Monitor
Making the health sector work for patients

NHS England

Guidance on mental health currencies and payment

A supporting document for the 2016/17 National Tariff Payment System: A consultation notice

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Contents

1. Introduction

This guidance supports Section 6 of the 2016/17 National Tariff Payment System and replaces the previous *Guidance on mental health currencies and payment: a supporting document of 2015/16 National Tariff Payment System*.[1] It sets out:

- how payment can support the vision for mental health services
- guidance on local payment rules covering mental healthcare
- building blocks needed to support payment development for mental healthcare for 2016/17 and beyond.

2. Role of the payment system in delivering the vision for mental healthcare

Mental health is an integral part of the healthcare system in England and has a fundamental role in supporting the objectives set out in the Five Year Forward View (5YFV). Providers and commissioners need to develop and implement payment approaches that support access to effective and efficient care that meets patients' needs and delivers outcomes they value. To ensure this care is delivered, providers and commissioners must draw on the evidence base.

Commissioners and providers will continue to agree prices for mental healthcare locally. We recognise that mental healthcare needs may differ across different local areas in England, as will local structures for care delivery and the levels of investment in support services by local authorities. As such, national prices for mental healthcare may be neither desirable nor appropriate.

Collaboration between providers and commissioners is needed in 2016/17 to enable the development of new payment approaches that effectively and sustainably support population needs. Objectives include:

Agreement of transparent payment arrangements for mental healthcare based on accurate and up-to-date data, information and evidence. Greater transparency in the payment approach helps providers and commissioners to:

- identify the local population's healthcare needs
- consider what service design and resource use will meet those needs in the most efficient and effective way
- make clear the expected quality of care and accountability for service delivery between commissioners and providers

[1] Available at: www.gov.uk/government/consultations/national-tariff-payment-system-201516-a-consultation-notice

- facilitate and enable constructive, evidence-based discussions between commissioners and providers
- highlight potential investment needs and workforce requirements to deliver effective and evidence-based care
- develop robust local payment arrangements that reflect costs and demand.

Delivery of evidence-based care and mental health access and wait-time standards: Timely access to evidence-based care (at a minimum this is National Institute of Health and Care Excellence (NICE)-concordant care) improves patient outcomes. This may also have long-term benefits for the local health economy as patients have a faster and more sustained recovery, resulting in reduced premature mortality.[2] This can lead to reduced use of hospital services[3] and improved employment rates.[4] Providers and commissioners should ensure their payment arrangements support holistic, integrated and evidence-based care for the biological, psychological and social (biopsychosocial) issues related to mental ill health. Care should be provided in the least restrictive setting and as close to a patient's home as possible. It must also be delivered to meet each of the new access and wait-time standards, as they are introduced.

Delivery of integrated and co-ordinated healthcare: The biopsychosocial needs of people with mental ill health must be supported by the chosen local payment approach. Mental healthcare providers and commissioners need to develop payment approaches that support greater integration of mental healthcare with physical healthcare, community healthcare and social care. This will help ensure people with complex care needs receive co-ordinated care, even when care pathways span different providers and care settings. The exact model adopted for co-ordination and integration will depend on the needs of the local population. Such co-ordination of care should extend beyond healthcare to include government and community services (eg debt advice) that can support mental wellbeing.

2.1. How to build a more transparent payment system for mental health services

To deliver the objectives above, providers and commissioners need to ensure a number of 'building blocks' are in place. These include:

- **accurate data collection, reporting and analysis** – to inform better understanding of patients' needs, service design and payment development. It

[2] Further information can be found at: www.rethink.org/media/973932/LOST%20GENERATION%20-%20Rethink%20Mental%20Illness%20report.pdf
[3] National Institute for Health and Care Excellence, 2014. *Costing statement: Psychosis and schizophrenia in adults: treatment and management*
[4] www.gov.uk/government/uploads/system/uploads/attachment_data/file/273433/psychological-wellbeing-and-work.pdf

should include a robust population needs assessment, benchmarking of current access, quality and productivity. This will ensure local areas have the data they need to inform strategic planning and operational decision-making processes[5]

- **development and use of quality and outcomes measures** – to measure the benefit of the care provided, and support the objectives of the 5YFV and the standards set by the National Quality Board
- **full implementation and use of mental healthcare clusters** (including diagnosis recording) – to capture the level of patient need and provide a basis to categorise costs, care and activity
- **patient-level costs and activity** – to develop accurate and bottom-up local prices for mental health services.

Further details on developing these building blocks and how they can support payment development are given in Section 4.

Providers and commissioners must develop their local payment approaches in accordance with the local payment rules and principles for mental health – further information is given in Section 3.

Poorly specified and unaccountable block contracts do not incentivise the delivery of quality care or continuity of care, or enable effective patient choice or personalisation (eg personal health budgets). In addition, they do not make it easy to identify what services are being delivered, what outcomes are being achieved or what it costs to deliver effective and efficient services.

Consistent with the rules, providers and commissioners should not use poorly specified and unaccountable block contracts. Contracts must be based on up-to-date data, information and evidence. Such information should be used to understand local population needs and demonstrate how the agreement effectively and efficiently meets those needs. Contracts should specify which organisation is accountable for delivering the services and achieving the specified quality and patient outcomes. Commissioners should ensure alignment of services across the care pathways for patients so that, for example, they can access the appropriate standards of care wherever they are treated.

2.2. Payment for mental health

Providers and commissioners must develop transparent, evidence-based payment arrangements that ensure the care needs of the local health economy are met, and support the objectives set out in the 5YFV. Where possible, in 2016/17 providers and commissioners should implement or shadow-test payment approaches based on an

[5] This should also inform the development of the Joint Strategic Needs Assessment.

episodic/year of care or a capitated payment approach. The local payment rules and principles allow providers and commissioners to do this.

- **Episodic payment approach**: This is the payment of an agreed price for all healthcare provided to a patient during an episode of treatment. The price paid depends on what a patient is treated for and any complicating factors they may have. For those with long-term needs, payment may be based on a year of care.

- **Capitated payment approach**: This is the payment to a provider or group of providers to cover a range of care for a population across a number of different care settings. Payments are made on a per person basis and are risk-adjusted to reflect the different needs of people with mental ill health.

Any payment approach for mental healthcare should have a component linked to achieving agreed quality and outcomes measures. This ensures providers remain directly accountable for providing evidence-based, patient-centred care.

As noted, prices for mental healthcare will continue to be agreed locally between providers and commissioners. It is difficult and may not be desirable to set national prices for mental healthcare for a number of reasons. These include differential investment in prevention programmes, social care and other essential local government services, eg housing, education, employment, debt management, community safety, local authority-commissioned alcohol and drug services; and lack of standardisation in the delivered care packages. However, a wealth of data/information is available to support providers and commissioners. This includes information on population needs, high impact prevention strategies for groups at highest risk, current levels of access to mental health services, care quality, spend for primary and specialist services, reference costs data, Mental Health Services Data Set[6] (MHSDS), NHS Benchmarking Network and locally developed data fields.

It is important to note that payment based on cluster should not mean payment based on individual appointments and/or cluster days, which would not incentivise patient-centred, evidence-based care. However, the initial assessment used to assign someone to a cluster or refer them to other services should be reimbursed separately.

[6] Formally known as the Mental Health Learning Disabilities Data Set (MHLDDS).

To support providers and commissioners to develop and implement these payment approaches locally, Monitor and NHS England have published two short guides to payment development, outlining the necessary steps to an episodic/year of care or capitated payment approach. These are non-technical in nature and appropriate for most stakeholders. We are developing more technical documents suitable for stakeholders within provider and commissioning organisations with finance, contracting and/or technical payment expertise.

Short guides and detailed guidance on developing episodic/year of care and capitated payment approaches can be found on our website[7]

Monitor and NHS England have also published several local payment examples: on outcomes-based payment for mental healthcare, developing capitated payment approaches, and multilateral gain and loss share arrangements. Providers and commissioners can use this practical information to implement payment approaches that best meet the needs of their local health economy.[9]

Local payment examples and other guidance can be found on our website[8]

3. Local payment rules and principles for mental healthcare

Key messages: Monitor has updated the local payment rules covering mental healthcare to clarify what is required of the sector. We are offering support to providers and undertaking audits to ensure adherence to these rules and principles.

3.1. Local payment rules and principles for all providers and commissioners

All mental healthcare providers and commissioners must adhere to the local payment rules and the principles set out in Section 6 of the 2016/17 National Tariff Payment System.

Further information: Section 6 of the 2016/17 National Tariff Payment System for the local payment rules and principles for setting local prices for mental health

Consistent with the local payment principles, providers and commissioners must ensure any payment approach is in patients' best interests; promotes delivery of evidence-based care (at a minimum this is NICE-concordant care); drives transparency and accountability; and encourages the

[7] www.gov.uk/guidance/new-payment-approaches-for-mental-health-services
[8] www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models
[9] Local payment examples are available at: www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models

sharing of best practice. Providers and commissioners must also work constructively to agree local payment arrangements. They should involve patients, clinicians and other relevant organisations in understanding local needs and developing the care packages and outcomes measures used to inform the local payment arrangements.

In addition, all providers and commissioners of mental health services covered by the mandatory currencies (care clusters) must comply with three mental health-specific rules:

- **Rule 8**: This requires providers to cluster patients using the Mental Health Clustering Tool (MHCT) and the *Mental health clustering booklet*. This can be downloaded from Annex 6 of this document and is also available to download from Annex B4 of the 2016/17 National Tariff Payment System.
- **Rule 9**: This requires all providers and commissioners of adult and older people's mental healthcare to agree local prices based on the care clusters, unless an alternative payment approach better meets the needs of patients. For example, a capitated payment approach could be agreed. Providers and commissioners must also ensure that any payment approach enables patient choice.
- **Rule 10**: This requires providers to submit care cluster data to the Health & Social Care Information Centre (HSCIC) and local cluster prices to Monitor. This rule also requires both providers and commissioners to agree and monitor quality indicators for the mental healthcare clusters. These may be based on existing data flows and/or on locally developed quality measures. These quality measures may also be linked to payment.

