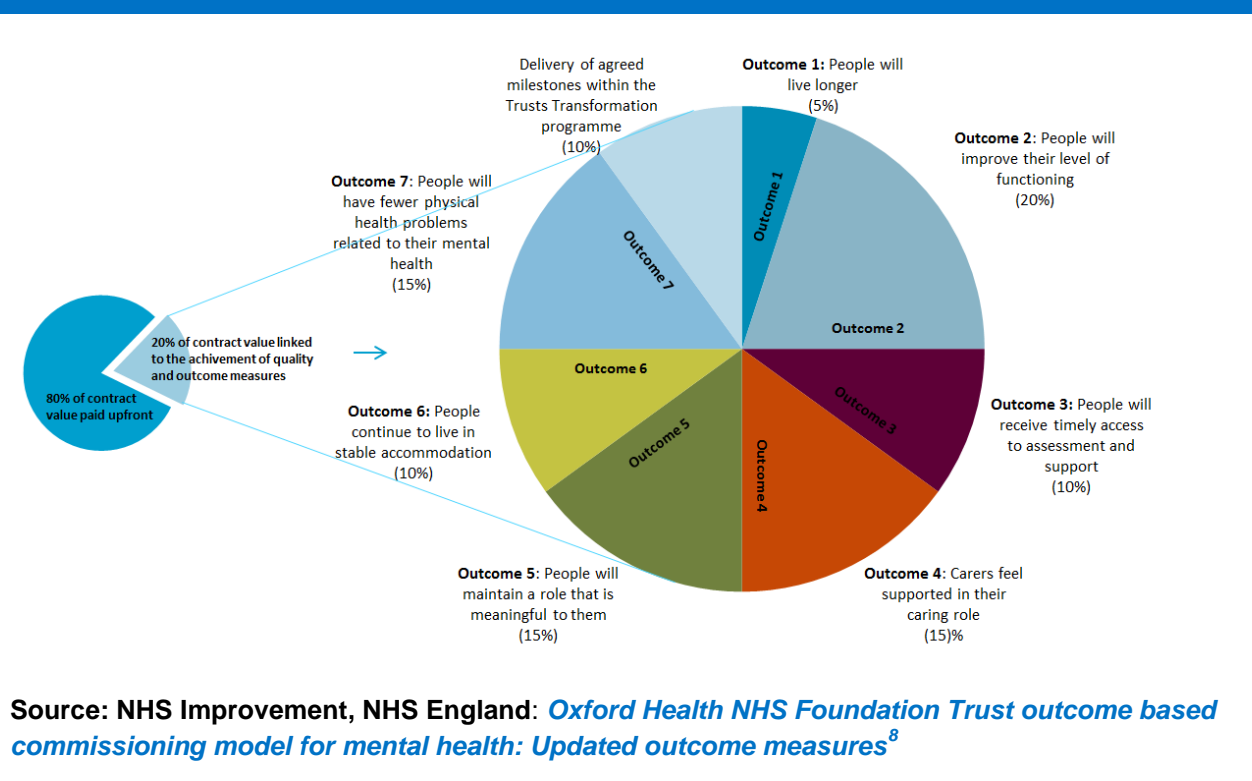
contract value (and thus payment) assigned to achieving the outcomes. Providers and commissioners can take two broad approaches to weight outcome and indicators:

- link the proportion of payment assigned for outcomes payment equally across all the outcome measures and indicators selected
- weight the outcome measures and indicators differently, based on factors that may, for example, reflect national/local priorities (eg higher priority areas could be assigned a higher weight and thus attract a higher outcomes payment, if achieved).

It is important that the views of experts-by-experience, clinicians, operational and finance colleagues inform the weightings agreed by providers and commissioners.

Figure 5 shows Oxford Health NHS Foundation Trust’s weightings for outcomes and corresponding indicators. In this example, there are 100 points and each of the seven outcome measures represents a proportion of the total contract value linked to payment.

**Figure 5: Weightings from Oxford Health NHS Foundation Trust**



<sup>8</sup> <https://improvement.nhs.uk/resources/new-payment-approaches/>

With measures that reflect system-wide objectives, as above, it may be appropriate to adjust thresholds or targets over time to ensure measures are stretching but achievable. This is a key tool that allows providers to be legitimately held to account for their role in improving the agreed outcomes, while recognising that they do not have sole control over them.

### **3.6. Phasing implementation**

Introducing and phasing payment approaches linked to locally agreed quality and outcome measures will depend on factors that include contract duration and the extent to which local building blocks and key enablers are in place.

Providers and commissioners may agree to phase in the mechanism over two to five years. Local health economies may also agree to phase in the:

- number of outcomes and indicators linked to payment, consistent with guidance
- percentage of contract value assigned to outcomes payment (within the suggested amounts – see Section 3.4)
- service scope and patient cohort that the outcomes/indicators relate to – eg over time, to ensure the outcome measures cover the widest possible patient cohort. Note that we still advise a limited set of three to seven outcome measures with between six and 15 indicators for payment purposes.

It is important to consider which type of outcome measure and indicator is selected for payment. Some measures may be designed to be realised in the longer term and others in the immediate or short term. Therefore, it may be appropriate for providers and commissioners to agree to phase in implementation for different types of measure. For example, in the early years, providers and commissioners may agree to link payment to process measures to help the system deliver the service reform. In later years, more holistic clinical and patient-related outcome measures can be linked to payment.

### **3.7. Monitoring and evaluating outcomes measures**

In some instances, it will be appropriate to phase out certain outcome measures and indicators over time, as objectives are achieved and new indicators/outcomes become more appropriate to incentivise behaviour. It is therefore important to periodically review and monitor outcome measures throughout the duration of the contract.

Providers and commissioners should analyse and evaluate how behaviour changes in the local health economy and how it affects the effectiveness, efficiency and sustainability of patient care. This should include analysis of both outcomes selected

for payment and wider measures monitored for continual improvement and development.

#### 4. Role of other mechanisms

It is important that providers and commissioners consider the role and effects of other local and national policies that may complement and/or influence local incentives and behaviour. The Commissioning for Quality and Innovation (CQUIN) scheme will operate alongside the 2017-19 local pricing rules, which require prices to be linked to locally agreed quality and outcome measures. The 2017-19 local pricing rules for mental health do not replace the CQUIN scheme.

Providers and commissioners need to ensure local alignment between the requirement to link quality and outcome measures to payment and the CQUIN scheme. They also need to ensure they adhere to NHS England's guidance and rules on CQUIN.

#### 5. Next steps

As stated in the 2017-19 local pricing rules for mental health, providers and commissioners of adult and older people's mental health services must link prices to locally agreed quality and outcome measures from April 2017. It is important that key building blocks and enablers (as outlined in this document) are locally developed and implemented.

Providers and commissioners are responsible for leading local payment development with the wider local health economy 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.

To help local health economies link locally agreed quality and outcome measures to payment, and develop either a capitated or year-of-care/episodic payment approach, NHS Improvement and NHS England will continue to offer support to the sector. This may include direct support, publishing practical guidance, workshops, webinars and further sector engagement. Further information on our sector support offer and guidance material can be found on [our mental health payment development webpage](#).<sup>9</sup> We welcome suggestions on additional material that would support local payment development.

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<sup>9</sup> <https://improvement.nhs.uk/resources/new-payment-approaches/>

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