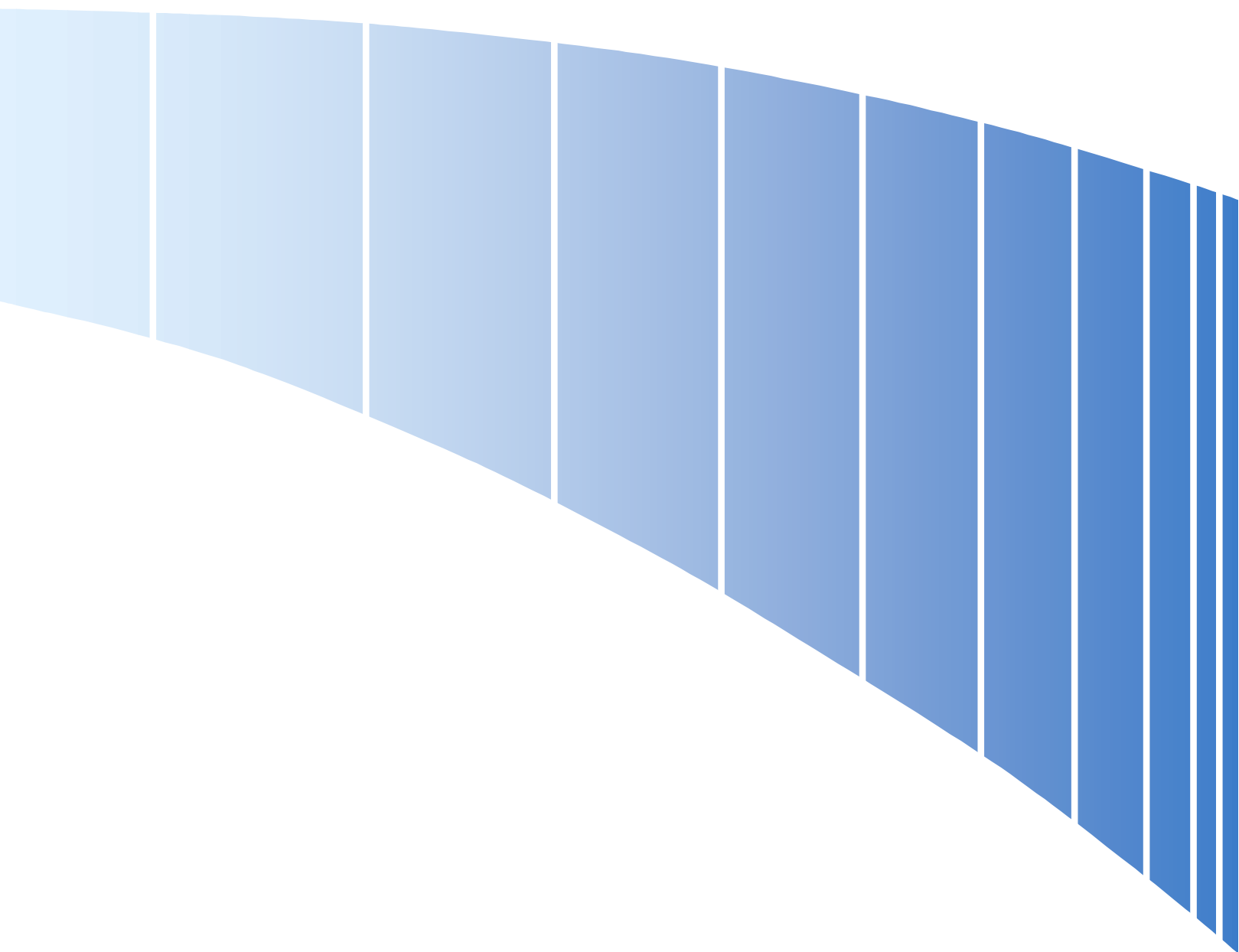


# Practical Guide to Preparing for Mental Health Payment by Results



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<b>For Recipient's Use</b>	

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## Foreword

When a new health policy appears, mental health services often feel they are kept waiting until it has been tried out on the acute health sector. Mental health is seen as too difficult and too different. This accusation might be levelled at Payment by Results (PbR), which has been in operation for acute care since 2003/04.

