Mental Health currency review

A proposed new approach to counting Mental Health activity

Contents

Introduction

From NHS England and Improvement's National Clinical Director for Mental Health

As we move to a new integrated health and care system focused on place-based care, and to develop new ways of working, moving primary and community mental health care close together, we have been thinking about how we can use a mental health currency model to guide evidence-based care; and create the infrastructure needed to support delivery of our evolving Mental Health services. The move to Integrated Care Systems, using population health management to deliver improved mental health and physical health outcomes, offers an opportunity to create a currency model for mental health that is more clinically meaningful, aimed at driving up quality, providing a national and local foundation to promote parity between mental and physical health services.

Following a review of the current mental health currency, this document sets out a suggested new model for grouping patients. This new model aims to create parity with physical healthcare resource groups and provides a consistent and clinically recognisable approach to grouping patients across the health system. With this new model, we also aim to reduce the bureaucratic burden on clinicians, to remove unwarranted variations in the ways patients are grouped, and to allow us to compare patient pathways and their associated resources. Having a more clinically meaningful set of groups for mental health services to use, when combined with SNOMED CT and PLICS data, will also help us to drive up the use of evidence-based interventions nationally.

Clustering has been in place since 2012, and there is a need to amend the model to ensure groupings are better recognised by patients and by clinicians; and this is especially important as we reconfigure services and change mental health practice through the Long Term Plan: we need to ensure widespread adoption, ownership and mainstream use of our new currencies in mental health. And by building in a regular review process to the new currency model, just as we do in physical health currencies, I believe we will have something that is future-proofed, remaining attuned to changes in research and clinical practice, and changes in mental health policy. Crucially, we want the new mental health currency model to aid in driving up the quality of care within mental health.

This document is published alongside *Developing the payment system for 2021/22* and sets out the details of our proposed new currency model. The tariff engagement gives us an opportunity to gather feedback on the proposed model, feedback that will be key in making sure mental health currencies work across the whole system and for everyone using them. The comments and recommendations will be considered during a consultation before the model is finalised and published in a future National Tariff. I look forward to hearing from you, and I would also like to thank you for helping to shape the future currency model for mental health.

Tim Kendall, National Clinical Director for Mental Health, NHS England

1. The future of the payment system

1.1 In Mental Health, payment flows are currently to a large extent dictated by historical or existing cost structures and are generally focused on inputs. Underpinning to the NHS Long Term Plan objectives of sustainable and high-quality care, there is a need for future payment to better align to the needs of patient populations, and we need to ensure that differences between patient needs are reflected in the design of the payment and contracting system.

1.2 The policies outlined in *Developing the payment system for 2021/22* aim to standardise the approach to payment across all secondary care services, both acute and non-acute. Increasingly payments are supporting systems in collaborative working and driving allocative efficiency across providers.

1.3 The ability to make sure resources are put in the right place within a system is reliant on having good quality data and information on activity and cost. Over time, the existence of a payment by activity system for much of acute physical health has driven granular, good quality information on the types and complexity of activities taking place.

1.4 However, there has been more limited success in driving similar quality information within Mental Health and community settings. There is an opportunity with the roll out of Patient Level Information Costing System (PLICS) into non-acute settings, and the potential to use SNOMED CT (Systematized Nomenclature of Medicine Clinical Terms, or “common clinical language”) information to greatly improve the quality and granularity of information collected.

1.5 Supplementing PLICS and SNOMED CT with a refined currency model for Mental Health which is supported by system stakeholders will provide the opportunity to develop a comprehensive set of patient level activity data, and eventually cost data. This enriched information will make it easier for systems to decide how to allocate resources across services and providers and drive the visions set out in the NHS Long Term Plan.

2. Current Mental Health payment arrangements

2.1 As set out in the National Tariff Payment System, Mental Health providers and their commissioners must adopt a blended payment approach in relation to Mental Health services for working-age adults and older people. The blended payment approach should include:

a. a fixed element based on forecast activity;

b. a variable element;

c. an element linked to quality and outcome measures and the delivery of access and wait standards; and

d. an optional risk share agreement, if providers and commissioners consider this appropriate locally.

2.2 Providers and commissioners can agree an alternative payment approach, as long as they apply the local pricing principles and comply with the procedure for departing from a national currency.

2.3 One of the barriers in implementing the blended payment model has been the relative complexity of the arrangements compared to a block contract, which is not made easier by having a Mental Health currency model which is not universally accepted or used by the sector.

