Mental Health Contracting Arrangements

Survey Report November 2015

Introduction

The HFMA's Mental Health Faculty Steering Group (the Group) recognises the importance of influencing the developing national agenda in relation to the reimbursement of mental health services.

Therefore, and in response to the Monitor/ NHS England consultation *Payment Proposals for Mental Health Services* (October 2015), a survey was undertaken in the autumn of 2015 to ascertain the progress made in relation to local contracting and payment arrangements and anticipate likely changes for 2016/17. The results of this survey will inform both the Group's response to the consultation and its approach in the coming months.

Overview

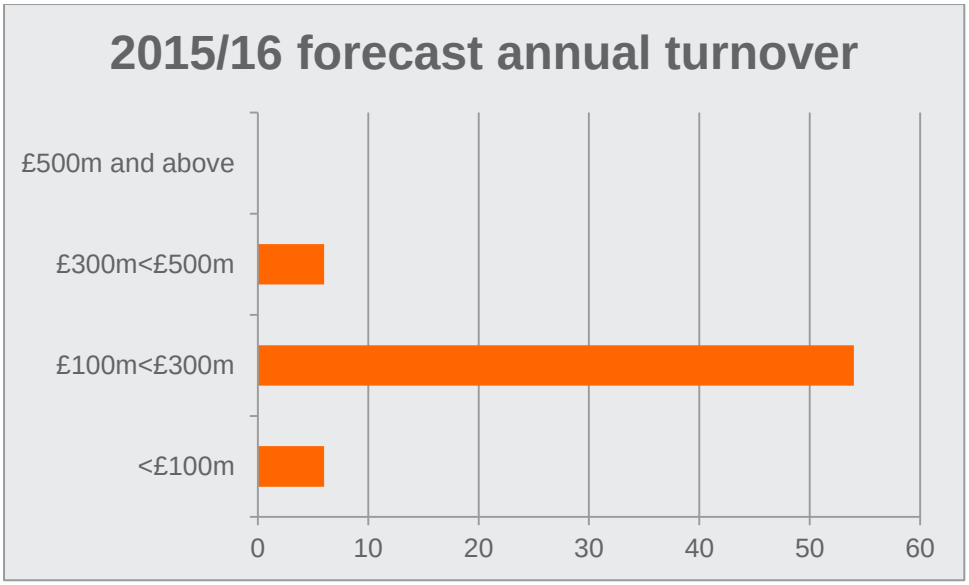
36 NHS mental healthcare providers completed the survey, representing 65% of faculty NHS healthcare provider members. The survey revealed the following key points:

- 89% of respondents currently have block contracts in place but this falls to 47% for 2016/17
- 45% of respondents anticipate moving to year of care/ episodic or capitated based contracts in 2016/17
- 86% of respondents stated that cluster activity was reported and monitored within their trust's most significant contract
- The management and risk of in-year activity variations lies predominantly with providers
- Although 37% of respondents have risk sharing arrangements in place, they are largely tied to high cost or volatile services and/ or contract lines
- 60% of respondents reported having outcome measures included in contracts for 2015/16
- 42% of respondents are confident[1] that year of care/ episodic or capitated payments could be introduced in 2016/17 (rising to 88% for 2017/18)
- 68% of respondents are confident[2] that outcome measures can be introduced to contracts in 2016/17 (rising to 85% for 2017/18).

