Paper 3:
Financial systems in the NHS in the UK

MH4U supporting activities

1.1.5 Advise MoH and Center of MH on best practices in MH in the scope of current healthcare transformation process (such as developing minimum data set for MH, revising payment mechanisms for MH services and introducing e-health for mental health providers).

1.1.5.2: Advise and provide international expertise on financing mechanisms for MH services and on the MH services which will be included in basic guaranteed package (regarding both MH services provision and pharmaceuticals).

Specifically, Implemental to provide:

- An overview of the characteristics of a well structured system for the financing of mental health services, based on international examples.
- An overview of the process the NHS should undertake when developing the basic package of mental health services.
- An overview of the key documents to be developed when developing the financing mechanisms.

1. Fiscal Context

The United Kingdom's health expenditure per capita among is average among OECD countries (at $4070 per capita). For mental health expenditure, this is harder to track due to the numerous commissioners described in paper 1. The **Mental Health Taskforce** reports that all spending for NHS England on Mental Health was at £1.25 billion for year 2018/19, up from £1.1 billion in 2015/16[1].

All Clinical Commissioning Groups must meet the Mental Health Investment Standard (described later), which tries to ensure an appropriate level of investment across all health services ('parity of esteem' at a local level). Overall, mental health as part of local health spend is at 13.9% of all spend for 2018/19, up from 13.1% in 2015/16.

Internationally, the United Kingdom spends a relatively high amount on mental health as a percentage of total health spend. The **'NHS Benchmarking Networking International Mental Health' (2018)**[2] provides an overview and suggests total spend was between 9-11% of total health expenditure, depending on the constituent country of the UK. This high level of expenditure is offset by the UK's relatively low total health expenditure.

2. Policy context

NHS Benchmarking network describes the UK's National Health services as follows[2]. England's national mental health system is a core part of the National Health Service (NHS), an inclusive free at point of delivery public health system that covers all of the country's residents. The NHS is a unique healthcare system amongst developed economies and covers the 4 countries of the United Kingdom.

Mental health care is commissioned by the NHS and covers England's whole population. The system is mainly supported by statutory NHS provider organisations, although the private sector also contributes and provides around 20% of the 25,000 mental health and learning disability beds available in England. The private sector tend to focus their provision on more specialist bed types including forensic care. In addition to the 25,000 beds around 700,000 adults are supported on the community caseloads of specialist mental health services in England. Almost all of these people are supported by statutory NHS provider organisations.

There are 54 specialist NHS secondary care mental health provider organisations in England, each serving an average catchment population of 1 million people. Around 2% of the population are registered with secondary mental health services. The NHS also has a well developed primary care system which is also free at the point of delivery. General Practitioners provide a first line response for common mental health conditions and refer to secondary care services for access to specialist mental health care.

A unique element of England's mental health strategy is the large scale Improving Access to Psychological Therapies (IAPT) initiative which by 2018 had supported an annual total of 1.1 million people in accessing psychological support for common mental health problems.

As a national healthcare system, the NHS in England can develop national strategies for mental health and oversee the implementation of these strategies with providers. The "Mental Health National Service Framework" published in 1999 outlined an overall strategic objective of moving away from reliance on inpatient beds towards more integrated community services.

As a result of this programme and subsequent strategies, the English NHS has developed comprehensive community mental health services and significantly reduced the number of inpatient beds. The NHS Long Term Plan, published in January 2019, builds further on these commitments and outlines a national investment programme to further enhance the capacity of mental health services and extend access to specialist care.

