

CAPITA

Payment by Results Data Assurance Framework

Report on Assuring Mental
Health Currencies

July 2013

Health

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Summary

01 For the past six years the Payment by Results (PbR) data assurance framework has provided assurance over the quality of the data that underpin payments in the NHS. The framework promotes improvement in data quality and supports the accuracy of payment within the NHS.

02 In March 2012 the Audit Commission set out the framework's programme for 2012/13¹. The approach included reviews designed to support tariff development and implementation, including a review of the quality of data underpinning mental health tariff development. This report summarises the findings of reviews undertaken at nine mental health trusts and their commissioners² between October 2012 and January 2013.

03 The Department of Health (DH) has mandated a set of currencies for adult mental health services for use from 2012/13. These currencies are care clusters. Providers allocate all patients to a cluster that reflects their needs. The clusters focus on the characteristics and needs of a service user rather than the individual interventions they receive or their diagnosis. Clinicians identify a cluster that matches the characteristics of the service user.

04 All mental health trusts had to present their 2011/12 reference costs based on clusters for the first time in the summer of 2012.

05 The work undertaken focused on three areas of development that will help the transition to commissioning and delivering services under a full PbR system. We reviewed:

- arrangements for accurately identifying cluster reference costs;
- accuracy of assigning service users to mental healthcare clusters; and
- governance arrangements in place between commissioners and providers to secure the accurate recording and flow of data to support planning and commissioning.

Findings

06 It is important to highlight that at the time of the review all the providers were implementing patient clustering. Trusts and their clinicians are working through the requirements, including collecting and assuring cluster data. Central guidance is being updated to reflect the learning and experiences from trusts and commissioners. The DH recently published the mental health PbR arrangements³ for 2013/14. It contains guidance that will help improve issues raised from our reviews, in particular data quality.

07 We have designed our reviews to identify where trusts and others should focus actions to develop local currencies and national tariff prices. We have completed these reviews at an early stage to highlight issues before national tariffs are introduced.

¹ Payment by Results Data Assurance Framework 2012/13: Improving the quality of contracting and commissioning data, Audit Commission, March 2012. ² See appendix two for a list of mental health trusts and commissioners. ³ <https://www.gov.uk/government/publications/mental-health-payment-by-results-arrangements-for-2013-14>

Summary_{continued}

08 We audited 540 patient clusters where the patient was clustered for the first time or where a cluster changed. We found one or more errors that would effect the accuracy of the cluster in 216 (40 per cent) of the clusters audited. This means that 40 per cent of the clusters had one or more of the following errors.

- The patient cluster or decision to re-cluster was not accurate.
- Time in that patient cluster was wrong.
- No evidence in the patient record to support the clustering decision – the case was unsafe to audit (UTA).

09 The main reasons for these errors were:

- clinicians did not follow, or poorly interpreted the Mental Health Clustering Tool (MHCT) guidance;
- inaccurate data recording on date of entry to cluster, change of cluster or discharge from service; and
- poor quality of medical records meant there was a lack of evidence to justify the cluster decision made by clinicians.

10 All the trusts reviewed completed their 2011/12 reference costs returns in line with the reference costs guidance. Apportionment processes used were reasonable and we did not find material errors in calculations used for reference costs. We did however find that:

- while all trusts sense checked costing submissions, only some actively benchmarked with other organisations to identify outliers;

- data quality issues were often not escalated through wider corporate governance arrangements to senior management;
- clinical engagement to improve the accuracy of cost data was evident at some trusts but limited at most; and
- there was a lack of board awareness of findings and issues identified in reference costs.

11 The Audit Commission flagged similar issues with reference costs in the acute sector in its 2010/11 annual report on the PbR data assurance programme⁴. This work informed the self-assessment quality checklist in Monitor's Approved Costing Guidance⁵ that acute trusts must complete to help them improve the accuracy of costing data.