2.4 The blended payment policies set out in *Developing the payment system for 2021/22* seek to simplify the payment arrangements for the NHS next year and set the same payment rules for all secondary care services. In the longer term, the proposal set out in this document would form the basis of how this model is applied to Mental Health services, starting first with how we count Mental Health activity in a more clinically meaningful way. Payments for Mental Health will be better informed by having better quality, more granular, clinically validated and sector accepted activity data.

3. Clustering and the currency review

3.1 The current currency model for non-specialist Adult Mental Health pathways is the clusters, which have been mandated since April 2012. A cluster is a global description of a group of people with similar characteristics as identified by clinical assessment and then rated using the Mental Health Clustering Tool (MHCT). In Mental Health there are 21 clusters that cover a range of diagnoses and needs. Each person is assessed by the clinician based on their symptoms and individual need.

3.2 Although clustering is mandated, not all providers report monthly data. Several reasons for this have been shared by providers including time and administrative burden on clinicians. A lack of clinical meaningfulness has also been cited, particularly as there is no process to regularly review of the groupings. This has resulted in the groupings not adapting to the changing environment of Mental Health practice.

3.3 As a result of these limitations, many providers have developed and are now using local approaches to group patients. Whilst this is meaningful locally, varied approaches create regional disparities in the way patients are grouped. There is therefore a need to align these local approaches to create a consistent national model, that is both meaningful and addresses the administrative burden.

3.4 NHS England and NHS Improvement's National Mental Health Policy team and the National Pricing team have been working with the National Clinical Director for Mental Health and a group of system stakeholders to review the currency model for Mental Health. Working with Mental Health clinicians and provider costing teams, national colleagues have captured and reviewed the key issues that need to be addressed as part of any change to the currency model, and the current local adaptation of the clusters model and best practice across the country. Potential new models have been developed and shared as outputs of that process.

3.5 To support assessment of any new model, the following list of factors has been agreed by the stakeholder group as important to be covered by a Mental

Health currency. The table below shows these factors and the assessment of clustering against each one. It is evident from this assessment, that current cluster model is not fit for purpose.

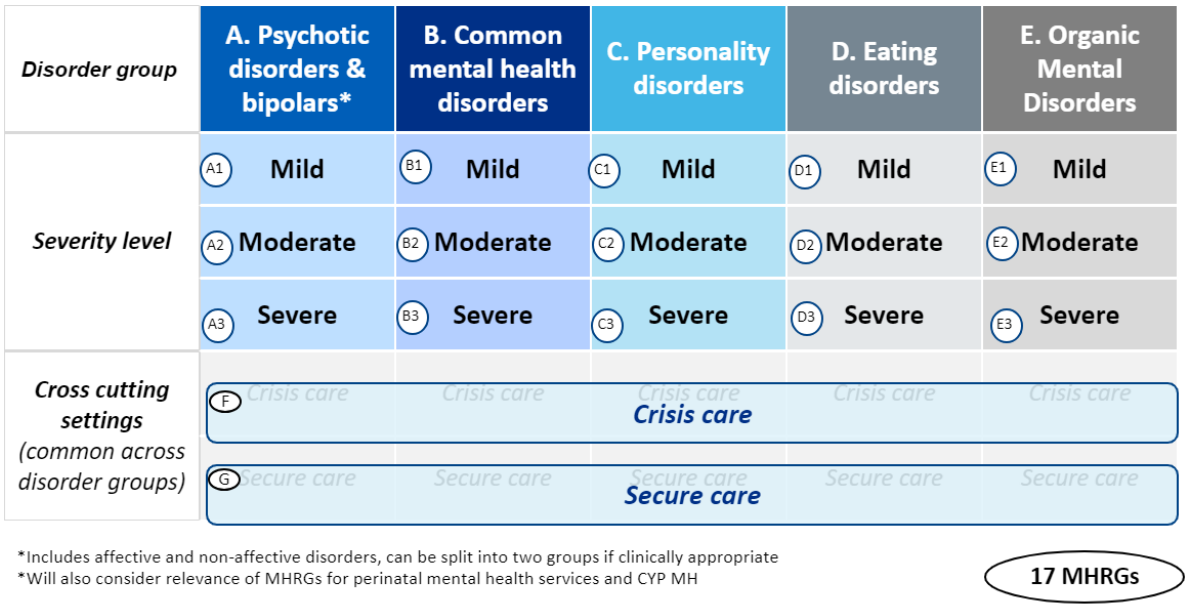
	Clusters
Currency design code covers	
Condition	Partially
Interventions	No
MH comorbidities	Partially
Complexities	Partially
Severity	Partially
Safety profile	Partially
Supplementary information available on:	
Outcome data	Yes
Cost by setting	No
Cost by pathway	Partially
Cost by step	No
Data collection is:	
Value add for clinicians	No
Low admin burden	No
Low risk of errors	No
The currency unit	
Groups to a single currency	Yes
Groups similar resource consumption together	No