As noted above, the current local payment rules for mental healthcare permit providers and commissioners to adopt an episodic/year of care or a capitated payment approach. On 20 October 2015[10] we proposed introducing these payment approaches as part of the requirements outlined in the 2016/17 local payment rules. Sector feedback was supportive of these proposals, but the sector was concerned about its ability to implement new payment arrangements in 2016/17.

We considered this feedback and plan to put forward the rule changes proposed in the 20 October 2015 consultation letter in the statutory consultation for the 2017/18 tariff. However, where providers and commissioners can move forward with implementation (or implementation in shadow form) in 2016/17, we believe they should do so. Where providers and commissioners need to put supporting elements in place, they should do so in 2016 to ensure implementation of one of the payment proposals by April 2017.

[10] The consultation letter is available at: www.gov.uk/guidance/new-payment-approaches-for-mental-health-services#proposed-changes-to-local-payment-rules-covering-mental-health-services

3.2. Monitor's enforcement and compliance policy and trust audits

During 2016/17, Monitor will undertake a series of audits of mental healthcare providers to assess compliance with Section 6 of the 2016/17 National Tariff Payment System. These audits will help identify the quality of data recording and adherence to the local payment rules and principles. Where we identify concerns we may undertake further enquiries and, if appropriate, begin investigations with a view to taking enforcement action. For further information see our *Guidance on how Monitor will approach breaches of pricing requirements*.[11]

3.3. Mental health access and wait-time standards

Providers and commissioners must put in place provisions to meet the following mental health access and wait-time standards by 1 April 2016:

- more than 50% of people experiencing a first episode of psychosis begin treatment with a NICE-approved care package within two weeks of referral[12]
- 75% of people referred to the Improving Access to Psychological Therapies (IAPT) programme treated within six weeks of referral, and 95% within 18 weeks of referral. This standard applies to adults only.

Since 2015/16, the Care Quality Commission (CQC) ratings for acute services have included a focus on liaison mental health services and mental healthcare, as well as the quality of treatment and care for physical conditions delivered to those with mental ill health.

Any payment approach for mental health services must support delivery of the access and wait-time standards. The joint planning guidance, *Forward view into action 2015/16,* made clear the requirement that commissioners agree robust implementation plans with providers as part of their 2015/16 contract development work.[2]

In addition, NHS England is developing access and wait-time standards for Child and Adolescent Mental Health Services (CAMHS) and Eating disorders; this will be baselined in 2016/17. As new pathways of care and access standards are developed and introduced for mental health, commissioners and providers must implement these as required.

[11] Available at: www.gov.uk/government/collections/the-nhs-payment-system-regulating-prices-for-nhs-funded-healthcare#2016-17-payment-system

[12] Resources for CCGs are available at: www.england.nhs.uk/resources/resources-for-ccgs/

4. Local building blocks needed for mental health

Key messages: Providers and commissioners need to ensure essential building blocks are in place to support new payment approaches for mental health. This includes understanding and improving existing building blocks, and developing necessary elements that are not already in place.

To locally deliver the objectives set out in the 5YFV, providers and commissioners must understand their current service model, assess the value this brings to patients and enable a culture of continual improvement. This involves having the data and evidence to understand patient need and the outcomes that are being achieved. In turn it will inform the development of appropriate evidence-based care, increase understanding of the cost of delivering that care, and facilitate local price setting. Providers and commissioners need to take steps in 2016/17 to ensure they have this understanding. Key building blocks include:

1. **data**: robust, quality-assured submissions to the MHSDS via HSCIC, data analysis, sharing of results to drive both data and care quality from 'board to ward', and benchmarking against nationally available data
2. **patient outcomes and quality**: develop and improve quality and patient outcomes measures, and link these to payment
3. **mental healthcare clusters**: ensure mental healthcare clusters are used and continue to test and develop additional mental healthcare currencies
4. **costs**: improve quality and understanding of provider costs, costing practices and processes – including improving reference costs data. Cost and relative outcomes of different care options should also be understood. A better understanding of costs can be achieved by developing and implementing patient-level information costing systems (PLICS).

Local need, which should underpin the commissioning of mental health services, should be robustly assessed using the Joint Strategic Needs Assessment (JSNA) tool. It should also be informed by the use of the Commissioning Intelligence Self-Assessment Tool[13] and supported by robust equalities impact assessment.

Providers and commissioners should already be working to ensure strong governance and collaborative local relationships are embedded in all local health economies. They should involve people who use mental health services, frontline clinical staff, and other relevant organisations and stakeholders (eg health and wellbeing boards, local authorities, third-party organisations and carers).

[13] www.england.nhs.uk/resources/resources-for-ccgs/commissioning-intelligence/

We recognise that many in the sector have made progress in developing and implementing some or all of the building blocks needed. Even where data and processes still require further development, experience from the sector illustrates that they can (and should) still be used to inform improvements to care and payment development in 2016/17.

4.1. Data collection, reporting and analysis

Accurate data collection, reporting and analysis can offer significant opportunities for both providers and commissioners to understand and improve services and patient outcomes, and to identify the value of what is being achieved. It is essential that both providers and commissioners use data and accurate information to understand and address patient needs, including to:

- inform service transformation
- improve quality of care and patient outcomes
- evaluate the wider impacts of proposed commissioning models
- monitor and manage performance and risks
- develop local payment approaches.

Sources of data and information to increase understanding of local patient needs and care delivery include, but should not be limited to, MHSDS, Office for National Statistics, NHS Data Catalogue, frontline staff, emergency services (eg police and fire), employers, schools/universities and local communities. Together, these can give a rich picture of the local population needs (including unmet needs) and reveal opportunities for improved care.

Further information: Annex 1 lists different data and analytical tools that can be used to develop payment for mental healthcare

Clinicians and other frontline staff need access to historical and real-time data and analysis. These can inform improved care for individuals with mental ill health, and support strategic improvements to care in wards as well as in the wider local health economy. Frontline staff are responsible for a large share of the data collection related to mental healthcare. To ensure they and those they care for benefit from that information, it is vital that information is fed back to them. This will also encourage improvements in the accuracy and robustness of data collection.

All providers must submit all mandatory data accurately and consistently to the MHSDS. Data submissions must meet the relevant HSCIC data reporting requirements and standards. Further information on the new MHSDS and technical

information on how to access and submit data are given in Annex 1 and the HSCIC website,[14] respectively.

In some instances it may be necessary or appropriate to develop and agree information and data-sharing agreements locally: for example, to enable data sharing with acute secondary physical care providers, primary care providers, social care providers, emergency services or other community providers. Such links will help the local health economy understand the holistic needs of the local population, as well as support integration and co-ordination of mental health services with other services and care providers. These may be further strengthened and developed through local digital maturity plans, which should align to the objectives set out by the National Information Board (NIB) and NHS England.[15]

Monitor and NHS England are working with HSCIC and the sector to develop guidance on information governance, and how providers and commissioners can use data to improve services and patient care. This is expected to be published in the 2016/17 financial year.

4.2. Developing and linking quality and patient outcomes to payment

Quality and outcomes measures need to be linked to payment for mental health services. This ensures providers and commissioners are clear about expectations for care quality and care objectives. Providers and commissioners will be asked to report on an agreed set of national measures, and encouraged at the local level to develop quality, patient outcomes and experience measures. The local measures should be co-designed with patients, families and clinicians, and reflect system-wide objectives.

As outcomes-based payment is developed and implemented for mental healthcare, commissioners and providers may start to incorporate measures that were part of Commissioning for Quality and Innovation (CQUIN) schemes in the outcomes portion of their payment. In 2016/17 we anticipate a scheme to incentivise the delivery of physical care for those with severe mental illness (SMI) will be a core aspect of mental health outcomes measures.

To support the development of quality and patient outcomes measures that are linked to payment for mental healthcare, we are working with a wide group of stakeholders (professional bodies, service user leaders, providers and commissioners), co-ordinated by the Academy of Medical Royal Colleges and Royal

[14] www.hscic.gov.uk/mhsds

[15] Commissioners and providers should assess their local area's digital maturity in line with NHS England and NIB objectives. They need to ensure that they have in place electronic case records (ECRs) and other direct entry of clinical data to reduce burden and maximise clinical time for care and patient self-management, and key safety in medicines and physical and mental healthcare diagnostics and treatment reconciliation across the pathways and at transitions.

College of Psychiatrists. Stakeholder engagement is part of a consultation process to identify outcomes measures that include clinician-reported measures, patient-reported measures and patient experience measures for routine universal monitoring. Guidance on the outcomes measures to be collected in 2016/17 is expected to be published in early 2016.

This work sits within the wider context of the work programme to develop clear pathways and standards for mental health, as set out in *Achieving better access to mental health services by 2020*.[16] Annex 5 outlines the framework and principles for developing and linking quality and outcomes measures to payment, which providers and commissioners could adopt.

4.3. Mental healthcare clusters

The national currencies for mental healthcare are the mental healthcare clusters. The mental healthcare clusters provide a way of grouping service users with similar needs. Patients grouped in each care cluster are likely to have a predictable cost profile. Further details on using the care clusters is outlined in Annex 2

The mental healthcare clusters have been mandated for use since April 2012, and apply to most adult and older people's mental health services commissioned by CCGs. We recognise the significant investment made by the sector to group patients in care clusters and we see the clusters continuing to play an important role in informing mental healthcare payment development.

