

Royal College of Psychiatrists' Statement on Mental Health Payment Systems (*formerly* Payment by Results)

Position Statement PS01/2014
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Royal College of Psychiatrists
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Payment Systems
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Introduction

In 2012/13 the NHS mandated national currencies for much of adult mental health services in England. The currencies consist of 20 Clusters, each of which are a global description of a group of people with similar characteristics as identified from a holistic assessment and rated using the mental health clustering tool (MHCT). Each Cluster is linked to a set of interventions (Care Packages) which have a total cost, and for which a tariff would be paid once the system is 'live'. Care Packages are a summary of the types of care to be delivered (often divided into 'core' and 'supplementary'), the time allocated to interventions and the personnel (of appropriate profession and skill level) to deliver them.

College Position

Royal College of Psychiatrists (College) members have provided feedback and discussion on this subject. The views expressed can be summarised in five broad areas:

1. The College membership supports a fair tariff, but not the current Clustering model. The concern from members is that the system has not been demonstrated to be valid or reliable. Whilst initial work was carried out (Self and Painter 2009) into the statistical model underpinning the 20 Clusters, further research into clinical validity was recommended. This work has not been done. Adherence to the MHCT process and data quality has been improving, but feedback from members indicates a lack of confidence in the Cluster model as a basis for payment and pricing.
2. The Currency must include diagnosis and a wider range of complexity. Whilst Clusters are based partly on scores for symptom items, and ICD-10 diagnosis forms part of the suggested process for allocating a Cluster, College members have expressed concerns that the diagnosis is still a secondary consideration in this system. Diagnosis has a high level of reliability, validity and some predictive value. Social, cultural, economic factors and comorbidity all have enormous impact on mental health and the provision of care, but

are excluded from this Currency. Various specialties have commented on the poor fit between their patients and the Clustering methodology.

3. Payment must be sufficient to deliver evidence-based guidelines. There is wide support among College members for embedding best practice into a payment system. Tariffs will need to reflect the cost of providing high-quality care. They must therefore incentivise evidence-based care, better experience, better outcomes, improved integration and improved Value-for-Money.
4. There is wide support for the use of a payment system to contribute to better outcomes for patients. Within this, there is support for the use of valid outcome measures, and for an understanding of local variations in costs and outcomes.
5. The concern from College members is that the implementation of the current system would risk severe destabilisation, both financially and organisationally.

Current system limitations

With the current Mental Health tariff system, form came before function - clusters developed before, rather than out of, care pathways (e.g. those developed through consultation and expert guidance by NICE). The sample from which the clusters were derived also did not include acute care, rehabilitation care or older adults; the clusters only essentially and inadequately related to the CMHT element of the pathway. There is no evidence that the clusters predict resource use, nor that they are helping to drive improved Value-for-Money. The tariff system does not actively incentivise 'pull through' from high cost out of area placements (which on average cost 65% more than NHS care – taking into account bed price and length of stay – and are of variable quality) and forensic care (Killaspy and Meier, 2010).

Relevant data is needed to profile need and predict resource use. The Mental Health Clustering Tool is one tool, but multi-axial diagnosis and recording of other factors known to lead to increased resource use (English as a second language, carer status, etc) need to be included. Clinical information systems need to enable efficient collection and routine analysis of whether evidence-based interventions are being delivered or accessed. Changes to the Mental Health Minimum Data Set are essential for this to happen, combined with support for clinicians to get this information on to clinical systems without it being an undue administrative burden. In some areas, clinicians are said to be spending as much as 60% of their clinical time entering data into their electronic patient record.

Responsible Organisations for Payment and Pricing

From 2014/15, NHS England and Monitor will have joint responsibility for the payment system for NHS-funded care, as set out in the Health and Social Care Act 2012. They assert an “emphasis on putting the patient at the heart of decision-making, and ensuring services are delivered to a high quality, as sustainably as possible”. Within the partnership, Monitor and NHS England have different responsibilities (Monitor, NHS England May 2013).

NHS England will be the overall commissioner of health care services and will specify the units of purchase (currencies) for what commissioners buy on behalf of patients.

Monitor is responsible for designing the payment rules and pricing methodologies which govern the flow of funding from commissioners to providers of NHS care from 2014/15 onwards. Monitor states that they will, “over time, create a single coherent system governing the payment of NHS services” (Monitor, NHS England May 2013).

Monitor and NHS England acknowledge that this is against the background of the agenda for improvement in quality, innovation, productivity and prevention (QIPP) which is driven by the need to make savings in the region of £20 billion by 2015. NHS organisations are also under pressure to improve or maintain safety (Francis Report, November 2011) and to accelerate the adoption of innovations.

