the association of foundation trusts and trusts

NHS providers

FUNDING FOR MENTAL HEALTH SERVICES MOVING TOWARDS PARITY OF ESTEEM?

April 2015

FUNDING FOR MENTAL HEALTH SERVICES MOVING TOWARDS PARITY OF ESTEEM?

> *To date it has been a very frustrating contracting round and unfortunately highlights the institutional prejudice that exists towards mental health services. It has not been recognised at the centre that there will need to be a significant cultural shift if parity of esteem is to even start to be delivered. This is both at clinical commissioning groups and within the colleagues that design and oversee the processes that support the annual contracting processes.*
>
> **Finance director, mental health trust**

INTRODUCTION

In March 2015, we surveyed NHS mental health foundation trusts and trusts to find out whether commissioners are planning to meet the requirement in the planning guidance to increase their real term investment in mental health services. We found that:

- The majority of respondents (53 per cent) were not confident that their commissioners would meet the planning guidance requirement on funding.
- Providers were more confident that they were going to receive additional investment from clinical commissioning groups (CCGs) than from NHS England local area teams.
- The majority of respondents (63 per cent) were confident that their commissioners would offset the tariff deflator by 0.35 per cent to support the implementation of mental health access targets.
- Only five per cent of respondents were planning to move to cost and volume contracts (away from block contracts) for 2015/16 for the majority of their services.

This briefing provides a more detailed overview of these survey results.

BACKGROUND

It is widely reported that mental illness accounts for almost a quarter (23 per cent) of the total burden of disease but currently only 13 per cent of the total NHS budget. Despite much discussion at both national and local levels about the need to address the mismatch between resources and demand for mental health services, it is still reported that mental health services have been cut in recent years. In the latest research from BBC news and the online journal Community Care, mental health trusts in England have seen their budgets fall by more than eight per cent in real teams over the course of this parliament, which represents almost £600 million being taken out of the sector.[1]

In 2014/15, NHS mental health foundation trusts and trusts also faced unfunded costs for the implementation of the recommendations included in the Francis inquiry and Keogh review. They did not receive additional funding to meet these new requirements but our own research highlighted that the whole of the non acute sector was facing around £160 million in additional costs for investing in extra staff in response to the recommendations.[2]

1 http://www.bbc.co.uk/news/health-31970871

2 http://www.nhsproviders.org/resource-library/ftn-briefing-the-cost-of-high-quality-care/

As the NHS faces the most challenging financial period in its recent history, mental health trusts are struggling to meet growing demand within current resources. According to latest figures from the Trust Development Authority and Monitor, at the end of quarter 2014/15, 21 per cent of mental health trusts were in deficit, compared to 8 per cent at the end of the previous financial year.

There is recognition from national bodies that improved mental health service provision is essential. The NHS *Five year forward view* and *Achieving better access to mental health services* aspire to deliver parity of esteem between physical and mental health by 2020. Over the past two years, additional funding has been announced for mental health services (annex A) and from 2016 access standards and waiting time standards for mental health will be introduced.[3] Furthermore, in the 2015/16 planning guidance The *Forward view into action* highlighted that commissioners must ensure that they increase their spending on mental health services at least in line with their overall allocation growth, but this can only be an expectation and it is unclear how and if this will be enforced. There is a clearly complex tapestry of policy and funding decisions for mental health services which are often well intentioned but don't always serve to address the problem they were intended to tackle.

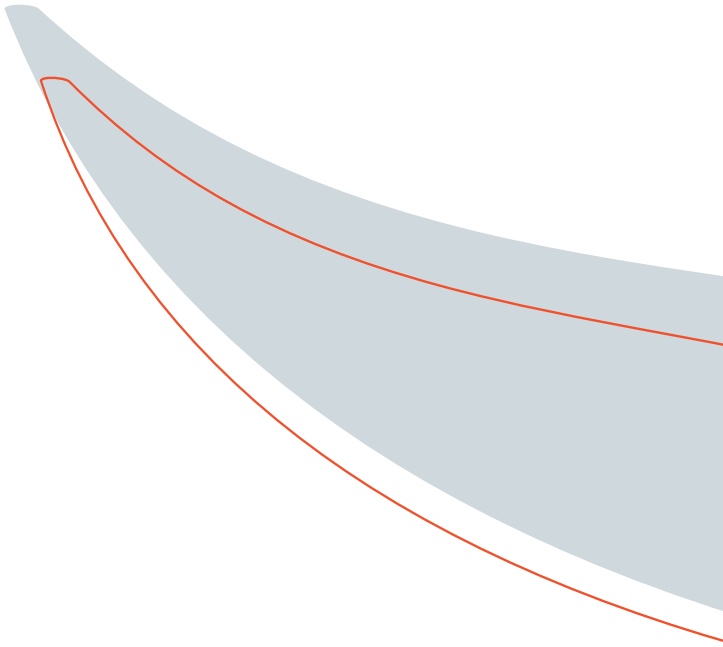
The commissioning landscape for mental health services is also mixed with decisions made by local authorities, public health, CCGs, local area teams and education all having an impact on the type and provision of services within a local area. For example, cuts in local authority support for housing, community support, day care and post discharge support are exacerbating the resource pressures on secondary mental health services.