3.6 As the NHS moves to system working, there is also an increased need to ensure alignment of models, structures and costing mechanisms across physical and mental health, giving systems the information needed to plan and delivery services in the most effective way.

4. Proposed new approach

4.1 NHS England and Improvement's Mental Health team and Pricing team propose the development of *Mental Health Resource Groups*, similar to the current physical health model but adapted to meet specific challenges and opportunities in Mental Health.

4.2 The model below has been developed based on the review described above. *Mental Health Resource Groups* would build on existing clustering whilst focusing on making the groupings more appropriate as a currency model, more clinically relevant and easier to review regularly.



4.3 In the model set out above, disorder group, severity and intervention would be combined to create a *Mental Health Resource Group* (MHRG) for each service user. The grouping for an individual would be regularly reviewed by the clinician. The proposed cross-cutting settings would each be one MHRG, regardless of the disorder group, the cost as in these settings is driven by the type of service rather than disorder grouping.

4.4 The groupings in the table above are an initial proposal; feedback is requested as part of this process on how the most appropriate and meaningful groupings.

Questions for consultation input:

Are the proposed groups clinically meaningful, structured by disorder group and severity level?

Are the proposed groups administratively meaningful to support counting activity and payment?

4.5 A MHRG proposed in this model can be created through information that is already collected by clinicians at assessment. The next Mental Health Services Dataset (MHSDS) version change, scheduled for September 2021, would include changes to enable the groupings to be captured nationally. The consultation for changes and any new additions to the MHSDS is currently progressing outside of this currency review process. Input from this consultation will be used to ensure the next version is configured to capture the appropriate currency data.

Questions for consultation input:

With consideration to use by local systems and any additional burden or workload, should MHRGs be determined locally and flowed to the MHSDS, or should the individual items needed to determine the MHRG be flowed to the MHSDS i.e. disorder group, severity and setting, and MHRGs determined at a national level?

4.6 The proposed model can be linked to PLICS data, SNOMED CT and eventually outcomes data. This will allow identification of how effective interventions are for patient groups, the associated costs, and in turn how service delivery can be improved. MHRGs facilitate the creation of bigger picture of costing, resourcing and delivery and aid the use of evidence-based care. Guidance for mental health services submitting PLICS data for 2019/20 asks for services to submit clustering information. Future PLICS guidance would be updated to reference the new model.

4.7 In line with the process that is in place for physical HRGs, a reviewing group will be established for each of the high-level disorder groups to ensure the MHRGs are correct following their introduction, clinically up to date and adapted based on evidence-based care. It is proposed that review groups would agree co-morbidities across the groups and how best to use the currency model to incentivise best practice. Reviewing groups would be clinically led, meeting at regular intervals to ensure that disorder groups remain clinically relevant in a changing environment.

Questions for consultation input:

Should there be one review group for the whole model, or a number of different review groups providing input on each of the A. to G. disorder groups specifically?

4.8 The proposed model has a number of notable benefits at local, system and national levels. The proposed MHRG model:

a. has the opportunity to be more clinically meaningful than clustering, driving evidence-based care and, in the longer term, measuring and reporting of outcomes;

b. creates more parity with acute care Healthcare Resource Groups (HRGs), moving to a consistent approach across healthcare;

