Shaping healthcare finance...

HFMA Briefing

Mental Health Payment by Results Survey Report

June 2011

Mental Health PbR is getting closer to a reality with the Mental Health sector starting to tackle the practicalities of a whole new assessment process and the associated issues of costing long term care for people with mental health problems. It is planned that 2012-13 will be the year where adult services will be contracted upon with payment on a PbR basis in mind so the next twelve to eighteen months will be critical to an effective implementation. Whilst the Department of Health have got a very close eye on progress and issues arising, the HFMA Mental Health faculty took the opportunity to survey its peer group to establish what the state of nation was and the results were very interesting and show a wide spread of progress at this stage.

As Chair of the HFMA's Mental Health Faculty I feel that the outcome of the survey provides us with some very supportive evidence of what the faculty has been discussing as real issues over the past few months. The members are always very willing to contribute to our surveys, share progress and views in order to constructively take the agenda forward therefore the information contained within the survey results will be very useful. We hope this survey will support the further work that will be undertaken by the Department of Health, Strategic Health Authorities and local organisations over the coming months. The immediate challenge for us now is to help and support those organisations who are not as ready as others to implement MH-PbR and HFMA will be taking a supportive role to enable forums for discussion, problem solving and sharing best practice.

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Mental Health Payment by Results Survey Report

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MH Finance is the faculty of HFMA which represents the financial management interests of the mental health community. In May 2011 HFMA MH Finance conducted a survey of senior mental health finance staff to assess the current situation in relation to the operation of payment by results within the mental health sector.

The sample
In total 46 mental health provider organisations responded to the survey although as some organisations submitted more than one response, 69 responses were received overall and four of these were from private sector providers. These were split across SHA areas as follows:

SHA Area	Percentage	Count
East Midlands	11%	7
East of England	9%	6
London	12%	8
North East	4%	2
North West	15%	10
South Central	7%	5
South East Coast	7%	5
South West	13%	9
West Midlands	9%	6
Yorkshire & Humber	13%	9

The majority of responses were from directors of finance or deputy directors although responses were also received from PbR project leads, heads of financial planning and heads of costing.

Currencies
89% of respondents were aware of the currencies to be mandated from April 2012 but there were a few comments about how the clusters would be converted to national currencies.

There was a mixture of responses in terms of whether organisations had defined the packages of care that would be associated with each cluster as can be seen from the table below.

Has your organisation defined the packages of care that will be associated with each cluster?	Response Percent	Response Count
Yes for all	11.1%	7
Yes for some	49.2%	31
No	39.7%	25
	answered question	**63**
	skipped question	**6**

Comments suggested that work was complete or underway to establish clinical evidence bases to underpin the clusters.

Comments included:

'This is an area of detailed debate and a lot of clinical time is going into this to establish what each organisation.... Engagement with clinicians and commissioners locally on this issue is essential to get a good quality outcome... but as per other sectors there will need to be ongoing refinement over a number of years.'

The survey asked about the percentage of service users allocated to a cluster in the last 12 months and the following results were received:

What percentage of service users have been allocated to a cluster in the last 12 month period?	Response Percent	Response Count
Less than 50%	36.1%	22
51 - 75%	21.3%	13
76 - 90%	19.7%	12
Over 90%	18.0%	11
Don't know	4.9%	3
	answered question	**61**
	skipped question	**8**

Comments suggested that the clusters were being used mainly for new referrals to mental health services and that further work is required in relation to the accuracy of cluster allocation. Regular review and the development of compliance with care transition protocols would also be important.

For some organisations, identifying the active caseload i.e. when is a patient with multiple referrals genuinely discharged – had also proved difficult; however, over 50% of respondents anticipated having full coverage within 6 months and a further 35% anticipating full coverage within 12 months. The comments received highlighted concern that emphasis was being placed on clustering activity rather than on the quality of the clustered activity.

Costing of Clusters

The survey asked respondents to identify the extent of their costing of clusters. The survey identified that more than 50% of respondents have not completed any costing of clusters and the remainder have undertaken some costing work as shown in the table below.