The care clusters alone are not a tool for measuring holistic needs. Evidence-based guidance (that at a minimum is NICE-concordant care), should be used to help define the care pathway for patients. There is substantial evidence that the majority of patients in specialist mental health services have complex needs and a number of mental and physical conditions that require specific NICE-concordant treatments. For example, 90% of people with alcohol abuse conditions have co-existing depression and anxiety, liver disease and other physical illnesses.[17] Of people with longer-term psychosis disorders, 60% to 80% will have co-existing alcohol or drug misuse[18] or other co-morbidities, including malnutrition, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease (CVD). The move to more transparent payment approaches aims to better reflect the complexity of patients needing care, drawing on the most recent evidence for clinical pathway development. The *Mental health clustering booklet* suggests the NICE guidance that is most commonly associated with each cluster.

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[16] Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/361648/mental-health-access.pdf
[17] fingertips.phe.org.uk/profile-group/mental-health/profile/drugsandmentalhealth
[18] fingertips.phe.org.uk/profile-group/mental-health/profile/drugsandmentalhealth/data

Mental health currency development

For 2016/17, we do not propose any detailed changes in how clusters are used in local payment agreements. However, as with healthcare resource groups (HRGs), the mental healthcare clusters will be subject to future review and refinement. NHS England is developing other currencies for mental health, in particular for IAPT, secure and forensic, CAMHS, perinatal conditions and eating disorders. Annex 3 provides further information on these currencies.

4.4. Patient-level information costing systems

Patient-level information costing systems (PLICS) can help providers and commissioners better understand costs, improve transparency and support the integration and co-ordination of mental healthcare with other services. They can also help providers and commissioners plan and develop more effective and efficient care delivery models and payment approaches for mental health.

While these systems may not be in place in all organisations, providers can, for example, use the MHSDS (which has patient-level information) to develop a bottom-up approach to inform payment. Annex 4 outlines how local health economies (both providers and commissioners) can use patient-level data to inform contract values using the relative resource intensity approach. Where PLICS data are available, these should be used to help inform contract values.

Monitor is planning to mandate the collection of patient-level activity and cost data by all mental healthcare providers by 2019/20. To help achieve this objective, Monitor has launched the costing transformation programme (CTP; see Figure 1) to deliver a step change in the quality of costing information in the NHS to support the sustainable delivery of high quality patient care. We will develop a mental health costing roadmap for the roll out of PLICS.

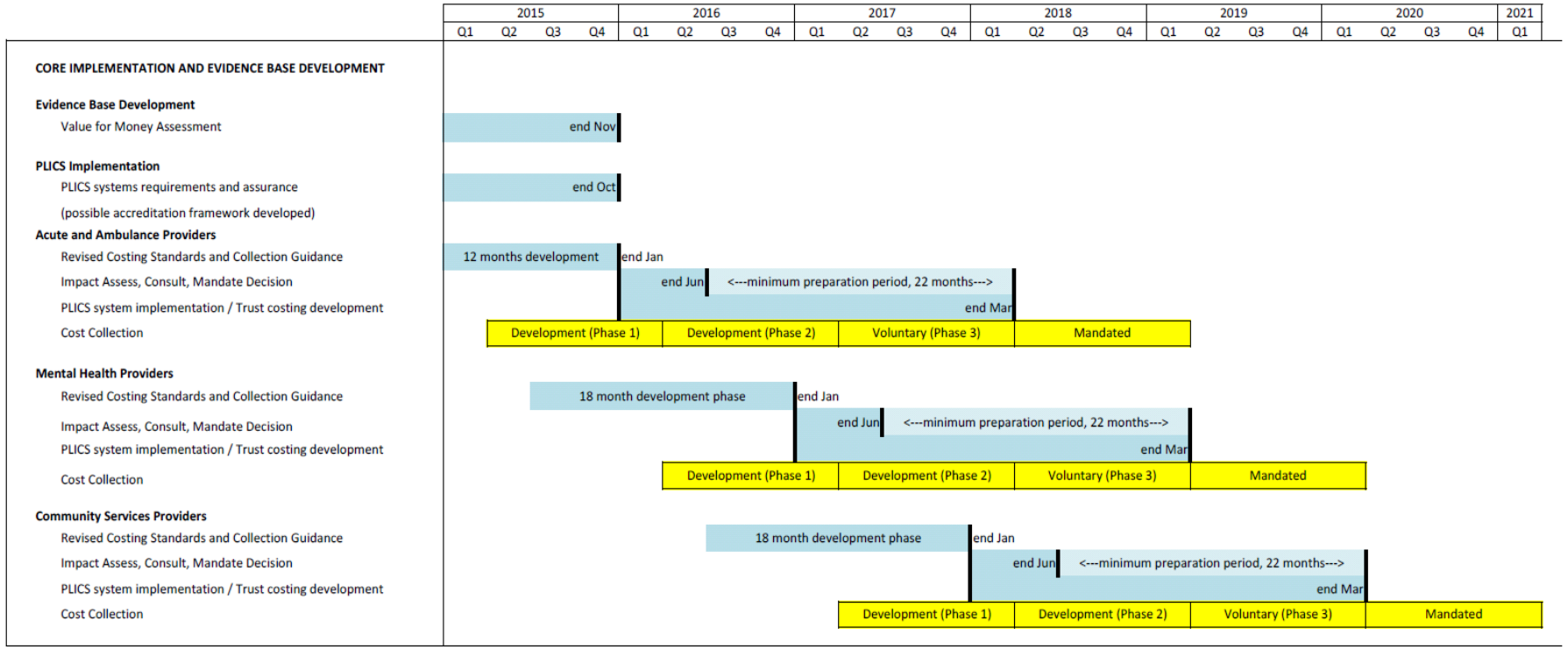
As part of this programme, we will engage mental healthcare providers to develop mental health costing standards. We are working with providers of IT infrastructure to ensure software systems comply with our cost collection guidance and can output patient-level cost data as per our requirements.

For further information on the CTP: visit our website[19] or email Monitor at costing@monitor.gov.uk

Monitor's Costing team will contact all mental health trusts in early 2016 to identify partners to develop the mental health costing roadmap and input to the development of the mental health costing standards. This development work will start in summer 2016. In the short term, however, we expect providers to continue to better understand, refine and improve reference costs data.

[19] www.gov.uk/guidance/costing-transformation-programme

Figure 1: Costing transformation programme implementation timeline



4.5. Developing payment approaches for mental healthcare

Local payment examples

NHS England and Monitor have published a number of local payment examples to help local health economies to shift to new payment approaches that underpin the new care models set out in the 5YFV.[20]

- **Multilateral gain and loss share arrangements**: This local payment example sets out the steps in designing and implementing gain and loss share arrangements between multiple commissioner(s) and providers. It discusses the key considerations at each step. The document provides guidance on how gain and loss share arrangements can be introduced, and two pragmatic examples of possible arrangements.

- **Outcomes-based payment for mental healthcare**: This local payment example shows how payment for mental healthcare can be linked to delivery of agreed outcomes. It gives details of a local payment approach for a lead accountable provider model, drawing on case studies from Cheshire and Wirral Partnership NHS Foundation Trust and Oxford Health NHS Foundation Trust. The payment approach has three components: a fixed core payment; a proportion of total payment based on outcomes; and a mechanism for sharing gains or losses. Providers could use the outcomes measures described in this local payment example in their own local health economies.

- **Capitation: a potential new payment model to enable integrated care**: This local payment example shows how a capitated payment approach can be developed. The principles and guidance outlined can be applied to many other mental health services.

- **Improving Access to Psychological Therapies payment**: This local payment example outlines a payment approach for IAPT services which rewards providers for delivering outcomes.

Managing financial risk

Risk-share agreements can reduce financial risk associated with payment flows or unanticipated fluctuations in demand on both providers and commissioners. We understand that change can bring risk and uncertainty, and that this is a particular concern in financially challenging times. However, developing more transparent and accountable payment approaches offers a clear opportunity for providers and commissioners to understand patient need, to discuss optimal service designs to

[20] www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models

meet those needs efficiently, and to consider the best payment approaches and investment needed to support those care packages.

5. Next steps

We recognise that some in the sector have made progress in developing and/or implementing data-driven and evidence-based episodic/year of care or capitated payment approaches. These providers and commissioners should continue to develop and improve these payment approaches in 2016/17. Where providers and commissioners have not yet decided on a payment approach, they should take steps over the coming year to ensure the building blocks are in place to support implementation of one of these payment approaches in 2017/18.

To help the sector to develop and implement the building blocks and payment approaches in 2016/17, in 2016 we will provider further sector support in the form of detailed guidance, webinars and a series of workshops.

We expect all providers and commissioners to work collaboratively to develop and improve accurate data collection, reporting and analysis; development of quality and outcomes measures; use of care clusters; and development of patient-level costs and activity.

It is fundamental that any payment approach developed is consistent with the local payment rules and principles, is transparent, meets the needs of patients, and achieves the agreed patient quality and outcomes measures. Providers and commissioners are responsible for progressing this in their own local health economies.

We will provide further guidance on quality and outcomes measures as part of the programme set out in *Achieving better access to mental health services by 2020*[16] and the mental health taskforce report.

Annex 1: Mental health data and information

Data and information tools available to providers and commissioners

There are many publicly available data and information tools to help providers and commissioners understand patient need, activity, outcomes, quality and costs. Key resources relevant to mental health are summarised in Table A1.1.

