

**Evaluating the implementation of Payment by
Results in mental health services:**

A case study of Nottingham

by

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Abstract

The aim of this study is to evaluate the implementation of the Payment by Results (PbR) policy in mental health in England through the identification of the driving factors that have caused the delayed implementation of the system. Payment by Results, the English version of Diagnosis Related Groups, is a prospective payment system under which the nationally-fixed prices are set against the clinically-classified groups in which patients share similar health care needs. First introduced in acute services in 2003/04, PbR was expected to control healthcare costs, increase providers' efficiency and improve the quality of service delivery in the market-based healthcare system. An expansion of PbR to mental health was initially planned to come into effect by 2013, but at the time of writing (October 2015) it had yet to become the definitive framework of funding for the NHS secondary mental health services.

In light of the debate on the feasibility of implementing this policy in mental health, this study has adopted a mixed-methods approach to conduct a three-stage analysis of the PbR policy. Firstly, through the theoretical analysis of the initiation of the PbR policy, this study has revealed that the policy was poorly initiated due to the mismatches between the market theory and public services in the current context. Secondly, through the investigation of the design of PbR, this study has argued that the policy was poorly formulated due to the conceptual and the constructional drawbacks of the Mental Health Clustering Tool (MHCT) classification system as well as the inappropriateness of applying the "standardisation-to-the-average" principle to the cost calculation. In the fieldwork stage, this study has carried out 12 semi-structured interviews and

online surveys to explore the implementation phase of the policy-making process. The divergent, and even conflicting perspectives obtained among the three interest groups have pointed to the fact that the policy was poorly executed, and it suffered from "bad luck" (Hogwood and Gunn, 1984) as a result of from the political context of austerity.

Through the comparison of the implementation of PbR in mental health with that in acute services this study has highlighted the importance of the external context to the success of any policy. It has also argued that one size does not fit all systems since the PbR payment system may be able to serve the purposes in acute services, but it does not fit mental health services. In this respect, this study reminds policymakers to consider the potential trade-offs between the political objectives and the inevitable consequences. As a policy evaluation, based on the experiences drawn from the failure of implementing PbR in mental health, this study has suggested that policy should be consistent, and policy should be tested prior to full implementation.

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List of Abbreviations

AC	Average Cost
A&E	Acute and Emergency
CCG	County Clinical Commissioning Group
CHAI	Commission for Healthcare Audit and Inspection
CHI	Commission for Health Improvement
CPA	Care Programme Approach
CPPP	Care Pathways and Packages Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician-Rated Outcome Measurement
CSR	Comprehensive Spending Review
CV	Curriculum Vitae
DH	Department of Health
DRGs	Diagnosis Related Groups
DSM	Diagnostic and Statistical Manual
FCE	Finished Consultant Episode
FT	Foundation Trust
GDP	Gross Domestic Product
GP	General Practitioner
GTM	Grounded Theory Methodology
HoNOS	Health of the Nation Outcome Scales
HRGs	Health Resource Groups
ICD	International Classification of Diseases
IRAS	Integrated Research Application System
LOS	Length of Stay
MC	Marginal Cost
MHCT	Mental Health Clustering Tool
MHMDS	Mental Health Minimum Dataset
MH PbR	Mental Health Payment by Results
NFCAS	Needs for Care Assessment Schedule
NHS	National Health Service
NHT	Nottinghamshire Healthcare NHS Trust
NICE	National Institute for Health and Care Excellence
OBD	Occupied Bed Days
OCD	Obsessive-compulsive disorder
OECD	Organisation for Economic Co-operation and Development
OPCS	Office of Population Censuses and Surveys
PAS	Patient Administration System
PbR	Payment by Results
PCG	Primary Care Group
PCT	Primary Care Trust
PDCA	Plan-Do-Check-Adjust
PPA	Purchased Power Adjustment
PREM	Patient-Reported Experience Measurement
PROM	Patient-Reported Outcome Measurement
QIPP	Quality, Innovation, Productivity and Prevention
R&D	Research and Development
SARN	Summary Assessment of Risk and Need
SSI	Site-Specific Information

1. Introduction

1.1 Background of the study

There have been policies to adopt patient-centred approaches into the National Health Service (NHS) over many years and by different governments as patients were seen to be expected to fit around services rather than vice versa. The Labour government used the term “patient-centred care” as part of their manifesto in the 1997 general election (Gillespie et al., 2002; Goodrich, 2009). Although with limited success in changing the dominance of the medical model (Appleby and Coote, 2002), there has been an escalation of rhetoric and a series of policies to expand patient choice following the 1997 election, (e.g. *Delivering the NHS Plan: Next Steps on Investment, Next Steps on Reform* (Secretary of State for Health, 2002), *Creating A Patient-led NHS: Delivering the NHS Improvement Plan* (Department of Health, 2005a)). In *Equity and Excellence: Liberating the NHS* (Secretary of State for Health, 2010), the Coalition government reiterated the importance of providing patient-centred health care by appreciating the patient’s individual needs for care and their personal values.

Recently, improving healthcare efficiency has attracted greater worldwide attention due to the intense financial pressure facing the healthcare industry as a whole (Barton, 2003). Since the birth of the National Health Service (NHS), the British healthcare system has been funded by taxation in which patients have the same access to healthcare services without having to pay for them directly (NHS Choices, 2013). In turn, universal availability has resulted in concerns regarding over-

demand – the so called “moral hazard”, due to the empirical evidence that indicates an increase in demand and the excessive consumption of healthcare resources (Blunt, 2014). Consequently, the British healthcare system has been under intense financial pressure to improve its efficiency, even though it has been consistently rated as the most efficient system in the Organisation for Economic Co-operation and Development (OECD) by the Commonwealth Fund (NHS Confederation, 2014).

Developed by Yale University, a prospective payment method called Diagnosis Related Groups (DRGs) represents a new way to reimburse providers. Unlike the previous “cost-based” payment method, it relates the type of patients treated to the costs incurred by providers in managing collective healthcare costs (Averill et al., 2003). Underpinned by the case-mix principle, DRGs groups patients into categories according to their diagnoses and needs for care, in which patients are expected to consume the same level of healthcare resources as their peers (Fetter and Freeman, 1986). The costs for each group are therefore determined as the basis for this prospective payment method. In other words, this prospective payment system pays providers a predetermined, set rate based on patients’ needs in an evidence-based way (Mayes, 2007). Since the 1980s, this system has been widely approved and adopted due to its comprehensive and accurate disease classification system, and therefore, its effectiveness for cost control (Fetter et al., 1980). DRGs, or the case-mix based classification systems, have been widely implemented in acute settings in most of the developed countries throughout the world (Mason et al., 2012), as well as in a selection of developing countries such as China and Mexico.

The case-mix based classification systems and accordingly the cost calculation systems were firstly developed for surgical services for which the groups with clinical meaning and economically homogeneity are easy to derive. However, due to the complex nature of mental disorders, only some countries have implemented or planned to implement DRG-like systems in psychiatry. England is currently in the process of expanding this system to mental health. It has been a decade since Payment by Results (PbR), the English version of DRGs, was implemented in acute services, and the government had originally planned to introduce this classification system into mental health by 2013. However, at the time of writing (October 2015), it has yet to come into effect as a payment system. Mental health services are still contracted under the Block Contract while PbR has only been invoked as a classification system with care pathways still under development. Moreover, the terms “dangerous” and “unintended outcomes” have been employed to describe the rush to implement PbR in this field (Lintern, 2013).

As a policy evaluation, this study focuses on investigating the fundamental, mechanical and practical problems that have caused the delay in implementing PbR in mental health in England. Through a case study of the implementation of PbR in mental health in Nottinghamshire, this study aims to present a comprehensive overview of the policy-making process and therefore, evaluate the gaps between the initial political intents and actual frontline outputs. The main thrust of the study is on the application of the market theory and the case-mix based health resource management instrument in an area characterised by complex individualised conditions. Unlike the acute services where the groups with clinical meaning and

economically homogeneity are easy to derive, the individualised needs for care in mental health services highlight the challenges, or even inappropriateness of commodifying mental health services. This weakens the theoretical validity and feasibility of applying the Quasi-market theory to the simplification of the management of mental health resources (this will be discussed in Chapter 3). In other words, the complex nature of mental disorders rejects the fundamental preconditions of PbR, which makes the policy itself less valid and thus adversely affects the formulation and implementation of PbR in mental health (MH PbR). This study further investigates the formulation of the PbR policy based on the argument regarding the failure to apply the Quasi-market theory at the fundamental level, which indicates the difficulties in standardising mental health services. This refers to the process of transferring the idea of commodification into practice through a clinical classification system called the Mental Health Clustering Tool (MHCT). The failure of the MHCT to serve its function demonstrates the drawbacks of the policy formulation. Additionally, it also points to the difficulties in implementing this scheme. This is confirmed by the study fieldwork in which semi-structured interviews and online surveys were conducted with key players in the commissioning cycle.

This chapter provides an overview of the research topic and the corresponding research design. Drawing on the importance of understanding the policy itself as well as the nature of mental health services to evaluating this policy, this chapter begins with a brief overview of the birth of PbR and the development of mental health services, followed by some a review of available evidence regarding its development in acute services and mental health services. The background information facilitates

serves to inform the significance of this study, which will be discussed in Section 1.2. Subject to the research questions and aims outlined in Section 1.3, Section 1.4 describes the research design and corresponding methods. Section 1.5 presents an outline of the structure of the thesis with an emphasis on demonstrating the intrinsic logic which has informed it.

1.1.1 The birth of DRGs and PbR

1.1.1.1 Development of DRGs

DRGs are groups of cases that share similar characteristics and health needs with unified payment standards attached to each case group to promote a more efficient utilisation of healthcare resources (Ranjan et al., 2003). Seen as a solution to the challenges with the allocation efficiency that most developed countries are currently facing (Busse et al., 2011), the DRGs system features four characteristics (Sanderson et al., 1986): managing healthcare resources according to patients' needs; the inclusion of comprehensive classification indicators (e.g., the International Classification of Diseases (ICD)) applying the case-mix principle; categorising the confusingly large number of individuals into a manageable number of clinically-meaningful and economically homogeneous groups; whilst finally connecting treatments to specific prices to formulate a coherent evidence-based health resource management system.

Since 1983, when the DRGs system was first introduced as the basis for paying hospitals in the United States, DRG-based hospital payment systems have been widely adopted in most developed countries, albeit with slightly different purposes and to different extents (Paris et al., 2010). DRGs are adopted as a classification system in some countries, such as Sweden and

Finland, whereas in countries such as England, Germany and France, DRG-based systems (with different country-specific versions) are used as a synonym for payment rates (Geissler et al., 2011).

1.1.1.2 PbR in England

With the intentions to meet the large demands for service and to continue providing patients quality healthcare services, the English government introduced Payment by Results in 2003 (Secretary of State for Health, 2002). The introduction was meant to replace the Block Contract and to establish a new financial framework to pay different providers on a fair and transparent basis for service delivery. Employing economic theories, the rationale for designing PbR is to contain cost, increase efficiency and promote quality through a provider-side, non-price competition in a mimicked market called the “internal market” (Miraldo et al., 2006).