SURVEY RESULTS

NHS Providers surveyed member trusts providing mental health services in March 2015. We asked trusts how confident they are that their commissioners will meet the requirement in the planning guidance to increase their investment in mental health services, what kind of contract offers they have received so far, and what needs to be done to ensure that mental health services have a better financial footing for 2015/16.

Responses were received from 19 providers of mental health services (32 per cent of the sector[4]), representing a mix of standalone mental health providers and integrated providers of mental health and community services. All responses from individual providers have been anonymised.

At the time of the survey, not all providers had received formal contract offers from their commissioners, with contract discussions still ongoing. As such, the findings highlighted in this briefing provide a picture from our members about the likely direction of travel as of March 2015, but this might change in the final contact with commissioners.



3 By April 2016, 50 per cent of people experiencing a first episode of psychosis should receive treatment within 2 weeks and at least 75 per cent of adults requiring IAPT services should have their first treatment session within 6 weeks of referral, with a minimum of 95 per cent treated within 18 weeks.

4 58 of the 59 NHS foundation trusts and trusts across England which provide mental health services are members of NHS Providers. This survey excludes non-NHS providers of NHS mental health services.

The national tariff and mental health services

Although the national tariff is often assumed to have most impact for providers of acute care who are paid directly through the tariff, the efficiency requirements and cost adjustments included in the package impact on all providers of locally priced services, such as mental health trusts.

This means that the deflator set in the tariff – for 2015/16 under the enhanced tariff offer (ETO) it is **–1.6 per cent** – is supposed to be used as the starting point between commissioners and providers for services with local prices, such as mental health services.

In addition, £40 million of the £80 million NHS England is investing in 2015/16 to implement access standards for mental health services is rooted through the tariff, which should correspond to a 0.35 per cent uplift for all mental health services providers who signed up to the ETO (annex A). This uplift offsets the headline deflator so that the starting point for discussions between commissioners and providers for the provision of mental health contracts in 2015/16 is **–1.25 per cent**.

If the application of this deflator worked properly in 2015/16, commissioners would be expected to set a realistic level of efficiency, recognising that providers are often able to make efficiency gains on their service lines each year. At the same time, the overall funding for the contract should still increase to reflect the increase in the number of people who need to access mental health services and the range of services to which they have access.

ARE COMMISSIONERS MEETING THEIR COMMITMENTS TO PARITY OF ESTEEM?

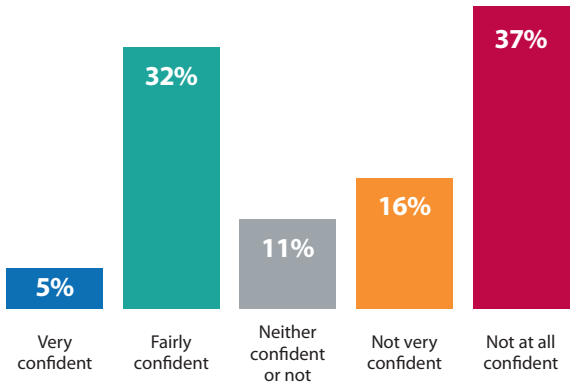
The majority of respondents are not confident that their commissioners would meet planning guidance requirements on funding

Our survey reveals that over a half of trusts (53 per cent) are not confident that their commissioners will meet the parity of esteem commitment to increase their investment in mental health services (figure 1).

Figure 1:

How confident are you that your commissioners will meet their parity of esteem commitments in 2015/16?

