NHS England

Mental health and neurodevelopmental resource groups guidance

A supporting document to the 2025/26 NHS Payment Scheme

Contents

Who this document is for

This document is primarily intended for finance, costing and data teams in NHS mental health and NHS Talking Therapies (formerly known as IAPT) providers to help them understand how Mental Health and Neurodevelopmental Resource Groups are derived from existing data, so this data can be improved. We ask chief medical and chief clinical information officers in Trusts to ensure service managers are aware and to monitor data quality is monitored at board level. Similarly, mental health, commissioning, population health and analytics leads in ICBs should draw on this document to ensure that a shared understanding of populations need, system-level costs and ongoing provision is being developed from implementation of MHNRGs. We welcome providers and systems sharing any local applications of the new currencies to planning, population health management, contracting, patient flow management, service evaluation, outcomes management or others with the national team for the development of case studies.

Executive Summary

Mental Health and Neurodevelopmental Resource Groups (MHNRGs) – the new mental health currencies replacing clustering – are a patient segmentation tool for providers and systems to plan, fund, benchmark and improve their services in a more data-based way. MHNRGs are a key lever for achieving parity of esteem with the acute sector, with better outcomes reporting and robust costing to demonstrate value for money and improve the quality of care for our patients.

We are developing MHNRGs iteratively, starting with a simple patient segmentation model to improve data quality before adding granularity over time. Further development is planned and will be guided by our ongoing sector engagement. Our long-term vision is that MHNRGs become a tool for understanding population and patient needs, the activity performed to meet those needs, and the associated costs and the outcomes achieved for different cohorts. Currencies therefore have the potential to provide a measure of the value created for patients in return for spend on services, giving you the tools to improve outcomes.

We aim to use currency models to improve data quality, refine our patient segmentation, and understand opportunities to identify value for money in mental health services. MHNRGs will be a key element of the data base to inform funding of services over the coming years.

Iterative development timeline:

- In May 2024, we soft launched population level currency models and asked providers to begin improving their data quality in key fields such as presenting complaint, team type, reason for referral, PROMs (Patient Recorded Outcome Measures) and needs and complexity factors.

- From 2025/26 onwards, we will require providers to flow high quality data within the fields underpinning currencies to the MHSDS (Mental Health Services Data Set), IAPT (Improving Access to Talking Therapies) Dataset and to link this to the PLICS collection. We will also require systems and providers to begin using MHNRGs to support service development, benchmarking, planning, and funding discussions.

- We will be proceeding flexibly and collaboratively, reacting to the needs of the sector and at a pace based on engagement and policy priorities. The development of any future linkages with funding and payments will be subject to sector engagement as well as via the NHS Payment Scheme consultation.

1. Introduction

This guidance document has been developed to help providers, commissioners, and Integrated Care Systems (ICSs) across England implement the Mental Health Currency Models, named the Mental Health and Neurodevelopmental Resource Groups (MHNRGs).

Adrian James, National Medical Director for Mental Health and Neurodiversity, says: *"The new mental health and neurodevelopmental currency models are a key step toward achieving parity of esteem and addressing inequalities in mental health. By equipping our services with tools to better understand and meet local needs, these currencies will highlight where investment is most needed to improve outcomes. Co-developed with clinicians and service users, they reflect real-world needs, and since they are built on existing data, they add no extra burden to frontline staff. We will continue evolving these models in partnership to support our mental health and neurodiverse patients across the country."*

MHNRGs are a patient segmentation tool for providers and systems to plan, fund, benchmark and improve their services in a more evidence-based way. MHNRGs are a key lever for achieving parity of esteem with the acute sector, with better outcomes reporting and robust costing to demonstrate value for money and improve the quality of care for our patients. The currency model aims to support system based collaborative working based on national policy ambitions, creating a common understanding of care provision, and providing a standardised evidence-base which can support effective and equitable funding models.

MHNRGs have been developed with the input of expert working groups led by clinicians and patients, supported by an overarching steering group. NHS England is dedicated to developing granular patient-level currency models future iterations.

This guidance introduces the first iteration of the model, which we will further develop collaboratively over the coming years, placing the patient and their needs at the centre. In 2025/26, we want providers to implement the foundational structure of MHNRGs by creating the right data flows and processes locally. In future, MHNRGs will be embedded as a tool to understand mental health patient needs across multiple settings. They will provide a standardised way of segmenting data to support effective service development and benchmarking, population health management, planning, and funding discussions.

1.1 What is a Currency?

A currency model segments patients and activity based on needs and similarities in clinical resource use. Each unit of currency must be evidence-based and analytically identifiable, but most importantly it must be clinically meaningful. The currency must be rooted in the care the patient receives and be practical to implement.

Currencies can take different forms. For example, they can be based on specific activity or the time period in which a patient can be treated for a condition. One example of an activity-based currency is an appendectomy carried out on an adult patient with a complications or comorbidities score of zero. The resources used to perform the procedure (staff, equipment, location, and consumables such as dressings and drugs) are similar for different patients, so this type of appendectomy can be defined as a unit of currency. Another example of how a currency can work is through a year of care payment for patients who have cystic fibrosis. The complexity of the patient is banded into a number of groups which are linked to a payment for their year of care.

A currency is often confused with a price or a specific payment model, however these terms are not interchangeable. A currency refers to grouping healthcare activities into units of similar resource and clinical need. A price refers to a value assigned to a unit of currency or bundled package of care as part of a funding mechanism. Appropriate valuation is identified via costing processes, which themselves support clinical, operational, and financial improvement processes, as well as planning and funding arrangements.

This guidance focusses on a currency model, rather than a payment model. We have developed MHNRGs with many use cases in mind, including support for operational planning, population health management, service benchmarking, costing, and outcome analysis beyond funding.

1.2 Aim of Introducing Currency Models

MHNRGs will be a key driver of data quality and parity of esteem, while also supporting quality care provision. Currency models have so far been developed for many services, predominantly in the acute sector. There has been a long-term ambition to develop currency models for mental health, reflecting the complexity of care provided and putting the sector on a level playing field with the acute sector.

The currency models will support collaboration across various provider types, by creating standardised ways of grouping data about patients and the care they receive. Our long-term vision is that MHNRGs become a tool for understanding population needs, the activity performed to meet those needs, and the associated costs and the outcomes achieved for

different cohorts. MHNRGs therefore have the potential to provide a measure of the value created for patients in return for spend on services.

