HFMA Briefing

Mental Health PbR Commissioners Survey Report

October 2011

MH Finance is the faculty of HFMA which represents the financial management interests of the mental health community. In September 2011 the MH Finance Faculty conducted a survey of senior finance staff in commissioning organisations to assess the current situation in relation to the introduction of payment by results (PbR) within the mental health sector.

The sample

In total 32 commissioning organisations responded to the survey. These were split across SHA areas as follows:

SHA Area	Percentage	Count
East Midlands	0%	0
East of England	9%	3
London	3%	1
North East	7%	2
North West	28%	9
South Central	9%	3
South East Coast	3%	1
South West	19%	6
West Midlands	0%	0
Yorkshire & Humber	22%	7

The majority of respondents were directors of finance or deputy directors although responses were also received from some senior finance managers.

Currencies

All respondents were aware of the PbR currencies to be mandated from April 2012 but concerns were raised as to how they would work for costing purposes.

How aware are you of what the national currencies are for mental health services that will be mandated for commissioning purposes from April 2012?	Response Percent	Response Count
I am aware of the currencies	100.0%	26
I am not aware of the currencies	0.0%	0
	answered question	**26**
	skipped question	**7**

The next question looked at the type of contracts currently held with MH providers and the results were that all respondents had block contracts agreed with their providers.

Comments included:

'Whilst the contract remains a block, our local provider has worked with us over the last year to break it down by service line and to provide some analysis by GP practice so that we can better understand the service provision and the issues specific to localities.'

'We also hold a cost and volume contract for specialist services.'

Involvement
The survey asked respondents to consider the amount of involvement which commissioners have with the work on MH PbR with the following results:

As a commissioner, are you involved in the work on MH PbR?	Response Percent	Response Count
Yes - joint approach being taken with a high level of involvement	50.0%	13
Yes - some involvement e.g. via CQUIN or QIPP schemes	26.9%	7
No	23.1%	6
answered question		**26**
skipped question		**7**

Additional comments included:

'We have a dialogue and representation at on-going meetings to ensure continued progress is made on moving to the new currencies.'

'Over the last year we have had a joint Project Board to oversee the MH PbR work, involving members from our provider Trust, both PCTs and Social Services. This Board has agreed principles and overseen the detailed work that has been carried out by the Trust. A shadow tariff working group is now established to agree approaches to various financial and information issues.'

'We are part of a working group with the Lead Commissioner of our main Mental Health contract to try and understand the cluster information from the Provider and link to cost.'

The next question looked at the extent of discussions with providers around what packages of care will be associated with each mental health cluster. The results were as follows:

Has your organisation discussed with providers what packages of care will be associated with each mental health cluster?	Response Percent	Response Count
Yes for all	19.2%	5
Yes for some	34.6%	9
No	46.2%	12
answered question		**26**
skipped question		**7**

Comments suggested that:

'Work is on-going to agree the care packages and pathways that will be used for each cluster.'

'We are working with clinicians to identify the required packages although at present all work has been undertaken by the trust.'

The survey asked whether commissioners knew what percentage of service users their providers had allocated to a cluster in the last 12 months and the following results were received:

Do you know what percentage of service users your providers have allocated to a mental health cluster in the last 12 month period?	**Response Percent**	**Response Count**
Less than 50%	11.5%	3
51 - 75%	15.4%	4
76 - 90%	23.1%	6
Over 90%	11.5%	3
Don't know	38.5%	10
answered question		**26**
skipped question		**7**

However, as can be seen from the table above, nearly 40% did not know the extent of clustering by providers.

64% of respondents anticipated that their providers would have full allocation within 6 months with the reminder believing that it would be 12 months or over.

Costing of Clusters
The survey asked respondents to identify the extent to which providers had costed their clusters. The survey identified the following:

Do you know if providers have completed any costing of the mental health clusters?	**Response Percent**	**Response Count**
Yes - detailed patient level bottom up costing carried out for all clusters	11.5%	3
Yes - detailed patient level bottom up costing carried out for some clusters	19.2%	5
Yes - high level top down costing for all clusters	19.2%	5
Yes - high level top down costing for some clusters	7.7%	2
They haven't completed any costing	7.7%	2
Don't know	34.6%	9
answered question		**26**
skipped question		**7**

Comments included:

'Initial prices have been developed using a top-down approach. Once all patients are clustered and care packages defined for each cluster, detailed bottom-up prices will be developed. A first view of these prices is expected to be completed by Jan 2012.'

'They shared some initial costs before Christmas 2010 which suggested they had done bottom up costing for all clusters but not sure it was patient level or more service/ward level.'

'High level costing has been carried out for some clusters, initial patient level costing is currently underway, this will be shared with commissioners in October.'