(n = 19)



Just over a third (37 per cent) of respondents were confident that they would receive a real term increase, highlighting there are good practices to share. For example, one trust reported that their lead CCG had offered them an additional investment of £1.6 million for 2015/16, split across child and adolescent mental health services (CAMHS), eating disorders and crisis services, which effectively means that the tariff deflator will not be applied. However, this is clearly not consistently happening across all local health economies. For patients, this means that they could see different services being available not just in different parts of the country, but between adjacent areas.

There are a number of factors which might explain why NHS mental health providers are not receiving additional investment

We asked respondents why their commissioners were not planning to use the additional funding for mental health services at their respective trusts:

- 19 per cent considered it was because the additional funding is being withheld to address the commissioners' financial position;
- 19 per cent highlighted that commissioners have suggested that the additional funding they have received in 2015/16 is marginal once you take in to account, for example, the incorporation of resilience funding in to commissioner baselines;
- 13 per cent highlight that commissioners have earmarked investment for other mental health services, such as in primary care and the third sector.

One finance director said : "…I would expect commissioners to be facing so much uncertainty that they will be putting as much money as possible into reserves. They can badge a proportion of this 'mental health' so that NHS England is content with their plan but will anyone check what the reserves are actually spent on?"

Several providers indicated that they simply didn't know enough about their commissioners' plans at the time of surveying as the CCGs weren't prepared to make an allocation for mental health services until they knew what their acute spend was likely to be. But, clearly mental health services are essential enough that they need to be funded irrespective of spending in other areas.

A number of providers suggested that commissioners were planning to use some of the allocation growth for non-NHS mental health provision, and also for some services which are not always provided by secondary care mental health foundation trusts and trusts, such as improving access to psychological therapies (IAPT).

Commitments to fund the move to parity of esteem differ between CCGs and local area teams

There were marked differences in respondents' perceptions of support from CCGs and NHS England local area teams. Twenty-five per cent of respondents expected to receive over 75 per cent of their principal CCG(s) additional allocation for investment in mental health services (figure 2); whereas 77 per cent did not expect to receive any of the local area teams' additional allocation (figure 3).

Figure 2:

From your principal CCG(s) do you expect to receive:

(n = 16)

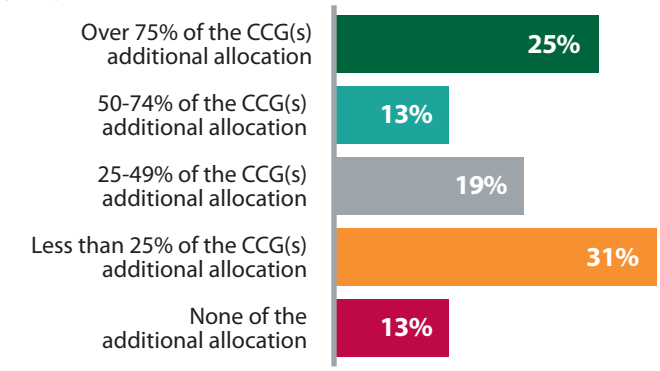
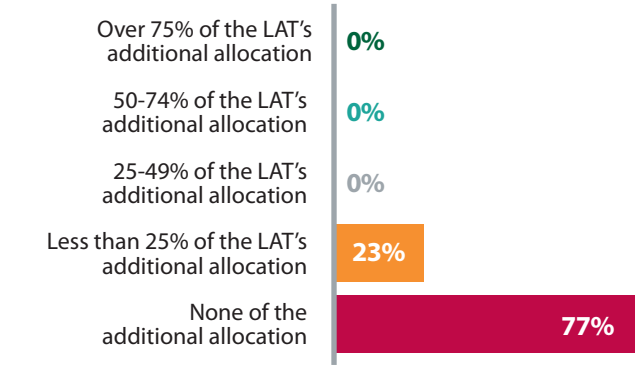


Figure 3:

From your main NHSE LAT do you expect to receive:

(n = 13)



One finance director expressed concern that local area teams "seem to think that parity of esteem does not apply to them". Another finance director highlighted that the trust has been offered "deflated prices and same volumes as last year only, with no new investment or price increase" despite substantial increases in demand and activity for their specialised mental health services.

There is a mixed picture about whether commissioners are proposing additional investment in mental health services in their contract offers

At the time of surveying, only 12 respondents indicated that they were in receipt of contract offers from their main CCGs and only 7 from their NHS England local area team.