Limitations of Incentivising by Payments Alone

Monitor and NHS England recognise that the payment system alone cannot bring about all the changes the NHS needs. Nor is it the only lever enabling change in the NHS. Other incentives are being explored: quality and safety, reputational, inherent behavioural and organisational. There is work taking place to engage clinicians in detailed understanding of effective incentives that would improve outcomes.

Monitor and NHS England state that for some types of care, patient choice and competition may also have a role to play in effecting change, and work is proceeding to ensure alignment with the monitoring function of the Care Quality Commission (Monitor, NHS England May 2013).

Transparency

Any payment system for Mental Health needs to be informed by accurate information on the services provided, and the costs and quality of what is being commissioned. Transparency of the evidence base, the description of what a service provides, the cost of this provision and its quality are key areas for allowing a payment system to operate fairly and to encourage improvement.

Embedding best practice is strongly supported by clinicians; service provision should be based on the best available evidence and income should be at a level that supports this. There is a need therefore for College members to contribute to the design of Care Packages and services, and to the audit and evaluation of services to demonstrate adherence to best practice.

Standardisation of meanings and descriptions of services may bring about a clearer understanding for commissioners and providers wishing to explore best practice and benchmarking fairly. Wide variations exist in the actual work, goals, and personnel of nominally identical services. This is not to say that there is an expectation of uniformity of service delivery, but differences in service provision need to be reflected in differing descriptions. College members are well placed to lead on collaborating nationally on defining clear service descriptors.

Patients, advocates, carers and employees need to have access to clear and accurate descriptions of the range of services provided. Holding services to account if they fail to achieve minimum expectations would be a vital part of the discourse with commissioners.

Patient choice, where it will be available, must be based on a clear understanding of what is expected from and what is actually provided by a service. One consequence envisaged by Monitor is that patients armed with information on the quality of care could “spark a beneficial rivalry among providers seeking to attract patients” (Monitor, NHS England May 2013).

Wide variations exist in the cost of providing similar services around the country. These variations are not understood. They may occur for social and demographic reasons, for clinical severity reasons or because of variations in efficiency. It is likely that few psychiatrists entered the profession to become part-time accountants. It is though a key area for College members to be involved in, so that clinicians and finance leaders can work together towards the same shared organisational goals rather than in their professional silos.

Monitor states that it believes legitimacy is achieved by basing policy on the “best available evidence and being transparent. The National Tariff must be based on the best available data, include a clear methodology, and encompass appropriate rules and guidance”. It undertakes to base policy decisions on “evidence from commissioners, providers, clinicians and technical experts” (Monitor, NHS England May 2013).

Pricing

Organisations will fail to solve the 'cost and quality problem' as long as clinical and finance leaders continue to work in professional silos. They need to work together in partnership, both aiming for the same shared organisational goals.

Monitor will publish the results of joint work in the National Tariff. This will set out the services and their national prices, how these prices are calculated and the rules associated with payment. In carrying out these tasks, NHS England states that it is guided by its "mandate, its clinical priorities and, above all, its commitment to understand and act on the needs of patients". Monitor states that it is "guided by its primary duty to protect and promote the interests of people who use health care services".

Outcomes

At the present time, 'Payment by Results' in the Acute Sector has paid for activities, not patient outcomes. As it stands, the model of Clusters and Care Packages would have a similar approach. Monitor and NHS England acknowledge that "there are few types of care in which paying for activities is sufficient to encourage the best patient outcomes". There is a 'Quality and Outcome' group with clinical membership providing evidence to the Department of Health, and there have been a number of areas of progress.

A Patient rated outcome measure (PROM) in the form of the Warwick and Edinburgh Mental Well-being Scale – Short Version (SWEMWBS) - and a Clinician-rated outcome measure (CROM) in the form of HoNOS 4-factor tool are being piloted at a number of sites around England. In addition, recovery-based tools and the 'Friends and Family' test are being explored for their suitability for piloting.

Feedback from College members has been positive about the development and implementation of outcome measures. Concerns exist about the burden of data collection, but the concept of capturing objective evidence of effectiveness has wide support.

'Year of care' approaches

An important issue is the integration of mental health service provision with primary care, to strengthen liaison at all points of the pathway to improve the physical health care outcomes of the mentally ill, i.e. to reduce premature mortality, and also to improve outcomes for those with physical illness with unaddressed mental health problems. College members have concerns that Clusters and their transition protocols do not address this sufficiently.

A longer timeframe for providing integrated care is required. A 'year of care' approach exists as a method of creating a currency for chronic complex conditions requiring multiple agencies; diabetes and cystic fibrosis are two examples. This long-term approach is adopted in the Forensic version of currency using five 'forensic pathways', with some pathways expected to involve two or more years of in-patient treatment. This way of using longer timeframes or whole pathways may be a more stable way of costing and pricing a predictable set of complex needs.

