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## MENTAL HEALTH

# A refreshing approach to contracting services

Given the true cost of mental ill health, choosing the right contractual model for commissioning providers is vital, say Jenny Palmer, Emma Stanton and David Cox

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#### A PROBLEM SHARED

Encouraging collaboration between patients and health services has become increasingly important in the NHS and should, it is hoped, improve patient outcomes. To this end, the My Shared Pathway programme was launched in 2010 with the aim of empowering patients to drive their own care pathways and facilitating collaboration between themselves, clinicians and commissioners. Rosie Ayub and colleagues explain how Yorkshire and Humber Specialised Commissioning Group led an initiative to change the culture of secure mental health services to support patients in achieving their own outcomes, which would help them to move out of secure care. Visit [hsj.co.uk/shared-pathways](http://hsj.co.uk/shared-pathways)

Norman Lamb, minister for care and support, last month invited bids from health economies to become integration “pioneers” by running integrated care experiments at scale to improve value to patients, both in terms of improved outcomes and providing better value for money.

It is anticipated that some, if not most of the pioneers, will look to deliver care through an innovative contractual model, bringing new and incumbent providers to the market. While this is an exciting opportunity for the selected regions, there is a lack of consistency and understanding about what different contractual models are available, their relative strengths and weaknesses, and which ones are most suited to achieve the desired outcomes.

Mental health is costly to society and people with mental health conditions experience poor outcomes. The sector provides ample opportunity for new contractual models because of the current model of reimbursement, level of fragmentation and disease prevalence.

#### The cost of mental health

Mental health problems are the largest single cause of illness in the UK, accounting for 23 per cent of the total “burden of disease” according to the Department of Health. The NHS spends £13bn on mental health services, taking up 11 per cent of the NHS secondary health budget.

This spending does not include costs elsewhere in the health or social care system, but

does take into account the impact of mental health on the cost of physical healthcare. It is estimated poor mental health costs the UK economy £77bn per year through absence or underperformance at work along with welfare benefits.

Current contractual models for mental health do not optimally serve the needs of patients, providers or commissioners. People with mental health conditions may experience difficulty accessing the support they need. Too often care is poorly coordinated and delivered via a fragmented system of multiple providers and touch points.

At present, providers are not incentivised to collaborate to manage patients along end-to-end pathways. NHS commissioners contract mental health trusts through an outdated block payment system with only limited levers to incentivise providers to deliver care in different ways to improve outcomes. In many regions, one dominant provider exists that is contracted by several clinical commissioning groups.

Different initiatives have sought to address these issues, such as introducing quality accounts and the commissioning for quality and innovation programme, which is backed up by a clear government policy of putting mental health on a par with physical health. To date, such initiatives have struggled to drive quality at a system level through an innovative approach.

Although alternative ways exist for how commissioners can contract with providers, there

are often misconceptions and concerns about the different contracting vehicles and the relative benefits they provide. Here, we describe three alternative contractual models:

- alliance;
- prime contractor; and
- integrator.

#### Alliance

The alliance model is closest to how clinical commissioning groups currently contract with providers. For this model, a group holds multiple contracts with providers through a pathway approach. Typical pathways include crisis or





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recovery. Commissioners will often arrange provider forums and facilitated events to ensure a collaborative provider culture for a given pathway. Full accountability and financial risk lie with the commissioner.

This model provides low risk to disrupting the current provider market. In addition, it provides a forum for collaboration between the providers and the commissioner.

The alliance model does not involve risk sharing between the commissioner and providers, therefore the risk of fragmentation remains. Innovative service redesign may also be slow when negotiating with multiple organisations that deliver care.

### Prime contractor

The term “prime contractor” is frequently interchanged with lead provider; both mean a CCG has contracts with one provider to deliver all care for a particular

**Segmenting mental health services is the most effective way to ensure patients’ needs are met**

population segment or disease profile. The prime contractor then subcontracts with other providers, presenting themselves as a single entity to the CCG. The lead provider is performance managed by the CCG and held to account, usually in the form of the achievement of patient outcomes.

Recent examples of the prime model include the Bedfordshire CCG contract for musculoskeletal services. Depending on the level of risk a commissioner chooses to share, some or all of the financial risk may lie with the prime contractor on successful achievement of outcomes. The prime contract is usually for a population segment such as child and adolescent mental health care or for alcohol and addictions.

Through this model, the commissioner manages only one contract with one provider. This may enable innovation and releases budgetary spending from organisational silos.

Critics of this approach suggest the lead provider

organisation could exert too much power over subcontractor partners by controlling contractual and financial mechanisms. This may be particularly true for smaller, third sector providers that are heavily relied on to deliver mental health services.

A prime model relies on strong cooperation between provider organisations.

### Integrator

For the integrator model, the commissioner contracts with the integrator, which then subcontracts to other organisations. The difference between this and the prime contractor model is that the integrator does not directly provide care. Instead, it facilitates and coordinates care across the population segment using mechanisms such as case management and single point of access.

The commissioner has one contract with the integrator and, like the prime contractor model, the commissioner puts some level of risk with the integrator. The contract is for a defined population segment such as people with psychosis or people with complex comorbidities.

The purpose of the integrator function is to better coordinate care along clearly defined pathways to achieve patient-focused outcomes. Not being a provider means the integrator can maintain objectivity about how care is delivered. Integrators typically have a strong skillset in coordination, logistics, analytics, information technology and technical expertise in outcome-based care that is consistent with the evidence base.

This model puts a middle organisation between the commissioner and providers, which risks being seen as an unnecessary additional level. Like the prime contractor model, the integrator may also be seen to hold too much power with the organisations from which they subcontract, and providers may not want to be one step removed from the commissioner.

### A segmented approach

Mental health needs a segmented approach. Too often it is referred to as one distinct area of health; in reality, however, just as for physical health care, it is a heterogeneous spectrum of diseases affecting people in different ways and at different stages of life.

As a pragmatic approach to segmenting a population of people with mental health problems already known to the current delivery system, the data from the Health of the Nation Outcome Scales for Payment by Results super clusters of non-psychosis (anxiety and depression), psychosis and cognitive impairment may be used to gain an overview of relative spend and outcomes.

Alternative approaches for mental health segmentation can be based on life stages (for example, children and young people; older adults) or disease focused (such as alcohol and addictions). There is no one methodological approach for segmenting mental health needs across a population that will be perfect but any approach will help to inform a commissioning strategy.

It is hoped that more commissioners will follow the example of Oxfordshire CCG, which is seeking to implement a new outcomes based contractual model for mental health. By first defining the population segment, it is easier to set and measure the outcomes that matter for people with mental health problems.

Of course, a new contractual model is not the sole answer to improving outcomes for people with mental health problems and providing better value for money. Nevertheless, for the NHS it is a seismic shift in enabling and incentivising a delivery system to be truly based around the people who need it most. ●

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