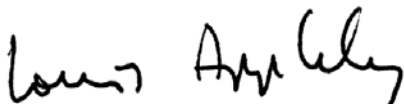
However, in the case of PbR, this delay for mental health has been primarily due to the much greater challenges of devising a structure for reimbursing treatment and care, sometimes over the long-term, when problems and disorders do not easily fall into discrete biological categories. Mental health care is complex. Countries that have developed similar funding mechanisms for healthcare have struggled to develop one for mental health.

A new funding methodology was required, to identify service users with similar characteristics, which should predict need more accurately and hence potential costs. Rather than a straight adaptation of the existing PbR system, we have looked to the NHS to create a new approach based on grouping service users into 21 “clusters”. This approach, developed by the mental health community in the North East and Yorkshire and Humber regions, is clinically intuitive. Indeed, it started life as a clinical tool – only later did its potential to support funding flows become apparent.

It focuses on the characteristics of individual service users, allowing a tailored approach to care. This means that it is in tune with the need for personalised care. Service users will benefit from an informed discussion of their care options and a clear understanding of the support they will receive.

It is this benefit for individuals that is the primary reason why we should implement mental health PbR. This will not be easy – it will require significant improvement in the data collected by mental health services. Yet this is not a challenge we can avoid. And, comparatively later implementation does have some advantages – we can learn from the experience of the acute sector in putting PbR into practice.

This practical guide will help you prepare for mental health PbR – it is a prompt for action that has been developed with input from people who have seen what works and what does not. We hope it is helpful for everyone who provides and commissions mental health services.

A handwritten signature in black ink, appearing to read 'Louis Appleby'.

Professor Louis Appleby, National Clinical Director for Mental Health

## Introduction

This guide is to help people prepare locally for the introduction of Payment by Results (PbR) to Mental Health services. PbR for mental health services is not going straight for the national currency/national price model that was used for providers dealing with acute physical illness. Instead, as set out in both *High Quality Care for All* and the recent *Dear Colleague* letter, the first stage with mental health is to make national currencies available for use, with prices continuing to be set locally.<sup>1</sup> These currencies will be available from 2010/11 for those wishing to use them and will, in due course, become mandatory (see action 10).

The chosen currency units for mental health are clusters based on service user characteristics. These clusters (there are currently 21, but the number may change as they are subjected to further refinement and testing) can then be used in contracting arrangements, so that a commissioner will be paying for x people in cluster 1, x people in cluster 2 and so on. The 21 existing clusters are designed to cover working age adult and older people's care.<sup>2</sup>

This practical guide sets out ten important actions that should occur locally to prepare for mental health PbR. **The overall goal of these ten actions is that people will be able to understand the service they provide or commission in terms of the clusters.** Ultimately, this will mean allocating all service users to the clusters on the basis of clinical judgement (see action 5) supported by available tools (see action 4).

This guide is not exhaustive, but is a pointer to key considerations and areas for local discussion. As well as the ten actions, the guide contains a glossary (Appendix 1) to help ensure that everybody is using common terminology. The preparation actions fall primarily on providers because they will be doing the allocation to clusters and ensuring the collection of the relevant information. However, involvement of commissioners will be crucial (see action 2) and a checklist specifically for them has been included at Appendix 2.

Mental Health PbR is a policy that is continuing to develop through the work of the NHS, the third sector and the private sector, with the support of the Department of Health. The practical guide will be updated periodically to reflect these local and national developments.

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<sup>1</sup> *High Quality Care for All*, June 2008, Chapter 4 Para 23; *Dear Colleague Letter*, Jan 2009, [http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH\\_092963](http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_092963)

<sup>2</sup> There is local work on applying a similar approach to learning disability, CAMHS and forensic services. We are currently considering nationally the benefits of extending this approach to secure services. For further information please contact [pbrcomms@dh.gsi.gov.uk](mailto:pbrcomms@dh.gsi.gov.uk).