12 Commissioners are at different stages in dealing with the transition to PbR for mental health. We found that better performing commissioners:

- held joint PbR boards with commissioners and providers;
- worked with providers to monitor shadow contracts based on cluster activity while they used block contracts to risk share and guarantee income levels for the provider;
- reviewed provider internal audits of cluster data to gain assurance it was accurate;
- used joint provider and commissioner risk registers that included the risks associated with poor data quality and mitigation; and
- built open and transparent relationships with providers to understand performance.

improvements in the quality of mental health activity data are essential

13 However, there were commissioners who were at an early stage in the development and understanding of the mental health currencies and care packages. The time scale for the development of the PbR system for acute trusts gave commissioners the opportunity to learn and put in place effective arrangements to commission. As PbR for mental health develops, commissioners have a similar opportunity. The DH guidance Key steps for successful implementation of Mental Health Payment by Results⁶ (2013) sets out actions for commissioners to effectively implement PbR locally.

Conclusions and recommendations

14 Improvements in the quality of mental health activity data are essential for the implementation of local currencies and prices, and subsequently national tariffs, to be successful. It is important that all mental health providers heighten the awareness and importance of improving their data.

15 Commissioners need to improve their understanding of mental health PbR to engage with and support local implementation.

16 Costing, and subsequently tariff data, is only as reliable as the activity data that underpins it. Our review showed the accuracy of internal data trusts submit to the Mental Health Minimum Data Set (MHMDS) must be more reliable to be the basis for costing and charging.

17 In 2013/14 trusts and commissioners will continue to deliver under block contracts. However, they will also run shadow contracts using clustering data. This lead in time will help give:

- trusts time to improve clustering data quality and improve the data that underpins costing; and
- commissioners the time to set the commissioning agenda to drive forward the local delivery of a PbR system.

18 National bodies and commissioners can help by supporting and engaging with providers and commissioners to drive improvements in activity data quality.

Recommendations for NHS England, Monitor and the Health and Social Care Information Centre

- Support organisations to improve the quality of data that underpins clustering and costing by regularly reviewing guidance, with commissioners, and offering technical support to commissioners when resolving PbR queries. For example, share progress on work of the mental health product review group on learning disability and ADHD clustering so commissioners do not develop local approaches in isolation.
- Monitor should fully integrate and tailor specific mental health costing guidance and standards into its Approved Costing Guidance. For example, develop the costing

⁶ Key steps for successful implementation of Mental Health Payment by Results, Department of Health, 2013

Summary^{continued}

self-assessment quality checklist so it is specific to mental health trusts and consider integrating the HFMA mental health costing standards into the Approved Costing Guidance.

- Develop costing validation and benchmarking processes that are specific for mental health trusts to support improvement in costing accuracy.

Recommendations for mental health providers

- Allocate patients to clusters accurately. There should be a clear demonstration that the clusters reflect patients' assessed needs. For example, putting in place consultant sign off for cluster allocations where the MHCT "must scores"⁷ are outside the expected range for the cluster can help ensure that the cluster fits the patients needs.
- Ensure that medical records accurately record the patient's mental state. This will help improve the clinical record underpinning the clustering decision and improve the clinical use of the MHCT guidance.
- Accurately record the date patients start or change clusters and the date when patients are discharged.
- Improve the use of benchmarking for costing and activity data to help understand and improve service delivery and developments.

- Report cluster activity data accurately to the MHMDS and local data collection systems. (This is a key requirement set out in the DH PbR guidance for 2013/14.)
- Identify internal data quality issues associated with the development of the PbR approach, and escalate these through wider corporate governance arrangements to highlight problems and concerns to senior managers.

Recommendations for commissioners

- Improve local understanding of the PbR system for mental health and provider data quality issues by implementing the actions set out in Key steps for successful implementation of Mental Health Payment by Results⁸.
- Use good practice and learning to improve commissioners' implementation of PbR.