Rather than the previous lump-sum payment under the Block Contract, PbR uses a fixed price system that makes a direct link between the hospital’s income and the number of the cases treated, termed “cost-and-volume” payment system (Farrar et al., 2009). In this system, payment is directly related to specific cases and treatments regardless of the provider under the classification system according to the case-mix principle (Boyle, 2007). Similar to other DRG systems, the concept of PbR consists of two main components: a nationally agreed set of prices for healthcare services called “tariffs”, and a classification system in which certain cases are categorised into specific treatment groups that are similar in intervention design and resource consumption (O'Connor and Neumann, 2006).

The purchaser/provider split entitles commissioners the right to purchase healthcare services offered by a range of providers, including public, private or voluntary sectors. Under PbR, commissioners pay national tariffs for each patient treated. The linear relationship between cost and volume creates incentives for providers with lower costs than the national tariffs to undertake more activities in order to increase their revenue in proportion to their growth in activity (Miraldo et al., 2006). Without price competition, providers are expected to be motivated to improve quality to attract more patients. Conversely, providers also face financial risks when costs exceed the national tariffs, which drives providers to control costs and improve efficiency (Appleby et al., 2012).

1.1.2 Development of mental health service management

Tracing the history of mental health development, the initiative of the “mental disorders” was from an opposite standpoint from that of physical illnesses. In contrast to the sympathetic understanding of people with physical illness who have been seen as deserving of effective help to overcome their illness, people with mental difficulties have been stigmatised and were even the victims of witch-hunts in 18th century Europe (Schoeneman, 1977). With the development of social understanding and treatment approaches, “mental disorder” is no longer viewed as a myth or seen as the result of evil spirits, but rather is viewed as a disease similar to physical illness (Szasz, 1960). Nevertheless, despite significant developments, the structure and function of mental health services are still different from that of the services offered by general hospitals. The fundamental reason for this difference is largely due to the

natural characteristics of mental disorders – intangible pathology and unclear aetiology, particularly since mental disorders cannot be objectively defined or diagnosed through any laboratory test regularly used acute services (Frances, 2010). Even in organic conditions of neurology, in which the damages could be found on a clinical image, there exist some cases like dementia for which the brain damage is not always detectable in post-mortem (Rogers and Pilgrim, 2010).

Therefore, the ability to distinguish people with mental difficulties from the general “healthy” population is closely related to professional and social environmental forces. The lack of clear markers of diagnosing mental disorders leads to greater reliance on the professional judgment of one’s mental condition, which is the process of distinguishing the “abnormal” from the “normal” group. As Rogers and Pilgrim (2010) illustrate from the statistical aspect, under the assumption that characteristics in any population follow a bell-shaped normal distribution, the frequently occurring behaviours are set as the standards of being “normal”, whereas the infrequent behaviours, or the deviances in the normal distribution, are regarded as “abnormal”. Practically, classification systems have been designed to capture the “abnormal” from the “normal” phenomena and, hence, identify the “shared characteristics” from the “abnormal” phenomena by arranging them into pre-determined categories to facilitate the provision of targeted treatments (Dalal and Sivakumar, 2009).

The ICD is the most popular classification system, and has been adopted in a majority of countries, whereas the Diagnostic and Statistical Manual of Mental Disorders (DSM) is prevalently used in mental health in the US. Both systems validate particular

behaviours as “normal” and establish privileged signs according to the case-mix principle. These categorical models provide a “discrete entity” view of “abnormality”: pathology detected means “abnormal”, otherwise means “normal” (Jablensky, 2009). Underpinned by population-level statistical analysis, features are isolated, behaviours are labelled, and patterns of the abnormal cases are identified (Kraemer, 2007). The classification and coding system translate the observed behaviours into certain syndromes against specific diagnoses. This process reveals the essence of identifying the “abnormal” in mental health, which is also the essence of the case-mix principle: to reduce variations between patients with similar needs by standardising “shared characteristics”. However, given the prevalence of individualised conditions, there is a large variation in severity and need, even in the same group defined by a diagnosis and especially given the absence of a “gold standard” of aetiology (Dalal and Sivakumar, 2009). Such diversity in conditions leads to the variation in resource consumption and cost, which then increases the difficulties in accurately measuring costs and calculating the corresponding prices. Since PbR in England is used as both a clinical classification system and a payment system, the MHCT, a classification system based on the severity of symptoms as well as the primary diagnosis, has been introduced in mental health to guide the calculation of price (Department of Health, 2012a) (this will be discussed in Chapter 2).

1.1.3 Current status of PbR

1.1.3.1 Lack of sufficient research on intended consequence

Although it has been two decades since the DRGs system was first introduced in the United States and over ten years since implementing different versions of the DRGs systems in European countries, Brügger (2010) argues that there is still a lack of sufficient evidence illustrating the effects of DRG-based payment systems on controlling cost, increasing efficiency and improving quality. The available studies focusing on PbR comply with the findings from other countries by indicating a relative lack of sound evidence regarding the achievement of PbR.

The difficulties in measuring the effect of PbR on cost are due to the difficulties in isolating its impacts under a wider reform programme. The Audit Commission (2005) reports its presentence of stronger incentive on cost reduction compared to the Block Contract payment system. By contrast, Maynard and Bloor (2004) note the inability of PbR to address the increase in regulatory costs brought about by the adoption of market theory. In light of the external confounding factors such as research contracts from both public and private resources, the downward pressure on the reference cost has been mitigated by the cross-subsidy obtained from these sources of income (PriceWaterhouseCoopers, 2009).

Longitudinal studies concerning the effects of PbR on efficiency have failed to confirm its positive impacts. Specifically, interviews and observation conducted by the Audit Commission (2008) reveal that PbR has not yet significantly increased provider capacity due to its unclear effects on capacity in general. Farrar et al.'s (2007) study indicates the difficulties in

attributing changes in efficiency to the introduction of PbR.

As Or and Häkkinen (2011) argue, the difficulties in observing and quantifying the quality of care have led to a lack of agreement on how to effectively measure quality. Moreover, drawing on the existence of the immeasurable services, such as those behind the scene, Levaggi (2005) raised concerns regarding the withholding of services by providers that are not verifiable, particularly due to the lack of consideration of quality in the design of the payment mechanism.

1.1.3.2 Delay in implementing PbR

Besides the lack of sufficient evidence illustrating the practical effects of PbR against the political intents in acute services, the delay in implementing PbR in mental health has been noted. An expansion of PbR into mental health was initially planned to come into effect by 2013, it has yet to become the definitive framework for funding NHS secondary mental health services. In 2013, guidelines were published by Department of Health (Lindblom and Woodhouse) which included indicative costs for each of twenty-one treatment packages intended for implementation in 2013/14. This was delayed until 2014/15 (Mayden, 2013), and an article in the Health Service Journal named "*Updated: Monitor Questions Payment by Results for Mental Health*" (Lintern, 2013) revealed that this too had been delayed. Stephen Dalton, chief executive of the Mental Health Network also questions the appropriateness of the rush to implement this scheme in mental health in the absence of sound evidence supporting its impacts in acute services (Lintern, 2013). By February 2015, the changing political landscape appeared to have moved this debate even further, with the focus

shifting from PbR as a core feature of competitive tendering to an emphasis upon a “system-wide approach” (Keohane, 2015).

PbR has been implemented in the inpatient, outpatient and Acute and Emergency (A&E) (Secretary of State for Health, 2010) areas, which has followed the planned schedule, leaving the expansion to mental health services delayed. Therefore, the following questions remain: 1) Does the theory of PbR fit into mental health services; 2) Is the mismatch between the mechanisms of PbR and the complex nature of mental disorders responsible for the delayed implementation, and to what extent it influenced the process of the implementation of PbR in mental health if this is the case; 3) What are the other factors that have caused the delay in implementation? These questions await further research into the policy itself and mental health services, not only as individual components, but also as a whole in the specific political context.

1.2 Study significance

1.2.1 Significance of the evaluation

Equity and Excellence: Liberating the NHS (Secretary of State for Health, 2010) reiterates the importance of paying more attention to mental health services to facilitate an integrated, high-quality service system. Due to the nature of mental disorders, the derived factors including intangible pathology, individualised conditions, heavy influences from the external environment, and the significant variations in service, have established a different treatment logic from that seen in acute services.

Previous studies have evaluated the intended and unintended consequences brought about by the internal market, particularly in acute services (Allen, 2002a; Baggott, 1997; Propper et al., 2008; Propper et al., 2004; Propper et al., 1998). However, how and to what extent it influenced the development of mental health services still remains unclear, due to the dominant position of the Block Contract underpinned by the lump-sum payment mechanism. When narrowing down to PbR, recent studies have begun a systematic evaluation of the impact of PbR on acute services, an area PbR was initially designed for (Allen, 2009a; Mannion et al., 2008; Street and Maynard, 2007; Street et al., 2011). Nevertheless, the practical impact of those intended benefits is still unclear in acute services. Under such circumstances, besides the initial problems of PbR that have been identified in the currently available research subject to acute services, the case of PbR can be especially worth investigating in the context of mental health.

Apart from the overall impacts of PbR at the macro level, it is also worth exploring the constructional elements, including the design of classification system, the cost calculation system and the interaction between the two. This is particularly important in a field like mental health where the classification criteria are often unclear. Recent studies have placed greater emphasis on the constructional problems of the MHCT and the Health of the Nation Outcome Scale (HoNOS), whereas less attention has been paid to the conceptual drawbacks of the MHCT as a needs assessment instrument and how these together with other external factors influenced the appropriateness of services provision. Apart from the lack of analysis at the functional/mechanical level, the delayed implementation indicates a lack of sufficient empirical evidence regarding the

utility of the classification and therefore its influence on the frontline clinical practice and even the whole service commissioning process as a whole.

The lack of understanding of the problems at different levels results in a lack of understanding regarding the collaboration between these elements. Therefore, the general picture of how this policy comes into effect, as well as the gaps between the political intents and the practical outputs is of concern. John (2012) points to the existence of significant gaps between policy objectives and the actual implementation, which echoes Dunsire's (1978) theory of "the implementation gap". Consequently, more literature has focused on the gaps between the two to facilitate a better understanding of the factors that have caused the failure to transfer the desired practices into reality (Hill and Hupe, 2002). This in turn highlights the importance of evaluating public policy: to assess the extent to which the outcomes have achieved their initial objectives, to improve understandings of the policy itself regarding its validity, as well as to facilitate future policy-making (Hogwood and Gunn, 1984). Regarding this study, the delayed status indicates the failure of this policy to deliver the intended outputs. As a continuous learning process (Cabinet Office, 1999), it is important to understand the factors that have caused the failure to make adjustments to the existing policy in order to facilitate the development of future policies.

1.2.2 Significance of the research design

In terms of conducting a successful evaluation, emphasis has been placed on the political context, the objectives and the implementation. As Hogwood and Gunn (1984) illustrate, all

public policies are formulated with considerable influence from the past, the assumptions and expectations concerning the future. Walt et al. (2008) further emphasise the importance of contextualising the place and time that the policy occurred in order to evaluate policies in health care, taking into account external factors, such as professionalism (this will be discussed in Chapter 3), financial pressures and political considerations (this will be discussed in Chapter 6). The purpose of evaluation is to understand the gaps between theory and practice, and it is considered difficult to identify and define these gaps without an understanding of the initial purpose of the government. Serving as the other element of the evaluation, the identification of the outputs depends on the investigation of the implementation process. By acknowledging the existence of a long journey between policy initiation and its realisation, Hallsworth et al. (2011) point to the limitation of guidance in directing how to execute policies in practice, which indicates the existence of unforeseen variables within the process and the importance of understanding these variables in the implementation process.