## Understanding the Benefits

Implementing mental health PbR may seem an additional burden on an already busy mental health sector. However, two over-arching benefits make it a worthwhile task:

1. The opportunity to better understand the needs of service users and ensure that service responses to these needs are high quality (safe, effective and a positive experience) and good value (by being efficient and productive).
2. The chance to make much more informed operational and strategic decisions for mental health services by radically improving available information.

Beyond these two key benefits, there is a host of other related advantages for commissioner, provider and service user:

- A commissioner can expect to have a clear understanding of the number and nature of service users being treated, a transparent framework on which to align outcome measures and the opportunity to have meaningful discussions with providers about the service response to each care cluster. Because the clusters focus on individuals, they should also facilitate the coordination of multiple providers delivering different aspects of care.
- In carrying out preparation, a provider will be able to get a detailed understanding of their business, including the costs of individual service users, the ability to reorganize service provision based on service user characteristics and a transparent means of demonstrating their productivity and efficiency through benchmarking with other providers. Providers may want to use the clusters as their service lines for management purposes.
- Service users should have well-defined responses to their individual care needs, with clarity over treatment and support options. This approach could support the setting of personal health budgets.

## The Clustering Approach

The mental health community in the North East and Yorkshire and Humber regions, organized as the Care Pathways and Package Project, have developed a clinically intuitive way of grouping service users into 21 clusters based on their characteristics. The clusters are detailed in the *Clustering Booklet for Mental Health Payment by Results*, which should be read in conjunction with this guide.

The methodology has two distinct parts – the 21 clusters themselves and an assessment tool which facilitates allocation of service users to the clusters. The allocation tool within the Clustering Booklet is entitled HoNOS (Health of the Nation Outcome Scales) PbR as it contains the twelve original HoNOS items and the additional items to support cluster allocation.<sup>3</sup>

Both the clusters and the assessment tool will develop over time – the next iteration is expected in December 2009 – as the NHS tests and refines them. As Mental Health PbR becomes established, new versions will be made available on the Department of Health website on an annual basis.

Whilst it is intended that there should be national consistency in the use of clusters and the assessment tool,<sup>4</sup> the service response is not being nationally defined (aside from existing guidance such as that produced by NICE) and a menu of care options available to individuals will need to be developed locally.

Providers and commissioners will therefore want to understand how their service users match up to the clusters. This will require assessment and allocation to the clusters. They will then need to consider how their existing service responses relate to the clusters and start to design responses to the needs of individuals for each of the clusters.

The rest of this guide considers the underpinning actions that are required to support this work.

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<sup>3</sup> There is an evaluation programme looking at how well HoNOS PbR and SARN v2 (Summarised Assessment of Risk and Need, the Care Pathways and Packages Project's assessment tool) can allocate to the clusters.

<sup>4</sup> Improving Access to Psychological Therapies (IAPT) services do not collect HoNOS or related data. There is a current project looking at how IAPT services can be mapped against the clusters in a transparent, clear and non-burdensome way. Once this is completed, information will be made available on the Department of Health website.

## **Action 1: Identify both a senior lead individual within your organization to have responsibility for this work and key supporting project members**

For any major implementation project there needs to be clear ownership of the work required. It is suggested that, if this has not already occurred, commissioners and providers identify a lead individual for implementing mental health PbR in their organization. This individual needs to have sufficient seniority to secure the resources necessary for implementation. They should act as the voice for mental health Payment by Results within the organization.

For provider organizations in particular, there should be a need for other identified leads or “champions” for PbR in specific areas. There should be a need for a clinical lead who ensures frontline staff are communicated with and involved in the decision-making, ultimately overseeing the achievement of clinical buy-in to the approach of assessing, recording and then clustering individuals. There should be a need for a finance lead who can take responsibility for identifying the costs of providing care to individuals within the different clusters. Finally, there should be an informatics lead who can ensure the local capture of all the necessary information to allow the use of currencies. These leads can form the nucleus of a project structure to support local implementation.