Table A1.1: Summary of mental health data and tools

Data/tool	Description
Public Health England (PHE) Children's and Young People's Mental Health and Wellbeing tool	Collated data on risk, prevalence and the range of health, social care and education services that support children with, or vulnerable to, mental illness fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh
PHE Co-existing Substance Misuse and Mental Health Issues (CESMMHI) tool	Data on smoking, alcohol use and drug use, including prevalence and treatment demand and response, to inform practice around co-existing substance use and mental health issues fingertips.phe.org.uk/profile-group/mental-health/profile/drugsandmentalhealth
PHE Common Mental Health Disorders tool	Collated data on risk, prevalence, early intervention and treatment outcomes, and service costs relating to people with common mental health disorders, including depression and anxiety disorders fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders
PHE Severe Mental Illness tool	Collated data on risk, prevalence, early intervention, assessment and treatment, outcomes and service costs relating to people with severe mental illness Also provides a set of high level indicators that relate to the psychosis care pathway fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/data
PHE Suicide Prevention Profile tool	Brings together national data on suicide, risk factors for suicide and service contacts for groups at increased risk of suicide. The data are presented at a local level to develop understanding, and support benchmarking, commissioning and service improvement fingertips.phe.org.uk/profile-group/mental-health/profile/suicide
NHS Benchmarking Network	Valuable activity, costing, finance and analytical information on mental healthcare providers and commissioners The network's data and analytical tools are open to members only

	www.nhsbenchmarking.nhs.uk/index.php
Mental Health Services Data Set (MHSDS)	Patient-level, output-based, secondary user dataset on children, young people and adults who are in contact with mental health services. This reuses clinical and operational data for purposes other than direct patient care www.hscic.gov.uk/mhsds
MHLDDS (MHSDS) linked to hospital episode data (HES)	Contains data on patient spells of care in NHS-funded adult specialist mental health services, combined with a range of patient-level demographic detail Hospital episode statistics (HES) contains around 1 billion records on patients attending A&E, being admitted for treatment or attending outpatient clinics at NHS hospitals in England. The linking of HES and MHLDDS enables patients' mental health data going back to 2006/07 to be matched to recorded interactions with acute secondary care services. This link makes it possible to analyse acute patient pathways for mental health service users in England, giving a much clearer picture of mental health service users' interactions with acute secondary care www.hscic.gov.uk/hesmhldds
Improving Access to Psychological Therapies (IAPT) dataset	Monthly national data collection supporting the IAPT programme to encourage improved access to talking therapies for people with common mental health problems Providers and commissioners of adult mental health services can retrieve processed IAPT extracts covering their own services by logging into the mental health Bureau Service Portal (BSP) using their Open Exeter account www.hscic.gov.uk/iapt
Mental health reference costs data	Reference costs data on mental health services provided by NHS trusts in England. These data are also available for cluster-based services and for specialised mental health services www.gov.uk/government/collections/nhs-reference-costs#published-reference-costs
Data related to the Mental Health Act	Information and annual data on inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment in England www.hscic.gov.uk/mentalhealth
Commissioning for value resources	This provides regions with practical support in gathering data, evidence and tools to help them transform the way care is delivered for their patients and populations www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/

NHS Atlas of Variation 2015	This includes data and 102 maps detailing widespread variation in the quality, cost, activity and health outcomes of healthcare in the English NHS. The tool analyses and groups the maps by locality and includes extended interpretation to highlight where local commissioners may wish to focus their pathway improvement efforts www.rightcare.nhs.uk/index.php/nhs-atlas/
Local primary care mental health data	90% of patients are cared for in primary care and this information provides information on some care received by people with mental ill health. Providers and commissioners should use local primary healthcare data to understand patient activity, profiles and need www.hscic.gov.uk/mentalhealth
Local alcohol and drug services data	The National Drug Treatment Monitoring System (NDTMS) collects, collates and analyses information from and for those involved in the drug treatment sector. This can provide valuable information on vulnerable people with mental ill health who may also have alcohol and drug issues www.nta.nhs.uk/ndtms.aspx
Social care data	This provides information on local social care and wider local area needs and services. It also contains information on carer needs and services, access to stable accommodation and employment www.hscic.gov.uk/social-care

Mental Health Services Data Set

The MHSDS went live on 1 January 2016, has replaced the Mental Health and Learning Disabilities Data Set (MHLDDS) and consolidates/replaces other standards, including:

- child and adolescent MHSDS
- mental healthcare cluster
- Mental Health Clustering Tool.

Providers of mental healthcare, CAMHS and learning disabilities services are required to collect data from 1 January 2016.

The HSCIC has its own data assurance processes and produces regular data consistency reports, known as Data Quality Measures reports. These should be used by providers and commissioners to support improvements in MHSDS data quality.

Intervention codes were introduced with version 1 of the MHLDDS and allow type of interventions to be captured. A requirement may be to map existing local intervention

codes to those presented in the dataset. Further detail is available in the *Mental Health and Learning Disabilities Data Set (MHLDDS) v1.1 User guidance* (the MHSDS user guidance).[21]

Submitting data to and accessing data from the MHSDS

Only limited historical extracts are stored on the system, so commissioners are encouraged to download and save their extracts promptly. Providers are encouraged to review all these reports to ensure their submissions accurately reflect caseload and activity, and to meet the submission requirements described in the MHSDS user guidance.

The specification for commissioner extracts can be found on the HSCIC website. These extracts are pseudo-anonymised: they do not include the patient's NHS number but each data row includes a spell ID. Providers that submit data to MHLDDS have access to an extract in the same format as that received by commissioners (except provider extracts include patient identifiable items) as well as a range of validation reports at the point of submission.

Providers and commissioners need to apply to register for access to the MHSDS on the Bureau Service Portal (BSP). To do so:

1. Check that your organisation's Caldicott guardian (a senior person responsible for protecting patient information) is on the (Open Exeter) register. If they are not, they need to register. Instructions on how to obtain a user login are given on the HSCIC website and in the MHSDS user guidance. For further help, contact: exeter.helpdesk@nhs.net

2. Complete a data user certificate and email it to the Open Exeter helpdesk. Providers and commissioners should complete the same form.

Providers can find information on the timetable for submitting data to the MHSDS on the HSCIC website.

[21] Available at: www.hscic.gov.uk/media/15156/MHLDDS-v11-User-Guidance/pdf/MHLDDS_V1.1_User_Guidance.pdf

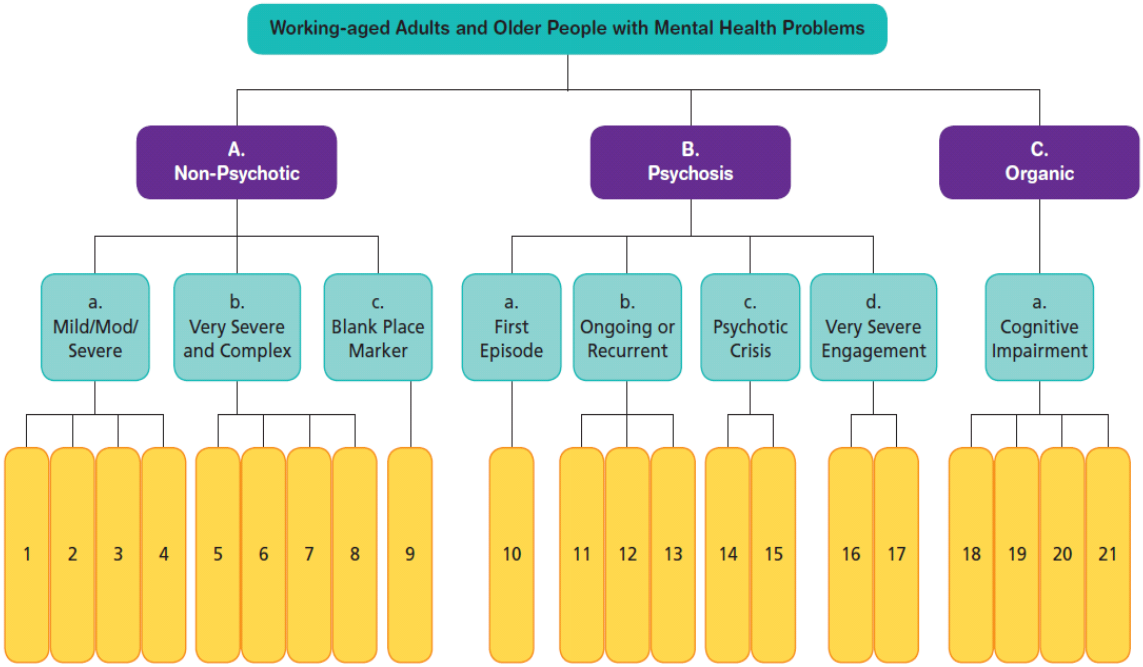
Annex 2: Using the adult and older people's mental healthcare clusters

The 21 mental healthcare clusters (Figure A2.1) and initial assessments for clustering are the currencies that apply to mental health services for working-age adults and older people. The use of these currencies has been mandatory for all mental healthcare providers since April 2012.

The care clusters are organised under three 'super clusters' (non-psychotic, psychotic and organic), plus a variance cluster (0). Cluster 9 is intentionally blank. These clusters are mutually exclusive and a service user can only be allocated to one cluster at a time. If they transfer to a new cluster after reassessment, the previous cluster episode ends. The care clusters aim to:

- give providers a better understanding of the care they provide to patients and the resources used to deliver that care
- help commissioners agree and monitor contracts
- help clinicians make decisions that deliver the best possible outcomes for patients and improve the quality of care provided
- provide information that enables commissioners and patients to compare provider organisations and to make evidence-based decisions about service design, value and choice.

Figure A2.1: Structure of the mental healthcare clusters



The clusters do not identify the physical health needs of a person in the care of a mental healthcare provider. The identification of such needs should be included in the more holistic assessment of new service users, and the total care package should ensure these needs are met either directly by the mental healthcare provider or by co-ordinating this with other organisations. The package may include community, inpatient, outpatient, aspects of social care and other government services (eg housing), where appropriate.

Assigning service users to care clusters

When a service user is assessed as needing mental health treatment but does not match to any cluster, the variance cluster (cluster 0) can be used. The reasons for selecting this cluster must be recorded along with the service user characteristics and MHCT ratings. The frequency with which 'cluster 0' is used should decrease as clinicians gain more confidence in clustering. When matching a service user to a cluster, clinicians should be encouraged to adopt a 'best-fit' approach at the time of clustering.