In this respect, this study aims to evaluate the policy of implementing PbR in mental health through identifying the factors that have caused its delayed status. By appreciating the importance of contextualising the place and time, this study is designed as a case study to investigate the implementation of Mental Health PbR (MH PbR) in Nottinghamshire between the years 2010 and 2015 (this will be discussed in Chapter 4). As a policy evaluation, this study focuses on identifying and analysing the mismatches between the political intents and the frontline outputs. For the comprehensiveness of the evaluation, this study includes a multi-level analysis of the policy

considering its context, its political objectives and its implementation, whereas greater attention is paid to the implementation process. This study appreciates the lack of a sharp divide between policy formulation and its implementation, which highlights the importance of the policy design (Hogwood and Gunn, 1984). The multi-level analysis involves the evaluation of the fundamental theories behind PbR, which considers the political context and intents behind this particular policy; examination of the concept and construction of MH PbR, which reflects the issues in the policy formulation stage; and the investigation of the frontline practice and its actual implementation.

This multi-level investigation considers the major risk factors for the failure of implementation. According to Hogwood and Gunn's (1984) research, the failure of a particular policy is attributed to three major reasons: bad luck, bad execution or bad policy. The investigation into the foundation of PbR might enable a deeper understanding of how political intents have influenced the idea of health service management by investigating the application of the Quasi-market theory to the regulation of the provision of mental health services. The initial conflicts between the hypotheses of the Quasi-market theory and the features of mental health services indicate the weak theoretical foundation of PbR, which adversely affects the execution of the policy. This conforms to Bardach's (1977) argument that a policy will fail regardless of how good the implementation process is as long as the underpinning theory is fundamentally flawed. Considering the design of the classification system and the cost calculation system as a means that transfer the Quasi-market theory into specific programmes, the validity and credibility of these two systems partly reflects

the execution of this policy. By acknowledging the lack of sufficient research on the constructional relationship between disease classification and cost calculation, this study examines the conceptual and constructional flaws of the classification system, followed by an illustration of how these flaws have subsequently influenced the cost calculation process. The investigation of each element will provide a deeper analysis of the internal construction of the MH PbR system. The interaction between each element might facilitate a better understanding of how and to what extent these mechanical drawbacks have created the practical obstacles. Considering that there is limited frontline level information regarding implementation, one of the aims of this study is to provide readers with up-to-date information on the current condition of the early implementation of MH PbR. It also facilitates the identification of external factors to determine whether the failure of MH PbR should be attributed to the external constraints – “bad luck” (Hogwood and Gunn, 1984). Conflicting perspectives among the key players from different interest groups reveal the problems encountered during implementation, including the ideological drawbacks of the programme design, problems with execution, as well as the adverse external factors that have made the implementation more difficult.

By triangulating the findings from different levels and different angles, this study presents readers with a closer look at the policy-making process of the implementation of PbR in mental health, a better understanding of the gaps between theory and practice by using Nottinghamshire as a case study, and an illustration of the reasons for the failure which may facilitate the future policy-making.

1.3 Research objectives and questions

Based on the significance of evaluating utility of PbR and its impact on mental health, this study aims to enhance our understanding of the application of this policy by focusing on an exploration of the most recent and important issue: delay in implementing MH PbR and its associated factors.

To facilitate a step-by-step investigation, the general aim is translated into the following four specific research questions as follow:

- 1) What is the fundamental basis of PbR? Is it theoretically feasible to be implemented in healthcare services?
- 2) To what extent is PbR theoretically valid regarding fulfilling the function of a clinical classification system and a payment system in mental health?
- 3) What is the current stage of the implementation of PbR in the mental health sector?
- 4) What are the obstacles that have hindered the implementation of PbR in the mental health sector?

To effectively answer these questions, the objectives of this study are derived as follows:

- 1) Review the relevant policy documents to set a specific political context for the investigation of this particular project, given the impacts of different policies generated within the disjointed NHS reforms.

2) Review the academic literature to evaluate the MH PbR policy regarding the fundamental theories informing the policy initiation phase, as well as the concept and construction of MH PbR in the policy formulation phase.

3) Conduct semi-structured interviews with participants from different interest groups, including commissioners, managers and frontline professionals, who engage in the commissioning circle to explore their perspectives on both the actual progress and the practical obstacles to the implementation of PbR in mental health. Accordingly, the research sites are set as Nottinghamshire Healthcare NHS Trust, Nottinghamshire County Clinical Commissioning Groups (CCG) and Nottingham City CCG.

4) Conduct online surveys with participants from the above three organisations and Derbyshire Healthcare NHS Foundation Trust to verify the findings from the qualitative data.

5) Synthesise the findings derived from all three stages of analysis to elicit a general discussion regarding the validity of the implementation of MH PbR and provide implications for policy analysis and future policy-making.

1.4 Research methodology

1.4.1 Research design

This study is an analytical case study which addresses the research questions described above from both theoretical and practical perspectives. Since the liberalisation of the NHS, the devolution of power has led to an increase in the geographical

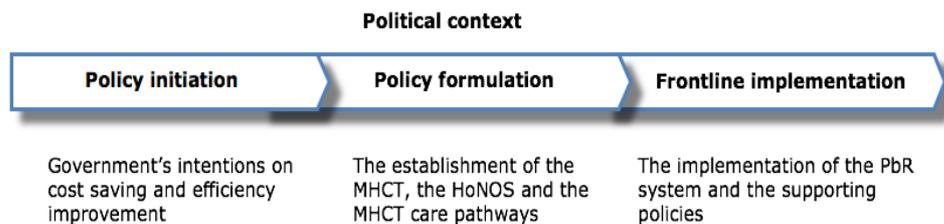
variation of service provision and the progress of implementation. According to *Mental Health Bulletin: Fifth Report Mental Health Minimum Dataset (MHMDS) Annual Returns* (The NHS Information Centre and Mental Health and Community Team, 2011), the provision and use of mental health services varied across England, which creates difficulties in representing the whole picture of PbR implementation across England. Disjointed policies released at different stages have exerted heavy influences on the implementation of this particular project (the political environment and, therefore, incentivising factors differ between implementing PbR in acute services and mental health services). As discussed earlier, it would have been impossible to have a clear understanding of the generation, development and implementation without considering the context within which it occurred (Baxter and Jack, 2008). Under such circumstances, this study set the research location and time span to investigate this complex issue within a particular context. It conforms to Yin's (2014) suggestion that the use of a case study suits research studies that take particular contexts into consideration. According to Robson (1993), case studies provide greater detail to facilitate an in-depth analysis of a particular subject. Thus, this study focuses on an investigation regarding the implementation of MH PbR in Nottinghamshire under the Coalition government between the years 2010 and 2015.

Figure 1-1 below illustrates the theoretical process of how PbR policy comes into effect. Generally speaking, it takes three major steps for an idea to translate into political outputs. Regarding the process as a whole, it begins with the policymakers' general intents; next it transfers into a sequence of programmes that specify the initial intentions; and in the last

stage, the frontline staff execute these programmes following the targets through which the original intentions are translated into everyday practice. Regarding this politico-administrative relationship, it originates with one question: "Who rules?" (Potucek and Vass, 2003). As Shaw (1994) demonstrated, the actual collaboration between actors is not as smooth as expected in theory, which indicates that the central government control the process (Aberbach and Rockman, 1988). Lipsky (1980) was the first to note the importance of frontline administrators in the realisation of a particular policy, which challenges the conventional top-down management under which policymakers dominated the policy-making process (Hogwood and Gunn, 1984). According to Lipsky's (1980) "street-level bureaucracy" theory, in health care, patients' individualised conditions with individualised needs for care affect the working context. Given frontline clinicians' irreducible responsibility for providing appropriate responses to each client's personal situation, such responses, by definition, cannot strictly follow administrative agency guidelines and result in difficulties in rationalising or simplifying the frontline service delivery process. It points to the limitation of the forward-mapping approach to implementation analysis, which is formulated with the assumption that policymakers control the implementation process (Shaw, 1994). According to Barrett and Fudge (1981), the implementation process is not the single transmission of policy into consequential actions, rather, it is a process of interaction and negotiation between the policymakers and those who take action. This highlights the importance of the backward-mapping approach which appreciates the importance of frontline-level participants in the service-delivery process. Indeed, they are the key participants who transfer a policy into real outputs by adapting political

intents into workable forms. Therefore, understanding their situations and perspectives will facilitate a critical judgement of the outcomes of the process. In this case, it is worth investigating the factors and variables in each stage of the policy delivering process. Furthermore, according to Lipsky's (1991) theory, a comprehensive understanding of a particular policy should consider the political context, the policymakers' allocation decisions and frontline practice. This perspective also conforms to Glennerster et al.'s (1983) theory of "administrative anthropology", which considers multiple angles of the implementation process through historical documentary analysis, structured interviews and observation of practice.

Figure 1-1 The analytical framework



By adopting the "administrative anthropology" theory, this study aims to understand the policy-making process of the MH PbR scheme by analysing the issues at the fundamental level, the mechanical level and the practical level through theoretical analysis, semi-structured interviews and online surveys. Based on the background information regarding the initiation and development of the PbR policy under different political environments presented in Chapter 2, this study executed out a theoretical analysis of the initiation and formulation of this policy at the fundamental and mechanical levels, respectively. To facilitate an understanding of the political intents behind the

policy, this study reviewed the application of the Quasi-market, which is the fundamental theory underpinning PbR. Through a discussion of the gaps between the preconditions of this managed market and the practical realities of health care, particularly mental health services, the first preliminary finding was acknowledged: applying the Quasi-market in mental health services lacks theoretical viability. At the same time, it sheds light on the discussion regarding the classification mechanisms of MH PbR by pointing to the failure of the commodification of mental health services. Based on this argument, the second level analysis mainly focused on evaluating the validity and reliability of the clinical classification system in mental health, due to the incomplete cost calculation system. The initial drawbacks of the classification system on the one hand indicated a poor formulation that failed to translate political intents into detailed policies/targets, whilst on the other hand it implied that this would cause a more challenging implementation of the policy since it had already been poorly initiated and formulated. Regarding the implementation of MH PbR, semi-structured interviews and online surveys were conducted to explore the actual impacts of the MH PbR policy on the daily practice of those healthcare professionals on the frontline. Accordingly, the semi-structured interviews and the online surveys paid particular attention to the gaps between the government's priorities and the services provided at the frontline level, which revealed the "bad execution" and "bad luck" of this policy (Hogwood and Gunn, 1984).

Hence, the top-down evaluation of the policy initiation, formulation and implementation may help to present a multi-level and multi-angle perspective to understand the process

whereby political intents are translated into clinical outputs (Hunter and Wistow, 1987).

Regarding the fieldwork, the subsection below presents an overview of the research methodology guiding the semi-structured interviews and online surveys.