## **Action 2: Make preparation a joint project involving commissioners, providers, local authority partners and public health colleagues**

To be successful, mental health PbR must meet the needs of local stakeholders. It cannot succeed if developed solely by a commissioner or provider, nor if it is seen as something to be done by the NHS without the involvement of social care.

For commissioners and providers it is recommended that PbR preparation is treated as a joint project. Clear terms of engagement around information sharing should be set out at the start and an open book relationship should be used wherever possible.

PbR for mental health needs to be sufficiently flexible to recognise the varied levels of integration with social care that exist across the country. It also needs to support the personalization agenda. The best way of achieving this is a full discussion with local authority partners, so that the social care contribution to the cost of treating service users in particular clusters can be identified and so care packages can be formulated that can be tailored to individual's requirements.

For further information on the social care elements of mental health PbR, please see the joint position statement from the Association of Directors of Adult Social Services and the Department of Health.<sup>5</sup>

By allowing classification and benchmarking, the clusters also provide an opportunity for greater involvement of public health professionals in mental health care. For instance, public health colleagues could help in estimating the local level of need within each care cluster.

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<sup>5</sup> [http://www.adss.org.uk/images/stories/Mental\\_Health/payment.pdf](http://www.adss.org.uk/images/stories/Mental_Health/payment.pdf)

## Action 3: Discuss with your Strategic Health Authority (SHA) your local approach

Five SHA areas (Yorkshire and Humber, North East, London, North West and West Midlands) have a coordinated approach to the development of PbR for mental health within their boundaries. The projects range from well established to just starting out. Table 1 gives the contact details for each project.

SHA Area	Project Name	Project Contact for further information
Yorkshire & Humber and North East	Care Pathways and Packages Project	Carole Green ( <a href="mailto:carole.green@humber.nhs.uk">carole.green@humber.nhs.uk</a> )
London	London Mental Health Currency Development Programme	Brian Clark ( <a href="mailto:brian.clark@symmetricsd.co.uk">brian.clark@symmetricsd.co.uk</a> )
North West	NW PbR Mental Health Development Group	Martin McDowell ( <a href="mailto:Martin.McDowell@northwest.nhs.uk">Martin.McDowell@northwest.nhs.uk</a> )
West Midlands	Productivity Improvement Programme and Care Pathways Project	Michael Clarke ( <a href="mailto:michael.clark@wmrdc.org.uk">michael.clark@wmrdc.org.uk</a> )

Such an SHA-wide approach has advantages in terms of creating economies of scale for the preparatory work, as well as the opportunity to bring together providers and commissioners with different areas of expertise.

If you are in one of the other five SHA areas, it is suggested that you talk to your SHA mental health and PbR leads to establish whether an SHA-wide approach might be beneficial for your locality. Any approach will of course need to take into account the autonomy of organizations such as Foundation Trusts.

You might also consider speaking to health economies that have already made some progress in preparing for mental health PbR to see if they can provide any advice.<sup>6</sup>

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<sup>6</sup> We are happy to signpost organizations towards early implementers who may be able to “buddy” with them. Please e-mail [pbrcomms@dh.gsi.gov.uk](mailto:pbrcomms@dh.gsi.gov.uk).

## Action 4: Make use of available resources on-line

All the intricacies of the currency methodology cannot be covered in this short practical guide. However, there is plenty of more detailed information on-line. First stop should be the Department of Health's *Developing PbR for mental health services* webpage.<sup>7</sup> Information includes:

- **Clustering Booklet** – This explains the information that needs to be collected as part of the assessment process and then how this relates to allocation to clusters. This will be updated periodically as development work progresses.<sup>8</sup>
- **Fact Sheets** – These are quarterly updates on progress in a simple to read two page format. They also identify upcoming events and conferences.
- **Project Board and Expert Reference Panel minutes and terms of reference** – The terms of reference cover the function of these two governance groups. Minutes are added as they are approved to make project deliberations and discussions as transparent as possible.