> **Further information** on clusters and how to cluster service users is given in the *Mental health clustering booklet* (see Annex 6)

There are three potential time points for the clustering of service users:

1. **On completion of the initial assessment**: The initial assessment period for the purpose of the cluster allocation begins when a mental healthcare provider receives a new referral. Initial assessment is normally completed within two contacts or on admission to an inpatient setting. On the basis of the initial assessment, the person is either allocated to a cluster or discharged. The initial assessment can be classified in one of two ways depending on whether or not a person is allocated to a care cluster: (i) assessed, not clustered and discharged, and (ii) assessed, clustered and accepted for treatment.

2. **At scheduled cluster reassessments (maximum review periods)**: Reassessments happen at intervals that align with the maximum cluster review periods for each cluster classification (Table A2.1). They can also occur when a person with a cluster allocation has been receiving treatment and is discharged. The MHCT should be used again and all items recorded and submitted to the MHSDS. The *Mental health clustering booklet* contains guidance on likely and unlikely transitions, known as the care transition protocols. These protocols should be used before changing the cluster following a reassessment. A service user may have a lower score because they are receiving effective treatment, but if their treatment were stopped or reduced, their needs could increase again. MHCT scores must be recorded and entered in the Health of the Nation Outcome Score (HoNOS) fields in the MHSDS when service users are discharged after a period of treatment, but these service users should not be

reclustered at this point. Scores at discharge are necessary to support the use of clinician-rated outcomes measures.

Table A2.1: Maximum cluster review period

Cluster number	Cluster label	Cluster review period (max)
0	Variance	6 months
1	Common mental health problems (low severity)	12 weeks
2	Common mental health problems	15 weeks
3	Non-psychotic (moderate severity)	6 months
4	Non-psychotic (severe)	6 months
5	Non-psychotic (very severe)	6 months
6	Non-psychotic disorders of overvalued ideas	6 months
7	Enduring non-psychotic disorders (high disability)	Annual
8	Non-psychotic chaotic and challenging disorders	Annual
9	Blank cluster	Not applicable
10	First episode in psychosis	Annual
11	Ongoing recurrent psychosis (low symptoms)	Annual
12	Ongoing or recurrent psychosis (high disability)	Annual
13	Ongoing or recurrent psychosis (high symptoms and disability)	Annual
14	Psychotic crisis	4 weeks
15	Severe psychotic depression	4 weeks
16	Dual diagnosis (substance abuse and mental illness)	6 months
17	Psychosis and affective disorder/difficult to engage	6 months
18	Cognitive impairment (low need)	Annual
19	Cognitive impairment or dementia (moderate need)	6 months
20	Cognitive impairment or dementia (high need)	6 months
21	Cognitive impairment or dementia (high physical need or engagement)	6 months

Source: *Mental health clustering booklet*

3. **When the cluster allocation no longer reflects patient need**: There will be occasions when a service user's needs increase or decrease and their cluster allocation no longer reflects their needs. Each cluster has a suggested maximum review period, but if needs have clearly changed, the MHCT should be used again to allocate a service user to a more appropriate cluster that better meets their needs.

The MHCT provides a way to capture patients with similar levels of presenting needs, although their specific diagnoses may differ, in the same cluster. This tool should be used by clinicians to cluster mental healthcare service users to appropriate clusters. The MHCT has 18 scales (eg depressed mood, problems with activities of daily living). The first 12 are taken from HoNOS and the remainder are based on Summary of Assessments of Risk and Need (SARN).

The Royal College of Psychiatrists (RCPsych) with partners will publish an updated version of HoNOS during 2016. While some of the wording in relation to each scale will change, the number of scales and scoring system will not. As soon as this is available, we will update the *Mental health clustering booklet* to ensure consistency.

Providers should ensure clinicians using the MHCT receive regular training for this. The RCPsych provides such training. In addition, providers should take steps to ensure the use of the clustering tool is embedded in clinical practice in a meaningful way, with relevant and insightful feedback provided to both individual clinicians and clinical teams.

Initial assessment algorithm

The algorithm is a real-time electronic decision support tool to assist the clinician in allocating a service user to the correct cluster based on the *Mental health clustering booklet*.

Clustering algorithm: To access this in Excel format, please see Annex 6 of this document

The decision support tool is not designed to replace clinical judgement, but is required to ensure consistency of clustering and to improve the overall accuracy of cluster allocation. The clinician should always make the final decision in relation to the most clinically appropriate cluster and must be able to override the algorithm result.

The algorithm has been designed for use with the first MHCT assessment in any mental health clustering assessment period, ie the assessment and clustering of new referrals to an organisation. Its use is **not** appropriate in decision-making related to MHCT reviews. The algorithm can be applied to a clinician's MHCT assessments retrospectively. This makes it possible to compare the clinician's allocation with that of the algorithm, which may help identify unusual cluster allocations that may require further investigation. However, the algorithm output should never be used to override the clinically allocated cluster.

Technical guidance is available on the MHCT and algorithm. The guidance is aimed at anyone who would like to understand how the algorithm processes the MHCT assessment scores and derives the percentage fit against relevant clusters. It includes technical information on embedding the algorithm in local systems, and for systems suppliers who may wish to embed it in their systems. The algorithm can also be accessed online, via the CPPP website.[22] This should be embedded in clinical systems and used as a part of routine clinical recording.

For further information on the technical guidance, see Annex 6 of this document

[22] www.cppconsortium.nhs.uk/cppp.php

Annex 3: Using and developing other mental health currencies

Improving Access to Psychological Therapies (IAPT)

IAPT is a programme that aims to increase access to talking therapies for people with anxiety and depression.

All providers must ensure service users receiving IAPT services are routinely allocated to a mental healthcare cluster following an initial assessment. Service users accessing IAPT services directly or via their GP generally fall within clusters 1 to 4. Where secondary care services offer combined treatments that include NICE-approved psychological therapies for anxiety and depression, service users will be clustered in the normal way (see Annex 2). These clusters, including the use of other data and information (eg from the ONS), should be used as the basis for payment.

To assist the roll out of IAPT-compliant services and support patient-centred care, patient outcomes are measured against those things that matter most to people and support their daily activities, including:

- specific and relevant clinical outcomes
- access standards
- user experience
- choice
- employment
- more holistic measures of wellbeing.

Commissioners can influence provider-delivered outcomes by adjusting the relative level of reward associated with individual performance measures and incentivising delivery of the outcomes that matter most locally, eg improving access by older people or ethnic minorities.

Our local payment example on IAPT describes a payment approach that could be implemented by local health economies.[23]

CAMHS

A development project was begun in 2012 to identify a set of currencies that would be appropriate for CAMHS services. It concluded in March 2015 and the final report was published in June 2015.[24] During 2016/17 we will be working with providers and commissioners to test and refine the draft currencies.

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[23] Available at: www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models#improving-access-to-psychological-therapies-payment

[24] http://pbrcamhs.org/final-report/

Secure and forensic currencies

Secure and forensic services are specialist mental health services and are commissioned directly by NHS England. Providers and commissioners have developed and tested a set of currencies for these services over the past three years. These are based on the clusters for working-age adults and older people, but also reflect the inpatient nature of the services. The work has been led by clinicians, including members of the relevant NHS England Clinical Reference Groups, and has had very strong service user input, especially in relation to outcomes. It is already a contractual requirement for all providers to collect and provide data to commissioners based on the currencies. For 2016/17, these services will continue to be paid for based on occupied bed days, but we will start to collect 2015/16 reference costs data against the new currencies.

Other mental health services falling outside the care clusters

Table A3.1 lists service areas not covered by the mental healthcare clusters, including specialist services for adult mental healthcare commissioned directly by NHS England. More detailed descriptions of the services NHS England commissions can be found on its website.

Locally, there may be other more specialised non-standard services that both providers and commissioners agree should fall outside the clusters. Prices for these services still need to be agreed in accordance with the local payment rules and principles set out in Section 6 of the 2016/17 National Tariff Payment System.

Table A3.1: Services not included in the care clusters

Service	Description
Forensic and secure services (commissioned by NHS England)	Adult secure mental health services include high, medium and low secure inpatient care and associated non-admitted care, including outreach when delivered as part of a provider network
Perinatal psychiatric services (mother and baby units) (commissioned by NHS England)	Specialist perinatal mental health services are provided by specialist mother and baby units. Services include inpatients and associated non-admitted care, including outreach provided by these units when delivered as part of a provider network. This applies to provision in adults and young people
Tertiary eating disorder services (commissioned by NHS England)	Include inpatients and bespoke packages of intensive day care (as an alternative to admission) provided by specialist adult eating disorder centres. The service includes associated non-admitted care, including outreach, when delivered as part of a provider network

Gender dysphoria services (commissioned by NHS England)	Include specialist assessment, non-surgical care packages, transgender surgery and associated aftercare provided by specialist gender identity disorder centres. This applies to provision in adults and children
Specialist mental health services for deaf people (commissioned by NHS England)	Include inpatient and non-admitted care, including assessment and treatment services for deaf people provided by specialist centres. In addition, the services include advice to general mental health services on the management and treatment of the deaf person's mental illness
Other services falling outside the mental healthcare cluster currency model	• Discrete IAPT services • Specialised addiction services • Specialist psychological therapies – admitted patients and specialist outpatients • Learning disability services for non-mental health needs • Acquired brain injury • Complex and/or treatment resistant disorders in tertiary settings • Specialist services for autism and Asperger's syndrome • Liaison psychiatry • Mental health services under a GP contract
Severe obsessive compulsive disorder and body dysmorphic services	Include services provided by highly specialist severe obsessive compulsive disorder and body dysmorphic disorder centres. These apply to provision in adults and adolescents
Specialist services for severe personality disorder in adults	Include inpatients and bespoke packages of intensive day care services (as an alternative to admission) provided by specialist centres. The service will include associated non-admitted care, including outreach, when delivered as part of a provider network

Annex 4: Using patient-level data to calculate relative resource intensity

The relative resource intensity (RRI) can be used to weight activity and allocate costs to clusters. Its takes a bottom-up approach to allocating costs and developing local payment approaches (eg using patient-level data from the MHSDS coupled with other provider costing data), and can be used in the interim before PLICS has been developed.