Financial Risk

In developing the payment system to promote value for patients Monitor and NHS England state that they must be mindful of the allocation and management of risk: "If a provider receives from commissioners less than it costs that provider to deliver good quality care, it becomes increasingly at risk financially. But without incentives to manage provider costs and limit commissioner spending, the affordability of NHS funding overall is compromised. In seeking to achieve a sustainable balance, the design of the payment system must reflect that different payment approaches allocate risk differently between providers and commissioners". Around 20% is to be taken out of the current system over the next three years. Unless our tariff and supporting intelligence systems incentivise economic remodelling within an integrated pathways framework, there is a huge danger that quality will be compromised.

Informatics

Good patient-level cost and quality data are essential for aligning the payment approaches with priority clinical outcomes and running an economic, efficient and effective health care organisation. Monitor state that they aim to improve the flow of accurately coded and allocated cost data, for example through patient-level information and costing systems (PLICS), and associated quality data. They state that they intend to use this data to inform national prices and rules for price-setting and payment. They also intend to publish better data on cost and quality to support commissioners and providers in making local payment decisions. College members have fed back that data collection for Cluster allocation, outcome measures and Care Package delivery is time-consuming work that detracts from clinical time. Information Technology is in variable states around the country, but most feedback highlights the inadequacy of systems to cope with the smooth operation of this system.

Specialties

Child and Adolescent Mental Health Services (CAMHS)

CAMHS are developing needs-based clusters separately from the standard model. They are aiming to develop an algorithm to support clustering. The group is aiming to deliver a data collection tool that enables

clustering and will inform the development of a needs assessment tool. It also aims to work with the Health & Social Care Information Centre to develop the CAMHS minimum data set to allow a payment system to function. It aims to identify appropriate pathways and packages of care and their costings. The CAMHS team recommend an approach to monitoring user outcomes which links to the needs-based currencies and appropriate care.

Forensic

The Forensic 5 pathway model uses legal status, risk, offence and clinical factors in addition to the standard model to determine the needs of patients within secure services. Work is currently taking place to further develop the data collection tool and procedure, to understand the relationship between Clusters and Pathways, to develop evidence-based care packages linked to the 5 Pathways, and on quality and outcomes measures and finance.

Learning Disability

The LD model has undergone piloting; feedback included concerns that co-morbidity is not reflected in the current clusters, and that there is too much emphasis on needs and not enough on “assets” and strengths. There is concern that it does not aid personalisation/joint commissioning and there is a need to demonstrate how outcome measures (including the Health Equalities Framework) can be used to differentiate between clusters and the interventions they trigger.

Psychological Medicine

This is the most recent addition to the Payment Systems approach; currently a group is exploring ways in which the complexity of mental health and physical health co-morbidity can be captured in a way that ensures best practice is supported through appropriate funding.

Rehabilitation Psychiatry

Rehabilitation services play a pivotal role within the mental health system as a whole, particularly in relation to demand management within acute inpatient and forensic mental health settings. For example, around 20% of service users in inpatient mental health rehabilitation beds are referred from inpatient secure services (Killaspy et al., 2013). Ineffective management of flow through the rehabilitation service ‘steps’ results in huge expense at the very ‘top end’ of the system. Getting the configuration of and flow through rehabilitation services right within a local mental health system is absolutely critical to ensuring that the system works. Incentivising good care and use of local services rather than out-of-area treatments, with all of their drawbacks, is key. This care pathway, and how it might best lend itself to tariff-based payments, is

currently in development. **(A paper outlining the case can be found in Appendix 1).**

Ongoing work

This is an evolving process and this statement is an expression of the views of the College at this time. There is engagement between the College and Monitor, NHS England and ministers to continue to communicate the views of College members and inform the evolution of costing and pricing for mental health services.

Proposed Next Steps

Given the huge shifts in the financial, policy and operating environment and the transition of responsibility for tariff development from the DH to NHSE and Monitor, a stocktake and forward planning exercise seems timely. It is clear that whatever the tariff system, it must effectively support and incentivise:

- Evidence-based care in line with NICE guidelines and quality standards and improved outcomes;
- Improved access to mental health services;
- Improved access to physical healthcare and a reduction in premature mortality;
- Care in the least restrictive setting that delivers recovery-based outcomes;
- Whole-system service redesign - this will be the only safe means by which significant QIPP (Quality, Innovation, Productivity and Prevention) requirements can be delivered without adverse impact on quality. A tariff system concerned only with secondary mental health care provision will not be fit for purpose.