In the future, we plan to include:

- A Powerpoint presentation on Mental Health PbR that people can use as the basis for presentations to their local audiences.
- An ISAT (Independent Self Assessment Tool) for organisations to use to assess their readiness for mental health PbR.

### Other Useful Links

The Care Pathways and Packages Project [www.cppconsortium.nhs.uk](http://www.cppconsortium.nhs.uk)  
(this site will be operational from 1<sup>st</sup> July 2009)

London Mental Health Currency Development Programme  
[www.london.nhs.uk/mentalhealthcurrencies](http://www.london.nhs.uk/mentalhealthcurrencies) (this site will be live shortly)

The Royal College of Psychiatrist IFQO pages (Information-based funding, quality and outcomes):  
<http://www.rcpsych.ac.uk/members/currentissues/ifqo.aspx>

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[http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSFinancialReforms/DH\\_4137762](http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSFinancialReforms/DH_4137762)

<sup>8</sup> The booklet's first update will be in December after the evaluation work on HoNOS PbR and SARN has been completed and the necessary changes to the Mental Health Minimum Dataset have been agreed.

## Action 5: Allow for training time for staff

For provider organizations, preparing for mental health PbR will mean that clinical staff need to be trained in the methodology, especially the use of an assessment tool to support their clinical decision in allocating service users to the 21 clusters. Because the assessment tool is based on HoNOS, organizations regularly collecting this mandatory outcomes data should have a head start.

This training is likely to require at least half a day. It is suggested that as a minimum training should include:

- Intro – Why are we doing this? (see for instance the section on understanding the benefits)<sup>9</sup>
- The assessment approach<sup>10</sup> and when to assess<sup>11</sup>
- Clusters and cluster allocation
- The local method for capturing the data<sup>12</sup>
- How the data will be fed back to clinicians

One training method, which has proved successful for the Care Pathways and Packages Project, is to provide in-depth training to a small number of individuals in a provider organization and then those skilled trainers pass their learning on to the rest of the organisation.

The Department of Health is in discussion with the Royal College of Psychiatrists and other partners as to what support they can provide in developing training packages and information.

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<sup>9</sup> This should link to any local transformational workstreams.

<sup>10</sup> It is imperative that clinicians understand the allocation process and make the final decision, although we are committed to developing a robust electronic tool that can assist with this as part of the refinement process.

<sup>11</sup> Assessments are expected to occur at three points – for a new referral, as part of a CPA (Care Programme Approach) Review and if there is a significant change in presenting needs.

<sup>12</sup> Services using FACE or other standard assessment tools to capture HoNOS data should embed or append the additional 6 HoNOS PbR items within the assessment in order to ensure accurate generation of the PbR groupings. If implementing a new information system (within the same timeframe) it would be sensible to align that in one training approach.

## Action 6: Understand the information issues

Mental Health PbR is dependent on information. For this reason, Action 1 suggested each provider organization identifies an information lead.

For local preparation, there are two big issues the information lead will need to address. First, there is the issue of collecting the necessary information. To place individuals in clusters their assessment scores need to be collected.

This issue is primarily a cultural one – HoNOS scores should already be collected as part of the Mental Health Minimum Data Set (MHMDS), but completion rates are low. To realise the benefits of mental health PbR, such as a tailored response to individual service users' needs, will need a cultural change within organizations to prioritize the collection of this information. Good training (see Action 5 above) can obviously support this.

The second information issue is the ability to record the necessary assessment scores and the clusters on information systems. Nationally we will include all the necessary data items in the MHMDS so that all software providers will have to incorporate them in their information systems. We are aiming for a DataSet Change Notice (DSCN) to support this in March 2010. This will then ultimately allow the MHMDS to be used by the Secondary Uses Service (SUS) for reporting and payment based on the clusters.

In the short-term, providers will need to examine the flexibilities in their existing systems to capture this information. Some organizations have contracts directly with their information system suppliers and can specify changes. For those without this option, simple work-around solutions may be required. Local organizations will obviously be best placed to decide how to facilitate the collection of data e.g. clinicians using hand-held devices.