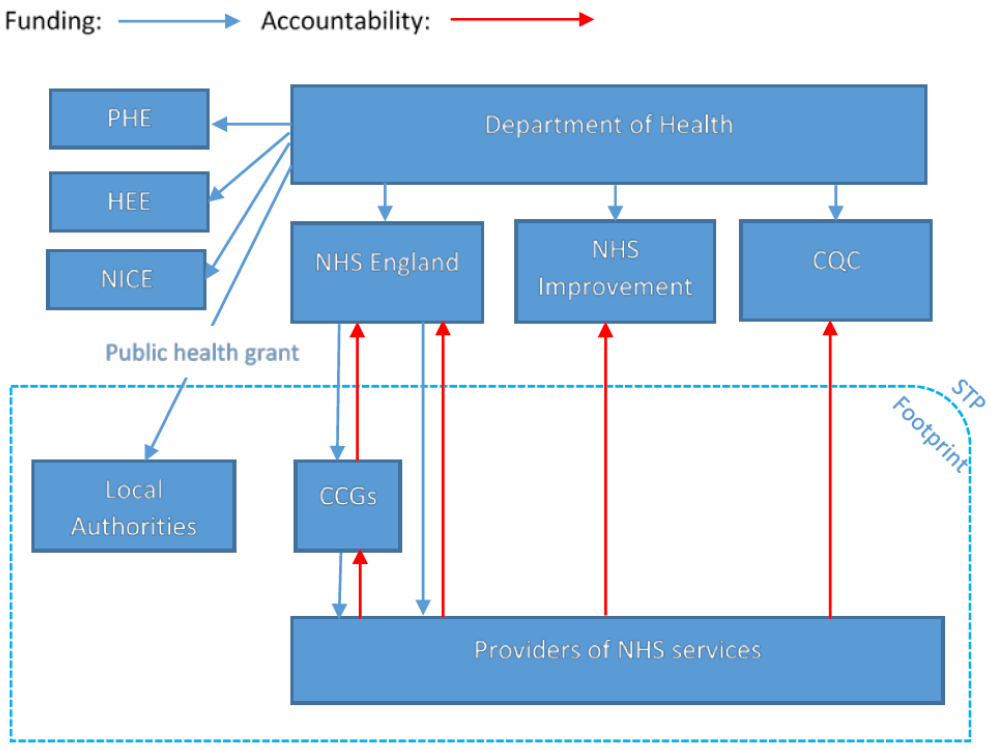
Amongst the priority areas in the NHS Long Term Plan are commitments to; further extend access to services for common mental health problems through

the Improving Access to Psychological Therapies initiative (to 1.9 million people per annum by 2024), expand Perinatal mental health services, improve access to crisis care, expand targeted services for people experiencing first episode psychosis, further enhance the level of specialist care available in the community, and ensure rapid access to services for children and young people.

The NHS Long Term Plan is backed by a detailed implementation plan for mental health which outlines details of the workforce and skills requirements to ensure that comprehensive national services are provided.

3. The structure and financial organization of the NHS in England

A general overview of the NHS in England (current at 2017) is provided below[3]. The department of health (and now social care) funds the non-departmental public bodies that that have executive control over the NHS. NHS England is the largest of these bodies and controls the bulk of the financial distribution and is accountable for the outcomes of the NHS.



A much more comprehensive overview of the NHS has been recently provided by the **National Audit Office**[4] and in Paper 1 of this series **'Commissioning mental health services in the UK'**.