Nature of Respondents

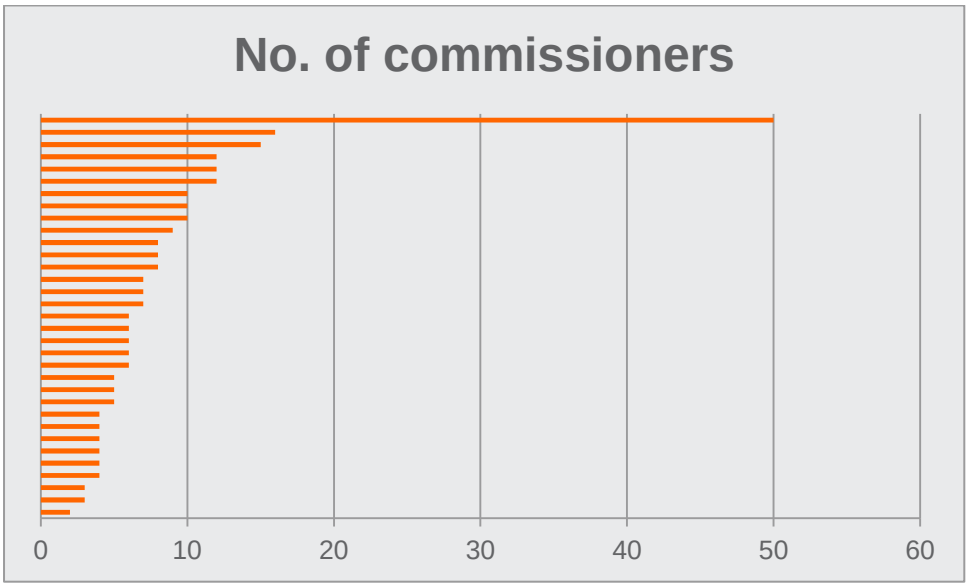
By annual turnover, respondents are grouped as follows:

[1] Moderate, high or very high
[2] Moderate, high or very high



Contracts and Activity

Respondents were asked the number of commissioners with which contracts are currently held (2015/16). Answers ranged from 2 to 50 and are shown in the chart below:



Nature of contracts

Respondents were asked to identify the basis of the contracts in place for 2015/16 (more than one option could be selected). The most common basis for current contracts is block without a cap/collar[3] arrangement (72% of respondents). When taken together with block contracts with a cap/collar arrangement in place, this increases to 89%. We also asked the question in relation to likely arrangements for 2016/17; the results show a move towards new contract bases and a more diverse range of results. The full results are shown in the table below:

[3] Where a cap is in place, variations to funding agreements are subject to a maximum amount. A collar allows a range of activity changes to take place without an associated resource implication for either the commissioner or the provider. Any activity changes within this range can be reflected by agreement in future years' contracts.

	2015/16 %	2016/17 %	Change %
Block without cap/collar	72	25	(47)
Block with cap/collar	17	22	5
Cost per case	22	14	(8)
Cost and volume[4]	28	14	(14)
Hybrid by cluster on block and some on cost and volume	22	36	14
Year of care or episode of treatment	0	14	14
Capitated	6	31	25
Other	19	17	(2)

Comments included:

'Due to data difficulties in respect of cost and volume, a block has been agreed for 2015/16.'

'Block without cap and collar with a risk share for cost per case/emergency placements (MH only).'

'Commissioners did not want cost and volume or cost per case even with caps and collars in 2015/16 as they were trying to move to block type arrangements for acute.'

'We have been piloting with one of our commissioners a programme approach (listed in local payment examples) expanding that into other CCGs this year.'

'We will at best have shadow arrangements in place for payment on a cluster basis as our clustering performance and data quality needs to improve (it slipped back due to a lack of clarity on future use of clustering in national guidance and lack of commissioner engagement in 2014/15 and 2015/16).'

'Would want capitated but data collection not set up in readiness for this, so expect a year of transition with aspiration to move to this.'

It is clear that a number of local health economies are some way from implementing new and/ or different arrangements. This situation is exacerbated for those NHS mental health providers dealing with multiple commissioners each taking a different approach to forthcoming contracts. 43% of respondents reported that this situation applies to them for 2016/17 contracts.

Comments included:

'Commissioners will push for block; this will not be an easy negotiation.'

'Maybe! Working to develop a Cheshire-wide approach. Notable exception will be specialised commissioners.'

'A coordinated approach would be helpful but unlikely.'

Role of clusters

86% of respondents noted that cluster activity was reported and monitored within their trust's most significant contract. For those organisations using cluster activity in this way, the following results were recorded (2013/14 results available from a previous faculty survey[5]):

[4] Here a fixed sum is paid for access to a defined range and volume of services but if there is a variation from the intended level of activity, there is a resulting variation in payment.
[5] *Mental Health Payment Mechanism Survey Report,* March 2014

	2013/14 %	2015/16 %	Change %
Days only	16	45	29
Caseload only	9	10	1
Both days and caseload	34	32	(2)
Currently no activity shared	N/A	0	0
Currently no activity shared but planned for next year	16	0	(16)
Other	23	13	(10)

It is clear that cluster activity is more widely shared between providers and commissioners than when this question was last asked of faculty members.