1.4.2 Research methods

The objectives of the study fieldwork were to gather material that describes how the MH PbR scheme was designed and developed, and to identify the actual outputs of the policy. As mentioned earlier, the key participants play a significant role in translating political intents into specific outputs. For the comprehensiveness of understanding, the study set commissioners, hospital managers and frontline clinicians as the target subjects. By appreciating the responsibilities of the frontline bureaucrats, the semi-structured interviews and the online surveys intended to discover frontline staff's attitudes towards the implementation of this policy, with particular attention paid to exploring the gaps between the government's priorities and the services provided at the frontline level. The adoption of these two approaches aimed to compensate the defects of each single method to consider both the depth and width of the research findings (this will be discussed in Chapter 4). The fieldwork findings presented divergent, and even conflicting, perspectives among various interest groups, which increased the comprehensive understanding of this topic.

Rather than using the within-method triangulation, this study adopted the between-method triangulation combining both qualitative and quantitative approaches. In recognition of the

limited statistical data resulting from the delayed status, the qualitative analysis was adopted as the leading approach, whereas the quantitative analysis of the online surveys was employed mainly for a confirmatory purpose.

The qualitative analysis was mainly employed for the semi-structured interviews. Based on the top-down theoretical analysis examining the fundamental and mechanical validity of PbR in mental health, the semi-structured interviews aimed to provide up-to-date and on-the-ground information regarding the implementation of MH PbR. Therefore, between November 2013 and April 2014, the semi-structured interviews involved 12 participants from three interest groups in three organisations within Nottinghamshire, including Nottingham NHS Healthcare Foundation Trust (NHT), Nottingham City Clinical Commissioning Group (CCG) and Nottinghamshire County CCG. The principles of Grounded Theory Methodology (GTM) were applied to analyse the interview data to facilitate a better understanding of the individuals' perspectives and how these perspectives were generated. As the leading approach of this study, the qualitative analysis provided up-to-date information about the current progress of the implementation of MH PbR, examined how, and to what extent, the theoretical flaws affected everyday clinical practice and outlined the external factors that hindered the progress of implementation at the current stage.

However, this study also noted the potential limitation of interviews on its representativeness (Mays and Pope, 1995). Although this case study focuses on the in-depth information regarding the current implementation status within Nottinghamshire, it is still of importance to expand the research

sample to achieve a more comprehensive understanding. To avoid the risk of being biased, this study adopted online surveys mainly for a confirmatory purpose. During the semi-structured interviews, the interviewees provided reliable informational resources of the implementation of MH PbR in Nottingham. They deepened the understanding of mental health services as well as how mental health policies have affected clinical practice. After gathering and analysing the qualitative data, the online surveys were sent to three organisations within Nottinghamshire and one Foundation Trust in Derbyshire (to enlarge the research sample using data from a comparable organisation, which will be discussed in Chapter 4) between June 2014 and September 2014. Quantitative analysis was then conducted to verify the findings derived from the previous qualitative analysis.

As a whole, this study elaborated how, and to what extent, political contexts and political direction have affected a particular policy from a top-down manner, based on which this study further discussed the interactions between policy-making and frontline practice using a bottom-up order approach (this will be discussed in Chapter 4).

1.5 Organisation of the thesis

Due to the delayed implementation, a practical evaluation of the implementation of PbR in mental health is lacking. Despite the fact that the government has planned the implementation of this project since 2008, MH PbR has only been partially executed. Therefore, central to this thesis is a detailed analytical examination of the factors that have caused such a delay, through which this study attempts to evaluate the MH PbR policy

by comparing its intended outcomes underpinned by the fundamental theories and considering the actual consequences of the implementation. This thesis presents the study from five major parts including eight chapters. Chapter 1 presented the research significances, research questions and research methods based on a brief introduction of the research background. This chapter also provided an overview of the thesis as a whole by outlining the general structure and illustrating the links between the neighbouring chapters.

Through the use of official documents, Chapter 2 presents a general picture of the theoretical mechanism of PbR and the political context in which the initiation and development of MH PbR are discussed. The consideration of the changing political contexts sheds light on evaluating the utility of MH PbR and therefore, the significance of this policy (e.g., the significance of implementing PbR differs between in acute services and mental health). This chapter attempts to make an explicit interpretation of the role of the political environment and how this affects the implementation of the MH PbR policy. It deals with the dynamic process of state intervention in healthcare policy in England since the early 1990s to contextualise the period in which the state started to pursue the marketization of the healthcare system; the fundamental idea underpinning PbR (this will be discussed in Chapter 3). Thus, the time span encompasses two decades, including four major reforms. Accordingly, this chapter illustrates the development of PbR in acute services and its expansion to mental health within the political contexts of these four reforms. Besides contextualising the policy to facilitate a better understanding of the development of PbR, the NHS reforms outlined in Section 2.3 pave the way for further discussion about the side-effects

brought about by the fast changing policies (this will be discussed in Chapter 6) and the importance of a supporting external factor to the success of a policy (this will be discussed in Chapter 8). The outline of the current progress of the implementation of MH PbR then leads to the generation of the research aim of the study.

As a policy evaluation, this study evaluates the validity and feasibility of implementing PbR in mental health from three levels including the fundamental level, the constructional level and the practical level, following the idea of “administrative anthropology”. Regarding the fundamental theory behind PbR, which is the application of the Quasi-market, Chapter 3 looks at its theoretical mechanisms and the underpinning preconditions. This serves two main purposes: firstly it reveals the political intents behind PbR which will be compared with the practical outputs uncovered by the fieldwork; secondly, it examines the initiation of the PbR policy by focusing on a fundamental question: is it feasible to apply the Quasi-market theory in health care, and in particular, mental health? By splitting the Quasi-market into the market mechanism and government regulation, this chapter deals with the theoretical flaws of each component according to which a primary finding derives: PbR, together with the fundamental theory behind it, is not theoretically suitable to the mental health domain. In particular, the failure to commodify mental health services revealed in this chapter assists in the investigation of the case-mixed based clinical classification system, which stands on the hypothesis of the standardisation of mental health services (this will be discussed in Chapter 5). The argument that the government lacks the ability to regulate service delivery serves as mutual evidence with the empirical findings regarding the difficulties in

involving frontline clinicians in the reform and the occurrence of the “gaming” behaviours (this will be discussed in Chapter 6). Thus, it helps to formulate the research objectives, which are to evaluate the construction of this system and to explore the practical experiences regarding its implementation.

Chapter 4 introduces the methodology and methods employed by this study to present a multi-level and multi-angle perspective regarding the delayed implementation of MH PbR. To justify the methods, it illustrates the philosophical assumptions that underpin the design of this study before introducing the research strategy and the techniques which are then supplemented by an outline of the process of how the research was conducted. This chapter firstly considers the research paradigm, which is the use of mixed methods. By acknowledging the debate on its validity, this chapter proposes to set qualitative analysis as the primary research method, while using quantitative method mainly for a confirmatory purpose to reap the benefits of using both qualitative and quantitative methods. Accordingly, this chapter focuses on illustrating the strategy for the leading approach - the adoption of GTM principles in analysing the interview data. This chapter demonstrates the reasons for not using “pure” GTM by contextualising this strategy in the research field where the literature review and therefore the preview of the background information is required before the research access is granted. Following the elaboration of the GTM principles and their applications in this study, this chapter ends with an introduction of the research design with a particular emphasis on the process of conducting the fieldwork, including interviews and online surveys.

In the fourth part, this thesis spends three chapters discussing the issues surrounding the implementation of PbR in mental health, in particular, the driving factors for the delayed implementation from different levels and angles. Before presenting and discussing the findings from the fieldwork, Chapter 5 theoretically evaluates the mechanism of MH PbR in the policy formulation phase. On the one hand, this second stage theoretical analysis, investigates the mechanism of standardising mental health services based on the arguments established in Chapter 3. On the other hand, the mechanism discussed serves as a bridge that translates political intents to detailed policies that guide frontline practice. Therefore, given its close relationship with the fieldwork, the interview structure is derived. In particular, Chapter 5 concerns the literature and arguments essential to evaluating the conceptual and constructional validity of PbR in mental health with particular attention paid to the MHCT classification system and its subsystems, including the clustering tool, the HoNOS and the care pathways. This chapter considers the “standardisation” of conditions and treatments, which is the basic assumption of the case-mix theory and the basis for cost calculation. Through discussing the theoretical viability of “standardisation-to-the-average”, the conceptual and constructional drawbacks of the classification system and therefore, the weak foundation for cost calculation, this chapter reveals the mechanical drawbacks of MH PbR, which heralds the subsequent investigation of its implementation in daily clinical practice.

Based on the theoretical evaluation conducted in Chapter 5, Chapters 6 and 7 present and discuss the findings from the semi-structured interviews and online surveys to evaluate the policy-making process in its implementation phase. Chapter 6

tests the primary outcomes through the review of practical issues, such as the current stage of implementation in different sectors and the impacts of the initial drawbacks and external factors on daily practice. This chapter outlines the current stage of MH PbR implementation, evaluates the core elements of the MH PbR system, investigates the driving factors for the delay and proposes some suggestions for improvement. Based on the primary findings presented in Chapter 6, Chapter 7 presents and discusses the findings from quantitatively analysing the online surveys mainly for a confirmatory purpose. This chapter illustrates the use of specific analytical approaches and summarises the achieved results. The outcomes are then compared with the corresponding findings from Chapters 5 and 6.

Chapter 8 reviews the findings and insights gleaned from the three-stage analysis, and discusses the relevance and utility of its topics. By summarising the previous findings, this chapter answers the research questions that the fundamental problems of applying the market theory, the conceptual and constructional drawbacks of the clinical classification system together with the negative external factors that have hindered the implementation of PbR in mental health. By triangulating the findings from three levels, this chapter then examines its insights and contributions to mental health policy evaluation, according to which three perspectives are elaborated: policy should be evaluated within the context; one size does not fit all systems; policymakers should consider trade-offs between objectives and the inevitable. Regarding the research design of this study, Section 8.4 highlights its contributions to research design. The utility of the analytical framework and the GTM principles may shed light on the future research design. This

chapter also considers the limitations in research design, sample selection and generalizability, in an effort to provide some implications for future research. Considering that policy-making should be a learning process (Hogwood and Gunn, 1984), this chapter provides implication for future policy development, including the idea that policy should be consistent and should be tested first. The chapter concludes with a review of the thesis organisation.

2. Background of Payment by Results

Introduction

The imbalance between demand and supply has aroused concerns regarding the efficiency of public-service provision, which led to the introduction of the “internal market” in the 1990s (Randall and Williams, 2006). Since then, the NHS has experienced four major reforms from the internal market to the Third Way, the NHS Modernisation and the latest Liberalisation. Despite the changes in structure and policy during the following disjointed reforms, performance improvement and efficiency have been seen as key priorities (Shapiro, 2010).

Particularly, *Reforming NHS Financial Flows: Introducing Payment by Results* (Department of Health, 2002b) made further efforts to promote cost-efficiency by breaking the monopoly, encouraging competition, supporting patient choice and promoting quality improvement (Miraldo et al., 2006). In the context of the NHS Modernisation, PbR was introduced to replace the Block Contract and to establish a new financial framework to pay different providers on a fair and transparent basis for service delivery. Employing economic theories, the rationale for designing PbR was to contain cost, increase efficiency and promote quality through provider-side competition and patient choice (Miraldo et al., 2006), guided by the theory of the Quasi-market generated following the internal market reform.