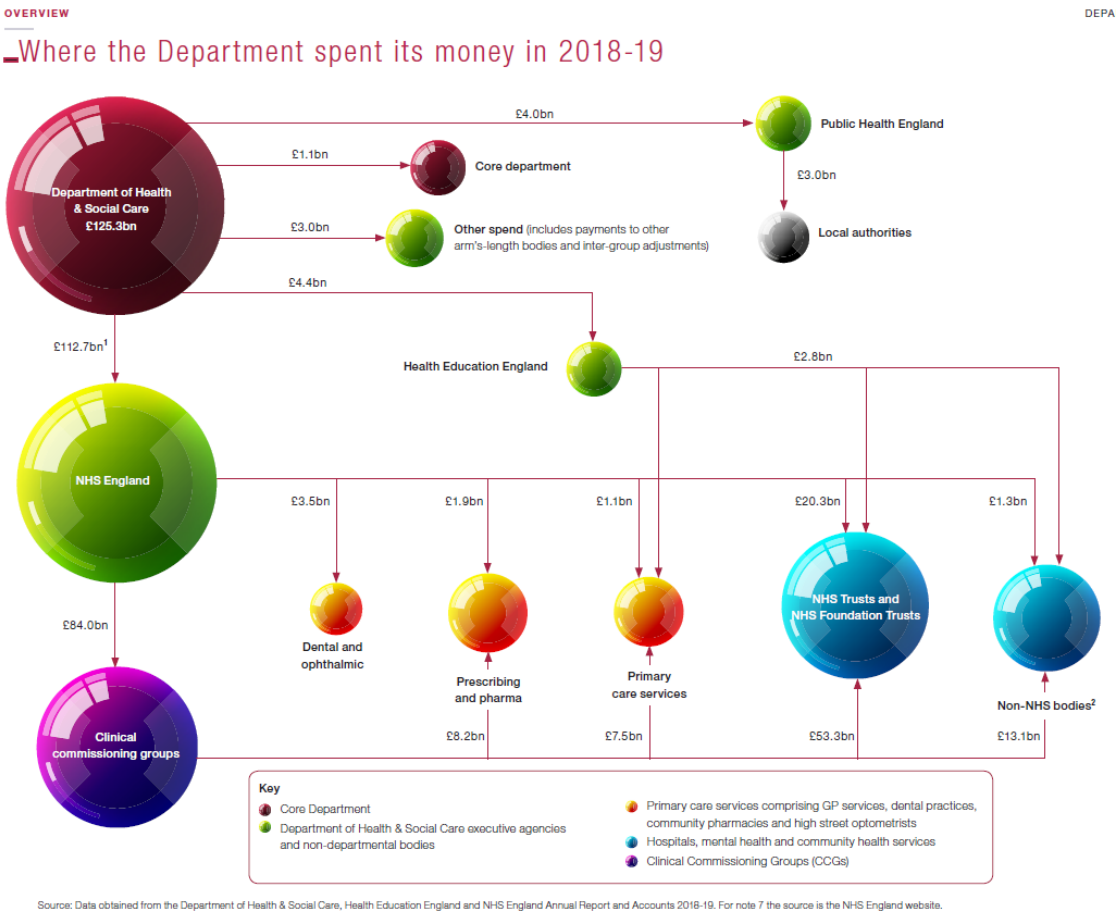
Current developments include the formation of Integrated Care Systems (which are building on the “STP” or Sustainability and Transformation Partnerships in the Figure above) which will cover the whole of England by 2021 and look to integrate social care and health.

4. How NHS funding flows

Funding for health services comes from the total budget for the Department of Health and Social Care (DHSC). The NHS England revenue and capital budgets are announced in the Department of Health and Social Care’s expenditure plans, published as part of each Spending Review (and amended by budget announcements).

In 2018/19 the total allocated budget for the DHSC was £130.3 billion[5]. Most of this budget (£114 billion) was transferred to NHS England with the remainder divided between DHSC’s other agencies and programmes, including funding for Public Health England, and arm’s length bodies like the Care Quality Commission, NHS Improvement and National Institute for Health and Care Excellence.

NHS England’s budget is used to deliver its mandate from the DHSC. NHS England is responsible for allocating resources to local commissioners of health services: clinical commissioning groups (CCGs) and local authorities. Most of the commissioning resource allocations go to CCGs (£75.6 billion in 2018/19). NHS England spend the remaining budget on specialised services which are often services that there is less widespread demand for and hence can be offered at specialist centers. The **national audit office**[4] provides a clear overview of these funding streams (see below).



5. How does NHS England distribute funding to CCGs?

NHS England is responsible for determining allocations of financial resources to Clinical Commissioning Groups (CCGs). CCGs were established in 2013/14 and are responsible for around 60% of the NHS budget. CCGs serve their local population needs and are made up of clinician led groups.

In 2019/20 NHS England distributed a total of £78.4 billion across 191 CCGs in England. The overall funding equates to £1,318 per registered patient in England. Funding per head is set to increase by an annual average of 1.7% in real terms between 2017/18 and 2023/24, rising from £1,274 per patient in 2017/18 to £1,396 in 2023/24.

