Department of Health

Department of Health

Payment by Results Mental Health Guidance Response Proforma

Issued: 6 October 2011

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(feedback to be sent to pbrcomms@dh.gsi.gov.uk
using this proforma and by this date)

Respondent Details

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Organisation	Healthcare Financial Management Association This response represents the views of our Mental Health Faculty – a group established by the HFMA to provide a forum for finance specialists in mental health trusts to share ideas and experience and develop practical guidance.
Your Role	Technical Editor
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Date of response	3 November

Feedback on the draft mental health guidance

Section: Introduction	
Please use the spaces below to feedback comments on the introduction to the guidance.	
Paragraph number(s)	**Comments**
2	The faculty recognises the deadline for all service users to be clustered by 31 December. However as some clients are seen on an annual basis this cohort are unlikely to be clustered by the deadline. It would be helpful if the guidance could outline what if any are the likely consequences of having un-clustered activity by this date.
3	The faculty is also aware that not all organisations will be in a position to contract with agreed local prices for 2012/13. In our view, it is preferable to operate in shadow form in these circumstances with work ongoing to finalise local prices than set precedents on incomplete data and analysis. It would be helpful if the guidance could clarify the arrangements which need to be in place if this situation rises.
4	The faculty welcomes the clarity provided by the guidance here in establishing what is required for 2012/13. We feel that this could be strengthened by stating that where developing local prices is difficult due to the lack of clustered data organisations will have clear plans and agreed timescales for how and when this will be resolved. While acknowledging the local and national issues in relation to data quality, a number of organisations represented within the faculty have tailored their approach to providing the information needed to support the contracting process for 2012/13. For example, one organisation is using cost and activity data for the 6 months to 30 September 2011 analysed on the same basis as 2010/11 reference costs. It is anticipated that this will provide a more accurate and complete data set for discussion of contracting arrangements.
5	The faculty feels that it would be helpful if this paragraph could also refer to the payments for assessment service work which will need to be monitored. We would like to suggest the following: 'They will also need to monitor the costs of initial assessments including assessment service work, for which there will be a separate payment.'
6	The faculty notes the starting point for local prices in 2012/13 being the reference costs for clustered and non-clustered activity adjusted by the appropriate tariff uplift. The faculty would welcome additional guidance to support the transition to single local price per cluster in order to minimise the potential destabilising impact of moving from block contracts to payments related to activity. In addition, as foundation trusts are required to make a surplus we would welcome further guidance to assist with ensuring that a reasonable surplus can be maintained by foundation trust providers and Monitor risk ratings remain unaffected.
7	The HFMA mental health faculty welcomes the support given to the importance of data quality within the guidance. We would also like to draw attention to the work of the HFMA's Costing Committee in developing the mental health clinical costing standards for 2012/13. The work of this group

	will assist with the consistent attribution of costs to clusters and therefore the advance of data quality underpinning PbR.
9	The faculty welcomes the inclusion of the requirement for existing commissioners to engage with clinical commissioning groups as they become established and would suggest that this is strengthened within the guidance to emphasise its importance.
10	The faculty recognises that a move to a national tariff is the ultimate objective, however concerns have been raised that more robust testing would be helpful before this step is taken. The mental health reference costs have not been subject to the same level of scrutiny as the acute reference costs, and a level of assurance would be beneficial before these decisions are taken.
11	It may be helpful here to add a reference to the metrics recommended in the outcomes strategy which could form a baseline for commissioners and providers to link outcomes to clusters.

Section: Mental health clustering tool

Please use the spaces below to feedback comments on the mental health clustering tool section of the guidance.

Paragraph number(s)	Comments
13	The faculty raised some concerns that cluster 0 may be used as an 'opt out' for clinicians who may wish to resist the introduction of PbR. The faculty would also welcome additional guidance in relation to the way in which cluster 0 data will need to be analysed by commissioners and providers to support their discussions. It would also be helpful if the guidance here could read '…If no match is possible but the service user requires treatment…'
15	The faculty welcomes the development of the national algorithm and an estimated date of availability would be helpful at this stage.
16	As the quality and outcomes work is likely to recommend the use of the mental health clustering tool at all points including discharge it may be helpful in this paragraph to advise that this is undertaken as a matter of course.

Section: Care clusters

Please use the spaces below to feedback comments on the care clusters section of the guidance.