This chapter provides background information surrounding the development of PbR as a new payment mechanism replacing the previous Block Contract. In the general context of the NHS

reforms, the birth and development of PbR was influenced by the general political context. Therefore, to facilitate a deeper understanding of PbR, this chapter illustrates its generation and development in the political context. This chapter is divided into five sections. The first two sections illustrate the economic, mathematical and working mechanisms of PbR. Drawing on the importance of contextualising policy to evaluating its impacts as discussed in Chapter 1, Section 2.3 demonstrates the fundamental reason for introducing PbR through outlining the three reforms between the 1990s and the 2000s. These three reforms indicate that policies changed according to the change in political context and that the introduction of the Quasi-market and therefore, the PbR policy, aimed to serve the purpose of controlling costs and, improving healthcare efficiency and quality. Section 2.4 introduces the development of PbR during the "NHS Modernisation". Due to the change in the political environment, the development of MH PbR is introduced in the context of "NHS Liberalisation" in Section 2.5. This chapter ends with a revelation of the delayed status of implementing MH PbR, which leads to the development of the research aim – to identify the driving factors responsible for the delayed implementation.

2.1 The birth of Payment by Results

Before 2002, Primary Care Trusts (PCTs) negotiated contracts with hospitals, in which both providers and purchasers came to an agreement on a total price of service provision without specifying the amount of activity (Pate, 2009). The fixed sum of money for a broad range of services was calculated largely based on historical funding and locally negotiated annual increase. Without specifying the amount of activity, the lack of

incentives for providers to reduce waiting times and the limited participants under the Block Contract had weak incentives for quality improvement (Marshall et al., 2014). Moreover, there was no specific penalty mechanism for commissioners to withdraw funding when providers failed to meet the requirements. The recognition of the lack of capacity in health care services and the needs for cost-effectiveness led to the reform of "Modernisation" (Macintyre, 2000). Accordingly, in 2003, the government introduced PbR to establish a new financial framework to pay different providers on a fair and transparent basis for service delivery and to promote quality improvement (Miraldo et al., 2006).

Based on the market theories, PbR was developed with the assumption that participants' behaviours follow the demand-supply interaction in a fully competitive market. The concept of PbR consists of two main components: a nationally agreed set of prices for healthcare activities called a "tariff", and a classification system in which cases could be categorised into specific treatment groups that are similar in healthcare needs and resource consumption (O'Connor and Neumann, 2006). Instead of the lump sum payment under the Block Contract, PbR uses a fixed price system where national tariffs are assigned to each classification group according to which commissioners pay a fixed tariff for each patient treated in the same group (Boyle, 2007). This creates a linear relationship between the amount of activity the providers undertake and the amount of income they receive. On the one hand, it is regarded as a financial incentive for providers to increase capacity as the market theory predicts (Miraldo et al., 2006), particularly under *Money Follows the Patient* policy (Secretary of State for Health, 2002) that entitles commissioners the right to purchase healthcare services from a

large range of providers. Without price competition, providers are encouraged to improve quality to attract patients. On the other hand, the nationally-fixed tariffs make it clear how much they will receive as activity increases in advance, according to which providers could make adjustments to resource allocation (reduce unnecessary services or cross-subsidize non-profitable services with profitable services) to reduce costs when their costs exceed the corresponding national tariffs (Appleby et al., 2012). The following subsections demonstrate the economic and mathematical theories behind PbR to illustrate how PbR is designed to serve the aforementioned purposes.

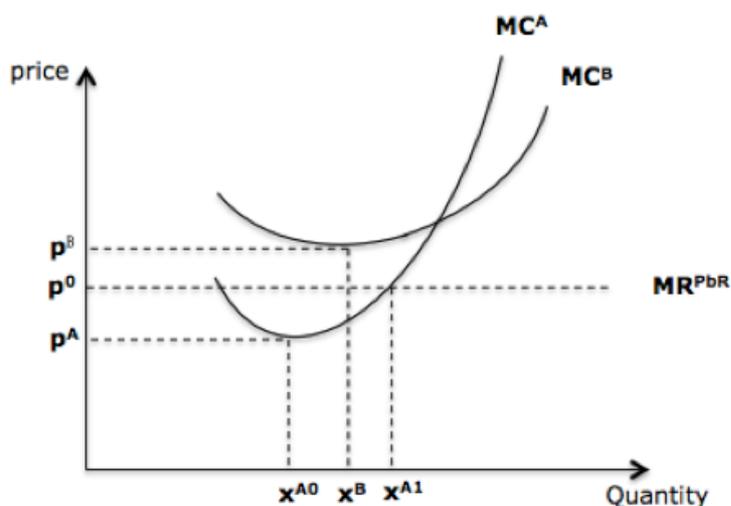
2.1.1 The economic theory behind PbR

The demand of patients is the target that PbR is set to meet; thus, the demand is pre-assumed to be unlimited in the theoretical economics model. According to the commissioner/patient relationship that posits commissioners make demand-side decisions on behalf of patients, the following discussion simplifies the patient-provider-commissioner model into a commissioner-provider model to explore the theoretical basis for PbR. Therefore, the relationship between a provider's income and their capacities depends on the interaction between their costs and the national tariffs.

Figure 2-1 illustrates the economic mechanism of PbR in theory. The extent to which this financial arrangement influences a provider's behaviour depends on the relationship between their marginal costs and the fixed national tariff. MC_A and MC_B represent the marginal costs for healthcare resource consumption of two different providers. Under the Block Contract, providers and commissioners negotiate the price and

the volume of a certain type of service locally. Thus, Provider A could provide service activity at x^{A0} amount and be paid at the price of p^A while Provider B could provide x^B amount of activity at the price of p^B (when marginal cost equals marginal price). The introduction of the nationally-fixed price p^0 calculated from the national average unit costs under PbR means the provider could not gain extra profit until its marginal cost curve intersects the flat marginal revenue curve (MR_{PbR}) under PbR (Baumol and Blinder, 2012). For Provider A, the relationship between MC_A and MR_{PbR} suggests that its profit reaches the highest at the amount of x^{A1} . In this case, the financial incentive encourages providers like Provider A to increase their capacity and thus improve their efficiency. By contrast, Provider B has a marginal curve depicted as MC_B , with higher marginal costs than MR_{PbR} in every level of activity. In other words, it costs more than this provider would receive in every case. Therefore, there is no choice but to reduce unnecessary costs in order to attain financial balance. In other words, the intention to avoid financial risks also stimulates cost-saving and efficiency enhancement of providers, as seen with Provider B (Mannion et al., 2008). Generally speaking, the nationally fixed tariffs are expected to reduce the variation in healthcare costs and as a result, the total expenditure. Meanwhile, the nationally-fixed tariffs rule out price competition, according to which providers can only compete on service quality to attract more patients. This facilitates the improvement or, at least, the maintenance of service quality. In addition, the regulatory agencies exercise the authority on behalf of the government to guarantee the quality of service.

Figure 2-1 Relationships between marginal costs and the PbR price



2.1.2 The mathematical theory behind PbR

The above illustration was developed without taking account of the restriction of one's capacity, which is often not the case in the real healthcare market. Still, based on the assumption that providers pursue the maximisation of profit, the formula below illustrates providers' behaviours regarding the adjustment of resource allocation in a context of limited capacity (Scott et al., 2011).

For this example, assume there are two HRGs/MHCTs, the amounts of each HRG/MHCT are x_1 and x_2 ; the quality of services subject to these two groups are y_1 and y_2 , respectively; F represents the indirect costs such as laundry that could not be calculated by the individual activity but among a number of activities. Thus, the total costs would be:

$$C = c_1(x_1, y_1) + c_2(x_2, y_2) + F$$

$$x_1 \leq D_1$$

$$x_2 \leq D_2$$

$$X \geq x_1 + x_2$$

Where D denotes to the general demand for the particular service and X denotes the provider's capacity

Further, assume the national tariffs for these two groups are p_1 and p_2 , thus, to maximise the revenue, the formula is:

$$\max_{x_1 x_2 y_1 y_2} \{p_1 x_1 + p_2 x_2 - [c_1(x_1, y_1) + c_2(x_2, y_2) + F]\}$$

Since there is no link between income and quality, the provider would set the minimum quality under the premise of meeting the national standards. Therefore, the formula could be simplified to:

$$\max_{x_1 x_2} \{p_1 x_1 + p_2 x_2 - [c_1(x_1, \bar{y}_1) + c_2(x_2, \bar{y}_2) + F]\}$$

$$X \geq x_1 + x_2$$

Take λ to denote the Lagrange multiplier, the optimisation could be either

$$p_1 - c_{1x} - \lambda = 0$$

$$p_2 - c_{2x} - \lambda = 0$$

$$X = x_1 + x_2$$

Or

$$p_1 - c_{1x} = 0$$

$$p_2 - c_{2x} = 0$$

In the former case, the formula indicates that the capacity of the provider is large enough when the fixed prices would always exceed the marginal costs in these two groups. Therefore, the provider would expand the activity across both groups. In the

latter case, there is a time that the marginal costs would equal, or even exceed, the fixed price. To make a profit or, at least, avoid budget deficits, the provider will make an effort to meet the first condition. When $p_1 - c_{1x} - \lambda = 0$ and $p_2 - c_{2x} - \lambda = 0$ could not be met simultaneously, the provider would adjust the proportion of x_1 and x_2 to reach the equation as follows:

$$\frac{p_1 - c_{1x}}{p_2 - c_{2x}} = 1$$

In other words, in this constrained case, the provider would increase those activities in the group with larger differences between the fixed price and the marginal cost and reduce those with less profit (Farrar et al., 2007).

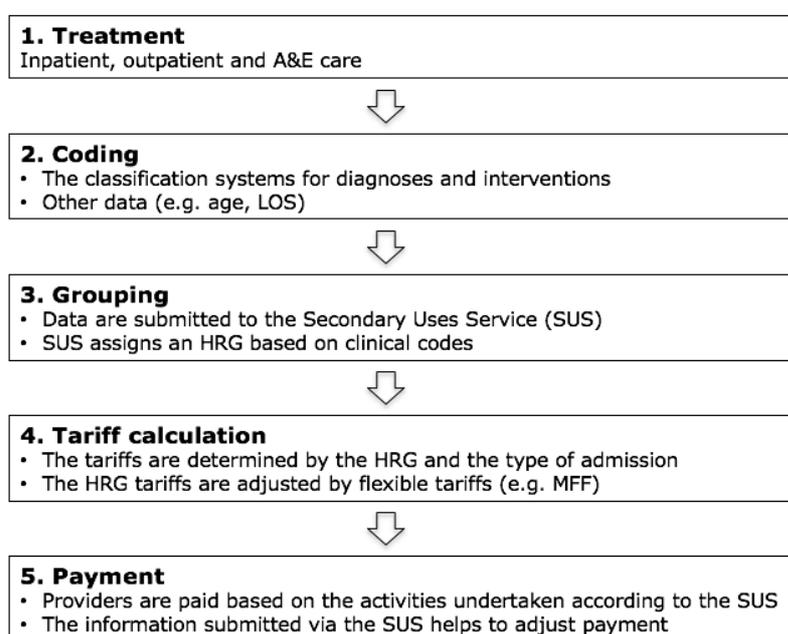
In summary, the economic theory behind PbR indicates a shift of focus to performance management in a context that the relationship between the costs of providing a particular service and the corresponding nationally fixed tariff influences providers' decision on whether to increase capacity or to reduce excessive costs (Conrad and Uslu, 2011).