The College's strong recommendation is that the tariff system should be designed to support and incentivise the commissioning and delivery of evidence-based integrated care pathways. The MH tariff system should be fully aligned with the pathways recommended by NICE guidelines and quality standards and should incentivise service models that are known to deliver high-quality care, good outcomes and value for money across the health and social care system.

This is work that the College believes can be delivered at pace if there is effective engagement and alignment of key system partners, particularly the Academic Health Sciences Networks and the developing Mental Health

Intelligence Network. The College believes that the key next steps should be:

1. To undertake a rapid stocktake and forward planning exercise, engaging all key system partners - Monitor, NHSE, DH, RCPsych, CQC, NICE, ADASS, Clinical Commissioning Network etc - to clarify a shared vision of what the MH tariff system is intended to deliver and a shared commitment to a delivery plan.
2. To review the current tariff development governance structures and membership to ensure adequate and effective representation of all key system elements and robust programme management arrangements.
3. To review the clustering model so that it supports high-quality assessment and formulation practice, identifying a broader range of factors that:
 - (a) Are known to predict resource use; and
 - (b) Should be used to ensure access to evidence-based interventions.
4. To agree best practice integrated care pathways based on NICE guidelines and quality standards. These must incorporate physical healthcare to drive a reduction in premature mortality and should incorporate choice considerations.
5. To ensure there is a robust economic case to support commissioning of these pathways.
6. To develop service / economic remodelling tools to help to effect whole-system change to support pathways delivery.
7. To identify the dataset required to analyse, cost and evaluate these pathways and update the MHMDS (Mental Health Minimum Data Set), and also primary care / social care datasets as required.
8. To identify the clinical system functionality required to support pathway delivery and data collection, whilst minimising the administrative burden on clinicians.
9. To identify tariff and contracting models that will incentivise effective commissioning and delivery of these pathways and support intelligent benchmarking.
10. To develop a set of best practice pathway-based tariffs for mental health services.

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APPENDIX 1

MH Tariffs and Rehabilitation Services Summary of Concerns and Proposed Way Forward

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Change History

| Date | Version | Summary of Changes | Author/Editor |
|----------|---------|---|---|
| 8.11.13 | v1 | Initial draft | Sarah Khan, Helen Killaspy, Sri Kalidindi |
| 15.11.13 | v2 | Updated following comments from the London MH Tariff Programme leads (WW, AH, FB, TM) | Sarah Khan |
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Approvals

| Name | Title | Approval | Date | Version |
|------------|--|--|----------|---------|
| Alex Horne | London MH Tariff Programme Clinical Lead | Amended draft approved for circulation | 15.11.13 | v2 |
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Executive Summary

1. Context

Mental health rehabilitation (rehab) services specialise in working with people whose long term and complex needs cannot be met by general adult mental health services. Use of health and social care resources by this group can be particularly intensive. This relatively small service user population accounts for 25% of the joint mental health and social care spend; this equates to approximately £1.5bn per annum.ⁱ

The primary aim of rehab services is to support service users to achieve the highest level of independence they can. This process can, and often does, take a number of years and services are delivered via 'stepped' whole system integrated care pathways – each step representing a further progression towards more independent living. Service users' complex mental health and social care needs are frequently compounded by one or more comorbid conditions, such as physical health and substance misuse problems that complicate recovery.^{ii iii} Holding a long-term, whole-system integrated pathway view in the planning, commissioning, delivery and evaluation of rehab services is essential to achieving good outcomes and value for money.

Mental health PbR will work to average-price tariffs based on cluster. Such an approach for the rehab service user group is likely to lead to poor commissioning and underfunding of key 'steps' within the pathway, resulting in destabilisation of providers of rehabilitation services and potentially serious failures in care for this vulnerable and high needs group.

Rehabilitation services play a pivotal role within the mental health system as a whole, particularly in relation to demand management within acute inpatient and forensic mental health settings. For example, around 20% of service users in inpatient mental health rehabilitation beds are referred from inpatient secure services (Killaspy et al., 2013). Ineffective management of flow through the rehabilitation service 'steps' results in huge expense at the very 'top end' of the system. Getting the configuration of and flow through rehab services right within a local mental health system is absolutely critical to ensuring that the system works.

2. Risks

A pan-London meeting of mental health rehabilitation clinical and service leads was held at the end of September 2013. The group identified a number of major risks should the current tariff system be implemented without taking the specific rehab issues into account:

| Key risks |
|--|
| 1. The average price per cluster assumption |
| 2. Varying definitions of what constitutes a rehab service and therefore which services will be 'in' and 'out' of tariff payments. |
| 3. Commissioning and management of multiple provider 'stepped' rehab pathways |
| 4. The lack of alignment between clusters and the rehab service pathways |
| 5. The lack of clarity regarding the interface with forensic tariffs. |

The potential impact of these risks is of significant concern:

- Potential destabilisation of the rehab provider market;
- Commissioners failing to commission effective rehab service pathways;
- System levers and incentives for 'pull through' being eroded;

- Service users getting 'stuck' in more restrictive care settings, which may be far out of area;
- Spend escalating rapidly, quality of care going down, good outcomes for service users being reduced.