## Action 7: Align development of outcomes measures

The introduction of mental health PbR offers a real opportunity to measure quality and outcomes. The assessment, including as it does HoNOS, an internationally recognized outcome measure, provides the opportunity to collect some longitudinal outcomes data for individuals. In many cases, it might be expected that an individual's assessment scores will fall over time as the agreed care has an impact.

This may allow commissioners to specify in agreements with providers (see next action) that a percentage of individuals within a particular cluster are expected, following care, to have their needs reduced and so move down to a less resource-intensive cluster or even be discharged from specialist mental health services completely.<sup>13</sup>

It is probable that as commissioning for outcomes becomes more refined, that it would be useful to have outcome measures for each of the clusters.<sup>14</sup> Such outcome measures should not purely be clinical but also include wellbeing, social inclusion and service user satisfaction. In developing outcome measures it will be important to draw on good existing work such as:

**Indicators for Quality Improvement** (existing indicators published to support *High Quality Care for All*, these will develop over time. The initial mental health ones are heavily primary care-focussed)

<https://mqi.ic.nhs.uk/PerformanceIndicatorChapter.aspx?number=1.07>

**The Outcomes Compendium for Mental Health**

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_093316](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093316)

**The Mental Health Recovery Star**

<http://www.mhpf.org.uk/recoveryStarApproach.asp>

**The Social Inclusion Outcomes Framework**

<http://www.socialinclusion.org.uk/resources/index.php?subid=55#section003>

**World Class Commissioning Assurance Indicators** (focused on substance misuse and suicide)

<http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Assurance/index.htm>

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<sup>13</sup> It will be important to recognise that in some cases need is only reduced because of the intervention and withdrawing an intervention will cause need to escalate again. In addition, for some mental health services users, it will be more about amelioration than recovery.

<sup>14</sup> The Care Pathways and Packages Project will make information on their workstream to develop outcomes linked to the clusters available on their website in July.

### **Improving Access to Psychological Therapies Toolkit**

<http://www.iapt.nhs.uk/2008/07/improving-access-to-psychological-therapies-iapt-outcomes-toolkit>

### **National Treatment Agency for Substance Misuse's Treatment Outcome Profile** (useful for outcomes relating to drug treatment):

[http://www.nta.nhs.uk/areas/outcomes\\_monitoring/](http://www.nta.nhs.uk/areas/outcomes_monitoring/)

Ultimately, it may be beneficial to have a range of appropriate outcome measures for each cluster published on the Department of Health website.

### **The CQUIN Payment Framework**

The Commissioning for Quality and Innovation (CQUIN) payment framework makes a small percentage of provider's income conditional on achieving locally agreed quality goals.<sup>15</sup> Commissioners and providers may wish to agree specific and stretching outcome improvements or innovations within particular clusters in their locally negotiated CQUIN scheme. The clusters may particularly lend themselves to pathway-related CQUIN goals that cross organisational boundaries and therefore feature in multiple CQUIN schemes across the local health economy.

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<sup>15</sup> For more information on CQUIN see:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_091443](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443)

## Action 8: Identify contractual issues

The 2009/2010 Interim Mental Health and Learning Disability Contract will be replaced by a three-year contract covering financial years 2010/11 to 2012/13. Within that timescale (see Action 10) it is expected that the currency units for mental health will be mandated i.e. everybody will need to be utilizing them as part of their contracting arrangements. Contracts therefore need to be sufficiently flexible that they recognise this development.<sup>16</sup>

As local preparatory work progresses, commissioners and providers may wish to agree specifications based on the care package responses providers will offer to individuals in each of the clusters.

Thought also needs to be given locally to how any sub-contracting arrangements will work. The currency model is focused on paying for individuals, not individual services. However, parts of an individual's care may be provided by different organizations e.g. voluntary and independent sector. Commissioners may want to specify that particular providers offer some elements of care to an individual whose needs are principally being met by another provider. If they want to contract directly with a provider for just part of the care package (i.e a subset of the response to the needs of an individual in a particular cluster) then that will be need to be factored into any locally established prices (see Action 9).