Have you completed any costing of the clusters?	Response Percent	Response Count
Yes - detailed patient level bottom up costing carried out for all clusters	6.6%	4
Yes - detailed patient level bottom up costing carried out for some of the clusters	9.8%	6
Yes - high level top down costing for all clusters	11.5%	7
Yes - high level top down costing for some clusters	19.7%	12
No	52.5%	32
	answered question	**61**
	skipped question	**8**

Comments suggested that some organisations were waiting until they had achieved a higher percentage of clustering prior to costing.

Some respondents are working towards submitting the cluster based reference costs but are setting up a patient level costing system to support this process. Comments included:

"To date, we have only calculated community costs for clusters and are yet to include inpatient / crisis costs. We are part of the Care Pathways and Packages Project and are working in line with their methodology and timetable for calculating cluster costs."

"We have costed ... all clusters and have three quarters of information on cost analysis. Information can be analysed at a patient level. However, again this is subject to continuous review and improvement, and requires considerable review, analysis and refinement including assessment of variation, stability and consistency over periods."

For some organisations, initial results have raised concerns over the spread of costs for the same cluster. The allocation of activity to a small number of clusters suggests insufficient granularity to the clusters at present.

State of readiness

More than 75% of respondents described themselves 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 trust to be able to use the national currency in its 2012/13 contracts?	Response Percent	Response Count
Fully prepared	3.3%	2
Partially prepared	76.7%	46
Not prepared at all	20.0%	12
answered question		**60**
skipped question		**9**

It was noted that there is a need to improve the understanding of cost behaviour within clusters.

Comments included:

'Much will depend on what is meant by using national currency in 2012/13 contracts. I would consider this organisation to be among the most prepared but moving from current contracts to contracts based on currency on a full cost per case basis would be a hugely risky step for commissioners and providers. We aim to agree local arrangements for inclusion of currency in contracts for 2012/13.'

'The trust information systems are not sufficiently developed to support PLICs.'

Of the mental health providers taking part in the survey, 60% of organisations believed their commissioners to be partially prepared for the introduction of the mandated currency in 2012/13.

How would you describe the state of preparedness of your commissioner to be able to use the national currency in its 2012/13 contracts?	Response Percent	Response Count
Fully prepared	0.0%	0
Partially prepared	60.0%	36
Not prepared at all	40.0%	24
answered question		**60**
skipped question		**9**

However, given the current state of flux within commissioners the introduction of the new currency was likely to take a lower priority in the coming months.

Comments included:

'We are working closely with commissioners and local GP's to ensure they are involved in the development of the cluster pathways and tariff but it is a very challenging agenda with a short timescale and whilst commissioning arrangements are changing, some staff are engaged in the PbR development, though some know very little about it.'

'We have done work and are making slow progress but the jump towards using these prices in contracting is a very big one!'

Reference costs

The survey asked whether or not respondents were in a position to submit cluster-based reference costs in 2011. Although 90% of respondents were confident that they could submit cluster-based reference costs this summer, 60% said this is likely to be on a sample basis.

Will you be able to submit cluster-based reference costs this summer?	Response Percent	Response Count
Yes, fully	30.0%	18
Yes, but only on a sample basis	60.0%	36
No, not at all	10.0%	6
	answered question	**60**
	skipped question	**9**

The survey asked respondents to indicate key difficulties anticipated and comments indicated that clustering and therefore costing was likely to be incomplete for many organisations this year.

Comments included:

'A lot of assumptions will need to be made so not certain of the robustness.'

'Main reason for not submitting full coverage will be due to not having all patient activity allocated to clusters.'

'Problem will be how to deal with the varying cluster coverage through the year (and) relate it to a full year cost. The latest draft guidance I have seen requires the breakdown of the cluster costs across the old reference cost measures ... which will be difficult as we have been completely restructuring services to service the clusters & have been combining community/day care/outpatient activity to calculate a cost per day in treatment.'

Guidance

The survey asked respondents whether the current guidance available from the Department of Health was sufficient to support the development of mental health payment by results to which a negative response was received from 65% of respondents. Comments focused on the need for operational guidance as well as detailed costing cluster and contracting guidance.