This approach is based on a calculation of the easily identifiable direct costs of interventions. These are then used to determine the RRI of care provided across the clusters. Therefore, the approach recognises the resource used in different cluster treatments and this can be used as a proxy in the development of local prices.

For simplicity, in this example we have taken a pragmatic approach by only using the cost of clinical staff time to identify the RRI between clusters. While staff time is one of the main cost drivers in the provision of mental health services, where possible providers should refer to the HFMA costing standards and include other relevant non-pay costs when calculating the RRI.

The data given in this example are for illustrative purposes only, and do not relate to a specific service and are not for direct comparison with a specific organisation. However, this methodology can be used to help organisations assess their own data.

Example: RRI calculation based on the clinical staff costs

An extract from the organisation's patient administration system (PAS) should be written for a defined reporting period, such as the most recent financial year, which includes the following patient-level information:

- patient ID
- cluster allocated – where no cluster is allocated, the patient is assumed to be in the initial assessment phase
- length of time of appointment
- staff band
- number of days the patient has been allocated to the cluster for the period reported on. This should be from the day after a cluster is assigned.

Using this information and details of staff pay, a cost can be calculated for the staffing resource used across the selected patients.[25] However, including a team

[25] All appointments before a cluster has been allocated to a patient are counted as initial assessment appointments. The appointment at which a cluster is allocated to the patient is counted as the final initial assessment appointment; all subsequent appointments are counted as treatment appointments against the allocated cluster(s).

and/or service in the extract from the PAS system would enable the production of weightings at team and/or service level.

Table A4.1: PAS data

Patient	Cluster	Appointment time (min)	Band	Staff rate per hour (£)	Cost of appointment (C*E) (£)
(A)	(B)	(C)	(D)	(E)	(F)
W	Assessment	45	Band 7	21.75	16.31
W	1	60	Cons	65.4	65.4
W	1	30	Band 6	18.55	9.28
X	Assessment	45	Band 7	21.75	16.31
X	1	30	Band 6	18.55	9.28
X	Assessment	45	Band 7	21.75	16.31
X	3	30	Band 6	18.55	9.28
Y	2	60	Band 8a	27.72	27.72
Y	2	60	Band 8a	27.72	27.72

Using a report from the information collected through the MHCT, we can obtain the total patient days (the total time patients have spent in each cluster – column H below). The cost of clinical staff time and the total patient days can be used to derive the average cost per patient day on each cluster (column I). These average costs are then converted into an RRI (column J), relative to the lowest cluster cost.

Table A4.2: RRI calculation

Cluster number	Total cost of cluster (£)	Patient days for period	Cost per patient day (G/H) (£)	RRI (cluster cost (I)/ lowest cluster cost (I))
	(G)	(H)	(I)	(J)
0	129,938	15,750	8.25	1.65
1	38,750	7,750	5.00	1.00
2	227,125	39,500	5.75	1.15
3	485,850	79,000	6.15	1.23
4	711,000	79,000	9.00	1.80
5	279,063	23,750	11.75	2.35
6-21*	8,954,400	546,000	16.40	3.28
Assessment	515,964	39,538	13.05	2.61
TOTAL	11,342,089	830,288		

*Clusters 6 to 21 need to be calculated separately.

The RRI is an indication of the relative resource utilisation of a cluster. From Table A4.2 you can see that, on average, cluster 5 is 2.35 times more resource intensive than cluster 1.

Once the RRI has been determined, it can be applied to the current annual contract value of the service to calculate indicative costs, as shown in Table A4.3.

Table A4.3: RRI and budget allocations to cluster

Cluster	RRI (cluster cost (l)/ lowest cluster cost (l))	Allocation of budget to cluster
0	1.65	2,189,781
1	1.00	1,327,140
2	1.15	1,526,211
3	1.23	1,632,382
4	1.80	2,388,852
5	2.35	3,118,779
6-21*	3.28	4,353,019
Assessment	2.61	3,463,835
Total budget		**20,000,000**

Ideally, this stage is completed using at least 12 months of data from the MHCT or PAS. Where the available data are limited, a sample will be more appropriate. We would encourage organisations to sense check the RRI with clinicians before using it as the basis for pricing.

The above calculation can be applied at an organisation, directorate and/or team level to develop benchmarking. As accuracy improves, the data collected will lead to bottom-up costing at team levels.

Annex 5: Developing and linking quality and outcomes metrics to payment

The 5YFV describes gaps in the way that services are delivered, namely in care, quality, finance and efficiency. Consistent with this, the National Quality Board has identified significant variations in the provision of quality services. It defines quality services as those which offer patients safe, effective and evidence-based care. To address these gaps for mental health services, commissioners and providers must place a high level of emphasis on the need to measure and demonstrate improvements across these domains.

Organisations in the mental health sector in England have already undertaken work to develop, test and select outcomes and quality measures for adult mental healthcare. Feedback from the sector shows that the development and use of outcomes measures focuses commissioners, provider organisations and frontline staff on delivery of effective and efficient patient-centred care. For example, psychological therapy services (including IAPT services for common mental health conditions in clusters 1 to 8 and IAPT SMI demonstrator sites) have shown that employing routine outcomes measures for mental healthcare can drive improvements.

Framework and principles for outcomes measure development

The use of agreed measures can set a common vision for expectations about quality and outcomes between all in the local health economy. Outcomes measures should reflect what service users want to achieve across biopsychosocial domains, as well as quality standards that should be expected from care. They should also reflect the needs of the whole local population and existing legal and equalities legislation[26].

Development of outcomes measures should involve input from clinicians, patients and other stakeholders. This ensures agreed measures meaningfully support clinical views and patient objectives, as well as system-wide objectives as outlined in the 5YFV and Mental Health Taskforce report.

For 2016/17 we will be confirming the framework that we want the sector to work within when applying national measures and developing local outcomes. The framework is being generated with wide input from clinicians, patients and others involved with the mental health sector. Support material on development and use of mental health outcomes will be published in early 2016.

[26] Evidence base and processes for quality indicators in England: http://hccg-fkm-ui.blogspot.co.uk/t.co.uk/

What should outcomes measures look like?

Outcomes measures should cover high level objectives for the mental healthcare sector and wider healthcare system. They should also include some process measures such as the mental health access standards. Evidence suggests it is appropriate to link a small number of indicators (between 6 and 12) for payment purposes. We note that a wider set of measures can, and should, be monitored for clinical use, supervision, clinical management and appraisal processes, and managerial oversight within organisations.

The measures could include a mix of national and local indicators that reflect local priorities, eg employment activity measures and/or outcomes on patient choice. Further work is being done to establish a common set of national measures. However, some existing MHSDS data can be utilised. Local measures may already exist, but it may be desirable to develop new ones.

Principles for linking to payment

Research[27] indicates that recording and monitoring outcomes measures leads to improved care. This effect can be enhanced by linking payment to the achievement of outcomes.

Preliminary review of the literature suggests payment for quality and outcomes is most effective when framed as a bonus over and above payment for efficient cost recovery. Structuring quality and outcomes payments as a penalty is less effective as it can demotivate staff and may penalise providers already facing financial challenges. It may also result in organisations becoming extremely risk averse to avoid incurring fines, making it even more challenging for them to innovate and improve performance.

Research also indicates that it may be most appropriate to link a relatively small proportion of payment (eg under 10%) to the achievement of agreed outcomes. This allows outcomes to be set in a way that will stretch providers and encourage continual improvement. We recognise that some local mental healthcare payment agreements have already linked a higher percentage to payment (eg 20% of the possible total payment envelope). We encourage local health economies to base the percentage of payment linked to quality and outcomes measures on local circumstances.

Development and implementation of outcomes measures

We recognise that outcomes data may not be readily available for the 2016/17 contracts, or the quality of available information may be of concern.

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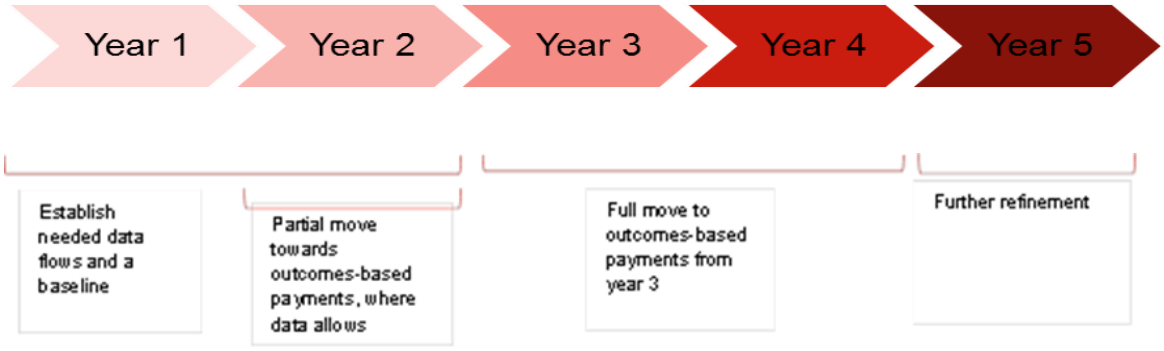
[27] Millgate K, Cheng SB (2006) Pay-for-performance: The MedPAC perspective. *Health Affairs.*

Providers and commissioners could move to an outcomes-based approach by, for example, setting up the required data flows and establishing a baseline, as illustrated in the example timeline in Figure A5.1.

Figure A5.1 Example timeline



Some areas in England have started to develop payment approaches linked to quality and outcomes measures, and we have published examples of these.[28] Providers and commissioners can use these quality and outcomes measures as a basis for the development of their own payment approach in their local health economies.