We asked those who were in receipt of contract offers to share details to highlight the extent to which commissioners are meeting their commitments. We only received a small number of detailed responses to this part of the survey, however all showed a shortfall between the additional allocation commissioners had received and the value of the proposed contract for 2015/16. A summary of the type of contract offers respondents received are highlighted in table 1.

These results indicate that there is little consistency between and within local health economies. We do not yet know how commissioners will increase their investment in mental health services but clearly the starting point for some contracting discussions, as indicated from the contracting offers, have not always been encouraging.

Table 1:
Examples of proposed contracts for 2015/16

Type of contract	Type of commissioner	Average growth in commissioner(s) allocation in 2015/16 [4]	Proposed percentage change between 2014/15 and 2015/16 contract	Shortfall in parity of esteem commitment
Adults and older people	CCGs	4.2%	-10.2%	-14.4%
CAMHS (Tier 1-3)	CCGs	5.6%	-1.7%	-7.3%
Adults of working age	CCGs	5.4%	-2.3%	-7.7%
Older people	CCGs	5.8%	-1.4%	-7.1%
Specialised mental health services	NHS England local area team	4.42%	-4.6%	-9.0%

5 If contract commissioned by more than one commissioner, this figure will represent the average allocation increase across all commissioners.

The majority of providers are confident that commissioners will at least be funding the additional investment earmarked to support the implementation of the waiting time standards by 2016

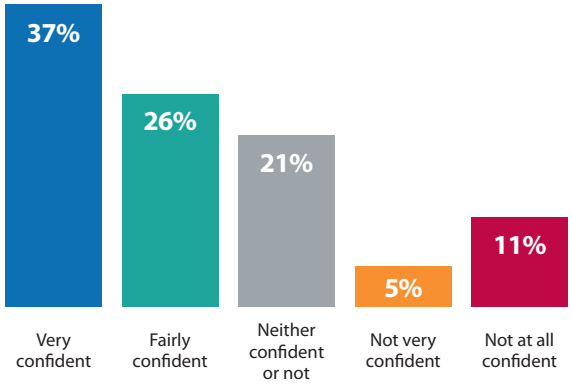
The majority of respondents (63 per cent) were confident that their commissioners will offset the tariff deflator by 0.35 per cent to support the implementation of mental health access targets (figure 4). And of those, most indicated that they were confident the uplift would apply to all their services, apart from NHS England commissioned services.

Although positive, this would not guarantee in itself that commissioners will increase their investment in mental health services, as the 0.35 per cent simply lowers the deflator which is used as the starting point for contract negotiations.

Figure 4:

Are you confident that your commissioners will be applying the 0.35 per cent uplift/offset to tariff deflation for the implementation of early psychosis treatment?

(n = 19)



Many services will be particularly pressurised if there is not a real terms investment in mental health services from 2015

Respondents were most concerned about the provision of services for adults of working age, CAMHS, older people, psychiatry liaison and IAPT if there was not additional real terms investment for 2015/16. Finance directors noted:

- "Without further commitment to invest or retain the deflator we will have no option but to deliver a reduced service".
- "…Liaison services have been decommissioned back to a core service for self harm in A&E only - one of our CCGs is reluctant to invest in IAPT to meet the new targets…"

Many respondents noted that across many service lines vital investment was needed just to cope with rising demand. For example, waiting times for people needing to see a specialist mental health team grew by a third between 2010/11 and 2012/13.[6]

Given that the vast majority of mental health providers operate on block contracts, they are often required to absorb this additional activity over contracted levels, placing significant pressure on services, and potentially adversely affecting patient access to services. This has been further exacerbated by cuts to social care and local authority funding which has placed greater pressure on demand for mental health services as mental health conditions are likely to become more severe and complex if not immediately addressed.

6 Quality Watch (2014): http://www.qualitywatch.org.uk/sites/files/qualitywatch/field/field_document/QW%20annual%20statement%2014%20%28final%29.pdf

How are mental health providers paid?

The vast majority of mental health providers are paid through block contracts – a payment/lump sum for a specific service. Unless carefully managed, this can expose mental health providers to a significant amount of financial and operational risk when activity exceeds contracted levels as it often requires providers to absorb this additional demand under the same fixed resource.

There have been moves in recent years by the sector towards other payment approaches, through the introduction of 21 adult mental healthcare clusters which group people with similar mental health needs. Each cluster is linked to a set of interventions (care packages) which have a total cost, and for which a price would be paid by commissioners.