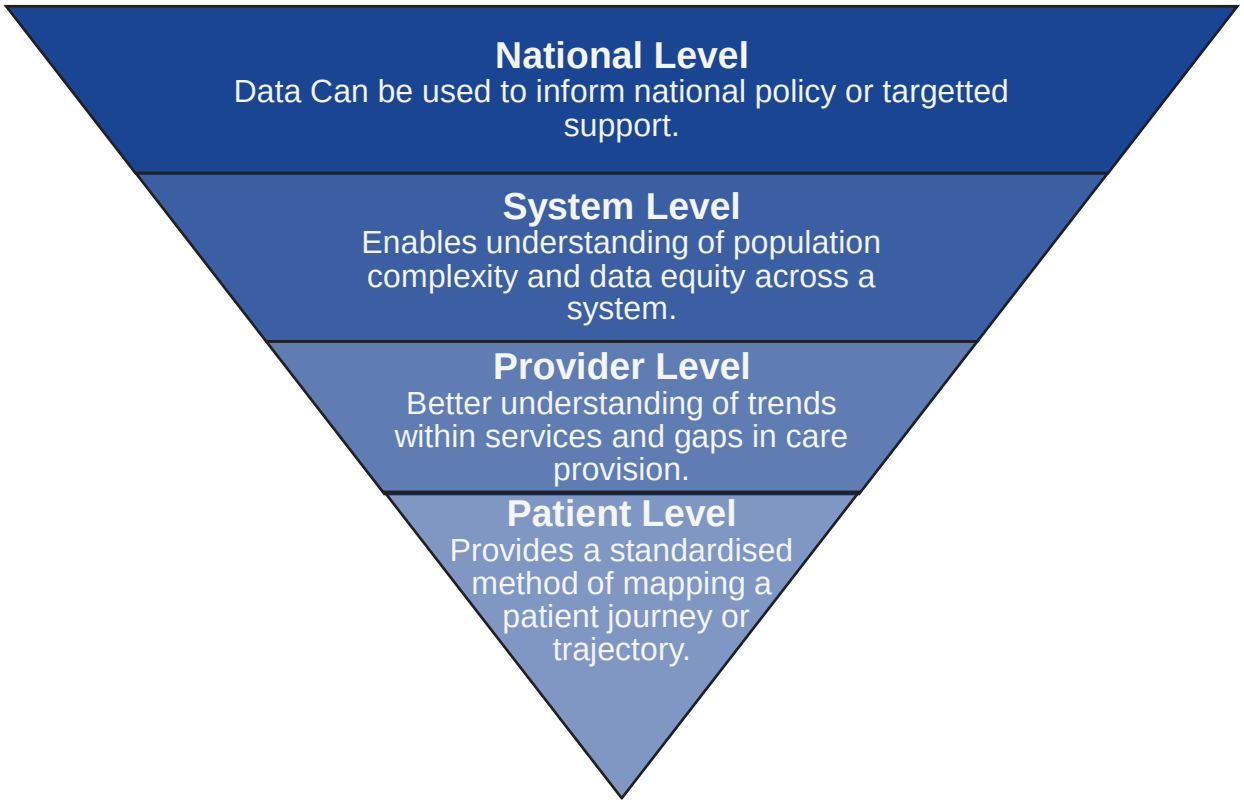
Mental Health currency models will:

- Support a standardised understanding of the patient population, by;
    - Standardising data collection processes.
    - Creating pivotal standardised units (currencies) for analysis.
    - Developing national data for a wide range of uses.
- Create a flexible and scalable model (see Appendix 1) which offers parity and comparable analysis with the wider healthcare sector;
    - Creating consistency in understanding data for benchmarking at patient, population, provider, and system level, supporting population health management.
    - Linking to other currency models to provide a holistic understanding of patient need, complexity, costs, and outcomes of care provision at system level.
- Support planning and funding arrangements, by;
    - Supporting future planning, commissioning and service design based on population need.
    - Providing a basis for costing care provision.
    - Creating an evidence base for payment, gradually moving away from block contracting.

In future, systems can use currencies to ensure service provision meets the needs of patients in a local health economy. This means currencies are a crucial enabler for transitioning to population and place-based commissioning. Currencies can also inform service development and re-design, thus ensuring the money spent provides best value for patient populations and reimburses providers fairly for the work they do.

We will begin to ask Integrated Care Systems (ICSs) and providers to increasingly use MHNRGs to support service development, benchmarking, planning, and funding discussions over the coming years, following improvements to data quality and the development of suitable depth and breadth within the currencies.

Fig. 1 How can data be grouped for various uses.



2. Mental Health and Neurodevelopmental Resource Groups (MHNRGs)

The NHS England Mental Health Programme and the Payment Development team have been developing the new Mental Health Currency Models to replace clustering for 2025/26. The development of currency models aims to address key issues from the previous clustering approach in Mental Health which were:

- Clinical burden - Clustering required the clinician to subjectively assess each person using the Honos questionnaire. This took up clinical time and introduced variation. The new model is data driven and currencies will be delivered via predominantly existing information from mandatory/required fields in the MHSDS and IAPT dataset.

- Addressing the challenge around complex cases and the small number of clusters to choose from. Clinicians across MH referrals had a choice of 21 clusters which was not enough to cover a range of presenting complexities. While the model set out in this document is simple in order to aid implementation, it will be fleshed out further in coming years. We are introducing seven unscored Needs and Complexity Factors to reflect complexity better. In future development we will consider the use and expansion of these factors.

- Data quality – which was insufficient to support a mature currency model at the time that clustering was developed but is rapidly now approaching maturity. MHSDS reporting was designated as official statistics from April 2024, and data quality continues to improve.

To ensure consistency across sector the currency development process will be transparently shared to ensure we address feedback and challenges and sharing benefits both in the short and long term. The aspiration is to ensure alignment and embed the new currencies.

MHNRGs have been developed based on the following principles:

1. **Clinically meaningful:** Currencies must be clinically meaningful and easy for frontline health and care professionals to use.

2. **Data driven and practical:** Minimises or does not increase the administrative and clinical burden on the healthcare system by tapping into existing data flows.