Besides the impacts on providers' behaviours, the introduction of PbR is also expected to facilitate commissioners' better management of the demand for care since every single admission is taken into account. The commissioning process may allow the government to gain more knowledge of needs, which is underpinned by the transparent information system resulted from the clinical classification system.

2.2 Working mechanisms of Payment by Results

Figure 2-2 outlines the working mechanism of PbR, which consists of a process of data collection, coding, grouping, cost calculation and payment setting. For the sake of clarity, this section begins with an overview of the whole information system as a whole and then it focuses on the two primary elements: the currency design and the payment settlement.

Figure 2-2 Process of PbR data collection (Department of Health, 2012b)



2.2.1 The process of information flow

Due to the incomplete information system of PbR in mental health and the similar theoretical basis it shares with the one in acute services, the latter is used as a theoretical basis to illustrate how this system functions.

According to Figure 2-2, when a patient finishes treatment and is discharged from a hospital, a clinical coder translates the patient's record into codes that describe the particular information about the patient's diagnosis (ICD) and

interventions (Office of Population Censuses and Surveys (OPCS)) in a standard format (Department of Health, 2012b). The codes, together with non-clinical information such as age and date of admission and discharge are stored in the hospital's local system called the Patient Administration System (PAS). With the categorised information stored, the hospital submits an extract of the PAS to the Secondary Uses Service (SUS) in a standard format of Commissioning Datasets. The SUS collects and stores the nationwide data and provides patient data for different purposes. By taking account of other patients' records cases will be assigned to certain HRGs based on the ICD and the OPCS codes using the software called "grouper". By assigning the actual costs into different groups, the SUS calculates the national level costs and set the corresponding prices using a top-down statistical analysis (Street, 2006). The prices are mainly set according to the HRG code and the type of admission. Additionally, special adjustments are incorporated for unavoidable geographical differences, specialised care, quality promotion, etc. (Department of Health, 2002a).

Guidance on the NHS Standard Contract for 2012/13 (Department of Health, 2011) announces that commissioners should use standard contracts to commission healthcare services using the PbR tariffs for the services covered by PbR and the agreed non-tariff prices (between providers and commissioners) where the national PbR tariff does not apply. The calculation mechanism of the nationally-fixed tariffs is illustrated in the section below.

2.2.2 Tariff calculation

Unlike the Block Contract, PbR is a data-driven system that

requires the collection and categorisation of the patient-level data. The foundation of PbR is the effectively built blocks of currency that group the codes into countable units performed by the “grouper”. According to the currencies and their cost-related information, prices are then calculated and set for each currency, which is called a “tariff” (Jones, 2012). This section will introduce the currency establishment, the general tariff calculation mechanism and the calculation methods to illustrate the process of producing national tariffs.

As previously mentioned, the complex nature of mental disorders determines the differences in needs assessment and service management between acute services and mental health services. In other words, although sharing the same structure, PbR for acute services and PbR for mental health were designed with two separate clinical classification systems. Considering the incomplete MH PbR tariff calculation system, the following subsections illustrate the tariff calculation mechanism of PbR for acute services as a theoretical basis of the subsequent MH PbR within which the mental health classification system will be discussed later.

2.2.2.1 Acute services

1) The establishment of currency

As the unit of payment under PbR, currencies are standardised groups dependent upon clinical treatments and resource consumption. In other words, patients in the same group share similar needs/diagnoses and will receive similar clinical treatments (Fairbairn, 2007). Four key components illustrate the process of currency establishment: ICD-10, OPCS-4, HRG and reference costs. Published by the World Health Organisation

(WHO), ICD-10 categorises diseases into specific groups based on signs, symptoms, and diagnosis (Department of Health and Human Services, 2001). The version applied in England contains 19,000 codes (Foster-McBride, 2012). Developed by the Office of Population Censuses and Surveys, OPCS-4 translates operations and interventions performed during a treatment spell into alphanumeric code. The latest version OPCS-4.6 includes over 9,000 codes (Foster-McBride, 2012). HRG is adopted as the “grouper” to integrate ICD-10 and OPCS-4 codes into numerable groups based on the similarities of diagnosis and resource consumption, which enables the associated tariffs to be set at a sensible and workable level (Jones, 2009). Adopting the case-mix principle, HRG reflects a system where a mix of care is provided for a patient and the individually-varied treatments are administrable. With the development of the classification system, HRG-4, which is the latest version, comprises of 1,500 case groups, covering 21 chapters of the body system (Department of Health, 2012b).

By assigning cases to different HRGs, information related to direct costs, such as drugs, clinical items and equipment consumption, could be easily identified in an activity. Further, indirect costs and overheads are collected and summarised into the corresponding currencies (Pate, 2009). The following subsection further illustrates how national tariffs are calculated based on the information obtained via the PbR information system.

2) The tariff calculation mechanism

The calculation mechanism of PbR is based on the principle of “standardise-to-the-average”. Within each HRG, national

average unit costs are derived from the mean value of the average total costs from all NHS providers, which is the “average of the average” (Self et al., 2008a). Generally speaking, there are three major steps within the calculation process: 1) against any case group of each provider, the unit cost is derived from the division of all costs for producing certain outputs by the total number of units; 2) dividing the sum of all providers’ unit costs by the number of providers becomes the national average unit cost for the particular case group (Self et al., 2008a); 3) the mean value is regarded as the cost with the highest frequency in the bell-shaped curve of the cost distribution, based on the statistical assumption that the costs from different providers follow a normal distribution. In this context, “deviances” are categorised as the extremes of both sides of the cost-distribution curve and the process of pursuing “standardised cost” is to reduce deviance employing “standardisation-to the-average” principle (Department of Health, 2012b).

In the latest HRG tariff calculation system:

HRG group base tariff \approx latest average unit cost + price inflation
+ uplift for “safety and quality” – assumed efficiency
improvement

By taking unavoidable differences into consideration, some flexible tariffs have been introduced as the supplement of the standard HRG tariffs. The Best Practice Tariffs, the Market Force Factor (MFF) and the Commissioning for Quality and Innovation (CQUIN) are the main components of the supplement to make the system more flexible and thus ensure that PbR is a tool rather than a straitjacket (Department of Health, 2012b). Best Practice tariffs are set at day case rates for the use of specialised

units to encourage patient care with both high quality and cost-effectiveness (Secretary of State for Health, 2008). To compensate the unavoidable cost differences due to geographic differences, MFF weights capitation formula to calculate the final tariff.

Therefore, in HRG4 tariff calculation system:

Final tariff \approx (HRG group base tariff + Best Practice Tariff) * MFF index

Given the differences in nature, despite the same logic and a similar structure with that in acute services, MH PbR is developed based on a classification system following another philosophy: classification based on needs. Due to the delayed implementation of this clinical classification system, there still lacks a tariff calculation system appropriate for MH PbR. Therefore, the next subsection illustrates the working mechanism of MH PbR by focusing on the clinical aspect.

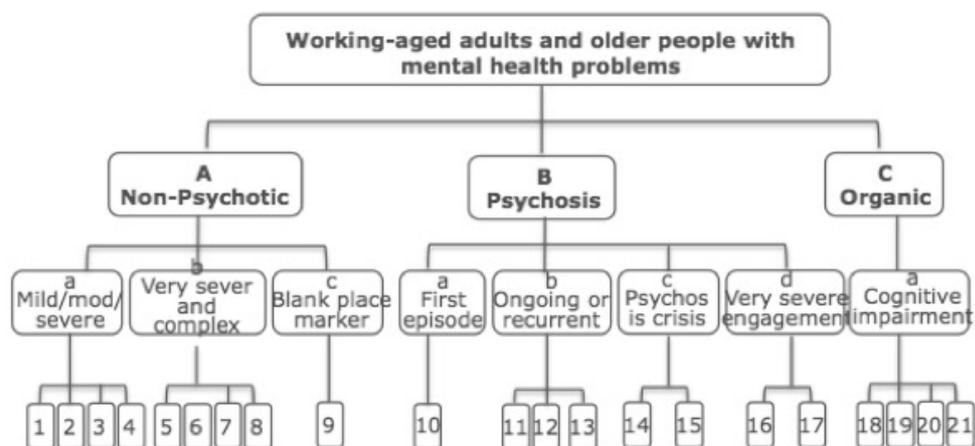
2.2.2.2 Mental Health PbR

Attempts to predict the resource implications of treating individual cases and therefore, to set a tariff in acute settings, have focused on defining case groups. These reflect an approach based on the assumption that, to some useful degree, diagnosis predicts the cost of providing care. In this context, physical medicine and surgery, "diagnosis" incorporates an understanding of why the patient is distressed, in pain or disabled to a level of certainty that a psychiatric "diagnosis" cannot. As a result, acute care diagnoses can often provide a sufficiently accurate prediction of what appropriate treatment might involve, and act as the basis of a tariff system. That is

not the case in mental health settings. Rather than basing MH PbR tariffs upon “diagnosis”, a different system has evolved, which is known as “clustering”. It is a process of classifying cases into 21 clusters that are considered to have distinct and distinguishable treatment resource implications. This classification is supported by a process and an algorithm that are together known as the MHCT, and it is intended to form the basis of tariff allocations and payments in mental health settings.

The MHCT firstly classifies a patient’s difficulties as “non-psychotic”, “psychotic” or “organic”. These are generally agreed distinctions, although the phenomenological boundary between “psychosis” and other forms of disturbed mental state is not fixed. The MHCT sub-classifies cases falling into each of these “super-clusters” by symptom severity. These sub-classifications and the relationships among them are discussed in Figure 2-3. Each of the 21 clusters is considered to define a group of patients with similar healthcare needs and resource requirements (Care Pathways and Packages Project, 2011), and therefore, a group for which a tariff can be derived and applied.

Figure 2-3 Mental Health Clustering Tool Decision Tree



Sub-classification into one of the seven second order groupings is made on the basis of clinical rules of thumb reflecting the grouping's description, but allocation to one of the 21 definitive clusters, which are intended to carry resource implications is more formally supported by scores on the HoNOS (Wing et al., 1998) and a Summary Assessment of Risk and Need (SARN) (Self et al., 2008a).

The HoNOS is a 12-item scale designed to estimate the severity of psychological disturbance. It was developed during the 1990s in pursuit of a measure that could be used to quantify changes during psychiatric treatment and thus to support expectations of verified service efficacy referred to in *Health of the Nation* (Secretary of State for Health, 1992; Thornicroft et al., 1992). The Supplementary SARN estimates the degree of disturbance across domains that are considered to reflect the most notable difficulties that can arise in relation to individuals with mental health difficulties. Each of the eighteen items is scored on a 0 – 4 basis, whereby 0 reflects “no problem” in that domain and 4 reflects “severe or very severe problem”. On the basis of psychometrics derived from some 530 sets of scores, an algorithm has been developed which links a profile of scores to one or another of the 21 definitive clusters. Figure 2-4 illustrates the 18 items, how an imaginary case might have scored and what the profile was supposed to be for Cluster 19, effectively someone with a significant degree of dementia.