Future work

19 Capita will be undertaking further reviews at selected mental health trusts in 2013/14 on behalf of the DH. The methodology used will be updated to take into consideration developments in clustering guidance and MHMDS guidance.

Introduction and approach

20 For the past six years the Payment by Results (PbR) data assurance framework has provided assurance over the quality of the data that underpin payments in the NHS as part of PbR. The framework promotes improvement in data quality and supports the accuracy of payment within the NHS.

21 In March 2012 the Audit Commission set out the framework's programme for 2012/13⁹. The approach included reviews designed to support tariff development and implementation, including a review of the quality of data underpinning new mental health currencies. This report summarises the findings of reviews undertaken at nine mental health trusts and their commissioners between October 2012 and January 2013.

22 The Department of Health (DH) has mandated a set of currencies for adult mental health services for use from 2012/13. These currencies are care clusters. Providers allocate all patients using mainstream adult and older people's secondary care mental health services to a cluster that reflects their needs. The clusters focus on the characteristics and needs of a service user rather than the individual interventions they receive or their diagnosis.

23 This is different from PbR for acute trusts which uses diagnosis codes (ICD-10) and procedure codes (OPCS-4) to assign patients to Healthcare Resource Groups. Instead, mental health professionals rate service users using the Mental Health Clustering Tool (MHCT) that helps them decide which cluster best describes the characteristics of a particular service user¹⁰.

24 Trusts submit MHCT data to the Mental Health minimum data set (MHMDS). The Health and Social Care Information Centre (HSCIC) maintain this. Having high-quality and complete clinical data flowing to the MHMDS is important. Commissioners and providers will rely on this information to cost services, and will use this as the basis for payment as the service moves towards a full PbR approach.

⁹ Payment by Results Data Assurance Framework 2012/13: Improving the quality of contracting and commissioning data, Audit Commission, March 2012. ¹⁰ See appendix one for a more detailed explanation of clusters and cluster scores.

Introduction and approach continued

Audit approach

25 The work undertaken focused on three areas key to the transition to commissioning and delivering services under a full PbR approach.

We reviewed:

- arrangements for accurately identifying cluster reference costs;
- accuracy of assigning service users to mental healthcare clusters; and
- governance arrangements in place between commissioners and providers to secure the accurate recording and flow of data to support planning and commissioning.

26 Each of these three areas is important for ensuring the effective implementation of a full PbR approach for mental health services. Costs need accurate determination, payment for service delivery must follow service users, and commissioners need to be able to place reliance on the data that underpins contracts and payment.

Accurate costs

27 Mental health providers should cost their services to the same minimum standards that apply to all NHS providers as set out in the NHS Costing Manual. DH recommends costing using a bottom-up, patient level approach to ensure the most accurate results.

28 We reviewed the trusts' arrangements for accurately collecting and recording costing and activity data included within reference cost submissions. We examined the following areas.

- Overall production of reference costs on clustering, sense check and benchmarking.
- Known data quality issues.
- Reporting and clinical engagement.
- Board engagement.

Accurate activity data

29 All providers have to put mainstream adult and older patients into care clusters. The three super clusters are:

- Non-psychotic.
- Psychosis.
- Organic.

30 The audit reviewed the accuracy of the cluster data submitted to the MHMDS. We recognise that most organisations are at an early stage in ensuring that clinical staff are following guidance systematically throughout the organisation. However, the key to costing accurately at cluster level is having the activity and interventions recorded correctly and the cluster assigned properly. In the future this data will be important for commissioners concerned with the accuracy of payments based on clustering.

31 We checked to see if MHMDS data was an accurate reflection of the patient record. Data checks focused on patients who were newly clustered in super cluster B – psychosis, or a recent clustering decision resulted in them moving cluster.

32 Scoring patients using the MHCT is a clinical decision. At each trust we worked with a representative with clinical experience of clustering to review each individual patient record against MHMDS data¹¹.