3. **Homogenous units of resource:** Currency units should be packages of care that require broadly similar levels of resource for each patient receiving that package, at least at local level.

4. **Interact with other currencies:** The boundaries of a currency model should be clear and easy to understand and should take other currencies into account to avoid double counting.

5. **Future proof:** The currency models should be designed and implemented in a way which is future proof, avoiding the need for fundamental changes in subsequent iterations of the models, whilst realising the opportunities on the horizon.

The new models will not require clinicians to group patients but will instead be derived from clinical data stored locally and submitted through the MHSDS and IAPT datasets in a generally automated process.

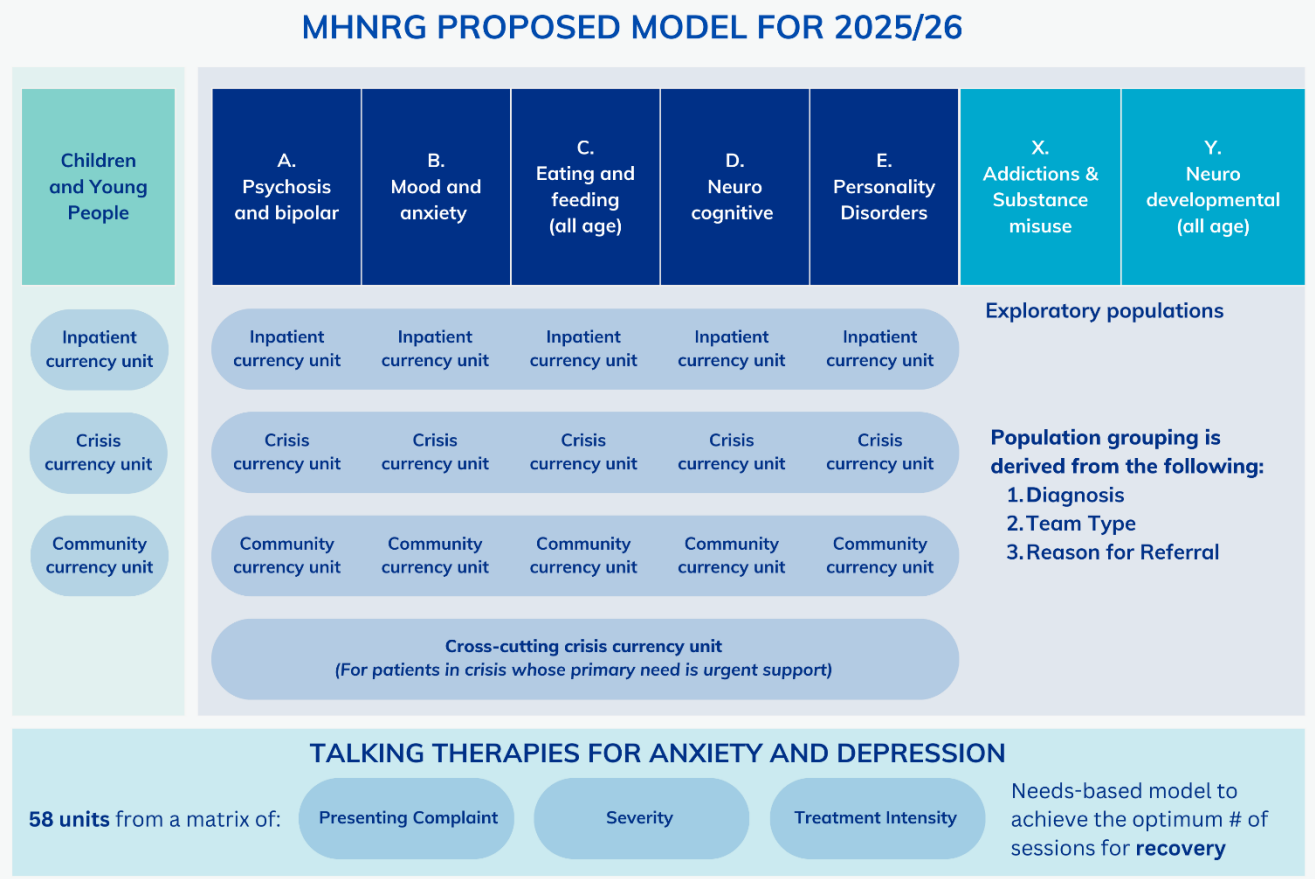
The currency development process is iterative and additive. This means we will launch additional, and more granular currency units based on need over time, over multiple phases of piloting. We will then add granularity where it is most needed and has been validated through piloting and data analysis.

The currency model will primarily focus on understanding patient needs and activity by providing an evidence-based segmentation of patients across relevant service and need categories. A key component of the currency model will be linking to contact and activity

information. Combining currencies to track patient needs with consistent activity-based data reflecting provision will support benchmarking, service planning and commissioning discussions.

A comprehensive list of the benefits of implementing currency models can be found in Appendix 3.

Fig. 2. Populations and currency units



We are taking a number of actions to ensure that the currency models are future proof and realise opportunities on the horizon.

- We are building currency models with ICD-11 in mind.
- The work of a task and finish group to consider community outcomes metrics will result in a wealth of new data through Patient Recorded Outcome Measures (PROMs).
- Consideration of Community Mental Health waiting times and productivity metrics to understand the impact of care and management of patient need.
- We are exploring and creating synergies with the ongoing development of the MHSDS. For example, the change from ‘provisional diagnosis’ to ‘presenting

complaint' will improve our understanding of need independent of formal diagnosis – as was successfully achieved for NHS Talking Therapies.

2.1 How MHNRGs were developed

The Mental Health Currencies Review of 2021 initiated a new wave of work following which we re-intensified our sector and stakeholder engagement from late 2022.

From 2022, six task and finish groups were established focussing on adult populations. Each group comprises of a cross-cutting membership of subject matter experts tasked with understanding the needs of the population group, understanding the data landscape, and developing a robust currency model which places the patient at the centre. You can find membership lists for each group on the Mental Health and Neurodevelopmental Resource Groups (MHNRGs) FutureNHS space.