State of readiness
Almost 80% of respondents described their providers as 'partially ready' to be able to use the national currency for 2012/13 contracts as shown in the table below:

How would you describe the state of preparedness of your local provider trusts to be able to use the national mental health currency in its 2012/13 contracts?	Response Percent	Response Count
Fully prepared	12.0%	3
Partially prepared	76.0%	19
Not prepared at all	12.0%	3
answered question		**25**
skipped question		**8**

Comments included:

'The PCTs and provider have agreed that 2012/13 will be a shadow year, to enable validation of the pathways and prices. This shadowing arrangement will be reflected in the contracts, which will remain as a block for payment purposes.'

'Probably better than most but although currency maybe available, it is not clear/agreed that changes in reported currency positions in 2012/13 will lead to any £ variations in the block arrangement.'

Similar percentages were returned in relation to the preparedness of local commissioners to be able to use the national currency in 2012/13 contracts.

In terms of whether pathways will need to be adapted to fit in with clusters, the results were:

Do you expect to have to significantly change pathways to fit in with the clusters?	Response Percent	Response Count
Yes	27.3%	6
No	72.7%	16
answered question		**22**
skipped question		**11**

A number of services were identified including

- Adult services
- Community services
- Inpatient services.

Comments included:

'There is some concern around national clusters and the pathways included i.e. some have outpatient pathways plus inpatient pathways, which may cause confusion in application.'

'Pathways are not clearly defined currently, so a significant benefit of the CPPA and PbR work is the development and agreement of clear pathways. This will inevitably lead to some changes compared with current practice.'

Guidance

More than 70% of respondents felt that the current guidance available from the Department of Health was insufficient to support the development of mental health payment by results. Comments included:

'Potentially the guidance leaves too much open to interpretation, therefore application of a nationally set tariff may cause issues in a couple of years' time.'

'Guidance is currently only being sent to trusts for comments and all groups seem to only include trusts -commissioner involvement is very limited - commissioners should be able to influence prices not be told by trusts what the prices are.'

'We are still awaiting clarity to define what will be nationally mandated and what will be within local control.'

'I think we have to adapt it to local pathways - it's not the guidance as much the capacity to undertake it.'

'The guidance is probably as good as it could be at this stage, however, this does feel like work in progress where guidance may need amending as providers go through the process and issues emerge.'

When asked what additional support is required, the following responses were received:

'Regional workshops to share knowledge, learning and best practice.'

'It is anticipated that there may be destabilisation from the adoption of MH PbR in the first year and it would be helpful for the SHA or DH to provide a steer on how this might be mitigated.'

'More information on pilots on what worked well/not so well. Sharing of information on what providers are including within each cluster to ensure more consistency. There appears to be, from a commissioners' perspective, a reluctance to share between providers.'

'Clarity from DH on expected timescales for transition to full PbR and on the programmes for IAPT and CAMHS services. Also I understand that the current IT system does not support coding for patients who are assessed but not clustered, which needs addressing. A DH Q&A forum may be of use as more operational issues arise.'

Local tariff

The survey asked participants how confident they were that there would be an agreed local tariff in place for April 2012/13. Of the 59% who were **not** confident that this would be in place, the reasons given included the following:

'The providers still have a little way to go to establish local prices, however we will work within a contract value (and apply as sensibly as possible) if this work is not quite finalised.'

'Local tariff will be used to leave the contract at similar levels to current block but unsure if there will need to be a re-basing between commissioners of the contract,'

'Agreement may be an issue due to the fact that the quality of the data coming out with regard to PbR is not fully robust as yet, so it would be difficult to sign up to an indicative element unless alternate risk sharing of the financial implications was sought.'

'I can't see it happening before CCGs (clinical commissioning groups) take over from PCTs as too risky and therefore we should wait for the CCGs to bed in and sort out implementation issues before we look at this suggest 2014/15 at earliest.'

In terms of whether tariffs will need to be unbundled to fit with local delivery models, 62% thought this wouldn't be necessary.

Additional comments included:

'Not all aspects of care are going to be provided by one provider and so tariffs will need to be unbundled to ensure each provider receives adequate payment for what they provide in the pathway. Don't know how this is going to be done as yet.'

'We have different providers along the pathway in some cases so community services primary care mental health will not be part of the care cluster although it is part of the pathway.'

When asked how much the use of local tariffs were likely to result in commissioners at the boundaries of providers switching activity to a neighbouring provider where the local tariff is lower, the responses were as follows:

'It is likely that commissioners will need to ensure that they are maximising the opportunities for QIPP and therefore where there is the ability to undertake this they will switch to another provider.'

'Currently we have one main provider locally, with only one other competitor locally. It is unlikely that this will happen, especially if a national tariff is supposed to be in place from 13/14.'

Responses were evenly matched in terms of whether the implementation of a local tariff was a priority and depended largely on geographical location. The results can be seen in the table below:

Is the implementation of a local tariff a priority for your organisation?	**Response Percent**	**Response Count**
Yes	54.5%	12
No	45.5%	10
	answered question	**22**
	skipped question	**11**

Additional comments included:

'Our efforts have been targeted at ensuring appropriate patient pathways and modernising mental health services. The move to mandated currencies may help move this forward but this is not yet known.'