3. Solutions

The pan-London meeting went on to focus on solutions. There was agreement that a tariff system could and should serve as a very effective lever for incentivising high quality commissioning and provision of rehab services, improving:

1. Quality of care;
2. Delivery of outcomes – in particular, supporting service users to achieve their optimum level of autonomy;
3. Service user experience;
4. Integrated working;
5. Least restrictive setting and care closer to home;
6. Value for money;
7. Demand management.

The group agreed that an effective tariff system for rehab services should take as its starting point expert consensus as to what a good rehab pathway looks like – across domains 1-7 above. The JCPMH commissioning guidance and relevant NICE guidelines were thought together to constitute excellent resources that could be used as a starting point.

The group also considered that a 'stepped pathway' approach (akin to the IAPT stepped care model) would be helpful for:

- Understanding costs;
- Understanding flow;
- Identifying appropriate quality and outcome measures.

This approach could also provide rich intelligence to support commissioning and demand management.

4. Next Steps

Workshop attendees agreed that the key next step will be collection of data in a staged manner to provide relevant figures by way of evidence of the issues raised in this paper.

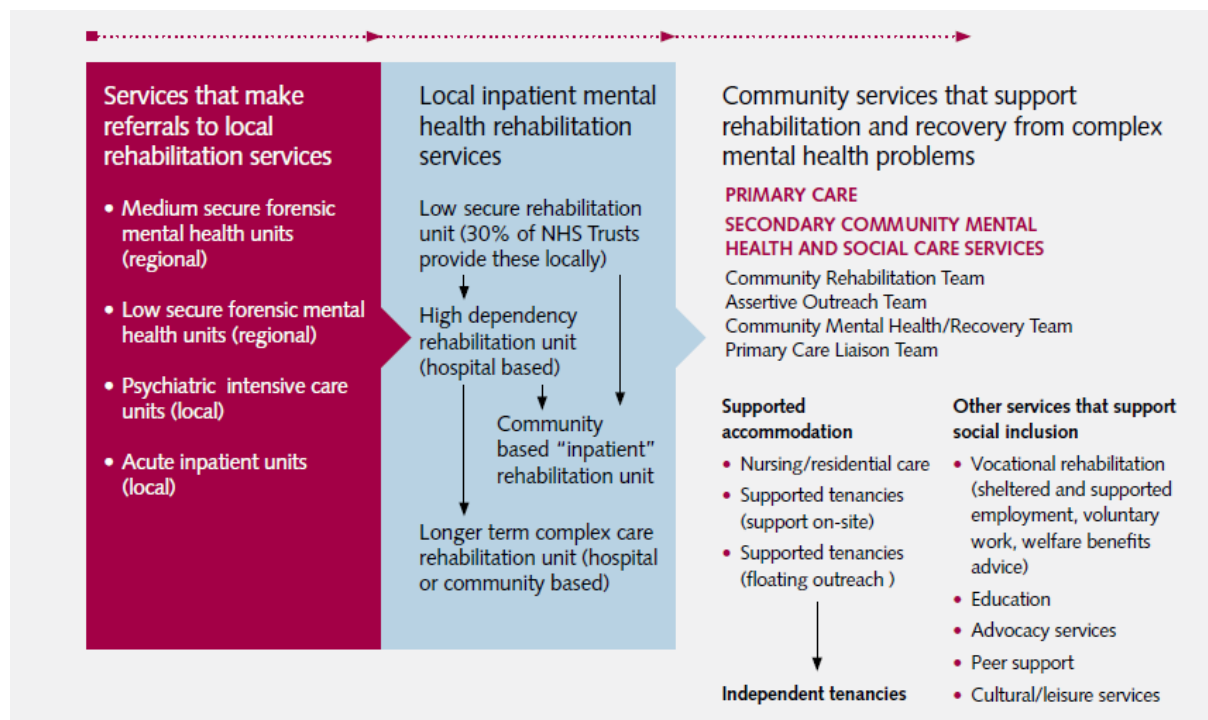
The London Currencies Development Programme, in partnership with the Royal College Rehab Faculty, is in an excellent position to lead this work.

