



**Getting it together for mental health care:
Payment by Results, personalisation and
whole system working**

A central graphic consisting of a dark purple sphere with a white highlight, containing the text 'mental health' in white, lowercase, sans-serif font. The sphere is positioned between two large, semi-circular shapes: a dark blue one on the left and a light purple one on the right.

mental
health



**National Development Team
for Inclusion**

Montreux House
18A James Street West
Bath BA1 2BT

T: 01225 789135
F: 01225 338017

www.ndti.org.uk

Contents

1. Introduction	3
2. Implementing personalisation and Payment by Results	4
3. What is personalisation?	6
4. What is PbR?	8
5. An integrated person-centred whole system?.....	11
6. Some issues to be addressed	13
7. Conclusion	15

Written by Anita Cameron for the NDTi January 2012



1. Introduction

This paper considers how the two policy initiatives of Payment by Results (PbR) and personalisation need to be developed in tandem with one another, and in the context of whole system commissioning, if the aims of both are to be achieved. It raises some questions for discussion about whether personalisation and PbR can meet the challenge of a more radical whole system approach and what impact success or failure will have on mental health services and outcomes for individuals. It concludes with some specific issues that need to be considered nationally and locally.

NDTi are seeking to encourage discussion and debate around the issues contained in this paper. To help do that, we are setting up a discussion forum on our website and we invite people to visit that Forum, post their comments, and see what others have to say. To do this:

- Visit the website at www.ndti.org.uk
- Click on 'Forum Login'
- Click on 'Login' at the top of your screen
- Type in the Login details – Username: ndti guest. Password: payment
- Click on the discussion thread entitled 'Payment by results and personalisation in mental health services'
- Click on 'Mental Health PbR Discussion Group'
- Click on 'Post Reply' to post a comment



2. Implementing personalisation and Payment by Results

Health and social care services are themselves agents for change, but they are also constantly having to respond and adapt to whatever political, social, technical and medical waves of thinking and innovation are breaking on their shores.

Among many others, there are currently two strong drivers being brought to bear on public services:

- Personalisation, which seeks to give people more choice and control and, in achieving this, involves far reaching changes in systems, attitudes and approaches
- and
- Payment By Results which is a system of payment for healthcare providers based on nationally determined currencies and tariffs and which has an impact wider than financial reward.

The recovery approach to mental health has been operating across the world for a number of years. Although it predates the introduction of personalisation as a general government policy, it is a good example of a personalised approach and emphasises for example, the need to build on strengths, self-management, the equality of relationships and social inclusion.

The aims of personalisation can only be achieved by taking a more radical whole system approach, working across and beyond health and social care systems. Achieving a person-centred Payment by Results system for mental health care is an example of the challenge that a more radical approach to forging new relationships, and new ways of doing things, brings.

Public services have long been struggling to embrace a whole system approach, largely without applying any real theoretical underpinning.¹ This leads to a broad concept of whole system working, focusing on how the various parts of the system need to work together to achieve the best, and most cost effective outcome for people. This very broad concept, when pursued, can be a step forward and can have positive results, but it can result in relationships that are in reality not much more than fragile 'joint working'. It remains to be seen whether personalisation and PbR can meet the challenge of a more radical whole

¹ *Whole systems working: a guide and discussion paper*, CSIP, Integrated Care Network, October 2006

system approach and what impact success or failure will have on mental health services and outcomes for individuals.



3. What is personalisation?

There has been quite an avalanche of literature on personalisation over the last few years and the terminology has been widely adopted. With regard to public services, personalisation is generally understood to mean a culture in which citizens are able to shape the services they need, with choice and control, so that support fits the way they wish to live their lives.^{2 3}

Personalised approaches recognise people's strengths, interests, preferences and abilities and value family and friends as partners. Many local authorities use a model of self-directed support. The self-directed support model described by In Control⁴, turns around the traditional 'assess, plan, allocate resources' approach. It starts with self-assessment, followed by the allocation of a personalised budget set from a pre-determined resource allocation system (RAS). In this model personal planning is at the heart of the process, with the person themselves and their family leading the decision making.

