



**Implementation of Payments by
Results (PbR):
Where are we now and
What needs to be done?**

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What is PbR?

Mechanism for determining what activity the commissioner intends to purchase from the provider

in terms of

**Quantity and
Outcome.**

**E.g. 20 hip operations with x readmissions & infection rate of 3% at £1000 each and
60 hernia operations with y readmissions and infection rate of 5% at £2000 each.**

Introduced in acute care in 2003/2004

Advantages of PbR

For Commissioners:

Increased information about care given:

How many

**What benefit –safe, effective, patient
experience.**

Greater transparency in who gets what.

Help to plan service developments.

**Help in using and comparing multiple
providers.**

Advantages of PbR

For providers:

Increased information about:

The population under their care

Costs of care-> improved productivity

Quality of care -> improved quality

Unmet need.

Could decide only to provide services where have maximum financial return.

Have first call on PCT finance

i.e. the 30% services not in PbR get the left overs. MH is 50% of this.

Development of Tariff

Trusts to provide reference costs:

Usual mechanism July 2011

Using clusters by Sept 2011.

All patients to be clustered by end 2011

Local tariff: 2012/2013 contract based on these figures.

National tariff: 2013/2014?

Depends what effect it would have:

- **costs -gaming**
- **service provision /financial instability.**

PbR for Mental Health: the problems.

- 1. Cost is not dependent on diagnosis or intervention.**
- 2. Difficulty in measuring outcome.**
Whose outcome? Patient, carer, professional?
- 3. Diagnosis does not determine intervention.**
- 4. Often co-morbidity- pd, substance misuse and physical health**
- 5. Social factors have strong influence on interventions and outcome.**

Nowhere in the world has cracked this one yet!

Care Clusters

**Care Pathways and Packages Project
NHS Yorkshire and North East.**

Clusters:

Patients who have some shared characteristics and whose care has similar cost.

Determined by Mental Health Clustering Tool (MHCT)

18 items: 12 HoNOS plus longitudinal information.

Mental Health Clusters

Cluster no and label	Cluster review interval
0 Variance	Not applicable
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)
5 Non-psychotic (very severe)
6 Non-psychotic disorders of overvalued ideas
7 Enduring non-psychotic disorders (high disability)	Annual
8 Non-psychotic chaotic and challenging disorders	..
9 Blank cluster	Not applicable
10 First episode in psychosis	Annual
11 Ongoing recurrent psychosis (low symptoms)	..
12 Ongoing or recurrent psychosis (high disability)	..
13 Ongoing or recurrent (high symptoms and disability)	..
14 Psychotic crisis	4 weeks
15 Severe psychotic depression
16 Dual diagnosis (substance abuse & mental illness)	6 months
17 Psychosis and affective disorder difficult to engage
18 Cognitive impairment (low need)
19 As above (moderate need)
20 As Above (high need)
21 As above or dementia (high physical or engagement)

Issue with tariff development.

- 1. What is the reliability of coding of clusters?**
Comparison of cluster description and clustering tool?
- 2. How reliably can costs be allocated by cluster?**
- 3. What happens to those for whom no code as yet? E.g. CAMHS, forensic, LD, eating disorders, ASD**
- 4. Is impact of co-morbidity adequately taken into account?**
- 5. What stops the gaming?**
- 6. Care package purchased should be based on NICE/SCIE evidence based care to support best outcome not just activity and costs.**
- 7. Risk of lower cluster with recovery leading to removal of support which brought about improvement.**
- 8. Need to move from local to national tariff.**
- 9. What happens to HRGs (physical) with mental health component.**
How do MH providers get reimbursed?

Commissioning options

- **Lead Provider**

Subcontract to other local health service providers

- **Principal provider**

Other also subcontracted by commissioners and care pathway defined. Tariff then unbundled.

Outcomes and Mental Health

- **NHS Outcomes Framework Consultation: Transparency and Outcomes.**
- **Outcomes**
 - **Effectiveness**
 - **Safety**
 - **Patient Experience**
- **Health Inequalities**
- **Partnership with local authority.**
 - **Prevent premature death**
 - **Enhance value of life for long term conditions**
 - **Help people recover episodes illness/ injury**
 - **Ensure positive experience of care**
 - **Treat in safe environment, protect from avoidable harm**

Outcomes and PbR

- **HoNOS for all clusters**
- **IAPT- current measures e.g. PHQ9, GAD7**
- **Physical health:**
 - offered smoking cessation
 - BMI or waist circumference
- **Duration of untreated psychosis?**

- **Function:**
 - Housing and Employment
 - Recovery star likely.

College recommends additional quality outcomes:

- **Drug and alcohol measure**
- **QUALY**
- **Patient goals re outcomes**
- **Patient and carer experience- e.g. CQC surveys**
- **Possible referrer survey**

What about including cluster transition?

Activity data incl. MH Minimum Data Set

- Equality of access-e.g. ethnicity, gender, age.
- Waiting times
- Throughput- new assessments/discharges/re-referrals
- DNA rates
- % on CPA & % on CPA reviewed annually
- CRHT episode rates (**link to CPA?**)
- Admission rates, mean LoS, bed days / year
- Readmission rate
- Detention rate (subdivide eg CTOs, S136, s2-4)
- % followed up in 7 days
- Serious Untoward Incidents

To be developed: intervention classification.

Health Warning



This is work in progress!