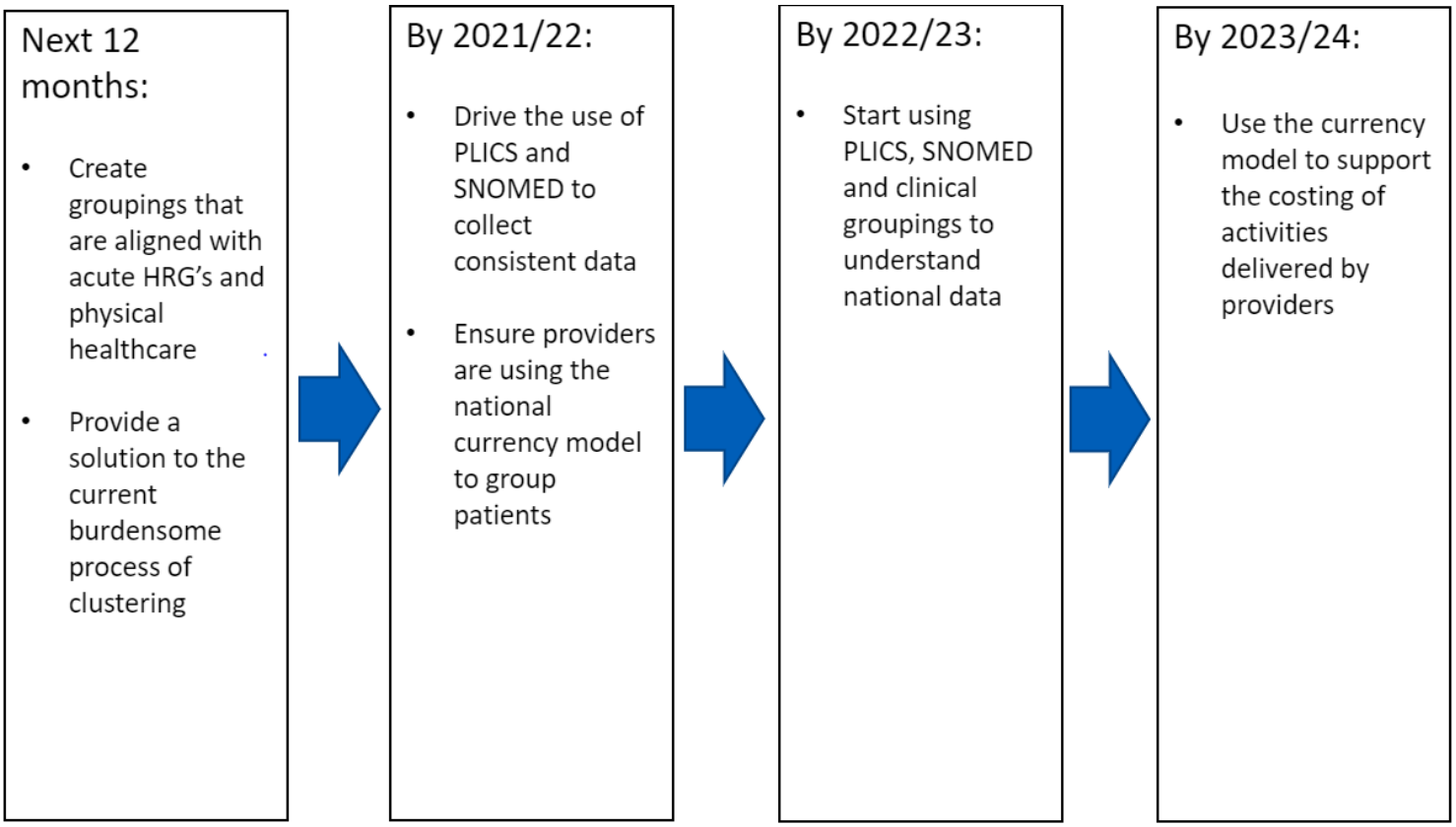
c. aligns to local models we are aware of, as such it would not replace work that is already underway locally;

d. relies mostly on information that is already collected by the clinician at assessment, reducing administrative burden; and

e. will incorporate a clearly defined process for clinical review, meaning that it is responsive to change in the system. This will ensure that it remains clinically meaningful in a changing environment.

5. Timeline for development

5.1 The timeline for continuing to develop the new model continues through to 2023/24 when full implementation throughout the Mental Health sector is expected and MHRGs used to support costing of provider activities.



6. How to provide feedback

6.1 To provide feedback on the proposed Mental Health Resource Groups and the model outlined above, please use the tariff engagement online survey.

6.2 All feedback is welcome, particularly on the questions for consultation input noted throughout this document. The deadline for feedback is the **10 December 2020**.

6.3 We will carefully consider all feedback as we continue to develop this work. Please contact england.mhinfrastructure@nhs.net if you have any questions.

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication approval reference: PAR0099