An ADASS survey on personalisation⁵ reports that '*councils are generally making good progress towards universal personal budgets*' and access to a personalised budget has undoubtedly had a positive impact for some people.^{6 7} However, personalisation is much more than the allocation of a personal budget and involves far reaching changes in systems, attitudes and approaches, putting people at the centre of decision making and service design. Crucially, it involves a strong collaborative approach between health and social care, who, in spite of heroic attempts at partnership working, have historically often found it difficult to sustain.⁸ It also requires both systems to see beyond their own orbit and engage in equal partnership with individuals, other partners and communities. We are still

² *Paths to personalisation in mental health; a whole system, whole life framework*, NDTi, DH March 2010

³ *SCIE Report 20: Personalisation: A rough guide*, SCIE, October 2008

⁴ See *In Control* website <http://www.in-control.org.uk/>

⁵ *ADASS Report on Personalisation Survey*, ADASS, September 2011

⁶ *The national evaluation of the Individual Budgets pilot programme*, Glendinning, C., et al, Social Policy Research Unit, 2008

⁷ *Stockport self-directed support pilot, mental health: Final Report of the Evaluation*, Dr C Eost-Telling, University of Chester, December 2010

⁸ *Joining up health and social care: Improving value for money across the interface*, Audit Commission, December 2011

waiting to have a more comprehensive view of the impact that personalisation is having on people's lives, and whether or not systems changes have been sufficiently far reaching. There will be a clearer picture, for example, with the results of the second part of the ADASS personalisation survey, and of the Right to Control Trailblazers⁹ programme in which people with disabilities living in seven test areas will be able to combine the support they receive from six different sources and decide how best to spend the funding to meet their needs.

⁹ See Office for Disability Issues web page: <http://odi.dwp.gov.uk/odi-projects/right-to-control-trailblazers.php>



4. What is PbR?

A simple guide to Payment by Results¹⁰ describes PbR as:

‘..the payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient’s health care needs. The two fundamental features of PbR are nationally determined currencies and tariffs. Currencies are the unit of healthcare for which a payment is made, and can take a number of forms covering different time periods from an outpatient attendance or a stay in hospital, to a year of care for a long term condition. Tariffs are the set prices paid for each currency.’

PbR has been in place for acute services for some time and is generally seen as having a number of benefits, particularly in the move away from block contracting, such as better incentives for providers to increase their activity and efficiency. However, some of the lessons learned from acute services have been about the conflicts of interest that PbR can create – for example, the conflict between the drive for primary care to keep people out of hospital and the drive for hospitals to bring people in to increase their income. In a discussion paper, *Commissioning in a Cold Climate*¹¹ the NHS Confederation recommended that the PbR system should be redesigned so that it ‘encourages efficiency across whole care pathways and care delivery systems’ and that incentives and rewards are needed that encourage NHS and social care organisations to collaborate effectively for quality as well as efficiency.

A PbR system for mental health is now in development to be introduced in 2012-13, shifting from block grants to PbR currencies which are ‘associated with individual service users and their interactions with mental health services’¹²

In theory, the learning from PbR so far will be applied to the introduction of PbR for mental health, but it remains to be seen what happens in practice. If the introduction of PbR has been slow to materialise for mental health care, it is not surprising, as there are a number of reasons why it is more complex to apply to this area. These include the diversity and potential complexity of needs, variation of treatment and responses, poor information

¹⁰ *A Simple Guide to Payment by Results*, DH PbR Team, July 2011

¹¹ *Commissioning in a Cold Climate: Discussion Paper*, NHS Confederation, June 2009

¹² *2012-13 Mental Health PbR guidance*, DH PbR Team, October 2011

systems and the lack of international experience to build on (which is not the case with acute services).¹³

The approach being taken to introduce PbR in mental health care, in response to the different nature of mental health services, is based on three main components:

Clusters which group people according to their needs : A model of care clusters has been developed by a consortium of care providers (Care Pathways and Packages Project)¹⁴. The clusters are based on descriptions of characteristics of people that is assumed will have similar mental health support needs. There are 21 clusters under three main groupings: non-psychotic, psychotic and organic.

Example of a cluster description:

Care Cluster 8: non-psychotic chaotic and challenging disorders. This group will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over dependent engagement and often hostile with services

A mental health clustering tool¹⁵ has been developed (and is still being refined) for use by clinicians to help them decide how to allocate someone to a care cluster.

Resources used to meet needs: Currency and tariffs¹⁶ are being developed to calculate costs of resources used to meet needs. As the intention is to avoid standardising responses to need, the clusters will be the currency unit (rather than the care pathways) and the emphasis is on how costs are calculated (rather than how or what care should be delivered). Having the means to calculate costs will not make much difference if work has not also taken place to make sure that there are co-produced options and diverse responses to need available to people.

¹³ *Policy Paper 4: Payment by Results: What does it mean for mental health?* Sainsbury Centre for Mental Health, December 2004

¹⁴ Care Pathways and Packages website: <http://www.cpppconsortium.nhs.uk/index.php>

¹⁵ *Mental Health Clustering Booklet* (2011/12), CPPP , V2.O2, April 2011

¹⁶ *Report on the development of a mental health currency model*, Self R, Painter J, Davis R, CPPP Consortium, April 2008

Quality and outcomes: Quality indicators and outcome measures¹⁷ are being developed, linked to PbR currency groups and with a view to ensuring that they reflect the right incentives.