The existing contract process for payment (monthly payment based on one twelfth of Estimated Contract Value with monthly activity reviews and regular (quarterly) reconciliation plus an end of year reconciliation) should support contracting using the clusters. This monthly reimbursement will need to take account of the fact that many clusters will be ongoing for prolonged periods of time (e.g. six months).

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<sup>16</sup> For information on the standard contracts please see [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_091451](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091451)



## Action 9: Local costing to determine prices

An original premise of the Care Pathways and Packages work was that people with similar need characteristics – and who therefore are in the same cluster – would have similar care pathways or service options. In other words, the health and social care resource requirements should vary with service user need, not with, for example, service configuration or point of access.

The ideas linking care clusters to a price or tariff are that:

- Where it is possible to set out what a person's care pathway or package is, has been or will be, it should be possible to cost it in some way.
- Where care packages for people within the same cluster are sufficiently similar, or it is possible to set out and agree what the care package should be, it should be possible to start setting a standard price for that cluster.

Anecdotally we know there is significant variation in the care people receive at present, so simply taking an average of the current situation is insufficient. Local health economies will want to understand what they currently spend on care within each cluster, in order to understand the impact of developing high quality care packages.<sup>17</sup>

Initial actions locally therefore might be:

- Ensuring that finance and information colleagues are involved in the project from the start.
- Understanding what information existing data systems give about the service user journey.
- Determine what level of detail on clusters and care packages is needed by finance and information colleagues to enable recording and costing of the high cost and variable items.
- Consider what costing improvements need to be developed. This may include implementing Patient Level Information and Costing Systems (PLICS) to support the capturing of information the activity and costs of care for individual service users.<sup>18</sup>

To support the development of high quality costing for mental health we have a mental health costing sub-group who have worked to develop mental health costing standards. We will seek to refine and publish these standards.

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<sup>17</sup> NICE's costing tools may provide a useful source of costing data:

[http://www.nice.org.uk/usingguidance/implementationtools/costingtools/costing\\_tools.jsp?type=&status=&p=off](http://www.nice.org.uk/usingguidance/implementationtools/costingtools/costing_tools.jsp?type=&status=&p=off)

<sup>18</sup> More information on PLICS can be found at:

[http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHScostingmanual/DH\\_080056](http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHScostingmanual/DH_080056). Several mental health trusts have started to implement PLICS.

## Action 10: Establish local timelines

To aid implementation it will be vital that organizations establish local timelines and milestones for implementing mental health PbR. In doing this it is obviously important to be cognizant of the national timescales (see box).

### **National Timescales:**

*High Quality Care for All*, committed us to having national mental health currencies available for use in 2010/11. Available for use means that people will have the opportunity to use them for the 2010/11 financial year for real reimbursement if they are confident enough to do so, but we expect that most health economies will use them in shadow form.

Beyond this commitment, our timescales are subject to review, but our assumptions are:

- 2011/2012 – All health economies should be using the currencies in some form and be establishing local prices.
- 2013/2014 – The earliest possible date for a national tariff for mental health (if evidence from the use of a national currency presents a compelling case for a national price).

This timetable and supporting milestones are being summarised in visual form for the Department of Health website.

Key deliverables to be achieved by a provider will include getting all clinical staff allocating service users to clusters using the assessment tool, a way of recording cluster allocation and the identification of the cost of provision for individuals within a cluster.

Commissioners might focus on agreeing the outcome measures to sit alongside the clusters and developing the sub-contracting arrangements once the currencies are used for reimbursement.

## **Need more information? Want to share a good local approach? Then get in touch.**

The approach we are taking for mental health PbR is one where development is occurring locally. We are very keen to hear about any local work that can help to inform the national picture, so do please get in touch if you have details to share.