For 2015/16 Monitor and NHS England confirmed their support for clustering as the basis for local payment, and made clear that the adult mental healthcare clusters must be the default payment arrangement for providers and commissioners.

In practice this would mean the implementation of cost and volume contracts, where a fixed sum is paid for access to a defined range and volume of services. If there is variation from the intended level of activity, there is resulting variation in payment usually through 'caps' and 'collars' to allow financial risks to be shared between commissioners and providers. This would make the contract more responsive to changes in demand which does not currently happen with block contracts.

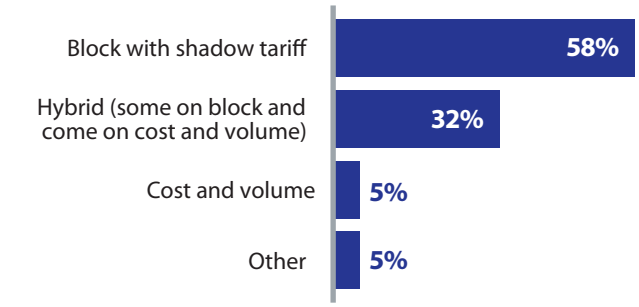
Some work has been done recently to improve data quality and information about mental health services, such as the development of Health and Social Care Information Centre (HSCIC) monthly reports for providers and commissioners, the planned publication of mental health benchmarking prices later this year and a new minimum data set to include access and waiting times at the beginning of 2016. However, further work is still needed locally and nationally to help providers and commissioners make informed decisions about whether they are able to move to clustering as a basis for contracts in the future – in our survey, only five per cent of respondents considered they are planning to have these kind of cost and volume contracts in place for the majority of their services in 2015/16 (figure 5).

There should be absolute transparency and accountability for services remaining on block contract for 2015/16, with regards to how the top-line payment value is generated and how over or underperformance will be managed.

Figure 5:

What type of contract are you expecting to have in place for your principal mental health services in 2015/16?

(n = 19)



WHAT NEEDS TO HAPPEN NEXT?

The commitment in the planning guidance for commissioners to increase their real term investment represented a real opportunity to reset the way funding for mental health services is prioritised, but our survey results highlight that this opportunity is not necessarily being realised across all local health economies.

The introduction of mental health access and waiting times should be a very positive development for patients but, unless properly funded, it will represent an additional cost pressure to the sector and put further services under significant strain as the evidence clearly shows demand for mental health services is far outstripping supply.

Many local health economies benefit from very positive collaboration and working relationships between commissioners and providers – these areas tend to enable a positive environment in which discussions about investment in mental health services can be supported. However, there are still too many areas where resources or circumstances mean that positive collaboration can be difficult, and for these areas further support and national guidance are needed to support commissioners and providers to realise their ambitions for investment.

NHS Providers believes that five things need to happen if we are to support the NHS to meet its parity of esteem commitments in the immediate future.

1 Robust assurance process of commissioner plans from NHS England

Commissioners need to be held to account over their spending decisions, particularly where they are not investing in services in line with planning guidance. We would urge NHS England to check through the planning process the level of increase in mental health spend that each commissioner is planning for, and to hold commissioners to account where they are not able to demonstrate they are increasing their real term investment in mental health services. It will not be sufficient to simply demonstrate that the total spend across all commissioners has increased as this will mask parts of the country where patients and service users are not having their services invested in. We are encouraged that NHS England is prioritising scrutiny of mental health spending in this planning round and understand that there will be a full assurance of CCGs and their direct commissioning expenditure which we welcome.

2 Further national guidance and rules from NHS England on what constitutes investment in mental health services

Our survey has indicated that commissioners are interpreting the planning guidance in different ways and are working to different assumptions. Key questions need to be clarified, such as:

- How can commissioners demonstrate they are increasing their real term investment?
- What baseline should commissioners use to demonstrate that they are increasing their investment, given that resilience funding has now been incorporated in to allocations?
- Is increasing investment in primary care mental health services but not secondary care mental health services sufficient?
- Does increasing investment in out of area placements constitute compliance?
- What is NHS England's expectation with regard to CCGs who are not seeing any growth in funding for 2015/16?