Paragraph number(s)	Comments
19	As the currency is based on the characteristics of a service user rather than diagnosis and therefore involves a professional opinion, we welcome the introduction of a nationally led assurance process (paragraph 15).
21	The faculty welcomes the development of the web-based tool and an estimated date of availability would be helpful at this stage.
23	In our view, further clarity in relation to the definitions to be used would be helpful, particularly in relation to the distinction between 'cluster episode' (paragraph 23), 'cluster payment period' (paragraph 52) and 'cluster duration'.
24	One trust within the faculty has identified that some people are treated in the inpatient setting in a number of clusters. This may have a significant impact

	on the distribution of price in a cluster, making the average price less meaningful; it would be helpful to reflect this in the guidance. The faculty has also raised the potential wider issue whereby clinicians could assign a service user to a higher cluster to increase income and it may be helpful therefore to strengthen the reference the PbR Code of Conduct within the guidance.

Section: Cluster payment periods	
Please use the spaces below to feedback comments on the cluster payment periods section of the guidance.	
Paragraph number(s)	**Comments**
26	In order to support the payment principles outlined, the faculty would welcome further clarification in relation to activity reporting by providers to commissioners. It would be helpful to understand if arrangements are likely to be determined nationally or whether local arrangements must be put in place. In addition, the faculty would welcome further clarification in relation to the word 'activity' here. For example, activity could be taken to mean occupied bed day or community face to face contact, or even an open case in cluster 4.
27	The table reference number is missing from the paragraph. The faculty would like to identify that for some organisations where current clinical working practice does not meet a prescribed cluster review interval, changing working practices within existing contract values may increase a provider's costs in the first instance.

Section: Initial assessment	
Please use the spaces below to feedback comments on the initial assessment section of the guidance.	
Paragraph number(s)	**Comments**
29-34	The mental health faculty welcomes this section of the draft guidance as it ensures that provider organisations will be funded for a large part of their activity. It is anticipated that this clear guidance will support organisations in developing new assessment/primary care liaison services with the confidence that funding will follow real time activity. However, many primary care services are aimed at preventing the need to access secondary care and it would be helpful if the guidance could clarify whether such activity is to be charged separately or included as an overhead on cluster costs. The faculty does recognise that organisations will need to be more sophisticated in their costing of assessments to support service developments. It may be helpful to define the initial assessment as relating to all contacts up to point at which the service user is allocated to a cluster (paragraph 31).

Section: What is an initial assessment	
Please use the spaces below to feedback comments on the what is an initial assessment section of the guidance.	
Paragraph number(s)	**Comments**

29 a	The faculty suggests that this should be entitled 'Assessed, Not clustered and Discharged'.
29 b	Although the faculty welcomes the clarity provided here, it recognises that a risk of duplicate charging exists where organisations are unable to clearly identify an initial assessment as compared to an ongoing assessment. Therefore, the faculty would suggest that the extent of progress to change information systems needed during 2012/13 be clearly identified to support the transition.
29 c	The faculty suggests that this paragraph would benefit from greater clarity in relation to what might constitute an assessment service, while recognising that they will vary by health economy. For example, in addition to GP input it may also include the majority of work undertaken by primary care link/ liaison teams and dementia workers; therefore, the inclusion of likely examples would be helpful. In relation to the prevention of payments for uncontrolled activity one solution could be the application of a cap on the number of contacts recorded before the service user becomes clustered.

Section: Duration of initial assessments	
Please use the spaces below to feedback comments on the duration of initial assessments section of the guidance.	
Paragraph number(s)	**Comments**
31	The faculty welcomes the clarity provided by the inclusion of this paragraph within the guidance, recognising the need to distinguish between the initial and ongoing assessment. As the latter should be part of the ongoing care of the service user it will be recognised in the total cost of the specific cluster care package. However, some concern has been raised in relation to the time taken to assess and cluster complex service users. In many complex cases the duration of assessment may exceed the 28 days that are aimed for under the care programme approach and the MHMDS. This would also be compromised by those service users failing to attend their first appointment. It would therefore be unlikely that all 'Assessed and clustered' service users would clustered within 28 days. Similarly, the mental health clustering tool and cluster allocation may be undertaken before the complete/comprehensive assessment is completed. Consequently, the faculty would welcome any further clarification which is possible at this stage of development.

Section: Funding initial assessment	
Please use the spaces below to feedback comments on the funding initial assessment section of the guidance.	
Paragraph number(s)	**Comments**
32	The faculty suggests that the initial assessment work could be categorised as a 'pre cluster tariff' to emphasise the distinction from the 21 clusters in terms of funding, the latter relating to treatment interventions once a mental health need has been identified.