33 We considered the accuracy of the:

- a super cluster and cluster; and
- b cluster start date and end date.

34 If we were unable to find any evidence to support the cluster data sent to the MHMDS we declared the record unsafe to audit.

Commissioner arrangements

35 We reviewed whether commissioners have suitable arrangements in place to ensure they use good quality data when contracting for mental health services.

36 We looked at the arrangements commissioners have in place to ensure good quality data recording by providers, and whether it is used to support planning and commissioning as services move towards a full PbR system.

Participating organisations

37 The Audit Commission and Capita would like to thank the participating organisations who volunteered to be part of this work to help inform the development of PbR. Appendix two gives details of all of the participating organisations.

¹¹ This approach was amended during the last two audits and clinical leads signed off the errors found by the auditors.

Review Findings

38 It is important to highlight that at the time of the review all the providers were implementing patient clustering. Trusts and their clinicians are still developing and understanding the requirements, including collecting and assuring clustering data. Central guidance is being updated to reflect the learning and experiences from trusts and commissioners. The DH recently released PbR guidance for 2013/14. It contains guidance that will help in improving issues raised from our reviews, in particular improving data quality.

39 We have designed our reviews to identify where trusts and others should focus actions to develop local currencies and national tariff prices. We have completed these reviews at an early stage to highlight issues before national tariffs are introduced.

Accurate costs Key finding

40 All the trusts reviewed completed their 2011/12 reference costs returns in line with the reference costs guidance. Apportionment processes used were reasonable and we did not find material errors in calculations used for reference costs. We did however find that:

- while all trusts sense checked costing submissions, only some actively benchmarked with other organisations to identify outliers;

- data quality issues were often not escalated through wider corporate governance arrangements to senior management;
- clinical engagement to improve the accuracy of cost data was evident at some trusts but limited at most; and
- there was a lack of board awareness of findings and issues identified in reference costs.

41 The Audit Commission flagged similar issues with reference costs in the acute sector in its 2010/11 annual report on the PbR data assurance programme¹². This work informed the self-assessment quality checklist in Monitor's Approved Costing Guidance¹³ that acute trusts must complete to help them improve the accuracy of costing data.

Overall production of reference costs on cluster activity, sense checks and benchmarking

42 All nine trusts are able to produce reference costs on cluster activity in line with the reference cost guidance. They all took steps to ensure that when they costed clusters they consistently followed the correct approach for reference costs. We found good compliance with the guidance and a good understanding of requirements. However, trusts must take action to ensure the data that underpins costing is more accurate.

43 All the trusts had undertaken a sense check of their returns using the DH's Unify2 system. Five of the trusts had good benchmarking in place, where they compared costs with other organisations outside the reference costs submission. These trusts had arrangements with nearby trusts, and agreed to share information to help improve their common understanding of service costs.

44 The trusts who were using benchmarking clubs:

- identified cluster costs that were high or low cost compared to other trusts;
- investigated why they were outliers; and
- took action to reassess costs or get senior sign off that the costs were accurate.

45 Trusts should work more cooperatively to share costing data to help understand how their costs compare with other organisations. When they identify costs that are outliers they should look into this, understand the cause and then take action if required.

Known data quality issues

46 Trusts raised and discussed data quality issues but did not escalate them through wider corporate governance arrangements to highlight problems and concerns at higher levels.

47 Only three trusts had good systems in place to identify known data quality issues and report these systematically at a senior level in the organisations. They put data quality issues associated with clustering and costing on their organisational risk registers.

48 For example, one trust identified concerns about the accuracy of clustering data and reported this to senior management on the risk register. In response to this, the Trust added a series of monthly audits to its annual audit plan to identify poor data quality, and support staff in scoring and clustering correctly in line with the MHCT.

49 These three trusts recognised they should improve accuracy and were raising this at a senior level in the organisation. Understanding data quality issues, particularly activity data, is key for trusts in deciding where improvements should be made to prepare for PbR.