3 Requirement on commissioners to publish their spending on mental health services

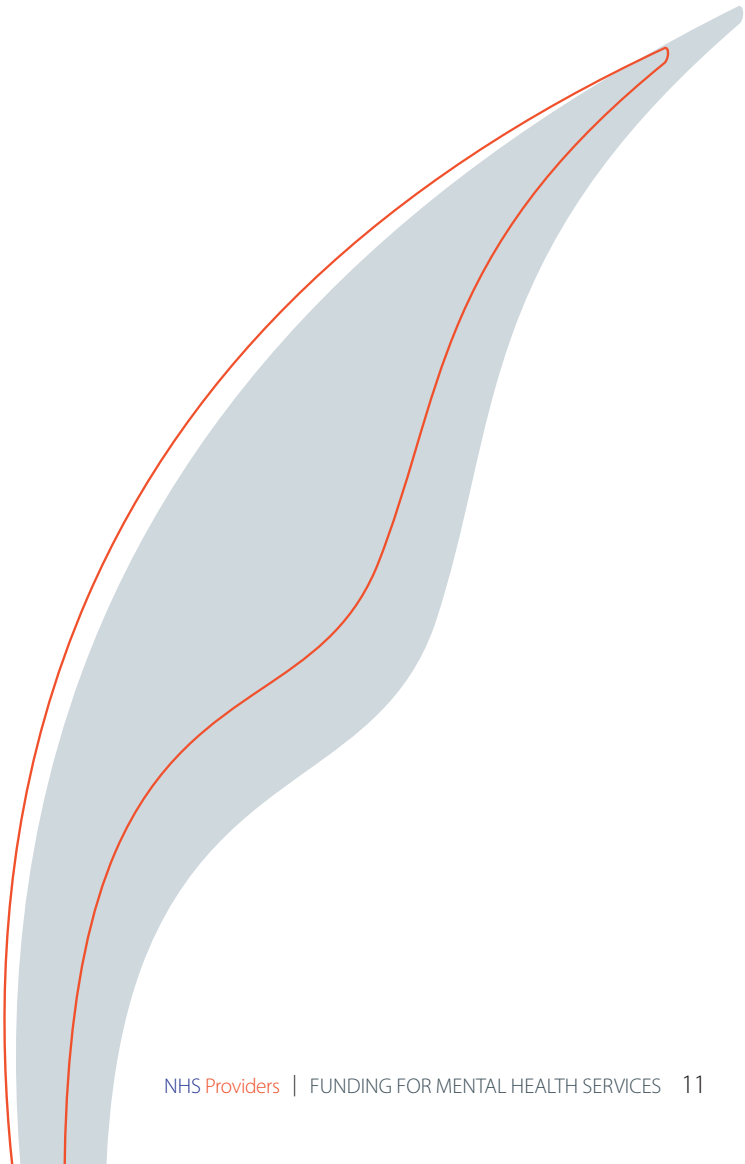
In order for the public to have absolute transparency over investment decisions that commissioners are making, both CCGs and local area teams should publish their spending on mental health services in a publically accessible format.

4 Clarification from the national bodies about how additional funding will be delivered and accessed by providers

It is currently unclear how wider funding commitments in mental health will be accessed by frontline mental health providers. We know £40 million of the £80 million earmarked for supporting access standards is to be rooted through the national tariff deflator, but it is unclear how mental health trusts will access the rest of the investment which is to be held and distributed nationally. There is also uncertainty over how providers will access the new funding earmarked in the *Autumn statement* and Budget for eating disorders and CAMHS.

5 Development and refinement of the payment system for mental health services

Too many mental health services are still paid for on a block contract which exposes providers to substantial risks when activity and demand starts to increase. More needs to be done to support providers move away from block contracts, and changing the default from 2015/16 will do little in itself to give the necessary reassurances to providers and commissioners to do this. Discussions around the national tariff are still overly weighted towards acute issues and for 2016/17 the national bodies need to reset the relationship with mental health providers to ensure that they are involved fully in the process.