Seven currency models are in development based on the following population groups:

- Psychosis and Bipolar Disorders
- Mood and Anxiety Disorders
- Talking Therapies for Anxiety and Depression (separate model)
- Eating and Feeding Disorders (all age)
- Neurocognitive Disorders
- Personality Disorders
- Children and Young People

A further two groups have been identified for the purposes of identifying patients at a population level and are:

- Neurodevelopmental Disorders (all age)
- Addiction, Alcohol and Substance Misuse

These two groups are exploratory populations which have not undergone detailed development work yet. However, they are included for completeness at a population level.

The adult populations have been defined with clinical and lived experience input to reflect the presenting needs of patients, clearly defining boundaries between each model (see Appendix for definitions). For children and young people, we have a single group initially which is defined primarily by age to cover majority of the population, and two population groups covered on an all-age basis – further development in this area will support further segmentation in future. Definitions can be found in Appendix 2.

2.2 Grouping Patient Populations (excluding Talking Therapies)

The currency models are designed to initially group patients based on three levels of data; age, population group and setting. In keeping with our iterative approach, future development is planned to add further levels, especially clinical outcomes. To support users to understand how this will be completed, we have also developed SQL code for local application as well as spreadsheet mapping relevant clinical codes to currency populations. This approach will be developed further over 2024/25, the latest version can be found on the FutureNHS workspace.

Step 1: Age

Patients are initially segmented by age to split the Children and Young People (CYP) and adult populations. The adult population can be defined by those patients who are referred to a mental health service after their 18th birthday.

The age range for children and young people is from 0 – 25 years as this acknowledges young people over the 18 in a CYP service who may be transitioning to an adult service in this period. The population group will be identified by identifying those patients who have an existing MH referral before their 18th birthday. Although there are some limitations with the methodology proposed, it is the most feasible initial approach to identifying the CYP population and this approach will be developed further in 2025/26.

Step 2: Population Groups

Once segmented by age, patients will be allocated across the population level groupings. Adult groups are based on diagnostic groupings which cover the majority of the population, whereas CYP are grouped as one population with the exception of two groups (Appendix 2). The grouping methodology sets out the order in which specific data items are used to segment the population.

Step 3: Deriving Patient Setting

Patients will be grouped into one of three settings: Community, Inpatient, or Crisis. The setting is derived using a methodology which categorises data from the MHSDS. This can be completed locally using the Grouping Methodology.

The methodology covers all care contacts or hospital episodes that take place within referrals where the person is 18 or over at the time of referral for adults or under the age of 18 at referral for CYP.

Community: All activity that is not covered by an inpatient episode, or in any of the crisis team types below are categorised as community activity.

Inpatients: All inpatient activity is covered by spells. Inpatient episodes are collected based on the count of all hospital spells and monthly combinations in the financial year. Hospital spells are a count of distinct hospital spells, only counted once throughout the reporting period.

Crisis: Contacts will be allocated to the crisis setting when they take place in one of the following team types:

- A02 - Crisis Resolution Team/Home Treatment Service
- A11 - Psychiatric Liaison Service
- A19 - 24/7 Crisis Response Line
- A20 - Health Based Place of Safety Service
- A21 - Crisis Cafe/Safe Haven/Sanctuary Service
- A22 - Walk-In Crisis Assessment Unit Service
- A23 - Psychiatric Decision Unit Service
- A24 - Acute Day Service
- A25 - Crisis House Service
- C05 - Paediatric Liaison Service
- A18 - Single Point of Access Service (only where the Clinical Response Priority is recorded as Emergency, Very Urgent, or Urgent/Serious)

2.3 Needs and complexity factors (excluding Talking Therapies)

Outside of the grouping methodology, we would like providers to routinely collect and improve the data quality of additional needs and complexity factors. The factors are currently unweighted. We have co-developed these factors with clinicians and lived-experience practitioners from all adult task and finish groups. The seven factors included here have been identified by clinical consensus as being relevant for health inequalities and/ or indicating care complexity and therefore resource use in patient care. The list covers some but not all characteristics that are out of direct control for the treating team but that may impact the resource required to get to equitable outcomes. We will keep the list and methodology related to these factors under review, with addiction and physical comorbidities likely factors to be included in future.

1. Issues related to housing – Identified through completion of accommodation fields within MHS003 Accommodation Status table.
2. Identification of older adults – Identified through completion of Person Birth Date field in MHS001 MPI table.
3. Deprivation – Identified through completion of Postcode of Usual Address field in MHS001 MPI table.

4. Employment status – Identified through completion of employment fields within MHS004 Employment Status table.
5. Ethnicity – Identified through completion of Ethnicity Category field in MHS001 MPI table.
6. Learning Disability – To identify patients with a learning disability or with a possible learning disability through codes 1 to 4 in Patient Diagnosis Status (Learning Disability) field (M005220).
7. Autism - To identify autistic patients, or patients who may be autistic through codes 1 to 4 in Patient Diagnosis Status (Autism) field (M005230)

Alongside these factors, providers should also refer to the Patient and carer race equality framework (PCREF), NHS England's first ever anti-racism framework. This is mandatory for all NHS mental health trusts and mental health service providers to embed across England.

2.4 Currency model for NHS Talking Therapies for anxiety and depression

This model has been developed for NHS Talking Therapies (formerly known as Improving Access to Psychological Therapies (IAPT)) and should be used by commissioners, providers and clinicians of services that deliver psychological therapies. For more information, please see the NHS Talking Therapies for anxiety and depression manual, including for:

- Definitions of the conditions in scope of this model;
- Definitions of clinical outcomes (e.g. recovery rates, reliable recovery);
- The responsibilities of providers and commissioners regarding data quality.

The purpose of this currency model is to help commissioners, providers, and clinicians to achieve the best possible recovery rates with their clients by providing guidance on the optimal average number and type of contacts for each presenting complaint and their severity. For this, we analysed the Talking Therapies dataset to determine the average number of sessions required to reach reliable recovery for patients with different clinical conditions and severities. The analysis is based on April 2023 to April 2024 England-wide Talking Therapies data (around 670,000 treated cases) and the results can be viewed in Figure 3 – Appendix 4.