1. Context: Mental Health Rehabilitation Services

Mental health rehabilitation (rehab) services specialise in working with people whose long term and complex needs cannot be met by general adult mental health services. Use of health and social care resources by this group can be particularly intensive. This relatively small service user population accounts for 25% of the joint mental health and social care spend; this equates to approximately £1.5bn per annum.ⁱ

The primary aim of rehab services is to support service users to achieve the highest level of independence they can. This process can, and often does, take a number of years and services are delivered via ‘stepped’ whole system integrated care pathways – each step representing a further progression towards more independent living. Service users’ complex mental health and social care needs are frequently compounded by one or more comorbid conditions, such as physical health and substance misuse problems that complicate recovery.^{ii,iii} This group of individuals is far less likely successfully to access timely and appropriate physical healthcare and physical health outcomes are among the worst of the SMI population where there is already a known 20 year mortality gap relative to the general population. Holding a long-term, whole-system integrated pathway view in the planning, commissioning, delivery and evaluation of rehab services is essential to achieving good outcomes and value for money.

The diagram below, taken from the JCPMH Guidance for Commissioners of Rehabilitation Services for People with Complex Mental Health Needs^{iv}, describes the components of a whole system rehabilitation pathway:



Providers within this pathway include:

- NHS secondary mental health care,
- Social care,
- Primary care,
- The independent sector,
- The third sector.

The independent and third sectors provide a considerable proportion of inpatient rehabilitation and residential care services to this group of service users. These are usually described as 'placements' or 'OATS' (out of area treatment). There are instances where NHS secondary mental health providers may act as providers of placements / OATS when they provide inpatient or residential care services to service users from other areas; this is quite common in some larger mental health trusts.

The drive within rehab services is to support service users to progress to ever more independent living. Best practice models involve a 'home team' – often a Community Rehab Team – providing rehabilitation, recovery and a 'placement management' and 'pull through' function whilst a service user is in inpatient or residential care to ensure that interventions are focused on preparation for the next stage of independence. This is particularly important when care is being provided out of area. Out of area placements cost around 65% more than local placements, are socially dislocating for service users and are of variable quality.^y

Responsibility for placement management and pull-through usually sits within the service user's 'home' mental health trust but this is not always the case. A recent pan-London workshop of rehab service leads identified all of the following as likely scenarios:

| | |
|-----------|--|
| 1. | A service user receives inpatient rehab care and community rehab input from the same provider organisation. The community rehab team supports 'pull through' to the next stage of more independent living. |
| 2. | A service user receives inpatient rehab care and community rehab input from different organisations. The organisation providing community rehab input provides the placement management and pull-through function. |
| 3. | As for 2 but the CCG and / or the Local Authority provides the placement management and pull-through function. |

Lengths of stay in high cost inpatient and residential care services are generally far more efficient under scenarios (1) or (2). Sometimes pull-through is further incentivised via

- Delegation of the placements budget to the provider organisation providing the placement management function (sometimes via a lead provider arrangement) and / or
- Risk / reward share arrangements around savings made via 'pull through' from high cost to lower-cost care settings. Savings are frequently invested in developing capacity within lower tiers of care.

However, placement management and pull-through functions are not always commissioned from secondary mental health providers and scenario 3 is not uncommon. This can result in very high spend on inpatient and residential care services as incentives for and expertise in placement management and pull-through are usually not so effectively combined within commissioning organisations.

It is important also to note (with reference to the diagram on page 3), the pivotal role that rehab services play within the mental health system as a whole, particularly in relation to demand management within acute inpatient and forensic mental health settings. For

example, around 20% of service users in inpatient mental health rehabilitation beds are referred from inpatient secure services^{vi}. Ineffective management of flow through the rehabilitation service 'steps' results in huge expense at the very 'top end' of the system as well as impacting significantly on the effective use of acute mental health beds. Getting the configuration of and flow through rehab services right within a local mental health system is absolutely critical to ensuring that the system works.

Given the context within which rehab services operate, it will be of the utmost importance that the Mental Health Tariff implementation approach does not:

- Ignore the complexities described above;
- Incentivise short-term perspectives;
- Disincentivise integrated, whole-systems working
- Disincentivise 'pull-through' the system – from forensic and acute services all the way down through the rehab pathway 'steps' to independent living;
- Destabilise rehab pathways that are working well.