'There has been a lot of work done between lead commissioner and provider. As an associate to the contract, there will be a consistent approach adopted, but it is not a priority for us at the moment.'

'Financial risk needs to be minimised at a time when savings are required and if local tariffs are not negotiated which keeps risk to a minimum for both commissioners and providers equally then this increases the risk of destabilisation with unmanageable increases in costs to commissioners or loss of income to providers.'

'We just require some visibility of our contract which we don't have as it's a block. We know local currencies will balance broadly back to the contract quantum so local currencies are a bit academic at this stage.'

The survey also asked respondents to identify potential barriers to delivery of local tariff in line with the DH timetable the results. These do not equal 100% as respondents were asked to select all options which they felt applied to their circumstances. The results received were:

What are the three key barriers in your organisation to delivery in line with the DH timetable?	Response Percent	Response Count
Poor data quality / collection	54.5%	12
Poor information systems	40.9%	9
Difficulties with costing	50.0%	11
Competing priorities due to merger / organisational change	86.4%	19
Other competing priorities e.g. time pressures	40.9%	9
Other	9.1%	2
answered question		**22**
skipped question		**11**

One respondent commented:

'Rather than these areas being barriers we recognise them as challenges and have an agreed framework for taking these forward.'

National tariff

More than 80% of respondents supported the introduction of a national tariff to mental health services:

Do you support the introduction of a national mental health tariff?	Response Percent	Response Count
Yes	81.8%	18
No	18.2%	4
answered question		**22**
skipped question		**11**

Additional comments included:

'The impact of providers having to develop and clarify pathways will be of great benefit to commissioners, as will visibility over relative resource usage. However there are significant concerns about risk management at a time of rising activity (high, and rising, prevalence of dementia) and limited funding, so without good risk management arrangements around over-activity this could be a key risk for commissioners.'

'From a commissioner perspective there is a need to understand what is being provided in the mental health contracts, to know what we are getting for our money and ensure we are getting the required outcomes for our patients. We need to be able to monitor our contracts to allow commissioning decisions to be made in the best interest of the people using the services....hopefully a mental health tariff will allow this to happen.'

'I think the timetable is too short and the care packages too complex to achieve a good outcome for commissioners. Information from MH providers is not particularly good and there is the potential of swings in coding (as seen with acute PbR).'

In terms of how the tariff could be successfully implemented, the following comments were received:

'It is critical not to force a national pace before local systems are ready and the information is being collected accurately and consistently and has been properly validated. '

'A greater understanding of how the clusters will work and how commissioners can challenge which cluster someone is assigned to.'

'Robust activity data collection supporting reference cost collections on same basis over a number of cycles, with detailed review of results to determine whether differences are because of different interpretations of the currency or whether packages of care are sufficiently different to render comparisons meaningless.'

The majority of respondents thought that a national tariff should be introduced between one and three years after the adoption of the national currency as can be seen from the table below:

How soon after the adoption of the national MH currency in 2012/13 should a national MH tariff be introduced?	**Response Percent**	**Response Count**
One year	0.0%	0
One to three years	88.9%	16
More than three years	11.1%	2
	answered question	**18**
	skipped question	**15**

Those opposing the introduction of a national MH tariff made the following comments:

'Mental Health is hugely different to the application of normal PbR within the acute sector. The more complicated part of acute PbR is excluded and has proved difficult to cost and benchmark against. This would be the same for mental health, where package costs can be hugely variable.'

'Although this will identify the costs for the service it does not reflect the requirement for trusts to work with local commissioners and there will need to be greater challenge available in terms of activity and costings to support local services. There needs to be an ability for trusts to work with other providers e.g. voluntary sector to deliver services and this will deflect from any consortium arrangements that may be in place.'

I think the lessons learned from the implementation of Nat tariff for mainstream secondary care shows that it creates perversities in the system. A better option would be to develop local prices. Give local commissioners the flexibility to get VFM by negotiating the price down.'

The role of HFMA

Finally, the survey asked respondents what they thought HFMA could do to support local practitioners in introducing mental health PbR.

Comments included:

'Offer examples of best practice where commissioners and providers have already engaged in using the clusters as the basis for contracting.'

'To lobby providers to share what they are doing with each other; ensure that the DH/SHA's are pushing all involved to complete the exercises to the timetables set, otherwise it will linger on.'

'Training sessions on coding and implications are already being conducted by the SHA, so any support would need to be in conjunction with this current level of support.'

'Communication is key, but locally the CPPP pilot is being active in disseminating information and assisting commissioners to a greater understanding.'

'I think some benchmarking would be really helpful so that we can compare Trusts as we can now on length of stay and admission rates.'

Key points
A number of conclusions can be drawn from the survey results:

- Support for the currency - The majority of respondents to the survey are in favour of mental health PbR

- Preference for a phased approach to implementation - There are concerns over the timetable for introduction

- Most organisations surveyed are partially prepared with less than 6 months to go.

- There could be difficulties in implementing at a time of structural and organisational change in the NHS