50 Most of the other trusts had internal arrangements to discuss data quality issues. These trusts can improve arrangements by keeping formal records of actions to ensure they make progress in resolving data quality issues. Trusts should record significant issues on organisational risk registers to ensure senior managers can track progress on issues.

Review Findings continued

Reporting and clinical engagement

51 We found evidence of clinical engagement and review of costing data but it was inconsistent. Engaging service managers and clinicians so they understand their own data and how this links to costs is important to help drive forward improvements in data quality. Three trusts had good arrangements in place to engage clinicians in costing clusters and, importantly, provide information about activity and costing to staff. These trusts:

- aligned activity and costing information when reporting this to key staff, made use of dashboards and timely financial information to focus effort on improving clustering and accurate costs; and
- used local internally designed systems to meet their own organisations priorities.

52 The remaining trusts were all engaging clinicians in apportioning costs and reporting data to them. However it was not integrated and consistent within all the organisations.

Board engagement

53 Over all there was a lack of board awareness of findings and issues identified in the reference costs submission. Board ownership helps to show a commitment to supplying accurate reference costs. Board level buy-in gives staff support to invest in improving reference costs.

The Director of Finance at all the trusts signed off the reference costs returns in line with the guidance. The degree of Director of Finance challenge varied.

54 All boards should be aware of the link between activity and costing data, and the impact this will have on developing national prices for clusters as mental health trusts move towards a full PBR.

Accuracy of cluster activity data

Key finding

55 We audited 540 patient clusters where the patient was clustered for the first time or whose cluster changed. We found one or more errors that would affect the accuracy of the cluster in 216 (40 per cent) of the patient clusters audited. This means that 40 per cent of the clusters had one or more of the following errors:

- the patient cluster or decision to re-cluster was not accurate;
- time in that patient cluster was wrong; or
- no evidence in the patient record to support the clustering decision – the case was unsafe to audit.

56 The main reasons for these errors were:

- clinicians did not follow, or poorly interpreted the Mental Health Clustering Tool (MHCT) guidance;
- inaccurate data recording on date of entry to cluster, change of cluster or discharge from service; and
- poor quality of medical records, meant there was a lack of evidence to justify the cluster decision made by clinicians.

Super cluster or cluster was not accurate¹⁴

57 We reviewed each patient record and looked for evidence to support MHCT scores recorded by the clinician and submitted to the MHMDS.

58 Of the 216 cluster episodes with an error, 134 (62 per cent) patients had the wrong super cluster or cluster (including those that should have remained in the previous cluster.) Figure 1 shows the spread of errors across the trusts.

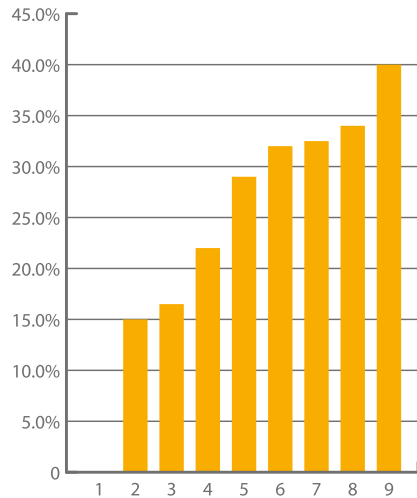


Figure 1: Percentage of clusters with a patient in the wrong super cluster or cluster¹⁵.

59 Trust one had excellent cluster assignment accuracy clearly supported in the clinical record. The Trust had detailed clinic notes, which referred to historical issues as well as current issues. When clinicians wanted to assign patients to a cluster that was outside the best fit in the MHCT, this was signed off by the lead consultant for the area. The evidence in the patient record supported these decisions.