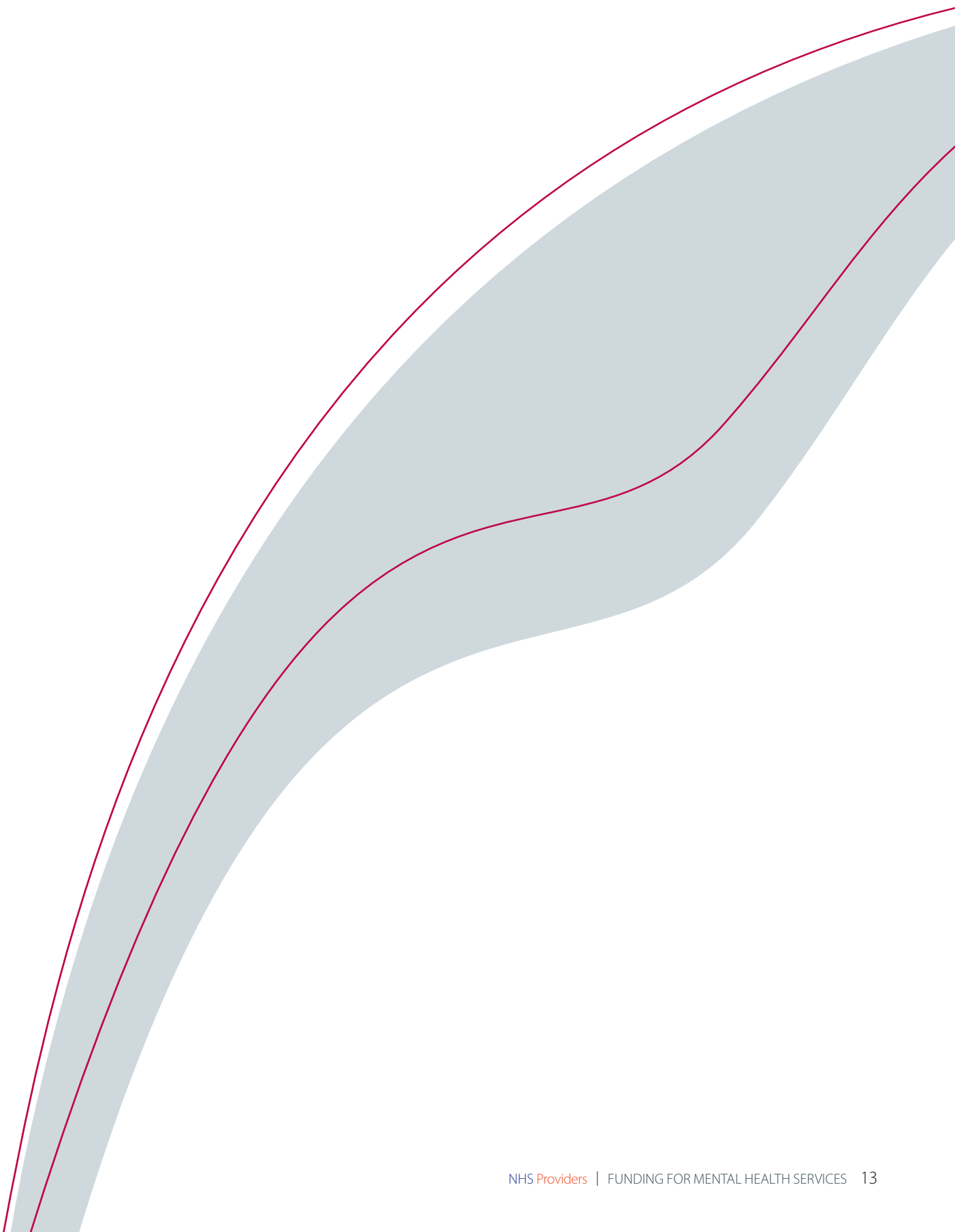


ANNEX 1:
NATIONAL INVESTMENT IN MENTAL HEALTH SERVICES

Investment (in £m)	What will this be used for?	How will this reach frontline providers?
	2014/15	
7	For an additional 50 beds for Tier 4 CAMHS to support young people from being admitted out of area	Extra beds from providers commissioned by NHS England local area teams
33	For early intervention services for psychosis and in crisis care	Primarily rooted through CCGs, who will commission additional services from providers
	2015/16	
40	To support the early intervention in psychosis standard	Has been included through a 0.35 per cent tariff inflator for those mental health trusts signing up to the enhanced tariff offer (ETO) – this means that the starting point for contracting will be -1.25 per cent for mental health services
30	To support delivery of the liaison psychiatry standard	Criteria for distribution still in development according to NHS England
10	To support delivering of the IAPT standard	
30	Announced in the 2014 *Autumn statement* to improve access for children and young people to specialist community CAMHS eating disorder services, and to support the implementation of access and waiting time standards for eating disorders in community CAMHS from 2016	
252	Announced in the Budget 2015 to invest in mental health services for children and young people, new mothers and veterans (England only)	