As CCGs serve a certain size population in a local area, each receives funding based on this. However, this capitation per head is further weighted by other factors, accounting for social determinants, such as age of the population, deprivation and other key indicators. This capitation is also adjusted based on CCGs funding per head relative to the other CCGs (known as Distance from Target). A full overview of the current formula can be seen in **'NHS Funding Allocations: Clinical Commissioning Groups' (2019)**[6]**.**

6. Financial models to commission services

As seen above, NHS England and CCGs hold most of the funds available for service commissioning services, either in their local area (for CCGs) or for specialised/primary care services through NHS England. In some cases, these two bodies can collaboratively commission with each other and in the case of CCGs, with other CCGs. CCGs must also take into account the needs assessment delivered through the local Health and Wellbeing boards discussed in Paper 1.

The NHS is exploring new payment approaches for mental health services[7] which follow the principles laid out in the 5 Year Forward and is seen in Appendix A. These are largely covered by a **'Capitated payment approach'** or an **'Episodic payment approach'**. Both these approaches are expected to include an outcome and quality measures component, as defined by the commissioners and service providers in the local area[8].

A '**Capitated Payment Approach'**[9] is a payment to a provider or group of providers to meet the local population's healthcare needs. Payment can be based on different segments of the local population. It can be adjusted to reflect changes in the size and characteristics of these segments, as well as in other variables (e.g. patterns of care, efficiencies and investment). As costs and patterns of care may change over time, basing payment on accurate and robust information prevents providers and commissioners from being locked into payments that are based on outdated and incorrect assumptions.

An **'episodic payment approach'**[10] provides payments to a provider or group of providers for an individual patient's episode of care. This payment will vary according to which of the national currencies for mental health services best describes the patient's needs. The characteristics of people who access secondary mental health services will vary from year to year, as will the number of people who require care. An episodic payment approach for mental health can help local health economies address the limitations of unaccountable block contracts, and help providers and commissioners better understand the care they provide, and the resource used to deliver that care. The IAPT service uses an approach close to this, linked directly to outcome measures[11].

Both systems rely on currencies known as care 'clusters', of which there are 21 and cover most mental health services for working-age adults and older people. A CAMHS equivalent is currently under development[12]. Each patient is recorded (and updated as needed) under a cluster as part of the Mental Health Services Data Set. An overview is provided in the Figure below.

Cluster	Cluster label	Max cluster review period	Suggested payment approach
0	Variance group cluster allocation not initially possible	6 months	Episode
1	Common mental health problems (low severity)	12 weeks	Episode
2	Common mental health problems	15 weeks	Episode
3	Non-psychotic (moderate severity)	6 months	Episode
4	Non-psychotic (severe)	6 months	Year of care
5	Non-psychotic (very severe)	6 months	Year of care
6	Non-psychotic disorders of overvalued Ideas	6 months	Year of care
7	Enduring non-psychotic disorders (high disability)	Annual	Year of care
8	Non-psychotic chaotic and challenging disorders	Annual	Year of care
10	First episode in psychosis	Annual	Year of care
11	Ongoing recurrent psychosis (low symptoms)	Annual	Year of care
12	Ongoing or recurrent psychosis (high disability)	Annual	Year of care
13	Ongoing or recurrent psychosis (high symptoms and disability)	Annual	Year of care
14	Psychotic crisis	4 weeks	Cluster episode (at first presentation)
15	Severe psychotic depression	4 weeks	Cluster episode (at first presentation)
16	Dual diagnosis (substance abuse and mental illness)	6 months	Year of care
17	Psychosis and affective disorder difficult to engage	6 months	Year of care
18	Cognitive impairment (low need)	Annual	Year of care (annual review)
19	Cognitive impairment or dementia (moderate need)	6 months	Year of care (annual review)
20	Cognitive impairment or dementia (high need)	6 months	Year of care
21	Cognitive impairment or dementia (high physical need or engagement)	6 months	Year of care

For mental health, there is no national prices available, despite the national currency being available in the form of the clusters above. The NHS does provide guidance on how to cost these in **'National Tariff Payment System (2019/2020)'**[13]**.**

7. Financial models to commission national initiatives

Whilst the funding processes and mechanisms behind commissioning are important, large scale transformation can often require the investment from central government. The development of the UK National Service Framework ensured funds were 'earmarked' for the transformation. These funds included £700 million over three years and an extra £120 million distributed via a Mental Health Modernisation Fund[14]. More recently, to help achieve the Long Term Plan,

the NHS has defined a £2.3 billion investment plan until 2023/24 to improve services in key areas[15].