60 In the other trusts we found evidence in the patient record that supported a clinical view the patient's needs were better suited to a different cluster. The information recorded in the patient record should in some cases have led to a higher or lower cluster score including the "must score" rating¹⁶ for the cluster. The patient record clearly showed the patient should be in a different cluster more fitting to their symptoms than the one assigned by the clinician¹⁷.

¹⁴ See appendix one for detailed explanation of clusters. ¹⁵ The trusts are numbered 1-9 to maintain anonymity. ¹⁶ In the psychosis super cluster patients must score between 0-4 on the severity scale for current problems associated with hallucinations and delusions. See appendix one for more detail. Details of "must scores" can be found in the Mental Health Clustering Tool booklet v3.0 at <https://www.gov.uk/government/publications/mental-health-payment-by-results-arrangements-for-2013-14>. ¹⁷ At each trust the auditor and the clinical lead came to a joint agreement about the cluster allocation based on the evidence in the patient record.

Review Findings continued

61 There are two possible causes for the errors.

- The patient record was not an accurate reflection of the patient's mental state. The patient record was completed poorly in many cases, often lacking clear evidence of good mental state examination. In these cases, the clinician may have made the correct cluster decision based on their existing knowledge of the patient, but the record keeping was poor and did not justify the MHCT scoring and clustering decision.
- Clinicians are not following the MHCT guidance¹⁸ effectively causing them to cluster patients incorrectly. We found evidence of issues in rating the most severe case in the previous two weeks for scales 1-13 and when rating scales A-E for problems that occur in an episodic or unpredictable way.

62 Trusts will start to deliver packages of care based on clusters. This will create a clearer link between the care a patient will receive and the patient's mental health needs based on their cluster. This link should improve the accuracy of clustering.

63 The other common error was patients should have been in cluster 14 – psychotic crisis because the patient record clearly indicated they were in crisis. Instead they were still allocated to the previous cluster. This was largely because they were admitted to an inpatient ward under the relevant section of the Mental Health Act 1983.

Cluster start or end date wrong

64 In 58 (27 per cent) of 216 cluster episodes with an error, the cluster start date or the cluster end date in MHMDS was not an accurate reflection of the patient record. Performance across the nine trusts varied (see figure 2).

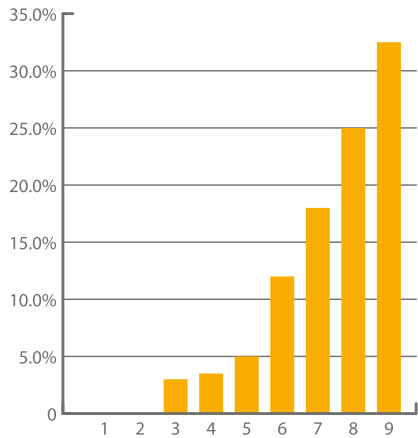


Figure 2: Percentage of clusters with a wrong start or end date.¹⁹

65 In trusts one and two the dates in the patient record matched the dates in MHMDS.

66 Errors in other trusts were caused by:

- clinicians clustering patients on discharge from inpatient units when they should be clustered on entry to the unit;
- poor data entry where patients were in the right cluster but it was not clear what day the cluster began;
- poor data entry where patients' discharge date and the cluster period end date differed in their notes and in MHMDS; and
- cases where the cluster end date should not have been added because there was no evidence in the notes to support a change in cluster. This often happened when patients were in psychotic crisis (cluster 14).

67 The duration patients spend in a cluster will become increasingly important as trusts move towards costing patients based on the recommended patient level approach. This approach relies on accurately recording how long patients spend in any given cluster. As trusts and commissioners move towards paying for services based on locally agreed currencies, commissioners will expect the data in the MHMDS to reflect accurately the date patients enter and leave a cluster.

Quality of patient records and mental state assessments

68 Out of 216 episodes with an error, 24 (11 per cent) were unsafe to audit (UTA). In these cases there was no evidence in the case notes to support the clustering or MHCT scoring. This affected five of the nine trusts.