	The guidance would also be strengthened by requiring providers to clearly identify those initial assessments involving specialist tests for example, MRI scans in order to support appropriate reimbursement.

Section: Existing service users	
Please use the spaces below to feedback comments on the existing service users section of the guidance.	
Paragraph number(s)	**Comments**
34/ Table 1	The faculty suggests that the cluster review period for clusters 18 and 21 may be extended from 6 to 12 months in line with long term residential care and memory services although we note that the option to review earlier exists under the requirement 'any reassessment following a significant change in need'.

Section: Pricing assessments	
Please use the spaces below to feedback comments on the pricing assessments section of the guidance.	
Paragraph number(s)	**Comments**
35	The faculty welcomes the requirement for the publication of prices for initial assessments. However, we would suggest that the guidance could be usefully enhanced by identifying the format and location of the information to be published.

Section: Clusters as contract currency	
Please use the spaces below to feedback comments on the clusters as contract currency section of the guidance.	
Paragraph number(s)	**Comments**
37	In our view it would be helpful for the guidance to emphasise that each cluster must have a care package(s) within it and confirm a milestone date for these to be in place.
38	The faculty has identified a number of potential issues in relation to this paragraph of the guidance: • The 'lead provider' model may enable large providers to control third sector organisations through sub contracting service provision thereby reducing the identity of the third sector provider • The 'principal provider' model may be very complex to operate as many care packages could be delivered across a number of providers. Some smaller third sector groups do not have the information and finance infrastructure to track and invoice at this level of detail • If a large organisation strove to be the lead provider it would be very difficult for the partner organisations to cost the elements of care outside of their own services.
39	The faculty welcomes the recognition given by the draft guidance in relation to multiple providers of mental health care. However, it would welcome further clarity as to how this would work in practice in the absence of

	unbundling; the current proposal could unduly complicate the payment and reconciliation process.
41	The faculty recognises the importance of understanding the total cost of the care packages across health and social care providers particularly as many teams are integrated and many care packages contain both health and social care funded interventions. However we would welcome further clarity in the guidance as to the treatment of social care funding as part of a pooled budget arrangement and where social workers are integrated into community mental health teams. Where joint teams are in place, it may be necessary to identify which member of staff provided care to a service user to generate the information necessary to support contract negotiations. We would suggest that until greater clarity is available in relation to social care funding, section 75 funding could be entirely excluded. In addition, we would like to draw attention to the work of the HFMA's Costing Committee in developing the mental health clinical costing standards for 2012/13. The work of this group will assist with the consistent attribution of costs to clusters.
43	In our view, it would be helpful if the guidance identified the need for providers to quickly establish and agree with commissioners what should be outside of the core cluster payment arrangements for 2012/13.

Section: Quality and outcomes	
Please use the spaces below to feedback comments on the quality and outcomes section of the guidance.	
Paragraph number(s)	**Comments**
44	The faculty would welcome the early release of any further guidance in relation to quality and outcomes. The faculty is aware that providers and commissioners need to agree a number of service specific quality measures and that those agreed need to be highly effective. We would therefore welcome an emphasis on outcome measures related to service user satisfaction.
45	It may be helpful here to recommend the use of the quality and outcome metrics within the report as a minimum approach while more local approaches are developed. It would also be helpful to understand if the discharge criteria forming part of the Transition Protocols are likely to be included as expected outcome measures.
47	The faculty would welcome the inclusion of examples within the guidance as to how CQUIN may be effectively applied to mental health services.

Section: Clusters and IAPT	
Please use the spaces below to feedback comments on the clusters and IAPT section of the guidance.	
Paragraph number(s)	**Comments**
48-49	

Section: Exclusions	
Please use the spaces below to feedback comments on the exclusions section of the guidance.	
Paragraph number(s)	**Comments**
50	The faculty would welcome further consideration in relation to the role of GPs with mental health service users. One faculty member has identified that some commissioners are looking for GPs to manage more mental health service users in primary care. This may include longer term service users and as such would involve the service user being re-clustered within primary care. This may work for some of the longer term shared care groups in 11 and 12 where only an annual review is required but is likely to be more challenging in clusters 1 and 2 where there is a much shorter cluster review period.
51	The HFMA's mental health faculty welcomes the inclusion of the list of excluded services from the clusters however, members have identified a number of other services which they feel should also be incorporated: o Specialised Mental Health Services for Deaf People o Specialised Addiction Services o Specialist Psychological Therapies - inpatient and specialised outpatient o Peri-natal Psychiatric Services (Mother and Baby Units) o Complex and/or Treatment Resistant Disorders o Asperger's Syndrome. We also feel that it is important for the list of exclusions to be clearly defined and not open to local interpretation during contract negotiations.