These transitional and development funds allow the system to build new capacity and services, while reducing the impact this has on the financial needs of their current service delivery. This reduces the risk of causing problems in the existing service and reduces negative impacts on these services.

8. Service level costing standards

Mental health services in England will be required to hold a patient-level costing (or PLICS) from 2020/21. NHS Improvement is currently working towards ensuring all data is collected in line with **Approved Costing Guidance (2019)**[16].

9. Outcomes / value-based commissioning

Building on the commissioning approaches outlined above, the NHS in England also provides a top up payment known as **"Commissioning for Quality and Innovation"** (or CQUIN). This provides up to 2.5% top up to services in key areas of improvement, in both CCG and national specialised services[17]. This is paid out through CCGs and through NHS England.

10. Key reflections

The mental health investment standard

This was previously known in the UK as 'parity of esteem'. This is a commitment that there should be equality between physical and mental health services. It was introduced by the UK in 2016/17. It requires all clinical commissioning groups to increase spending on mental health in line with the total funding allocated to them[18].

In terms of performance against this commitment, 90% of Clinical Commissioning Groups (CCGs) met this target in 2017/18. It is expected that 100% of CCGs will have met the target in 2018/19.

Transitional Funding and ring-fencing funds

Transitional funding, that increases the overall available budget, is essential for a system undergoing change. Whilst the system develops and changes services, the current level must be maintained. The overall costs of these developments require increases in manpower, new buildings and other costs.

Similarly, the mental health budget can be ringfenced, ensuring budget cannot be repurposed for other means. Even in NHS England, the British Medical

Association reported as recently as 2015 that mental health budgets were being acquired for other purposes[19] and surpluses in commissioning mental health services as recently as 2018/19 have been underspending, helping to balance the books[20].

Information systems

A national system requires a currency to commission services, and this can be readily tracked through information systems. The NHS currently requires all providers who are funded by the NHS to upload information on to the Mental Health Services Data Set (MHSDS)[21] providing a bank of information on care provision. This enables a comprehensive overview of the national picture and is available for the public[22].

Documentation drafted by Implemental Team
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Appendix A:

Principles underpinning payment approaches in mental health

1. There must be no more unaccountable block contracts for mental health (where a payment is made to a provider to deliver a specific, usually broadly-defined, service for example, a hospital given a block contract to undertake acute care in a particular geographical area).

2. Providers should never entirely be rewarded for providing a number of days of care within a particular setting, but instead be rewarded for delivering whole pathways of care with achievement of defined outcomes or meeting local population need, as appropriate.

3. Both national and local outcome measures should be used as part of the payment system, these should be co-produced and developed by all stakeholders with a leading role taken by people with lived experience of mental ill health (and their families).

4. Where integrated care is needed, payment should similarly be integrated. For example, for urgent and emergency mental health care, the payment approach should be embedded within the wider urgent and emergency care payment approach, and payment for mental health care within physical care pathways should be similarly integrated.

5. Payment approaches should include access standards, where these are developed, to drive achievement of improved access to timely, evidence based care with routine outcome measurement.

6. Payment approaches should be developed with experts-by-experience, reward engagement and delivery of access to excellent care for particular groups, where this is appropriate. This may include BAME populations and people with co-morbidities, such as substance misuse or diabetes.

7. Outcomes should be holistic and reward collaborative working across the system (e.g. stable housing, employment, social and physical health outcomes).

8. Payment systems must promote transparency and increased provision of high quality, relevant data that can drive improvement

9. Payment systems should support improved productivity, value, efficiency and reduced costs, where possible.

10. Payment systems should support pathways through services, rewarding and incentivising step down to lower-intensity settings and a focus on care in the least restrictive setting. They should aim to reduce avoidable crises, admission and detentions, while protecting against any misalignment of incentives that might give rise to cherry-picking or other risks that might impact negatively upon those people with mental health problems who are ‘hardest to reach’.

11. National guidance should support commissioners to commission effectively using appropriate payment approaches.

12. Additional support should be provided to commissioners to build leadership, capacity and capability in commissioning services, including for the use of new payment approaches that will necessarily require new skills and competencies.

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