'The guidance seems very top level with very little detailed guidance around such issues of inpatients, drug costs etc also it leaves open the possibility of some trusts shortcutting the process and just using top down apportionments for 100% of their prices. This surely would make any clustered reference costs and then national tariff of poorer quality.'

'Communication direct to PbR Leads not just reliant on leads picking up information from the website by chance.'

'There needs to be clarification on how the methodologies from different pilots (e.g. CPPP and West Midlands) will be brought together.'

Concerns were also raised in relation to the disparity in speed of implementation across England with some organisations moving much further towards implementation than others. Additional support would generally be welcome to support a consistent national approach to implementation including some best practice guidance.

Comments included:

'Trusts need much more clarity and guidance ... and more information sharing on approached being adopted by different sectors. At the moment there is a feeling that each organisation/cluster is doing its own thing as far as costing is concerned.'

'In the Acute Sector there was a clearly defined national project with resources attached and clear guidance about how each Trust submitted returns and how this would eventually become the acute national tariff. There does not appear to be the same sense of urgency or co-ordination of MH tariff ... A locally negotiated price is a step forward for many MH Trusts but perhaps the DH could describe how it expects locally determined tariffs to eventually be 'morphed' into a national price to attach to the currencies.'

'A stronger debate and more information shared on clusters and care pathways. Understanding this will help develop the pricing of the clusters. Also benchmark information from those organisations who have invested heavily in this work area.'

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 50% who were **not** confident that this would be in place, the reasons given included the following:

'We have not yet completed 12 months of cluster data in order to have a local tariff in place for next financial year we would need this data now for costing and sense-checking'

'Clustering is a very early stage, costing of clusters will be at an early stage, we will not have a true picture of the implications of clustering and the costs of service users in clusters in time to inform contract process for 2012/13.'

'The main difficulties in meeting the timetable are commissioner engagement and competing priorities (both for providers and commissioners). Trying to implement a new contract structure at a time where commissioning is going through a period of fundamental change is extremely challenging.'

'We intend to use a local tariff in shadow form in 12/13, due to the risk associated with it. The risk is due to not having large numbers of patients clustered until later this year, challenges in pulling data from our clinical information system, data quality issues, using a high level top down costing model to allocate costs to clusters.'

Commissioner involvement

86% of respondents stated that commissioners had been involved in the work on PbR with their organisations through joint project groups, regional workshops, joint meetings or joint programme boards. In addition, the survey identified that the implementation of a local tariff was a priority for more than 70% of respondents.

The survey also asked respondents to identify potential barriers to delivery in line with the DH timetable the results of which are as follows:

What are the key barriers in your organisation to delivery in line with the DH timetable?	Response Percent	Response Count
Poor data quality / collection	67.9%	36
Poor information systems	32.1%	17
Difficulties in developing a robust costing model	49.1%	26
Clinical engagement	32.1%	17
Competing priorities due to merger	28.3%	15
Other competing priorities e.g. time pressures	66.0%	35
Other	13.2%	7
	answered question	**53**
	skipped question	**16**

Responses given for 'other' included:

'Ensuring we have a cleanly agreed pathway to delivery which assesses risk and ensures that the currency supports effective service modernisation towards best practice rather than incentivising poor service delivery or locking in current blockages in the system. Use of the tool as a tool to support service improvement and understand resource utilisation is more important than simply introducing a tariff.'

'I think we have got clinical engagement, but a culture change does take quite a long time to embed. We ... are working on our information and quality data collection, we have invested in training but with the timing of clustering tool and pathway development we are seeing that additional training and change of practise needs to be embedded. Pressure in terms of ... structural changes has limited the resource available for PbR.'

National tariff

More than 70% of respondents supported the introduction of a national tariff to mental health services:

Do you support the introduction of a national tariff?	Response Percent	Response Count
Yes	70.9%	39
No	29.1%	16
	answered question	**55**
	skipped question	**14**

Additional comments included highlighting the need for a national framework but within which there is some flexibility for local tariffs to meet the needs of local populations and for innovation.