The Talking Therapies currency model gives commissioners, providers, and clinicians an objective methodology to count their number of high and low intensity contacts and referrals by presenting complaint and severity. Please note that this should be a comparison of **averages** since individual clients will differ in their needs. For a service to achieve optimal levels of reliable recovery, some patients will need more than the average number of sessions in Fig 3 (and a similar number will need less). All people being treated should receive an adequate dose of the treatment that is provided, in accordance with NICE guidelines. The number of sessions offered should never be restricted arbitrarily. When stepped care is indicated, people who do not respond to low-intensity treatments (and as such, still meet caseness) should be given at least one full dose of high-intensity treatment as well within the same episode of care. When NICE only recommends high intensity treatment, patients should go straight to that level of care after their initial assessment.

Step 1: Presenting Complaint

Referrals of discharged patients are initially segmented by presenting complaint (I603010 - PRESENTING COMPLAINT (CODED CLINICAL ENTRY), referring to the table below. Excluded from the scope of this model are any presenting complaints regarding medically unexplained symptoms since their low number of cases does not presently allow a comparative optimum of sessions to be calculated. However, it should also be recorded where the presenting complaint is unknown or not one of the specified ones.

Problem Descriptor	Problem Descriptor Identifier (ICD-10 code)
Depression	F32/F33
Generalised Anxiety	F41.1
Body Dysmorphic Disorder	83482000 (SNOMED CT code)
Post-traumatic Stress	F43.1
Obsessive Compulsive	F42
Social Phobias	F40.1
Hypochondrial disorder	F45.2
Specific Phobias	F40.2
Mixed Anxiety	F41.2
Agoraphobia	F40.0
Panic Disorder	F41.0
Other Anxiety	F40, F41, F42, F43
Other Mental Health Problems	Any other F code
Other/Unknown/Invalid	Any other code or no valid data

Step 2: Severity

Once segmented by presenting complaint, severity is identified via the most appropriate Patient Reported Outcome Measure (PROM), in line with the manual. Please refer to the accompanying currency code mapping spreadsheet ('PROMs' tab) on Future NHS to obtain the SNOMED CT code and the cut off points or medians for each measure. Segmentation into Mild, Moderate and Severe is used when the primary outcome measure for a clinical condition (for example PHQ-9 for depression) has published and well-validated cut-off points for a three-fold classification. Above and below the observed median for cases seen in NHS Talking Therapy services is used when such data is not available. See Appendix 5.

Step 3: Contact intensity type

The final step is to count the number of contacts by intensity of the contact. We split the intensity into high and low, which is defined as per the table below by any contact with at least one of the SNOMED CT codes recorded in the I202110 - CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT) field with in the IDS202CareContact table.

Category	SNOMED CT Concept ID	SNOMED CT Concept ID
Low Intensity	Guided self-help using book	748051000000105
	Non-guided self-help using book	748101000000105
	Guided self-help using computer	748041000000107
	Non-guided self-help using computer	748091000000102
	Structured physical activity programme	748061000000108
	Psychoeducation	702545008
	Signposting	975131000000104
High Intensity	Applied relaxation	1127281000000100
	Couple therapy for depression	1129471000000105
	Multidisciplinary case management	842901000000108
	Counselling for depression	286711000000107
	Psychodynamic psychotherapy	314034001
	Eye movement desensitization and reprocessing therapy	449030000
	Mindfulness-based therapy	933221000000107
	Cognitive - behaviour therapy	304891004
	Interpersonal psychotherapy	443730003

Step 4: Comparison to target averages

Following each step above, you will arrive at a matrix of 56 currency units (see Appendix 6).

To compare **with Table 1 (Average number and type of contacts required to achieve reliable recovery),** please ensure you are calculating local averages only from treated cases that have achieved reliable recovery. Appropriate statistical tests must be applied to determine the confidence levels with which your local averages are same or different from the national averages. The use of **averages** is intentional, and the results of this analysis are therefore only applicable to population-level data, not individual cases. The care of individuals should always be based on clinical judgement. Services should not set arbitrary limits on the number of sessions that individual patients receive. Instead, patients should be offered up to the NICE recommended full dose, unless they recover earlier, and discharge is mutually agreed.

We intend to develop further guidance and tools to support the use of currencies in conjunction with outcomes data on reliable recovery.

2.5 Additional Complexity Factors – NHS Talking Therapies

We have identified the need to understand other, additional factors which will impact the needs of a patient. Similarly to the additional complexity factors set out for the MHRNG's, these will highlight key data items which when collected will support a better understanding of patient complexity, and therefore the resources required to support a patient effectively.

NHS Talking Therapies Service Based Employment Advisors

There are poorer employment outcomes for people with coexisting mental and physical health problems. There is a high risk of unemployment, absenteeism, and poorer performance. It has been established that the longer people are absent, or out of work, the more likely they are to experience depression and anxiety. Therefore, employment advice, delivered as a core part of an NHS Talking Therapies service, is integral to the success of that service.

NHS Talking Therapies therapists work alongside employment advisers (EAs), to provide combined psychological treatment and employment support to those who have requested this intervention. For this reason, the original NHS Talking Therapies Service Model stated that each team should include one EA for every eight therapists. We now expect about 15% of people who complete NHS Talking Therapies treatment to take up combined treatment and employment support. Employment advice, money guidance and other social assistance should be available within the NHS Talking Therapies service and offered as part of an integrated care plan with close liaison between clinicians and EAs from the point of assessment, through treatment and to discharge.

EAs in NHS Talking Therapies work directly with individuals who are in employment, as well as people who are out of work including those who are on health-related benefits. They provide practical advice and relevant interventions to help individuals retain employment or enter the workplace. There is employment advice in the NHS Talking Therapies service model and there is scope to adapt aspects of service delivery at a local level.

Senior EAs aim to ensure that employment support is embedded within NHS Talking Therapies services and the work of EAs is sufficiently integrated with relevant employment bodies at a local level. This includes building relationships with Jobcentre Plus, Work & Health Programme and other relevant employment support providers, local chambers of commerce, training providers and local employers.

Recommended data fields

To better understand the needs and provision of support, we have highlighted the following data items we would like providers to ensure are completed with high data quality in 2025/26. This will support further development of the model, and a fundamental understanding of the resources which are required to support a patient.

IDS004 Employment Status Table (IAPT Data Set)

- All data items?