Figure 2-4 Colour coded rules of rating grids

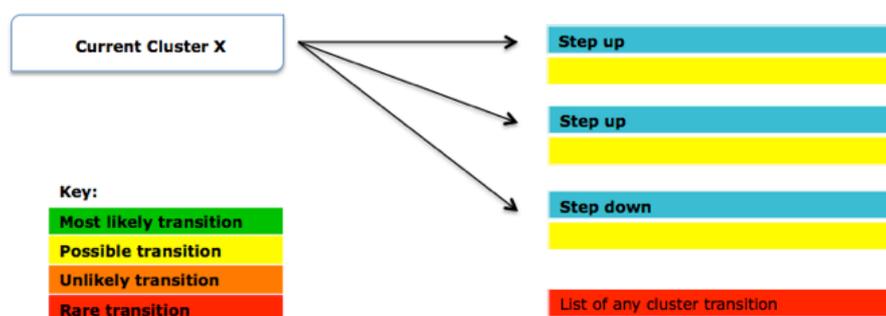
Description	No	ITEM DESCRIPTION	SCORE				
			0	1	2	3	4
Likely diagnosis	1	Overactive, aggressive, disruptive or agitated behaviour		x			
	2	Non-accidental self injury		x			
	3	Problem drinking or drug taking		x			
	4	Cognitive Problems			x		
	5	Physical illness or disability problems		x			
	6	Hallucinations and Delusions		x			
	7	Depressed mood		x			
	8	Other mental and behavioural problems		x			
	9	Relationships		x			
	10	Activities of daily living		x			
	11	Living conditions		x			
	12	Occupation & Activities		x			
	13	Strong Unreasonable Beliefs	x				
Impairment	A	Agitated behaviour/expansive mood	x				
	B	Repeated Self-Harm	x				
	C	Safeguarding other children & Vulnerable dependent adults	x				
	D	Engagement	x				
	E	Vulnerability	x				
Risk		Must score					
		Expected to score					
		May score					
		Unlikely to score					
		No data available					
Course							

As treatment proceeds and is reviewed and adjusted, needs for treatment can change. Figure 2-5 illustrates the process of reassessment and cluster reallocation that is intended to keep estimates of resource implications up to date with patients' changing needs (Department of Health, 2012a). Data populating these pro forma are generated at specified intervals by clinical staff in the course of their work with clients, theoretically as a by-product of routine assessments of progress; an agreed element of good clinical practice.

Figure 2-5 Cluster and care transition protocol

Care Transition Protocols

Cluster	Step-up criteria (the following criterion is met)	Example local discharge criteria for MH services	Step-down criteria (the following criterion is met)



Cluster allocation is only half of the PbR process theoretically linking clinical conditions to resource implications on a case-by-case basis. For that to happen, cluster allocation has to imply the suitability of a particular, costed package of care. Identification of the care packages associated with clusters defined in these ways was still under development at the time of writing (October 2015). Evans-Lacko et al. (2010) outline two core components of care pathways: a) the types of service provided in one particular pathway subject to one specific cluster; and b) timeline over which this series of services is conducted. In theory, care pathways serve as templates to show how patients enter health care, standardise how treatments are provided in what sequence, and predict when and in what condition, patients leave the healthcare settings. The standardised care packages are expected to reduce inappropriate variations in service provision among patients with similar needs categorised by MHCT and to promote multi-disciplinary teamwork in the clinical aspect (Cabana et al., 1999). In the financial aspect, care pathways are expected to

facilitate the calculation of clinical costs and therefore the corresponding national tariffs (Jones, 2004).

Regarding Marshall et al.'s (2014) insight, the successfulness and impact of one system relies not only on itself but also on the previous system it is designed to replace, the political context and other external factors. In other words, the investigation of the general political background helps understand the generation of the PbR system. Additionally, the changing political environment further facilitates understanding of the obstacles to implementing PbR in mental health compared with that in acute services. Therefore, the subsequent three sub-sections illustrate the generation and development of PbR by contextualising it within the NHS reforms since the 1990s.

2.3 The context of PbR: the NHS reforms

This section provides an overview of the process of NHS reforms from the 1990s to the 2000s, during which policies developed alongside the changes in the external environment and the political power structure. The continued shifts in balance between decentralisation and centralisation on the one hand, outlines the side effects of each approach to demonstrate the origin of reforming the payment system (this will be further discussed in Section 2.4), while on the other hand paves the way for the following argument regarding the relationship between the fast-changing policies and the frontline clinicians' reluctance to engage (this will be discussed in Chapter 6).

2.3.1 The Internal market: The birth of the market

Criticisms of the poor efficiency of public services together with the rapid development of the non-governmental sectors, has indicated that other sectors may be able to deliver some services with higher efficiency. Since the introduction of the New Public Management, the “internal market” reform under Thatcher and Major decentralised and externalised public services from the central government and replaced the centralised system with a market that was expected to stimulate efficiency through the provider-side competition (Torres and Pina, 2002). Central to the Internal Market was the process of commissioning led by the purchaser/provider split, in which the government participated as both the purchaser and the regulator through the use of purchasing power (McCrudden, 2004). As indicated by *Working for Patients* (Secretary of State for Health and others, 1989), instead of the previous model in which District Health Authorities (DHAs) took full responsibility for purchasing services as well as managing performance, the new contract-based system was established to separate the responsibility of purchasing from that of provision (Le Grand and Vizard, 1998). It was believed that choosing the most appropriate provider from a broad list could result in lower costs and greater efficiency of service provision (HM Treasury, 2005).

The main result of the Internal Market reform was the establishment of two new organisations including NHS trusts and GP fundholders. The purchaser/provider split in addition to the establishment of these two organisations, suggested a decentralisation of power, as well as an incentive to the provider-side competition in a healthcare market (Klein, 1995). Despite good intentions to improve efficiency and quality of service delivery, it ended with criticisms of the fragmented

sectors led by the decentralisation and the purchaser/provider split, the opportunistic behaviours led by the short-term contract (Kelly, 2007), the high managerial costs on procurement and the potential risk of the inequality of service brought about by the managed market (Ham, 1996).

2.3.2 The “New NHS”: The third way

The election of the Labour government under Tony Blair in 1997 brought an end to the “internal market”. The following reform called the “Third Way” was different from both the Internal Market and the application of the centralised plan by previous Labour governments (Harrison, 2002). Moving away from the over-concentration on competition, *The New NHS* plan (Secretary of State for Health, 1997) focused on providing high quality services by promoting a stable partnership between purchasers and providers. The establishment of the white paper highlighted that the emphasis would be placed on public health, primary care and evidence-based health care (Nettleton et al., 2008). During this period, the document set out a broad framework for setting national targets and standards for the continuous improvement of service quality as well as indicated a restructure of the NHS for a higher efficiency of primary care (Ham, 2010).

2.3.2.1 Targets and standards

Instead of the fragmented sections in the managed-market, the New NHS was devoted to reducing the geographical and organisational variations through centralising authorities as well as establishing national targets and standards. By bringing an end to the Internal Market that had only focused on efficiency,

the Blair government highlighted the importance of paying attention to health improvement, fair access, effective delivery, health outcomes and patient experience (Ham, 1999). The new organisation of National Institute for Health and Care Excellence (NICE) was established in 1999 to develop national service frameworks, as well as nationally unified targets and standards in order to reduce variations in services (Gray and Harrison, 2004). Based on the idea of "evidence-based health services", NICE was entitled with two responsibilities: 1) to undertake evidence-based appraisals including cost-effectiveness and clinical effectiveness of clinical interventions; and 2) to grant permission to evidence-based clinical guidelines for the management of particular conditions (Secretary of State for Health, 1998). Combined with the National Electronic Library for Health, the information-share function was expected to ensure the accessibility of patient information and the related service guidelines.

At the same time, the new organisation Commission for Health Improvement (CHI) was established in 1999 as a statutory body "at arm's length from government" for inspection and regulation (Secretary of State for Health, 1998). Besides the inspection on the clinical targets, financial targets were taken into consideration through the initiation of the Comprehensive Spending Review (CSR) that provided an approach to public spending in general and the NHS spending in particular. By combining the performance targets for different services, the CSR highlighted the cost-efficiency of investment (Chancellor of the Exchequer, 1998).

2.3.2.2 Service delivery

Another important issue of the reform was to build up new relationships between the Department of Health and the NHS organisations for a greater quality of health care delivery (Tailby et al., 2004). Since the establishment of CSR resulted in education and health receiving substantial increases in their budget, the NHS net expenditure increased by £4,900 million between 1997/8 and 1999/2000 (over 3.2% annual growth in real terms), since when the increase of rate rose (Harker, 2012). Funded by large investments, more strategic leadership and authorities were further decentralised to the local level to break down barriers between agencies and to encourage partnership not only within the NHS, but also across a wider range (Department of Health, 1999).

Instead of the previous structure in which GP fundholders took the responsibilities for providing healthcare services and buying part of the secondary services, Primary Care Groups (PCGs) were introduced to integrate the healthcare related primary resources. The involvement of local authorities freed up health authorities to concentrate on the strategic plans for the general population. Within the reform, the establishment of PCGs was the most important innovation that indicated a clear commitment to maintain the primary-care-led NHS and to enlarge its coverage (Ham, 2009). As an incentive for a better communication and resource transformation between primary and secondary care, PCGs were granted the power to control resources and unify different elements within the healthcare budget (Secretary of State for Health, 1997). Therefore, the shift in power to the local level enabled PCGs to be responsible for commissioning local healthcare services with higher efficiency while freeing up health authorities to assess the

health needs of the population they served and thus concentrate on the public health agenda.

2.3.3 The NHS Modernisation: The Quasi-market

Published in July 2000, *The NHS Plan: A Plan for Investment, A Plan for Reform* (Secretary of State for Health, 2000) on the one hand outlined the failure of the NHS to provide patient-centred services due to over-centralisation, while on the other hand marked the start of the “Modernisation” (Greenhalgh et al., 2009). According to Petsoulas et al. (2011), there were four major objectives of the policies established within the NHS Modernisation: 1) more investment to expand capacity; 2) more emphasis on service quality including establishing targets and arm’s-length regulation; 3) more decentralisation through granting Foundation Trusts (FT) autonomy and shifting power to the front line; and 4) more intense provider-side competition stimulated by the introduction of PbR. The theoretical foundation of this reform was the use of the Quasi-market: while the government can retain the right to plan and regulate healthcare services, the devolution and the implementation of PbR can promote the provider-side competition to improve efficiency and quality.

2.3.3.1 Top-down management: Investment and targets

The government highlighted the principle of providing patient-led services as a means to improve healthcare performance. *The NHS Plan* (Secretary of State for Health, 2000) was established to describe how the resources made available to the NHS would be used to deliver services to patients. To better serve the reality and expectation, the NHS Plan committed more

investment to the NHS to increase staff's salary, hire more staff, place more beds and update facilities to enlarge the capacity of healthcare services (Wanless et al., 2002). To support the increase in capacity, in the spending review for 2002, the Chancellor of the Exchequer announced to secure the increasing in funding of over 7% per year in terms from 2002/03 to 2007/08 (Wanless et al., 2002). Accordingly, the budget for the expenditure of the NHS in England would reach £90 billion in the fiscal year of 2007/08. Within the budget, the staff salaries and wages would be the largest single item of expenditure comprising 2/3 as in total to an additional £2.9 billion per year. The national plan also pledged to employ 7500 more consultants, 2000 more GPs and 20,000 more nurses (Secretary of State for Health, 2000).