Rather, the implementation approach should support and incentivise long-term, evidence-based, whole system integrated-pathway approaches to the planning, commissioning, delivery and evaluation of rehabilitation services

2. The Current MH Tariff Implementation Approach: Risks to Rehab Services

A pan-London meeting of mental health rehabilitation clinical and service leads was held at the end of September. The first part of the meeting focused on identification and agreement of the key risks that the current MH Tariff implementation poses to rehab services and whole system pathways. There was clear consensus that the following constitute significant risks:

| Risk | Potential Impact |
|--|--|
| <p>1. Average price assumption</p> <p>The current Tariff model is predicated upon the untested assumption that cluster will reasonably predict resource use, such that an average price for each cluster day / cluster period can be arrived at.</p> <p>Rehab services are very likely to skew this average – for example, the great majority of service users in Cluster 17 may be living independently with a weekly visit from an AOT care co-ordinator. However, 10% may be in in a secure rehab unit costing circa £2000 a week.</p> | <p>An average price approach is unlikely to be meaningful or workable. Implementation of this approach runs the very real risk of destabilising rehab service providers and potentially resulting in serious failures in care for this vulnerable and high needs service user group.</p> |
| <p>2. Definitions of rehab services</p> <p>Different organisations define rehabilitation services differently and lines between rehab, neuro-rehab and forensic services are blurred.</p> <p>There is a risk firstly that the Tariff clusters may not cater sufficiently for the range of service users receiving ‘rehab’ services.</p> <p>There is also a risk, with the average price per cluster approach, that providers of rehab services will be disincentivised from working with service users with more complex needs.</p> | <p>Rehab services ‘rebrand’ themselves as specialist or forensic to try to ensure better security of funding.</p> <p>Service users with more complex and / or challenging needs get ‘stuck’ in more restrictive care settings.</p> <p>Spend escalates rapidly, quality of care goes down, good outcomes for service users are reduced.</p> |

| Risk | Potential Impact |
|--|---|
| <p>3. Multiple providers</p> <p>As described in the previous section, best practice models involve a 'home team' providing a 'placement management' and 'pull through' function while a service user is in inpatient or residential care.</p> <p>Where a service user is receiving inpatient care via a placement / OATS arrangement, it will be crucial that both the placement provider and the 'home team' are appropriately reimbursed. Unless lead provider arrangements are in place, this will require unbundling of the tariff.</p> <p>There would also need to be a clear expectation that 'home team' input should be funded whenever a service user is in a placement.</p> | <p>Service users get 'stuck' in more restrictive care settings, which may be far out of area.</p> <p>Spend escalates rapidly, quality of care goes down, good outcomes for service users are reduced.</p> |
| <p>4. Clusters do not align well to rehab service pathways</p> <p>The clusters do not align well either to the whole rehab care pathway or to discrete pathway elements. Cluster information will not help or incentivise commissioners to commission effective rehab service pathways that manage demand effectively. This is of very significant concern given that:</p> <ul style="list-style-type: none"> • The rehab population accounts for 25% of the joint annual secondary mental health and social care spend. • Effective demand management within rehab services is absolutely critical to effective demand management within forensic and acute inpatient services. | <p>Commissioners fail to commission effective rehab service pathways.</p> <p>Service users get 'stuck' in more restrictive care settings, which may be far out of area.</p> <p>Spend escalates rapidly, quality of care goes down, good outcomes for service users are reduced.</p> |
| <p>5. Interface with Forensic PbR</p> <p>20% of service users in rehab beds have 'stepped down' from forensic services. Establishment of a separate set of forensic inpatient tariffs means that neither forensic providers nor rehab providers are incentivised to ensure that forensic service patients are 'pulled through' to less restrictive settings when this becomes appropriate.</p> <p>This risk is compounded by the separate commissioning arrangements for forensic and rehab services. No single agency will have oversight of the whole local pathway or responsibility for ensuring that demand is managed effectively and least restrictive setting principles actively incentivised. The use of settings not recognised by rehabilitation specialists such as 'locked rehabilitation' (a term used by forensic specialists) further compounds such</p> | <p>System levers and incentives for 'pull through' are eroded.</p> <p>Service users get 'stuck' in more restrictive care settings, which may be far out of area.</p> <p>Spend escalates rapidly, quality of care goes down, good outcomes for service users are reduced.</p> |

| Risk | Potential Impact |
|---|--|
| discontinuity / potential blocks in the system and lack of local investment in rehabilitation services. | |
| <p>6. Integrated services</p> <p>The current MH tariff model focuses only on the secondary mental health element of provision and funding. This is completely at odds with:</p> <ul style="list-style-type: none"> • The fact that rehab service users have complex mental health and frequently, physical health and social care needs. Co-morbid substance misuse is common. • The direction of national policy which is clearly stating that services should be integrated around the needs of complex patients and payment and pricing systems should support and incentivise this way of working. | <p>Implementation of MH PbR fails to incentivise care integrated around the very complex needs of these service users.</p> <p>Rehab service users continue to suffer the worst physical health outcomes within the SMI population.</p> <p>Existing integrated funding arrangements are destabilised.</p> |

3. Solutions: Initial Thinking

The second part of the pan-London meeting focused on solutions. There was agreement that a tariff system could and should serve as a very effective lever for incentivising effective commissioning and provision of rehab services, improving:

1. Quality of care;
2. Delivery of outcomes – in particular, supporting service users to achieve their optimum level of autonomy;
3. Service user experience;
4. Integrated working;
5. Least restrictive setting and care closer to home;
6. Value for money;
7. Demand management.