IDS201 Care Contact

- Appointment Type – 10 Employment Support
- Contact information

IDS201 Care Activity

- I202110 - CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT)
  - Employment Support (1098051000000103)
  - Associated activity information

2.6 The approach beyond 2025/26

The main focus for 2025/26 is to begin moving the sector towards using the new currency models. We therefore recommend that all mental health providers use this year to implement the foundational methodologies outlined in the guidance and to improve their data quality for the key MHSDS and IAPT data fields used. We will be supporting you by focussing on:

1. **Improving data quality across the sector** – using the currency models to drive data quality improvement and feeding back with analysis and intelligence to ensure providers and ICBs can see the effects of the focus on roll out during this time. The

results of this analysis will help to plan future incremental steps including what we aim to engage on for the 2026-27 NHS Payment System documentation and guidance.

2. **Developing and testing more detailed models** – our work with task and finish groups will continue, building on the population groups developed so far. Specifically, we will develop more granular currency units to reflect severity or acuity of patients. We will then test our development with providers, as well as adding more piloting partners as needed for areas such as CYP.

3. **Continuing engagement** – we will continue broader engagement to share best practice and developments in data quality, as well as to gather qualitative data on future incremental development steps. We will also engage the sector as part of plans for future years and prior to consultation on the NHS Payment System.

4. **Develop tools and products to support providers and ICBs** in using currency models and understanding data, as well as case studies and use case scenarios. This will include a simple SQL code-based grouper tool, support for the optional collection of mental health currency codes in this year's patient-level cost collection, and reports to help providers monitor their data quality in relevant MHSDS and IAPT data fields.

3. Collecting and using data

Improvement in data quality is essential to aid the development of currency models as it realises the benefits of benchmarking and understanding services provided. Providers should aim for better data quality at a local level and in tandem, to ensure consistent processes for local data to be submitted to the MHSDS.

3.1 Mental Health Services Data Set (MHSDS)

The Mental Health Services Data Set (MHSDS) is a patient level, output based secondary uses data set which aims to deliver robust, comprehensive, nationally consistent and comparable person-based information for people who are in contact with Mental Health Services.

The Mental Health Services Data Set covers Mental Health Services located in England or located outside England but treating patients commissioned by an English Integrated Care Board, NHS England specialised commissioner or an English NHS-led Provider Collaborative.

As a secondary uses data set, the Mental Health Services Data Set re-uses clinical and operational data for purposes other than direct patient care, and defines the data items,

definitions, and associated value sets to be extracted or derived from local information systems.

The Mental Health Services Data Set is used across the range of health care providers and organisations that provide Mental Health Services (irrespective of funding arrangements) including:

- NHS Mental Health Trusts
- NHS Learning Disabilities Trusts
- NHS Acute Trusts
- NHS Care Trusts
- Independent Sector Healthcare Providers offering a service model that includes NHS funded and non-NHS funded patients.
- Voluntary sector Health Care Providers
- Any qualified provider offering Mental Health Services
- Community Services offering secondary care to children.

All data items needed to segment into currency models are and will be included within MHSDS. Using nationally agreed terms and definitions supports cross-system working and benchmarking, ensuring comparability. Consistent use of SNOMED CT, ICD classifications, and other standardised data fields required within currencies will facilitate quality data to be collected by clinicians and for this data to move seamlessly through local systems for use both locally and in the MHSDS without need for extensive manipulation.

3.2 Improving Access to Psychological Therapies (IAPT) Data Set

The Improving Access to Psychological Therapies (IAPT) Data Set is a patient level, outcome based, secondary uses data set which aims to deliver robust, comprehensive, nationally consistent, and comparable information for people accessing NHS funded IAPT services located in England. Following a public consultation Improving Access to Psychological Therapy (IAPT) services have been renamed as NHS Talking Therapies for anxiety and depression. The data set will continue to be referred to as IAPT until the next uplift of the data set has received DAPB approval.

This national data set has been developed with the NHS England and the IAPT Programme to support service delivery, inform clinical decision-making and encourage improved access to talking therapies for people with common mental health problems such as depression and anxiety disorders.

As a secondary uses data set it re-uses clinical and operational data for purposes other than direct patient care, for example: commissioning, service improvement and service design. It

defines the data items, definitions, and associated value sets to be extracted or derived from local information systems. These national definitions allow providers to extract data from their local systems in a consistent manner, which supports national and local reporting to be undertaken.

4. Appendices

Appendix 1 – Grouping data for analysis.

Table 1

Patient Level	• Allows the identification of patient need using consistent language, using standardised SNOMED-CT coded data. • Provides a mechanism for consistent complexity assessment language to be applied for patients moving between providers and/or services. • Provides a standardised method of mapping a patient journey or trajectory over time.
Provider Level	• Provides an understanding of the local patient population and complexity of this population, supporting a population health management approach. • Supports a better understanding of trends within a service, and specific gaps in care provision. • Provides an understanding of the use of resources, and of patients with complex, multi-faceted needs. • Provides standardised data which supports conversations with other providers and commissioners. • Ensures independent and community providers have data which is comparable with acute providers.
ICS Level	• Enables an understanding of population complexity which will facilitate decision making on allocation of resources across an ICS footprint. • Using standardised, high-quality data is the cornerstone of collaborative working, ensuring we understand consistent terms across boundaries. • Data equity across a system, evidences the need for investment and equity in all parts of the system. • Provides a mechanism to support evidence-based commissioning

National Level	• Provides an understanding of local and national issues and overall changes in data over time. • Data can be used to support national policy or targeted support. Knowing we are using the same terminology supports data sharing, ensuring there is confidence in the data received. • Provides a methodology to support the Government's three fundamental shifts following the Darzi report: From hospital to community care, from analogue to digital & from treating sickness to prevention.

Appendix 2 – Population Definitions

MHNRGs are needs-based currencies. The proposed currency populations are therefore comprised of those people whose health and care needs are associated with a group of presenting complaints. One person can belong to multiple currency populations, reflecting their individual needs following 'best fit' rather than absolute categorisation.

We have co-developed these with clinical experts, mapping more and less common presenting complaints. team types, and referral reasons based on similarity in needs and service provision. Please refer to the MHNRG Grouping Methodology.

This is a pragmatic mapping reflecting where people and their needs tend to fit more closely to one group than any other. Individuals' cases can be complex, and currencies are not designed to support or influence individual clinical decisions in any way. While linked to common presenting complaints, this mapping does not suggest a person has or should have any particular diagnostic label.