Vital to the success of this approach is ensuring that each of these strands has the same level of attention to get it right, and understanding that the link between needs, resources and outcomes is a key success factor.¹⁸

The CPPP Consortium emphasises the scale of the change needed to successfully implement this approach to PbR.

‘The challenges involved in this ambitious project cannot be underestimated. They are far-reaching and will involve real changes to clinical custom and practice, commissioning arrangements and most significantly to clinical information systems and the way they are used.’¹⁹

In spite of the challenges, the introduction of PbR in mental health does have real potential to make better and fairer use of resources and result in a more personalised and responsive approach.

¹⁷ *Payment by Results Quality and Outcomes measures: Report for Product Review Group Quality and Outcomes Subgroup*, DH, October 2011

¹⁸ *Combining routine outcomes measurement and Payment by Results: will it work and is it worth it?* MacDonald AJD, Elphick M. Br J Psychiatry 2011; 199:178-179.

¹⁹ *CPPP Consortium: Draft costing group method statement*, April 2009



5. An integrated person-centred whole system?

The recovery approach to mental health is very much in line with personalisation:

*'Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems.'*²⁰

This approach emphasises the need to build on health and strengths and hope for the future, self-management, the equality of relationships between clinicians and patients, social inclusion and the role of family, friends and communities as partners.

The Care Programme Approach aims to integrate care and support across primary and secondary health care, health and social care, housing and employment support and across all sectors. Potentially CPA can be part of precisely the whole system approach needed for effective personalisation and has led to positive outcomes for people. However, the implementation of CPA has not been consistent or comprehensive and reports over the years point to continuing failures in the system. These include things which are seriously at odds with personalisation, recovery and inclusion such as the use of CPA as a managerial tool rather than a system of engaging people, a tick box approach rather than a change process, lack of attention to social care needs, a focus on problems and risks rather than strengths and recovery and lack of involvement of carers as partners.²¹

New guidance has been issued to address some of these issues²² and it highlights the need for a whole systems approach with an integrated care pathway, information sharing and whole system commissioning for a diverse range of services. It is possible to envisage an integrated RAS system for mental health, with only one assessment, one plan and one funding stream and Yorkshire and Humber are in the process of developing one.²³

²⁰ *Making recovery a reality*, Shepherd G, Boardman J, Slade M, Sainsbury Centre for Mental Health, March 2008

²¹ *Mental Health Trusts: Community Mental Health Service User Survey*, 2006. London: Healthcare Commission; 2006.

²² *Refocusing the Care Programme Approach: policy and positive practice guidance*. London: Department of Health; 2008.

²³ *Resource allocation in mental health: A discussion paper*, Centre for Welfare and Reform, September 2010

Personalisation has also faced challenges in its development and concerns have been expressed about, for example, patchy and inconsistent implementation and an emphasis on designing complicated new systems that do not necessarily deliver anything different, or lead to the outcomes that people want.²⁴ There are fears also that economic pressures will hold things back, and lead to misuse of personal budgets to cut costs, and a tightening, rather than a blurring of boundaries. There is a danger that this could lead to a loss of confidence and trust in the original ideas and principles of personalisation.²⁵

But now is not the time to lose heart. Significant progress has been made and the building blocks for change are still there. The introduction of PbR for mental health could be an added ingredient to make it possible to achieve a culture that embraces personalisation, recovery and a whole systems approach, with person-centred integrated planning, easily accessible personal budgets for health and social care, whole system creative commissioning in partnership with people and communities and recognising the contribution they make, and a personalised PbR system that will reward recovery and inclusion as well as activity and efficiency.

²⁴ *The architecture of personalisation*, Simon Duffy and Kate Fulton, The Centre for Welfare Reform, August 2010

²⁵ *The state of personalisation in adult social care: Community Care Personalisation Survey, 2009, Community Care*



6. Some issues to be addressed

6.1 Understanding the culture of personalisation

The implementation of PbR systems in mental health care is complex and challenging and it would be easy to lose sight of broader issues of the development programme. For example, the link between personalisation and PbR is vital if the ambition to offer people real choices and achieve more cost effective joined up commissioning and provision is to be realised. It will be important to check the extent of understanding of those developing and delivering mental health care about personalisation in practice, and the culture, attitude and systems changes that it brings, and not leave this to chance.²⁶ Some proactive programmes to ensure that there is a sound and common understanding of personalisation would be helpful.