Available resources

An extensive, though not exhaustive, list of clinical outcomes tools that can be used in mental health services can be found in the National Institute for Mental Health in England's *Outcomes compendium*.[29]

Next steps

NHS England and Monitor are supporting the development and use of outcomes measures for mental healthcare through the Mental Health Outcomes Work Clinical Reference Group.[30] Its remit is to identify the outcomes measures currently being used to support the delivery of high quality patient care, and give clear aspirations for the future routine use of patient-reported outcomes measures and clinician-reported outcomes measures.

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[28] www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models#outcomes-based-payment-for-mental-healthcare

[29] Available at: webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093677.pdf

[30] The Clinical Reference Group comprises the National Clinical Director for Mental Health, Royal College of Psychiatry and other professional bodies related to mental health, as well as service users and third-sector organisations.

The group is considering useful outcomes measures, and a framework for developing outcomes measures locally. Following further engagement by the group with the wider mental health stakeholder community, more detailed guides are being produced for use in early 2016.

Annex 6: Embedded documents/tools for download

Name of document	Document/tool (please click on the icon to download the document or tool)
Mental health clustering booklet	 Mental Health Cluster Booklet 2016  Annex 1 to MH clustering booklet Pra
Practice guidance note re clustering of bipolar patients 2016	 Practice Guidance note re clustering of I
Mental health clustering algorithm Excel (2003 version and 2007 Excel version)	 07-Algorithm spread sheet-Excel-2003-ver  08-Algorithm spread sheet-Excel-2007-ver
Mental Health Clustering Tool – Technical guidance – Discriminant-Fischer-scores	 Mental Health Clustering Tool - Tech
Mental Health Clustering Tool algorithm technical guidance: co-efficient reference table	 Mental Health Clustering Tool - Co-e
MHCT algorithm technical guidance	 Mental-Health-clustering-support-tool-alg

Annex 7: Glossary of key terms and definitions

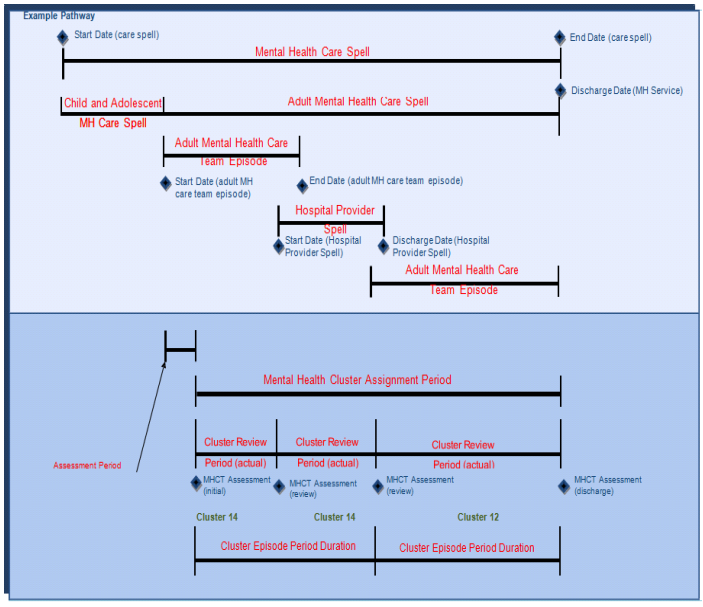
This glossary includes two tables:

- Table A7.1 outlines the preferred mental health terms and definitions for use nationally and locally.
- Table A7.2 outlines additional mental health terms that have been checked against the NHS Data Model and Data Dictionary. This glossary is not intended to map all terms against the NHS Data Dictionary, or to create new NHS Data Dictionary terms, but rather it is a cross-reference exercise to reduce ambiguity.

Table A7.1: Mental health glossary terms

Term	Description
Care spell	An overarching and continuous period of time that a patient spends in the care of a single or multiple healthcare providers
Child and adolescent mental healthcare spell	An overarching and continuous period of time that a patient spends in the care of a single healthcare provider of child and adolescent mental health services
Adult mental healthcare spell	An overarching and continuous period of time that a patient spends in the care of a single healthcare provider of adult mental health (including elderly) services
Hospital provider spell	A continuous period of care including periods of leave of up to 28 days in an inpatient setting where a bed is occupied
Adult mental healthcare team episode	The period of time a patient spends under the continuous care of a specialist adult mental healthcare team within a healthcare provider. For the purposes of mental health clustering, depending on patient need, these teams may be in or out of scope for the care clusters. Adult mental healthcare team episodes typically occur in community-based teams. A patient can have multiple episodes within an adult mental healthcare spell and these episodes can be concurrent
Assessment period	The period of time from the start date of the adult care spell (ie referral or transfer into service) to the date of the first MHCT and the start of the mental health cluster assignment period
Mental health cluster assignment period	The period of time for which a patient is assigned to a mental health cluster during a mental healthcare spell
Cluster review period (maximum, actual, average and agreed)	The time between consecutive MHCT assessments within a mental health cluster assignment period

Cluster episode period duration	The number of days a patient remains on the same cluster regardless of whether MHCT assessment reviews have taken place
Start date (hospital provider spell)	More commonly known as the admission date and is the event which triggers the start of a hospital provider spell
Discharge date (hospital provider spell)	Event that triggers the end of a hospital provider spell
Start date (adult mental healthcare spell)	The date on which a patient was referred or main responsibility for provision of their mental healthcare was temporarily or permanently transferred to a provider; this starts a new care spell
End date (adult mental healthcare spell)	The date on which a patient was discharged from an adult mental healthcare spell
Initial Mental Health Clustering Tool (MHCT) assessment	The first MHCT assessment in a mental health cluster assignment period. The assessment reason recorded at the time of this assessment should be '01 New Referral Request'
Mental Health Clustering Tool assessment review	After the first MHCT assessment within a mental health cluster assignment period, any subsequent assessments in the same mental health cluster assignment period should be MHCT assessment reviews. The assessment reason recorded at the time of these assessments should be other than '01 New Referral Request'
Mental Health Clustering Tool assessment (discharge)	Recorded at the point (or near to) discharge from the mental health clustering period. The MHCT assessment (discharge) is required to capture the assessment scales only, and the super class and cluster should not be captured at discharge
Clusters	The 21 clusters are based on the characteristics of service users, and group people in a clinically meaningful way
Mental Health Clustering Tool	In total there are 18 items in this tool. It includes the 12 standard items of the Health of the Nation Outcome Scores (HoNOS) rated on a current basis, and six additional items, mostly rated on an historical basis. The 13 current items are labelled 1 to 13, the five historical items A to E
Currency	A unit of healthcare activity such as a spell, episode or attendance. A currency is the unit of measurement for which a price is paid. Under the 2012 Act, the national tariff must 'specify' the health services (currencies) which are subject to national prices
Relative value	A unit that represents a weighted measure to reflect the differing

unit	treatment intensity associated with differing clusters at a team level. This weighting reflects the recorded time and skill mix of staffing input into the relevant cluster
Activity plan	A plan of chargeable activity for a given financial period (eg month, quarter, year) based on agreed cluster review periods
Active caseloads	Patients with a current (not closed) mental health cluster assignment
Cluster day	The shortest time period used to compare the length of the mental health cluster assignments
Mental Health Clustering Tool casemix	An aggregated profile (eg at healthcare provider, ward, mental health team or individual practitioner caseload level), usually including active patients (but could be historical patients), broken down by the number in each MHCT cluster
Mental healthcare cluster super class	Enables the mental health clusters to be narrowed down, by deciding if the origin of the presenting condition is primarily non-psychotic, psychotic or organic
Care packages	Name given to the responses designed to meet the needs of individuals within the clusters. Care packages will not be nationally mandated as part of mental healthcare (although many will inevitably be based on NICE guidance) to allow flexibility in meeting people's needs
Care pathways	The care packages an individual receives over a period of time can be described as their care pathway The diagram below shows an example of a service user pathway and how pathway periods and key events are applied through the pathway. The example may not be representative of pathways in different organisations but illustrates the hierarchy of terms 

Tariff	A tariff normally refers to the national prices set out in the 2016/17 National Tariff Payment System
Top-up payments	Some individuals in a cluster may be 'outliers', having needs additional to the core ones associated with the cluster (eg substance misuse may be an issue for an individual in cluster 3, Non-psychotic (moderate severity)), or a service user may require a translator. These may need to be met through an additional top-up payment, which will need to be agreed by commissioners and providers
Unbundling	The splitting of a currency into smaller units. A cluster can be unbundled if multiple providers have been commissioned to provide care, eg a main provider for the majority of care and a more specialist provider for part of the care pathway

Table A7.2: NHS Data Model and Data Dictionary definitions of mental health terms