Similarly, please let us know if there is further information you require. In both instances, please use Ade Adekaiyaoja ([adebayo.adekaiyaoja@dh.gsi.gov.uk](mailto:adebayo.adekaiyaoja@dh.gsi.gov.uk)) as a first point of contact.

## Appendix 1 - Glossary:

**Assessment:** Assessment in terms of Mental Health PbR means completion of the assessment tool i.e. the 18 data items included within “HoNOS PbR.” It is understood that this would just be part of a much wider assessment of an individual.

**Care Packages:** Care packages is the name given to the responses designed to meet the needs of individuals within the clusters. Care packages will not be nationally mandated as part of mental health PbR (although many will inevitably be based on NICE guidance) to allow flexibility in meeting people’s needs.

**Care Pathways:** The care packages an individual receives over a period of time could be described as their care pathway.

**Clusters:** The 21 clusters are based on the characteristics of service users and group people with similar characteristics together, in a clinically meaningful way.

**Currency:** In PbR a currency (sometimes called a secondary classification) is the unit for which a payment is made. For example, an outpatient attendance for a physical ailment is a currency. The clusters are expected to be the currency for mental health services. We are seeking to make these used nationally for contracting and commissioning.

**HoNOS PbR:** This assessment tool includes the original twelve items of the Health of the Nation Outcome Scores (HoNOS) rated on a current basis and six additional items, mostly rated on an historical basis.

**Tariff:** In PbR terms, a tariff normally means a nationally set price for a given currency. We have not committed to a timescale for, or indeed if we will move to, a national tariff for mental health services. This will be examined once a national currency allows for comparison of variation.

**Unbundling:** A term used in PbR to refer to the splitting up of a currency into smaller units. A cluster could be unbundled if multiple providers were commissioned to provide care e.g. a main provider offering the majority of care, and then a more specialist provider to facilitate a peer support group. Unbundling should be used with caution, as otherwise you simply end up paying on a fee for service basis.

## Appendix 2 – Commissioner’s Checklist

### Commissioner Checklist

The national PbR Team is aware that SHAs are at different stages with regard to implementation of mental health PbR (MH-PbR).

This section pulls out those actions that Commissioners should be initiating now (while recognising that some areas have already made progress on these)

1. Coordination - Does the SHA have a nominated lead for MH-PbR, who takes a coordination role of engaging with PCTs to determine where there would be benefits from a SHA wide approach to any or all of the elements of the MH-PbR implementation (Action 4)?

2. Capacity and Capability - Does your PCT have a nominated senior lead, with responsibility for the implementation of MH-PbR, who has access to appropriate expert advice from other colleagues (Action 1)?

*Where there is a Lead commissioning arrangement, the Lead PCT should identify across its PCTs, the resources to support MH-PbR implementation.*

*Where there is no Lead Commissioning arrangement, but a shared main Provider, is there a Coordinating PCT to lead the MH-PbR negotiations?*

3. Leadership – Has your PCT (Lead/Coordinating) set up a Joint Project Board for the delivery of MH-PbR (Action 2)?  
OR are you already part of a SHA-wide Joint Project Board?

*If yes see 4-11*

4. Have you agreed a local timeline for PbR implementation, in line with national assumptions (Action 10)?
5. Is there a clear communications strategy in place that keeps both Commissioning and Provider PCT staff up to date and informed?

YES	NO	BY WHEN

6. Have you started a process for reaching a joint understanding of information issues (Action 6)? For example, working with Providers to ensure that there are data collection systems and a process for checking data completeness and quality.			
7. Does the Joint Project Board have a clinical engagement plan, involving both primary and secondary care clinicians?			
8. Have you started a process to align the development of outcome measures (see Action 7)? For example, are there agreed outcomes linked to movement between clusters or discharge from service?			
9. Does the Joint Project Board have a training plan for key staff groups? (Action 5)?			
10. Have you started a process to identify contractual issues (Action 8)? For example, agreeing specifications based on the care clusters; sub-contracting and 'unbundling' the care clusters.			
11. Have you started a process for local costing to determine prices (Action 9)?			