As part of the culture, language is important in explicitly supporting personalisation, inclusion and recovery.²⁷ The language currently used in the PbR Clusters and the allocation tool tends to focus on symptoms and problems and is not helpful in this respect. Reviewing the language would be helpful as part of ensuring that culture and attitudes reflect the desired values and principles.

Systems like Care Management and CPA also need to keep pace and change, in response to personalisation and PbR, by being less bureaucratic and more trustful of local and individual decision making.²⁸

Question to consider. Are those people involved in developing PbR building in the culture of personalisation as an integral part of its implementation - and are those people involved with implementing personalised approaches and systems linking in with the development programme for PbR?

²⁶ *Puzzles and possibilities: Implementing personalisation and CPP in mental health in the north east of England*, Final Report of a Scoping Exercise, MHNE, May 2010

²⁷ *Mental health care clusters and payment by results: considerations for social inclusion and recovery*, Michael Clark, Mental Health and Social Inclusion, Vol 15, N0.2 2011

²⁸ *The architecture of personalisation*, Simon Duffy and Kate Fulton, The Centre for Welfare Reform, August 2010

6.2 Thinking and working together

Joint working potentially offers better outcomes for people and more efficient use of resources, but progress on effective partnership between the NHS and councils is still patchy.²⁹ Taking a whole system view and a serious partnership approach, sustained by ongoing attention to leadership, culture and relationships is more likely to achieve the aims of personalisation and PbR. Joint working also needs to be built into systems, for example integrated assessment and resource allocation. Outcomes and quality indicators will also need to reflect joined up personalisation, inclusion and recovery approaches. Crucially, systems and options will need to be developed and co-produced with people and their families if they are to offer the right approach and the choices that people want that will help and meet their needs.

Question to consider: Is joint working between the NHS and councils, and co-production with people who use services, families and communities at the core of the development of PbR systems?

6.3 Whole system commissioning

Real choice will be very restricted if there is not a whole system approach to commissioning which pays attention to, and supports, a wide range of options. This includes, for example, support from friends and families, universal and community services, individual purchasing and broader commissioning, and person-centred options for treatment and emergency support. (See Example of whole system commissioning diagram). There will also need to be a focus on a full mental health pathway, rather than just specialist health services.

Question to consider: Are the emerging PbR systems reflecting whole system processes and outcomes and not just specific healthcare interventions?

²⁹ *Joining up health and social care: Improving value for money across the interface*, Audit Commission, December 2011



7. Conclusion

The details of how to implement PbR in mental health care are still being worked out and it is important that key questions are considered in the process, based on what we have already learned. As with any development in public services, raising key questions in the development stage may avoid the danger of disappearing down a rabbit hole of systems development without coming up to see that on the surface nothing much has changed, and the burrowers have lost sight of important values and principles.

Understanding the culture of personalisation and keeping it at the core of PbR, partnership working, involving people in co-producing systems and solutions and keeping a wider, joined up, whole system view will be vital ingredients for success.

Example of whole system commissioning		
Sources of support and help	Key questions raised	Examples of commissioning response
Family/friends	What support do I have or can I reasonably expect from family and friends?	<p>Range of person-centred support for carers</p> <p>Recognition of carers as partners in care</p> <p>Resources for peer support</p>
Community/universal Public Health	<p>What can I access from my community/neighbourhood?</p> <p>What is available to all?</p>	<p>Information and advice about what is available</p> <p>Advocacy and personal support, where it is needed, to assist access to community and universal services</p> <p>Investment in community development and social capital</p> <p>Investment in public health initiatives, prevention and early intervention approaches</p>
Personal Budget	What can I buy with my personal budget to help me live my life and recover?	<p>Support for person-centred planning and for managing a personal budget.</p> <p>Integrated health and social care personal budget.</p>
Commissioned services	<p>What can I choose from services already commissioned?</p> <p>How can I influence what is commissioned?</p>	<p>Creative and collaborative commissioning beyond health and social care</p> <p>Information and support to navigate services</p> <p>Co-production in market development and management to ensure that the market is responsive to what people say they want.</p> <p>Support for providers to develop personalised</p>

		<p>approaches.</p> <p>Payment systems for providers that reward personalised and recovery approaches, collaboration and quality as well as efficiency.</p>
Treatment	<p>What treatment will I be offered to help me recover and live my life the way I want to? Will I have some control over decisions that are being made about my treatment?</p>	<p>Person-centred approaches to treatment</p> <p>Therapeutic aims and pathways that are supportive of recovery and inclusion</p>
Emergency/crisis support	<p>Will I have a say in what happens to me in an emergency/crisis and be supported to move on positively?</p>	<p>More responsive, personalised, emergency arrangements and support</p> <p>Support to move on positively from crisis situations</p>