69 In a small number of cases we declared the cluster episode UTA because the clinician had clustered the patient without seeing them. In exceptional circumstances this may be appropriate for a patient known to services who is difficult to engage and would be in cluster 17 – psychosis and affective disorder – difficult to engage. However, this was not the case for these patients.

70 As well as the UTAs, some trusts, including those with electronic records, had problems with the quality of the patient record. We found the quality of the patient record varied between clinicians, including consultants. In most of the trusts, we found evidence of poor recording of mental state examinations and inadequate record keeping. Examples of this include:

- records of contacts with patients where the clinician had just recorded what the patient had said to them with no analysis and assessment of their mental state; and
- clinical notes that continually stated the patient's presentation had not changed but where there was little in the notes to show what the patient's earlier presentation and mental state had been.

Review Findings continued

71 Notable exceptions include a few excellent examples of record keeping. We found good examples of mental state assessments particularly from accident and emergency psychiatric liaison staff that only assess patients. In one trust we found excellent record keeping backed up by regular case note audits that helped ensure the quality of the records and the assessments made by clinicians.

72 The patient record is the definitive source of information about the patient and must be an accurate record of the patient's presentation, diagnosis and treatment.

73 Trusts with electronic records had better quality records except where it was difficult and cumbersome to find specific parts of the electronic record.

Findings from commissioner arrangements

74 Commissioners are at different stages in the transition to PbR development for mental health. Sharing good practice will help commissioners to rapidly improve.

75 Leading commissioners are challenging their providers to improve data quality in a joined up and collaborative way. They are working actively with their main provider to develop care packages. We found good service development plans under the Commissioning for Quality and Innovation (CQUIN) payment framework.

These include:

- focus on improving provider performance and outcome metrics associated with clustering; and
- developing a local approach for assuring the quality of clustering at providers.

These commissioners are developing plans to put CQUINs into future contracts to promote improvements in quality data.

76 Some commissioners reported that data quality should be a core part of providers business and are therefore reluctant to use CQUIN to incentivise improvements in data quality. The view from these commissioners was that providers would be receiving income for care delivered under PbR, and should improve data quality without the need for added financial incentive.

77 We found that better performing commissioners held joint PbR boards with providers.

78 However, there are commissioners who are at an early stage in their development and understanding of the mental health currencies and care packages. Providers have driven forward local progress. These commissioners are now focusing on rapidly improving their capacity and knowledge to commission under PbR²⁰.

79 The time scale for developing the PbR system for acute trusts gave commissioners the opportunity to learn and put in place effective arrangements to commission. As PbR for mental health develops, commissioners have a similar opportunity. The DH guidance Key steps for successful implementation of Mental Health Payment by Results²¹ (2013) sets out actions.

“
**Commissioners
and providers
should drive
forward local
progress together**
”

²⁰ The reasons cited revolved round the commissioner structural changes in the last year. ²¹ Key steps for successful implementation of Mental Health Payment by Results, Department of Health, 2013.

Appendix 1 – Brief Explanation of Clusters

80 For a full explanation of mental health clusters refer to the Mental Health Clustering Tool (MHCT) booklet v3.0 (2013-14) in the DH's Mental health PbR arrangements for 2013-14²².

The following is an extract from the MHCT booklet v3.0.

81 In this context a cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and rated using the MHCT.

82 The MHCT has 18 scales covering current and historical characteristics such as depressed mood, problems with activities of daily living, delusions and hallucinations. The MHCT incorporates items from the Health of the Nations Outcome Scales (HoNOS), when rating the most severe occurrence in the previous two weeks scales 1-13. When rating scales A-E for problems that occur in an episodic or unpredictable way the Summary of Assessments of Risk and Need (SARN) are used. These provide all the information necessary to allocate individuals to clusters.