Section: Non-contract activity	
Please use the spaces below to feedback comments on the non-contract activity section of the guidance.	
Paragraph number(s)	**Comments**
52	The faculty would welcome more detailed guidance in this area. In our view as providers will not have agreements with commissioners out of their local health economy the price to be charged could therefore cause an issue. One suggestion is that this move is deferred until national tariffs are in place. Alternatively, the guidance could reflect the use of a current bed day price where an agreement on the price of care cannot be reached. The faculty recognises that the budgets for non-contract activity currently sit with commissioners rather than existing providers. The proposed cross charging between providers in 2012/13 would require an increase in contracts values to recognise additional expenditure on non-contract activity. Cross charging may result in a scenario whereby a second provider re-clusters a service user to a cluster which attracts a higher price than the original cluster; the initial provider will not have received sufficient income for the reimbursement. Alternatively the commissioner could change the provider being paid for the care actually being delivered by stopping payment to the

	previous provider and re-commencing payment to the new provider. The faculty also recognises that many organisations will need to improve their information recording and reporting in relation to non-contract activity in terms of both sending people out of area and people using local services from elsewhere in the country. Current information and data sets enable providers to establish who the responsible commissioner is based primarily on the service user's GP. However it is not possible to establish the current provider for a service user who is out of their normal area.

Section: Interaction between care cluster and acute HRGs

Please use the spaces below to feedback comments on the interaction between care cluster and acute HRGs section of the guidance.

Paragraph number(s)	Comments
55	The faculty raised concerns in relation to the potential for duplicate payments to be made where a mental health service user may undergo an acute spell of care. The commissioner may pay twice for the service user (as a cluster payment and through an acute HRG) and information systems will need to be able to identify this detail to avoid duplicate payments. In our view it would be helpful if the guidance could be expanded to reflect how trusts should demonstrate the extra care being provided and be able to identify that it has been delivered.
56	As in the response to paragraph 55 above, further guidance would be helpful for commissioners as to how they might ensure that the care required is being delivered. The arrangements put in place will need to be agreed by both commissioners and providers as part of the contract negotiations.

Section: Data sources for Commissioners

Please use the spaces below to feedback comments on the interaction between care cluster and acute HRGs section of the guidance.

Paragraph number(s)	Comments
58	Access to the portal is clearly vital for commissioners and providers but concerns were raised within the faculty as to whether all providers will have the necessary access.

General comments

Please use the spaces below to feedback any general comments on the guidance that do not relate to specific sections. For example, are there issues that need to be covered in the guidance that do not appear in this draft? Please add extra lines as necessary.

Issue	Comments
State of readiness	The HFMA's mental health faculty welcomes the draft guidance which has proved to be very helpful to its members. However, in our view the guidance could be usefully expanded to reflect what

	trusts must have in place for 2012/13 and what is realistically expected to be under development at that point. This is particularly pertinent where third or independent organisations are involved. A checklist for this information would be most helpful. This will allow trusts who are behind the ideal trajectory to have a constructive dialogue with commissioners as to where priorities should be focused in the remainder of 2011/12.
Supporting information systems	The implementation of PbR to mental health services will need to be supported by robust finance and information systems. The faculty would welcome further guidance as to how these systems need to be developed to support the introduction of the payment mechanism. We have highlighted some specific examples in our response above.
Communication	The draft guidance has been well received by faculty members. We would welcome regular progress updates over the coming months which can continue to reinforce the purpose and expected benefits of developing the new currency.

Equality	
Do any of these proposals have either a negative or positive impact on equality in relation to disability, ethnicity, gender, sexual orientation, age, religion, socio-economic status, human rights or belief.	
Issue	**Comments**
Disability allowance.	One faculty member has raised an issue in relation to service users receiving disability allowance as follows: The transfer of a service user to primary care may wrongly be assessed as the service user recovering. There is a risk that a service user receiving this benefit may have it reduced or removed if a transfer to primary care is misinterpreted as an assumption that they have recovered .This is not always the case as many will still have long term conditions with high levels of disability, albeit that this can be managed in a primary care setting.

WHERE TO SEND YOUR COMPLETED RESPONSE PROFORMA

Completed response proformas should be returned by close of business on 4 November by email to: pbrcomms@dh.gsi.gov.uk

To support our processing of the responses, please add the words “Mental Health Guidance feedback” to the subject heading when e-mailing your completed response proforma.