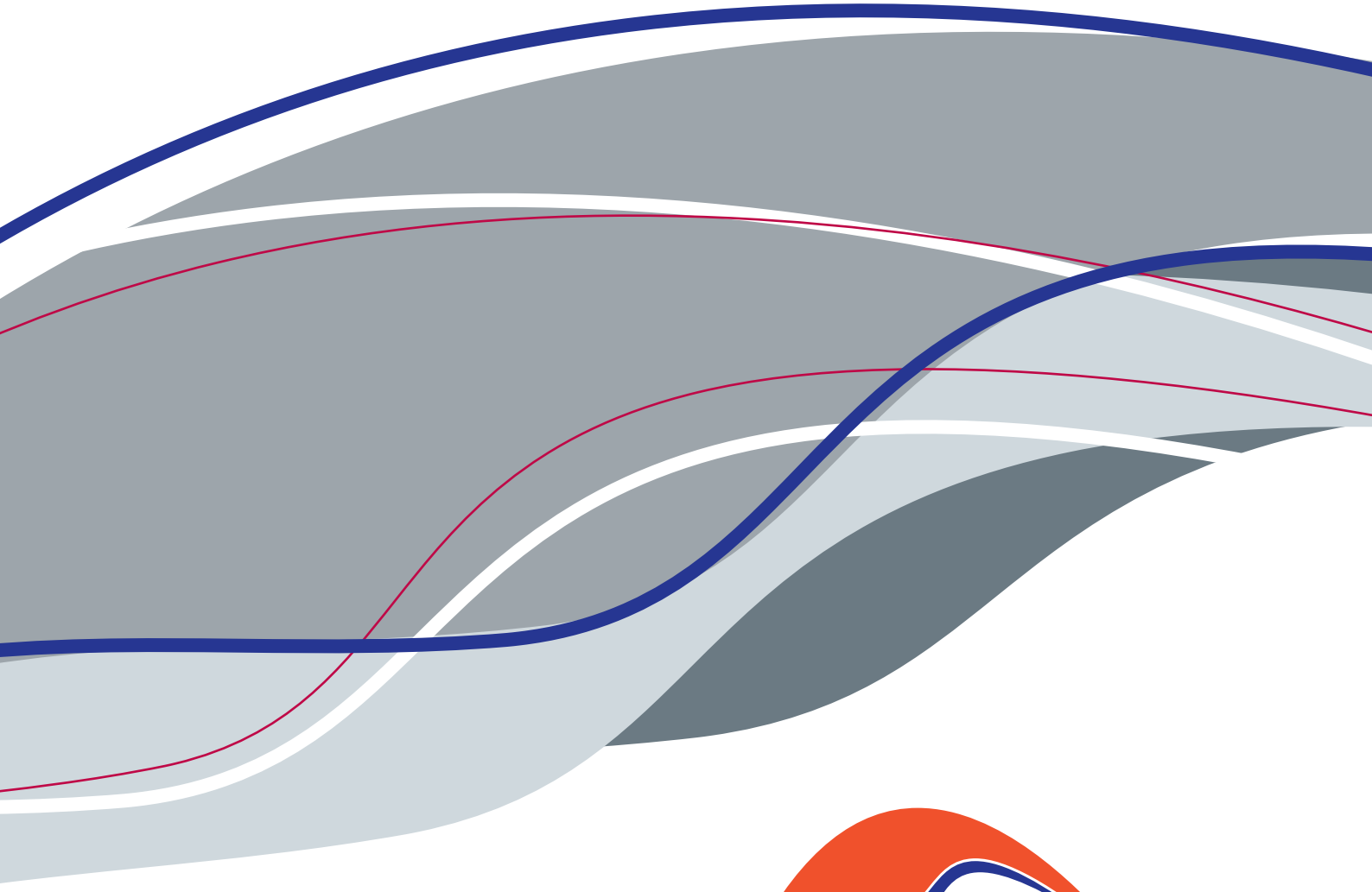
For further information

Phillippa Hentsch
Policy Advisor (Funding and Resources)
phillippa.hentsch@nhsproviders.org



NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high quality, patient focused, care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has 222 members – 93 per cent of all NHS foundation trusts and aspirant trusts – who collectively account for £65 billion of annual expenditure and employ more than 928,000 staff.



the association of foundation trusts and trusts
NHS providers

One Birdcage Walk, London SW1H 9JJ
020 7304 6977
enquiries@nhsproviders.org
www.nhsproviders.org
@NHSProviders