Comments included:

'I support the robustness of this approach and the ability to benchmark and also the potential of some protection to mental health funding and protection which national tariff will offer for efficient providers. However, I do not believe the current clusters are fully supported and not enough has been done to link explicitly with best practice guidelines.'

'It allows real dialogue with commissioners about level of service delivery and links with activity/income for the first time in any meaningful way; particularly in the current financial climate when simple block contracts leave providers open to swingeing cuts with no understanding of impact on services.'

'It is absolutely essential for mental health in order to drive standardisation of practice, lever efficiency, focus on quality not price and ensure true comparability of services.'

The survey then asked what needs to happen to achieve the successful implementation of a national tariff. The responses included the following points:

- Further guidance from the DH in relation to the national framework for the tariff
- Detailed analysis of activity and costs from the service in conjunction with work on best practice pathways
- National co-ordination and consistency
- Further clinical engagement to ensure any national tariff does not undermine new ways of working and funding plans of both providers and commissioners
- An audit of locally agreed prices to determine the most robust and realistic costing methodology. Region wide pilots should then be established to test the proposed methodology and prices before providing feedback to the DH
- Lessons learnt from pilot sites should be shared and tariffs amended on reflection before it is rolled out
- Finance and clinicians working closely together to ensure the national tariff relates to a national pathway for each cluster.

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 currency in 2012/13 should a national tariff be introduced?	Response Percent	Response Count
One year	10.5%	4
One to three years	71.1%	27
More than three years	21.1%	8
	answered question	**38**
	skipped question	**31**

It was suggested that the timeline should be reviewed following the reference cost collection in 2011.

Comments included:

'There is a need to have the tariff operating locally for a couple of years to see whether it is fit for purpose. Nationally set prices should be introduced on a transitional basis, as with Acute PbR, in order to allow providers and commissioners sufficient time to adjust their income base.'

Less than 30% of respondents did not support the introduction of a national tariff; the reasons cited for this were as follows:

'Until the mental health assessment tool is embedded and validated I am not sure that we would have a robust enough national data set to implement a national tariff. The income baselines of most MH trusts are based on historic block contracts - given there will be quite a lot of variation between providers which will be compounded by data quality variances this will potentially cause significant financial risk in the system which is not going to be underwritten as the acute implementation was. In these circumstances I cannot see any advantage of having a national tariff.'

'It would introduce financial instability at a very difficult time with no real benefit for the people who use our services. I am also concerned that data quality across MH is so poor that too many organisations are currently estimating activity levels (leading to over inflated estimates and prices being too low) and / or are not collecting all activity data leading to prices being too high - this will then jeopardise commissioners when Trusts become 'better' at collecting data.'

Suggestions as to what could be introduced instead included local negotiation with some national tariff on elements of the cluster i.e. bed day price.; using the MH assessment tool and clustering to create pathway currencies with indicative costs and the use of transition protocols to ensure the best level of base information.

The role of HFMA

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

The majority of respondents suggested promoting the sharing of best practice and information through regional workshops, a 'Frequently Asked Question' section on the website linking to all the current guidance. This would help to highlight major issues with MH PbR which are still to be resolved and key decisions which need to be made either at a national or local level. A learning and development role may also exist in relation to the provision of technical courses on costing, collecting data and sharing benchmarking information. This could also include training for clinicians.

It was also suggested that HFMA could influence the national agenda by engaging with finance staff and presenting suggested solutions to key decision makers. This could include input to the development of the relevant guidance.

Conclusions

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

- The majority of respondents to the survey are in favour of mental health PbR
- There are concerns over the timetable for introduction. If it is introduced too early it could have unintended consequences at a time when existing relationships between commissioners and providers may not be relied upon to manage the risks
- There are concerns over the current quality and consistency of data
- More guidance is needed to clarify many of the issues including standard interventions, costing methodology and utilisation of clustering in contracts
- There needs to be some flexibility to take account of local factors in order to meet the needs of local populations and to encourage innovation