Term	**Care spell**
Description	An overarching and continuous period of time that a patient spends in the care of a single or multiple healthcare providers
Data Dictionary definition	A continuous period of care (including assessment for care) for a PERSON for an illness or condition involving health and possibly other agencies which has been nationally targeted and prioritised as requiring an organised and cohesive programme or regime of care. Overall management and co-ordination of the care will be the solely led responsibility of a specific healthcare provider, or in the case of equally shared responsibility, the jointly led responsibility of two or more healthcare providers. Actual treatment associated with the programme or regime of care may be delivered by the responsible healthcare provider or by other healthcare providers
Further information	N/A
Term	**Child and adolescent mental healthcare spell**
Description	An overarching and continuous period of time that a patient spends in the care of a single healthcare provider of child and adolescent mental health services
Data Dictionary definition	A child and adolescent mental healthcare spell is a continuous period of assessment or care for a child or adolescent patient provided by a healthcare provider's specialist child and adolescent mental health services. The specialist mental health services are delivered by Child and Adolescent mental healthcare professionals, some of whom may

	receive referrals directly
Further information	www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/c/child_and_adolescent_mental_health_care_spell_de.asp?shownav=1
Term	**Adult mental healthcare spell**
Description	An overarching and continuous period of time that a patient spends in the care of a single healthcare provider of adult mental health (including elderly) services
Data Dictionary definition	A continuous period of care or assessment for an adult (including elderly) PATIENT provided by a Healthcare Provider's specialist mental health services. This includes the care or assessment of adult and elderly PATIENTS with drug or alcohol dependence but excludes child and adolescent psychiatry PATIENTS and PATIENTS whose only mental disorder is a learning disability. The specialist mental health services are delivered by mental health professionals, some of whom may receive referrals directly An adult mental healthcare spell is initiated by a referral, or the temporary or permanent transfer of main responsibility for provision of mental healthcare for the PATIENT from another Health Care Provider, and ends with a DISCHARGE DATE (MENTAL HEALTH SERVICE) For referrals, the adult mental healthcare spell commences with an initial assessment, which will determine whether treatment or care by the healthcare provider's specialist mental health services is appropriate. If not appropriate, then the adult mental healthcare spell will end
Further information	N/A
Term	**Hospital provider spell**
Description	A continuous period of care, including periods of leave of up to 28 days, in an inpatient setting where a bed is occupied
Data Dictionary definition	The total continuous stay of a PATIENT using a Hospital Bed on premises controlled by a healthcare provider during which medical care is the responsibility of one or more CONSULTANTS, or the PATIENT is receiving care under one or more nursing episodes or midwife episodes in a WARD A hospital provider spell starts with a hospital provider admission and ends with a hospital provider discharge. In some circumstances a PATIENT may take Home Leave, or Mental Health Leave of Absence for a period of 28 days or less, or have a current period of Mental Health Absence Without Leave of 28 days or less, which does not interrupt the Hospital Provider Spell, Consultant Episode (Hospital Provider), Nursing Episode, Midwife Episode or Hospital Stay

Further information	N/A
Term	**Adult mental healthcare team episode**
Description	The period of time a patient spends in the continuous care of a specialist adult mental health team within a healthcare provider. For mental health clustering, these teams may be in scope or out of scope for national mental healthcare clusters. Adult mental healthcare team episodes typically occur in community-based teams
Data Dictionary definition	A continuous period of care for a PATIENT by one or more adult mental healthcare teams
Further information	www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/a/adult_mental_health_care_team_episode_de.asp?query=teamepisode&rank=75&shownav=1
Term	**Assessment period**
Description	The period of time from the start date of the adult care spell (ie referral or transfer into service) to the date of the first MHCT and the start of the mental health cluster assignment period
Data Dictionary definition	The beginning of the assessment period is determined by the receipt of a referral or transfer into service from an external source or out of scope internal service Services would typically summarise their initial assessment using the MHCT, the date of which signifies the end date of the assessment period and the commencement of the mental health cluster assignment period. The assessment period in most cases should not be lengthy, and typically is completed within two contacts within a reasonable time period from referral or transfer into service In some cases, assessment may lead to immediate discharge or transfer to a more appropriate service external to the provider and in this case a mental health cluster assignment period would not be initiated by an MHCT. Local agreement will then be required to ensure payment for the assessment can be triggered
Further information	N/A
Term	**Mental healthcare cluster assignment period**
Description	The period of time a patient is assigned to a mental healthcare cluster during a mental healthcare spell
Data Dictionary definition	There would usually be one continuous mental healthcare cluster assignment period per adult mental healthcare spell. However, there could be multiple mental healthcare cluster assignment periods if a

	patient's pathway includes teams and services which are both in and out of scope, though for the mental healthcare cluster assignment period to end, the patient would need to be in receipt of services solely from an out-of-scope ward/team within the adult mental healthcare spell. Multiple care cluster assignment periods cannot run concurrently
Further information	www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/mental_health_care_cluster_assignment_period_de.asp?query=MentalHealthCareClusterAssignmentPeriod&rank=3&shownav=1
Term	**Cluster review period (maximum, actual, average and agreed)**
Description	The time between consecutive MHCT assessments within a mental healthcare cluster assignment period
Data Dictionary definition	The first MHCT assessment in the mental healthcare cluster assignment period is classed as the initial MHCT assessment. Any subsequent MHCT assessments are classed as MHCT assessment reviews. A cluster review period can be the time between an initial and review MHCT assessment or the time between subsequent reviews. A cluster review period can be measured in three different ways: **Maximum cluster review period** The maximum period is the per cluster period as specified in Table 7.6 of the '2014/15 National Tariff Payment System' **Actual cluster review period** When working with data at an individual patient level, the actual cluster review period will be based on the actual dates of the initial and subsequent MHCT assessments recorded in the client record **Average cluster review period** When working with aggregated data for groups of patients, an average Cluster review period can be calculated by computing the difference between the actual dates of the initial and/or subsequent Mental Health Cluster Tool Assessments recorded in the client records and then dividing this by the number of clients in the aggregated group. The *agreed Cluster Review Period* is a Period that is selected and agreed between a healthcare provider and Commissioner on the basis for contracting
Further information	**Example: Actual cluster review period** Client A starts cluster 13 on 01/01/2011, is reassessed on 12/12/2011 and stays on cluster 13. On 13/07/2012 client A is reassessed and moved to cluster 14. This equates to three cluster review periods, as shown below:

Client Name	MHCT Assessment Date	Cluster Assigned	Actual Cluster Period	Actual Cluster Period
Client A	01/01/2012	13	01/01/2011	13/12/2011
Client A	13/12/2011 (review)	13	13/12/2011	31/07/2012
Client A	31/07/2012 (review)	14	31/07/2012	

Term	Cluster episode period duration
Description	The number of days a patient has remained on the same cluster regardless of whether MHCT assessment reviews have taken place Using the same example as above, client A starts cluster 13 on 01/01/2011, is reassessed on 13/12/2011 and stays on cluster 13. On the 31/07/2012 client A is reassessed and moved to cluster 14. This equates to two cluster episodes, as shown below:

Client name	MHCT assessment date	Cluster assigned	Cluster episode period	Cluster episode period
Client A	01/01/2012 (initial)	13	01/01/2011	
Client A	01/05/2012 (review)	13		31/07/2012
Client A	31/07/2012	14	31/07/2012	

Data Dictionary definition	No Data Dictionary equivalent definition
Further information	N/A
Term	**Start date (hospital provider spell)**
Description	More commonly known as admission date and is the event that triggers the start of a hospital provider spell
Data Dictionary definition	The start date of the hospital provider spell is the date of admission: the CONSULTANT or MIDWIFE has assumed responsibility for care following the DECISION TO ADMIT the PATIENT
Further information	www.datadictionary.nhs.uk/data_dictionary/data_field_notes/d/disa/discharge_date_(hospital_provider_spell)_de.asp?query=admissiondate&rank=5&shownav=1
Term	**Discharge date**
Description	The event which triggers the end of a hospital provider spell
Data	DISCHARGE DATE (HOSPITAL PROVIDER SPELL) is the date a

Dictionary definition	PATIENT was discharged from a Hospital Provider Spell
Further information	www.datadictionary.nhs.uk/data_dictionary/data_field_notes/d/disa/discharge_date_(hospital_provider_spell)_de.asp?shownav=0
Term	**Start date (adult mental healthcare spell)**
Description	Date of referral of a patient or temporary or permanent transfer of main responsibility for provision of mental healthcare to a provider; this starts a new care spell
Data Dictionary definition	No Data Dictionary definition
Further information	N/A
Term	**End date (adult mental healthcare spell)**
Description	End date (adult mental healthcare spell) is the date a patient was discharged from an adult mental health care spell
Data Dictionary definition	Nearest equivalent is DISCHARGE DATE (MENTAL HEALTH SERVICE)
Further information	www.datadictionary.nhs.uk/data_dictionary/data_field_notes/d/disa/discharge_date_(mental_health_service)_de.asp?shownav=1
Term	**Initial MHCT assessment**
Description	The first MHCT assessment that occurs within a mental health care cluster assignment period should be the initial mental health clustering tool assessment
Data Dictionary definition	The Assessment Reason recorded at the time of this Assessment should be “01 New Referral Request”
Further information	www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/mental_health_clustering_tool_de.asp?shownav=1
Term	**MHCT assessment review**
Description	Following the first MHCT assessment that occurs within a mental health care cluster assignment period any subsequent assessments occurring within the same mental health care cluster assignment period should be MHCT assessment reviews. The assessment reason recorded at the time of this assessment should be other than ‘01 New Referral Request’
Data	See below

Dictionary definition	
Further information	www.datadictionary.nhs.uk/data_dictionary/attributes/m/men/mental_health_clustering_tool_assessment_reason_de.asp?query=clustering&rank=75&shownav=1
Term	**MHCT assessment (discharge)**
Description	Recorded at the point (or near to) discharge from the mental health clustering period, the MHCT assessment (discharge) is required to capture the assessment scales only. The super class and cluster should not be captured at discharge
Data Dictionary definition	See below
Further information	www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/mental_health_clustering_tool_de.asp?shownav=1
Term	**Relative value unit**
Description	A weighted measure to reflect the differing treatment intensity associated with differing clusters at a team level. This weighting reflects the recorded time and skill mix of staffing input into the relevant cluster
Term	**Activity plan**
Description	A plan of chargeable activity for a given financial period (eg month, quarter, year), based on agreed cluster review periods Can be calculated as the projected number of cluster review periods due in a given period, ie month, quarter, year, based on a snapshot of current MHCT casemix (total number of clients on each cluster) multiplied by the agreed (maximum or average) cluster review period duration
Term	**Active caseload**
Description	The number of patients with a current (not closed) mental health cluster assignment
Term	**Cluster day**
Description	The shortest time period used to compare the length of mental health care cluster assignments, ie the cluster a patient is assigned to on any given day within a care cluster assignment period
Term	**MHCT casemix**
Description	An aggregated profile (eg at healthcare provider, ward, mental health team or individual practitioner caseload level), usually including active patients (but could be historic patients), broken down by number in each MHCT cluster