For data coding purposes, please always consult the definitions for any MHSDS fields or codes as provided elsewhere. For definitions of the presenting complaints treated by NHS Talking Therapies, please refer to the latest version of the manual.

Psychosis and Bipolar Disorders Population Group

The proposed currency population is comprised of those people whose health and care needs are associated with a group of presenting complaints including Psychosis and Bipolar Disorders; and others identified by clinical experts as having similar needs.

Personality Disorders Population Group

The proposed currency population is comprised of those people whose health and care needs are associated with a group of presenting complaints related to Personal Difficulty, and others identified by clinical experts as having similar needs.

Neurocognitive Disorders Population Group

The proposed currency population is comprised of those people whose health and care needs are associated with a group of presenting complaints related to Neurocognitive Disorders, and others identified by clinical experts as having similar needs. Neurocognitive disorders are characterised by primary clinical deficits in cognitive functioning that are acquired rather than developmental.

Mood and Anxiety Disorders Population Group

The proposed currency population is comprised of those people whose health and care needs are associated with a group of presenting complaints including Mood and Anxiety Disorders; and others identified by clinical experts as having similar needs. This group includes people with needs relating to cyclothymia, however those with needs related to bipolar disorder are included in another group.

Eating and Feeding Disorders Population Group

The proposed currency population is comprised of those people whose health and care needs are associated with a group of presenting complaints including Eating and Feeding Disorders. The scope of this group has been expanded to include children and young people as guidance has evolved to support the treatment of this population on an all-age basis.

Addiction, Alcohol and Substance Misuse Population Group

The proposed currency population is comprised of those people whose health and care needs are associated with a group of presenting complaints including Addiction, Alcohol Dependency and Substance Misuse Disorders; and others identified by clinical experts as having similar needs.

Neurodevelopmental Disorders Population Group

The proposed currency population is comprised of those people whose health and care needs are associated with a group of presenting complaints related to behavioural and cognitive disorders that arise during the developmental period; and others identified by clinical experts as having similar needs. This group covers adults and CYP at a population level.

Children and Young People Population Group

The CYP population includes all children and young people who have mental health needs referred to in-scope services with the exception of the Eating and Feeding and Neurodevelopmental Disorders populations as they are designed to cover all ages. Community paediatric provision, including neurodevelopmental provision within those services, is excluded as the corresponding data flows to the Community Services Data Set and is captured by CYP Community Currency Model. The age range of this population is 0-25 with the majority of patients in the 0-18 range, accepting that there are patients who may be 18-25 and in the process of transitioning to an adult service.

Crisis

The proposed currency population is comprised of people who present with crisis-related needs, and who cannot be grouped to another population. Crisis care is about immediate risk often involving patients without a history in secondary mental health and therefore no diagnosis. The introduction of a cross-cutting crisis unit is to ensure we can group these patients consistently, however subsequent recording of specific needs and presenting complaint or diagnosis, and therefore assignment to one or more of the more specific populations, will be recommended.

For example, a patient for whom the only recorded need relates to intentional self-harm, would be slotted into the cross-cutting crisis currency unless and until data is flowed such that the patient can be grouped to a more specific population.

Appendix 3 - The Benefits of using the Currency Model

Clinical Use

The implementation of currency models has the potential to benefit clinical teams in several ways, from better understanding their patient population to anticipating demand and adapting their services accordingly.

1. A key criteria of a successful currency model is that it should be usable and add value to normal working practices by front line health and care professionals. The current model is a stepping stone towards a more granular model based on complexity which would better realise these benefits. At a patient level, the consistent use of standardised assessments allows the consistent mapping of a patient's journey or trajectory over time. Currency models will eventually provide an understanding of a patient's current wellbeing and the complexity of their care needs. The model aims to support the ability to track a patient's journey, identify current need and begin to anticipate their future care needs.

2. Whilst assessment metrics are key components of the currency, they can also be used for other clinical purposes, such as using them to develop tailored provision in a personalised way and tracking outcomes, including patient reported outcomes, relative to initial need.

3. As with individual patients, the use of consistent data can be scaled up to give clinical teams an overview of their whole patient cohort. A detailed population overview allows clinicians to identify the resource required to best care for cohorts of patients with varying complexities.

4. Currency models encourage the collection of standardised information such as; demographic, referral, and assessment data. Collecting and submitting standardised data allows all providers to be speaking the same language when it comes to their patient populations, supporting a shared understanding of a patient's complexity across services and providers. This provides benchmarking opportunities to consider alternative service models and understand the value of care provision.

Supporting an understanding of the care system

The currency models will support collaboration with the social care system, ensuring an understanding of the various team involved in multidisciplinary working and ensuring the value of care is understood across all provider types.

1. The currency models can support providers to shift towards a more collaborative approach across local systems, improving joined up care for patients. For example, improved and connected data from the voluntary sector would improve system level planning, ensuring patients receive the care they need in the right setting, providing care in the home, or in the community.

2. A collaborative approach across a system will support seamless transfer of care for patients across systems and services as required by patient need. A common understanding will also transfer with the patient, enabling a better understanding of need which can be grouped based on specific demographics to ensure positive outcomes for patients.

3. The sharing of consistent complexity measures will allow benchmarking across care provider collaboratives. Benchmarking in turn has the potential to identify opportunities for sharing best practice between providers and opening up conversations that could be used to inform improvements across all mental health care within a system or beyond.

4. As the currency model and associated data follows the patient, the model can be used to track patients on a wider basis than secondary care. Systems could use data sharing and a multidisciplinary team approach to implement a currency understanding across other settings such as primary care. This supports care to be delivered in the right location for the patient and could benefit those living in rural areas or where access to local hospitals may be difficult. Sharing data across primary and secondary care will support patient planning and ensure consistent understanding across important data fields such as diagnosis.

System Planning

Partners in integrated care systems (ICSs) can use the standardised patient, referral, and assessment data from the MHSDS and IAPT data sets to better understand their patient populations allowing for a population health management approach to supporting patients with mental health conditions, planning based on needs and delivering services which best support the local population.