83 Table 3 is an example of the HoNOS scale 6 - problems associated with hallucinations and delusions (current). Clinicians should include: hallucinations and delusions irrespective of diagnosis; and odd and bizarre behaviour associated with hallucinations or delusions. They should not include aggressive, destructive or overactive behaviours attributed to hallucinations or delusions, rated at scale 1 - overactive, aggressive, disruptive or agitated behaviour (current).

84 When a clinician has completed their assessment and rated all 18 scales they use the decision tree in diagram 1 and to cluster the patient. Each of the clusters is described in detail in the MHCT booklet.

Figure 3: Problems associated with hallucinations and delusions (current)

1

Somewhat odd or eccentric beliefs not in keeping with cultural norms.

2

Delusions or hallucinations (e.g. voices, visions) are present, but there is little distress to patient or manifestation in bizarre behaviour, i.e. clinically present but mild.

3

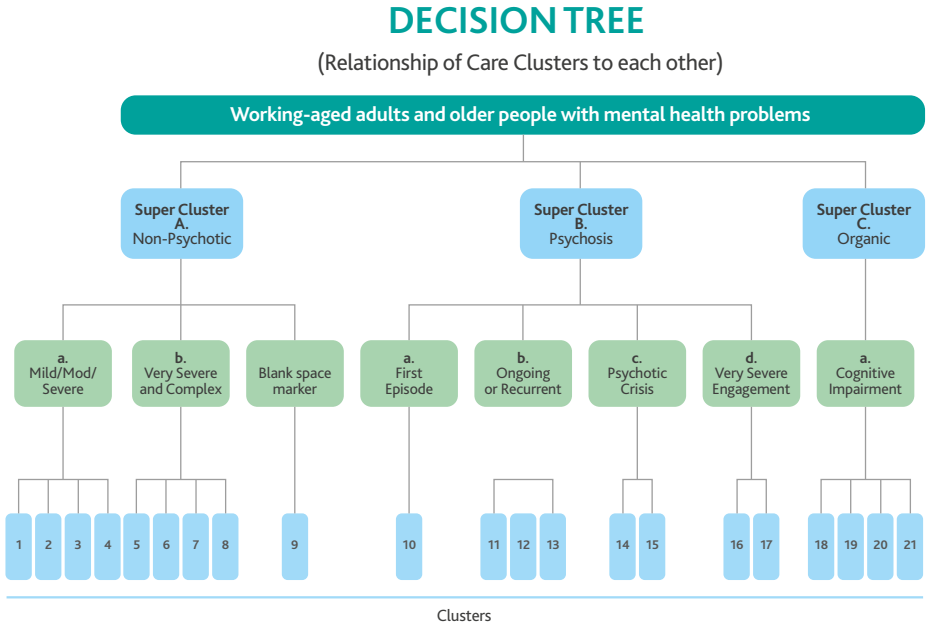
Marked preoccupation with delusions or hallucinations, causing much distress and/or manifested in obviously bizarre behaviour, i.e. moderately severe clinical problem.

4

Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with severe impact on patient.

Appendix 1 – Brief Explanation of Clusters continued

Diagram 1: Cluster decision tree



Appendix 2 – Participating Mental Health Trusts and Commissioners

Mental health trusts

Avon and Wiltshire Partnership NHS Trust
Black Country Partnership NHS Trust
Humber NHS Foundation Trust
Norfolk and Suffolk NHS Foundation Trust
Northumbria, Tyne and Wear NHS Foundation Trust
Plymouth Community Healthcare
South Essex Partnership University NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
South West London & St George's Mental Health NHS Trust

Commissioners

Lewisham Primary Care Trust
NHS East Riding of Yorkshire Primary Care Trust
NHS Plymouth Primary Care Trust
NHS South West Essex Primary Care Trust
Norfolk Clinical Commissioning Group
North of Tyne Primary Care Trust
North Somerset Primary Care Trust
Wandsworth Primary Care Trust
Wolverhampton Primary Care Trust

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