However, the group expressed concern that the current MH PbR model, unless refined, is unlikely effectively to support or drive delivery of these aims.

There was broad agreement that an effective tariff system for rehab services should take as its starting point expert consensus as to what a good rehab pathway looks like – across domains 1-7 above.

It was noted that the JCPMH Guidance for Commissioners of Rehabilitation Services for People with Complex Mental Health Needs, together with the relevant NICE guidelines and quality standards could constitute much of the required expert consensus and maximum effective use should be made of these resources.

It was agreed that it would be helpful to define ‘what good looks like’ in terms of:

- The required system intelligence (including public health);
- The commissioning approach;
- The pathway;
- Each of the steps of the pathway;
- The pathway management approach.

It was also agreed that a ‘stepped pathway’ approach (akin to the IAPT stepped care model) would be helpful for:

- Understanding costs;
- Understanding flow;
- Identifying appropriate quality and outcome measures.

i.e. the above could be understood / identified in relation to each pathway step. This approach could provide rich intelligence to support commissioning and demand management. The group considered that a set of tariffs linked to each pathway step, but understood in the context of an ‘end-to-end’ rehab pathway, could be an excellent ‘fit’ for rehab services.

4. Proposed Next Steps

The last part of the meeting focused on consideration of next steps. These were then further developed through discussion between leads at CNWL, SLAM and C&I.

It is recommended that steps 1 and 2 are taken forward immediately.

| | |
|-----|---|
| 1. | <p>Conduct initial data collection exercise</p> <p>This would examine, by borough or equivalent, for clusters 0, 8, 11, 12, 13, 16 & 17:</p> <ul style="list-style-type: none"> • The overall number of service users in each cluster • The number of rehab service users in each cluster • For the rehab population in each cluster, the range of service settings and the average daily cost in relation to each <p>The purpose of this exercise would be to demonstrate the ‘skewing’ effect that rehab services will have on average price</p> <p>The proposed data collection templates are attached as an appendix. The intention is to fast-track data collection in three London MHTs (CNWL, SLaM and C&I) and then to consider extending data collection across London and more widely.</p> |
| 2. | <p>Gain agreement from NHS England and Monitor for the London Currency Development Programme, in partnership with the Royal College Rehab Faculty, to lead work to develop the current MH Tariff model so that it better supports high quality commissioning and delivery of rehab services.</p> |
| 3. | <p>Achieve expert consensus on the definition of a best practice rehab pathway (as framed in section 3).</p> |
| 4. | <p>With support from Monitor and NHSE, refine the current MH Tariff model so that it will better support delivery of the agreed best practice rehab pathway.</p> |
| 5. | <p>Identify pilot areas to test the refined model.</p> |
| 6. | <p>Finalise the model using the learning from the pilot areas</p> |
| 7. | <p>Implement the model in the pilot areas</p> |
| 8. | <p>Develop implementation tools</p> |
| 9. | <p>Roll the model out across rehab services</p> |
| 10. | <p>Evaluate</p> |

ⁱ Mental Health Strategies (2010) *The 2009/10 National Survey of Investment in Mental Health Services*. London: Department of Health

ⁱⁱ Holloway, F. (2005) *The Forgotten Need for Rehabilitation in Contemporary Mental Health Services: A Position Statement from the Executive Committee of the Faculty of Rehabilitation and Social Psychiatry*. Royal College of Psychiatrists www.rcpsych.ac.uk/pdf/frankholloway_oct05.pdf

ⁱⁱⁱ Killaspy, H., Rambarran, D. & Bledin, K. Mental health needs of clients of rehabilitation services: a survey in one trust. *Journal of Mental Health*, 2008, 17: 207–218.

^{iv} Killaspy, H, Meier, R., Mitchell, S., Harrison, C. et al. (2013) *Guidance for commissioners of rehabilitation services for people with complex mental health needs*. London: JCP-MH.

^v Killaspy, H & Meier, R. A Fair Deal for Mental Health Rehabilitation Services. *The Psychiatrist*, 2010, 34: 265-267.

^{vi} Killaspy, H., Marston, L., Omar, R., Green, N., Harrison, I., Lean, M., Holloway, F., Craig, T., Leavey, G., and King, M. Service Quality and Clinical Outcomes: an Example from Mental Health Rehabilitation Services in England. *British Journal of Psychiatry*, 2013, 202: 28-34.