Payment by Results for Mental Health Services

The development of a payment by results (PbR) system for mental health would be a major achievement. As yet, we are unaware of any country that has been able to implement this type of system for national mental health services, although the Netherlands plans to implement the first parts of a casemix-funding system for mental health during 2006.

This factsheet reports on progress in the project, anticipated direction on resolving issues, and updates on timescales.

The publication of the White Paper "Our Health, Our Care, Our Say" has also provided a strong strategic direction of integration with social care, strengthened commissioning, best-practice costed care pathways and packages, increased choice and plurality, and unbundling for more care to be given in the community.

Latest developments

The project is developing proposals for mental health currencies for use in a Payment by Results casemix-funding system for inpatient, outpatient and community-based healthcare provided to adults of working age and older people in England

Under The Information Centre's project management, 22 NHS mental health organisations are involved, collecting patient-level, anonymised data.

The approach is to collect data to see whether any relationships between, or groupings of, mental health patients can be determined. This involves a special data collection exercise which is necessary due to a historic lack of data throughout the NHS mental health system. A specific hypothesis is also being tested, using a standardised needs assessment tool, in conjunction with a simple series of questions, to group service users into mutually exclusive "clusters" or populations. Each cluster proposes the packages that a typical service user might expect to be offered. Theoretically, each cluster could be costed on a per user average, or on a "most cost-effective" method, to produce a possible initial tariff.

The hypothesis being tested is that 85% of service users can be grouped into 13 clusters. Seven Trusts are using the needs assessment tool method of working, and other Trusts are interested in helping to determine if the hypothesis works elsewhere.

Whilst there are small differences between the two approaches in the data collected, it is the intention that the core information from all the research sites could be used for all types of analysis. Using data drawn mainly from the Mental Health Minimum Dataset allows patient activity across the whole of the care pathway to be captured. An important element of both proposals is the use of a measure of severity of mental illness (HONOS is being used as a proxy) or the needs assessment tool, in order to determine the level of case-mix.

At this stage, all sites are focusing on data collection, and the project as a whole is looking to maximise its sample size, quality and uniformity of data collected. This will allow a more effective analysis to support the identification of appropriate currencies for Mental Health. By the end of July 2006, we are expecting to have a database of anonymised patient-level information covering 10,000 service users and 200,000 contacts.

Analysis throughout the Summer will indicate whether it is possible to develop an initial currency from the project information, or whether further research and evaluation needs to be undertaken.

Social Care

There is often an indistinguishable boundary between health care and social care in mental health. With the development of Direct Payments and Individual Budgets, and the interaction between health and social care delivery through pooled budgets and section 31 agreements, we will be determining whether it is possible, practical and desired by all parties to include social care costs within any tariff proposals. This may include trying to cost the social care element delivered by mental health organisations to allow commissioners to choose whether to uncouple social care and health care costs, or pool them together.

We intend to explore the options in this area, whilst understanding that direct payments and individual budgets indicate a direction of travel undertaken by social care already.

Data

The project will feed into and help develop the mental health minimum dataset, linking into NPfIT and developments with Connecting for Health.

The project is likely to produce proposals for new data items to be collected, although we are not yet far enough along the project to indicate what any of those might be.

Discrete Interventions

There are some situations where a patient has a one-off mental health problem, can be treated over a short period of time and made well again, or “cured”. These situations are often linked to life events and are likely to include, amongst others, short-term depression or anxiety. NICE guidance suggests they can be overcome through a course of psychological treatments over a discrete period of time. These “spells” could be costed, would include a specific start date, treatment phase and discharge date, are likely to be elective, and an element of choice can be offered to the patient.

Immediate Timetable

Summer 06	Data collection, data quality improvements, analysis, sanity checks.
October 06	Proposals & recommendations on the next steps.
January 07	Decisions on next steps

Contacts and further information

If you have any queries or require further information on this project, please contact any of the following people:

Payment by Results Policy

Jean-Armand Clark 0113 254 5265
jean-armand.clark@dh.gsi.gov.uk

Mental Health Policy

David Daniel 0207 972 4242
david.daniel@dh.gsi.gov.uk

This is the second Mental Health Payment by Results factsheet. For a copy of the first factsheet or for further information, please contact Jean-Armand Clark, details given above.