Managing variations

The survey asked respondents how variations to planned activity are managed within current contracts. The most common approach is the revision of activity plans as part of the data quality improvement plan with no financial impact. This leaves the provider trust to deal with any associated financial consequences. Comments included:

'We have discussed variation in payment and caps and collars for 2015/16 but commissioner changed stance in contract discussions.'

'Sympathy but no cash.'

'No activity plans agreed within contracts.'

Risk sharing

37% of respondents have a risk sharing arrangements in place for 2015/16 (54% 2013/14). They include:

- Cap and collar arrangements
- Memorandum of understanding
- Specific agreements for specific services/ contract lines, for example:
    - The flow of patients outside of the county such that the trust is incentivised to maximise the availability of local services
    - The utilisation of inpatient beds
    - High cost placements only.

Outcome Metrics

Inclusion

60% of respondents reported having outcome measures included in contracts for 2015/16. Some organisations reported having output measures (as opposed to outcome measures). The additional comments suggest that this is still a challenging issue:

'No as they are not clearly defined or measurable.'

'For IAPT[6] services only.'

'Need to define further outcomes for clinical care. We do share information re 3 quality domains e.g. patient experience responses, incidents, audits etc.'

'Provider proposed outcomes based contract around discreet contract section relating to primary care mental health, not taken forward by commissioners.'

[6] Improving Access to Psychological Therapies (IAPT)

'Outcome measures are usually "proxy" quality measures and usually linked to CQUINS[7].'

Type of measure

For those organisations including outcome measures in current contracts, the survey asked respondents to identify the type of measures used (more than one option could be identified). The survey also asked which measures were likely to be included within 2016/17 contracts. Results were as follows:

	2015/16 No.	2016/17 No.
Access and waiting time standards	20	26
Financial outcomes	2	5
Service/user patient experience	16	19
Supporting delivery of concordant care	10	15
Local community involvement	4	6
Other	5	5
We have no such plans at present	0	5

Comments included:

'Access & waiting times is the only area we could be in a position to use outcome measures; however this is not proposed at this time.'

'As we have 4 vanguards across our geography expect some kind of system metric development is an aspiration by commissioners but not seen anything yet.'

Regular dialogue

35% (40% March 2014) of respondents have an open and regular dialogue with service users and carers about the development and use of outcome measures to support the payment mechanism.

Pace of Change

Finally the survey sought to illicit views on the pace of change in relation to the development of the payment mechanism. Two questions were asked here. Firstly respondents were asked to rate their organisation's confidence levels now and over the next two years in relation to implementing contracts based on either year of care/ episodic or capitated payments. Results were as follows and are shown in terms of the number of organisations completing the matrix:

	Very low	Low	Moderate	High	Very high
2015/16	47	31	22	0	0
2016/17	15	44	27	15	0
2017/18	3	9	53	32	3

There are clear signs that organisations are making progress and confidence levels increase over the next two years. Comments included:

'Commissioners seem very reluctant to move from their historic arrangements and develop longer term relationships with providers.'

[7] Commissioning for Quality and Innovation schemes (CQUINs): payments that are designed to ensure that a proportion of providers' income (currently up to 2.5%) is conditional on quality and innovation and is linked to service improvement and innovation.

'We are looking to implement one of these models going forward, however we would require mandatory rules around the implementation in order to prevent long, drawn out contract negotiations.'

'We will need to work through the financial impacts on the LHE. We have usually tried to be pragmatic avoiding causing any further financial distress elsewhere, This may change as we go forward as our initial thoughts are that we are underfunded in terms of the numbers accessing our services so Capitation share would be beneficial.'

Respondents were then asked to rate their organisation's confidence levels now and over the next two years in relation to implementing outcome measures as part of contracts. Results were as follows:

	Very low	Low	Moderate	High	Very high
2015/16	34	31	25	6	3
2016/17	12	21	50	15	3
2017/18	3	12	35	47	3

Comments included:

'The key is to agree outcome measures that are meaningful with commissioners.'