1. A population-based approach should support systems to identify the complexity and therefore needs of the population of people with mental health conditions. Understanding the complexity of patients, their families and carers will support planning based on resource requirements. This provides the opportunity to identify areas with high resource requirements and provides a data-based method of planning for resource allocation, and to introduce integrated multi-disciplinary team working which will support patients to access the most appropriate care in the right setting.
2. As data quality improves across regions, systems will have better access to information to understand the need for investment and equity across all aspects of healthcare funded by the NHS. Future services can be planned using this data and the nuances across system footprints can be taken into account as part of the planning process. Standardised data can then be used to assess the success of these services over time.
3. Data can be used to identify opportunities for joined up care, increasing collaboration which will support positive outcomes and experiences for patients and their families.

Flow to National Systems

The currency and underlying data can be used at a national level for a variety of reasons.

1. Based on the available data, national teams have means to better understand the mental health population at a national level and the ability to segment the population accordingly to analyse underlying trends in health and health inequalities across

regions. This will allow national teams to influence national policy to improve outcomes for patients receiving mental health care.

2. The data from the MHSDS and IAPT data sets will allow national teams to gain an understanding of the resources required for patients. From this, national teams can provide support to systems to apportion allocations across secondary care to ensure funding can be utilised effectively and to help develop more detailed, data-based fixed payments as part of their contracts.

Commissioning effective care

Currency models should support the service planning and funding process and be compatible with current and future payment methodologies.

The currency model will provide a common and standardised language for providers, meaning that they can be used by any and all providers across a system. When linked with outcomes this will provide a view of the overall value of care provision, as a comparison of need, provision, and experience. Tracking this information over time will provide a wealth of information to inform commissioning decisions.

Appendix 4 – Fig.3. Average number and type of contacts required to achieve reliable recovery

Problem Descriptor	Severity	Average number of contacts	Low intensity appts	High intensity appts
Depression	**Mild**	7	2.7	4.3
	Moderate	8	2.8	5.2
	Severe	9	2.6	6.4
Generalised Anxiety	**Mild**	7	3.1	3.9
	Moderate	7	3.5	3.5
	Severe	8	3.4	4.6
Body Dysmorphic Disorder	**Below Median**	13	0.8	11.5
	Above Median	14	1.8	12.3
Post-traumatic Stress	**Below Median**	12	1.3	10
	Above Median	13	1.2	11.1
Obsessive Compulsive	**Below Median**	12	2.3	9.8
	Above Median	13	2.2	10.8
Social Phobias	**Below Median**	12	2.4	9.6
	Above Median	12	1.6	9.6
Hypochondrial disorder	**Below Median**	10	2	7.3
	Above Median	11	2.1	8.9
Specific Phobias	**Below Median**	9	3.2	5.8

	Above Median	11	2.1	8.3
Mixed Anxiety	**Below Median**	7	1.8	4.4
	Above Median	8	2	6
Agoraphobia	**Below Median**	8	4.4	3.6
	Above Median	9	3	5.4
Panic Disorder	**Below Median**	9	3.8	5.3
	Above Median	9	3.2	5.1

Appendix 5 – Measures by problem descriptor

Problem Descriptor	Patient reported outcome measure	Severity
Depression	Patient Health Questionnaire (PHQ-9)	Mild
		Moderate
		Severe
Generalised Anxiety	Generalised Anxiety Disorder – 7 (GAD-7)	Mild
		Moderate
		Severe
Body Dysmorphic Disorder	Body Image Questionnaire (BIQ) Weekly	Above Median
		Below Median
Post-traumatic Stress	PTSD Checklist for DSM-5 (PCL-5)	Above Median
		Below Median
Obsessive Compulsive	Obsessive Compulsive Inventory (OCI)	Above Median
		Below Median
Social Phobias	Social Phobia Inventory (SPIN)	Above Median
		Below Median
Hypochondrial disorder	Health Anxiety Inventory (HAI)	Above Median
		Below Median
Specific Phobias	Generalised Anxiety Disorder – 7 (GAD-7)	Mild
		Moderate
		Severe
Mixed Anxiety	Generalised Anxiety Disorder – 7 (GAD-7)	Mild
		Moderate
		Severe
Agoraphobia	Mobility Inventory (MI)	Above Median
		Below Median

Panic Disorder	Panic Disorder Severity Scale (PDSS)	Above Median
		Below Median
Other Anxiety	Generalised Anxiety Disorder – 7 (GAD-7)	Mild
		Moderate
		Severe

Appendix 6 – Talking Therapies Currency Model

Problem Descriptor	Patient reported outcome measure	Complexity	Intensity
Depression	Patient Health Questionnaire (PHQ-9)	Mild	Low
			High
		Moderate	Low
			High
		Severe	Low
			High
Generalised Anxiety	Generalised Anxiety Disorder – 7 (GAD-7)	Mild	Low
			High
		Moderate	Low
			High
		Severe	Low
			High
Body Dysmorphic Disorder	Body Image Questionnaire (BIQ) Weekly	Above Median	Low
			High
		Below Median	Low
			High
Post-traumatic Stress	PTSD Checklist for DSM-5 (PCL-5)	Above Median	Low
			High
		Below Median	Low
			High
Obsessive Compulsive	Obsessive Compulsive Inventory (OCI)	Above Median	Low
			High
		Below Median	Low
			High
Social Phobias	Social Phobia Inventory (SPIN)	Above Median	Low
			High
		Below Median	Low
			High
Hypochondrial disorder	Health Anxiety Inventory (HAI)	Above Median	Low
			High
		Below Median	Low
			High
Mixed Anxiety	Generalised Anxiety Disorder – 7 (GAD-7)	Above Median	Low
			High

		Below Median	Low
			High
Mixed Anxiety	Generalised Anxiety Disorder – 7 (GAD-7)	Above Median	Low
			High
		Below Median	Low
			High
Agoraphobia	Mobility Inventory (MI)	Above Median	Low
			High
		Below Median	Low
			High
Panic Disorder	Panic Disorder Severity Scale (PDSS)	Above Median	Low
			High
		Below Median	Low
			High
Other Anxiety	Generalised Anxiety Disorder – 7 (GAD-7)	Above Median	Low
			High
		Below Median	Low
			High
Other Mental Health Problems			
Other Recorded Problems/ Unspecified, Invalid			