Facilitated by the investment, targets were set or adjusted in the plan. Among the targets, one of particular importance was cutting waiting times for treatment. The target maximum waiting times in hospital was reduced to three months for outpatient appointments and six months for inpatient treatment by 2005 (Wanless et al., 2002). The following *The NHS Improvement Plan: Putting People at the Heart of Public Service* (Secretary of State for Health, 2004) made a further commitment to limiting the waiting times from GP referral to secondary care to no longer than 18 weeks by 2008. Other targets were set for a better access to primary care, the improvement of patient satisfaction and the reduction in the health gap between the best off and worst off (Ham, 2009). To ensure the implementation of the new targets and to promote greater performance of the NHS organisations, the responsibility of CHI was strengthened and connected to a new "star rating" system. This external body held a rolling

programme of reviews, visiting every trust over a period of 3-4 years with the clinical guidelines issued by the NICE (Department of Health, 2005b). Directly related to this system, the “earned autonomy” system rewarded high-score trusts (Granted as FTs) with greater operational freedom to manage their services with less interference from the central organisations, as well as significant investments in local communities, staff and other stakeholders (Secretary of State for Health, 2002).

2.3.3.2 Devolution: Attention to a bottom-up management

In addition to granting the FTs autonomy, the government further undertook decentralisation by shifting power to the frontline by adjusting the NHS structure. Since 2002, the devolution of authority could be categorised into two parts: reducing the priority of the central organisations and integrating resources and responsibilities at the local level (Department of Health, 2001). At the central level, the NHS Executive within the Department of Health (Lindblom and Woodhouse) lost its separate identity under the leadership of a combined permanent secretary and the NHS chief executive. With the establishment of Strategic Health Authorities (SHAs), the number of health authorities reduced from 95 to 28 (the number of SHAs later further reduced to 10 in 2006), and the 8 Regional Offices were replaced by 4 directorates of Health and Social Care (Ham, 2009). At the local level, the small local-based purchasers PCTs (later reduced from 303 to 152 in 2006 (Boyce, 2012)) were established to take the place of the previous PCGs (Allen, 2002a). By streamlining the work of the central organisations and facilitated by a new payment system PbR, PCTs were expected to control over more than 75% of the NHS budget by 2004; reiterating the slogan “what counts is what works” (Rawnsley, 2001; Stevens, 2004). With more resources and powers granted to PCTs, they were encouraged to purchase secondary services aggressively on behalf of patients and to choose hospitals according to quality and cost. Supported by *Commissioning A Patient-led NHS* (Crisp, 2005), the roles of PCTs and GPs have been reiterated as that PCTs were expected to focus on promoting public health and thus ensure universal coverage of “practice-based commissioning” by the end of 2006, whilst GPs would take major responsibility for commissioning

services.

To be consistent with the prevailing political commitment to reduce waiting times and the political consideration regarding bringing in the market mechanism, the government designed PbR, the activity-based funding system to replace the Block Contract, although it has been proved to be effective in containing costs (O'Reilly et al., 2012). Regarding capacity as one target, the newly established PbR system under which hospitals would be funded based on the work undertaken was believed to promote greater healthcare performance (Boyle, 2007).

2.3.3.3 The Quasi-market: The provider-side competition

In the *Reforming NHS Financial Flows: Introducing Payment by Results* (Department of Health, 2002b), the government made the commitment to move from a monopoly provider of healthcare services that ran from Whitehall to providing a larger range and greater diversity of services. In addition to the provider-side competition, the establishment of nationwide standards and transparent inspection bodies were also expected to guarantee the quality of healthcare services. The following subsections illustrate the working relationships among these three interest groups:

1) Providers

Besides the 115 NHS FTs, three main groups of sectors were entitled as the providers of primary healthcare services: individual private providers consisting of GPs, Dentists,

Pharmacists and Opticians; PCT Provider Units and Independent Sector Providers. More voluntary sectors became involved to provide healthcare services offering patients a wider range of choices in this new system, which helped to reduce waiting times (Ham, 2009). The independent provider sectors included three main groups: 1) not-for-profit providers, 2) for-profit providers and 3) the alternative providers for primary care. Local voluntary groups, Foundation Trusts, non-profit social enterprises and co-operatives were encouraged to engage in the service delivery process. Based on the nationally-fixed tariffs, the increase in the number of providers was expected to intensify the provider-side competition and thus increase quality (Department of Health, 2006).

2) Commissioners/service users

On the commissioner side, PCTs and Practice Based Commissioners were entitled to buy primary services from different providers, including voluntary sectors and individual private providers as well as part of the secondary care from hospitals. With the help of expertise from private companies, various resources were offered to support the commissioning programme, which complied with the competition theory of the Internal Market.

Regarding secondary care, the *Money Follows the Patient* policy (Secretary of State for Health, 2002) under the PbR system was believed to increase purchaser power with a much stronger voice from the patient side (Department of Health, 2002a). As committed by the government, PCTs were required to provide choices among a variety of providers to patients who were awaiting referrals to hospitals, one of which must be an

independent provider (Dixon et al., 2010). Thus, the patients' own choices for better-performed hospitals acted as a "market choice" that incentivised providers to improve their quality and efficiency to increase profit or avoid financial risks in this payment system (Allen, 2009b).

3) Regulators

In this system, the establishment of the regulators implied a shift from a hierarchically managed healthcare system to a regulated one carried out by various arm's-length agencies on behalf of the government (Nettleton et al., 2008). Under *Health and Social Care Act* (House of Commons, 2003), a new executive non-departmental regulatory body called "Monitor" was established to ensure the quality of performance through authorising, monitoring and regulating the NHS FTs (more duties were granted under *Health and Social Care Act* (Secretary of State for Health, 2012)). Alongside the release of *Delivering the NHS Plan* (Secretary of State for Health, 2002) the establishment of the Commission for Healthcare Audit and Inspection (CHAI) replaced the CHI with responsibilities for overseeing providers including both public and private sectors. The establishment of this new organisation (was later replaced by the Care Quality Commission (CQC) in 2009) indicated a greater attention to regulation (King's Fund, 2008). The "bottom-up" mechanism instead of the "top-down" regulatory structure placed more emphasis on the front line, which agreed with the market theory that let service users' choices be the driver for higher efficiency and quality. Through expanding the type of providers, the NHS FTs alongside other third-party providers were expected to provide a broader range of choices for patients; the non-price competition mechanism was

supposed to promote the self-improvement of providers to achieve better care services, and the regulation and inspection systems were expected to guarantee service quality.

2.3.4 The generation of PbR

Table 2-1 outlines the process of the NHS reforms, from a decentralised market to a centrally-controlled system and then to the Quasi-market under the Modernisation. This illustrates the fundamental idea of the generation of the Quasi-market through outlining the different problems of the previous two systems.

Since the 1990s, the radical reform has introduced the market in the healthcare system. The purchaser/provider split promoted the competition among providers and put more emphasis on efficiency, which was the basis for the subsequent reforms. With the attention paid to the long-term purchaser-provider partnership and the process-oriented regulation, the new Labour initiated a reform advancing to an evidence-based healthcare system. By setting national targets and inspection sectors, regulation and inspection were expected to be evidence-based and therefore, more convincing. This reform established the framework of the ten years' Modernisation.

Table 2-1 The NHS reforms 1990s-2000s

Reform	Direction	Features	Problems
Internal market	Market theory	Purchaser/provider split Provider-side competition	Fragmented sectors Risks on equity & quality
The new NHS	Evidence-based activity Integrated local services	National targets & inspection	Lack capacity, standards & incentives
Modernisation	Top-down management	National targets & rating system	

By recognising the problems of over-centralisation and the lack of incentives for service delivery (capacity and quality), the government undertook the reform called “Modernisation”, with an expectation to increase patient choice and thus stimulate the competition among providers while continue to maintain government regulation. Within this reform, the most prominent change was the reform of the payment system: using PbR to replace the original Block Contract. The radical reform complied with the general idea of the Modernisation by applying the market mechanism while at the same time ensuring service quality using the nationally set care pathways and targets. Therefore, the next section illustrates how PbR was initiated and developed underpinned by a considerable amount of financial investment during the NHS Modernisation.

2.4 The development of PbR in acute services

Since the NHS Modernisation, the past decade has witnessed the development of PbR regarding the refining of the classification and payment system and enlarging its coverage from acute services towards mental health. Given the change in political power and policies when expanding to mental health, the following subsections first outline the development process of PbR before the NHS’s fourth reform in 2010, leaving the development of MH PbR to Section 2.5. Within the NHS Modernisation, the development process could be divided into three main phases, including the preparatory phase from 2003/04 to 2004/05, the transitional phase from 2005/06 to 2007/08, and the major change phase from 2008/09 to 2009/10.

2.4.1 The preparatory phase 2003/04-2004/05

PbR was first implemented in a small range of services in 2003/04 when the cost-and-volume agreement was introduced to six surgical specialities including Ophthalmology, Cardiothoracic surgery, ENT, Trauma and Orthopaedics, general surgery and urology (Secretary of State for Health, 2002). Nevertheless, the prices were still determined locally through the discussion between providers and local purchasers rather than being based on the nationally-fixed tariffs. National tariffs were first introduced in 15 HRGs, which were considered as key regions where national standards should be implemented to reduce waiting times (Department of Health, 2012b). In the fiscal year 2003/04, 15 HRGs against elective admission with national tariffs were implemented in all trusts. Only the growth activity delivered was funded by the national tariffs, while the baseline activity was still funded at a locally negotiated rate (Farrar et al., 2010). Besides acting as a payment method, the national tariffs were also used as benchmarks to compare local prices with the national tariffs, which helped commissioners and trusts to assess the accuracy of local reference costs and the quality of healthcare performance.

In 2004/05, Finished Consultant Episode (FCE), the activity count used for Service Level Agreements, was replaced by Spell. To avoid inconsistencies in the interpretation of the FCE definition and to integrate the information of treatment-related resource consumption, a single Spell period covers all finished consultant episodes from admission to discharge (Department of Health, 2005b). Thus, in this fiscal year, the principle of paying those activities above the baseline with national tariffs was maintained, while the coverage was expanded to 48 HRGs. Additionally, PbR was implemented within all the FTs and its

coverage was enlarged to Non-FTs (Pitches et al., 2007).

From 2003/04, PbR expanded its coverage gradually in England. It enlarged its coverage from elective admission to non-elective admission, outpatient, A&E and mental health with different speeds according to the type of providers.

2.4.2 The transitional phase 2005/06-2007/08

The government had planned to cover all elective and non-elective inpatient care, outpatients and A&E services within all NHS hospitals with the PbR tariffs in the fiscal year 2005/06 (Department of Health, 2012b). To prevent the increase in short stay admission in the HRGs with longer Length of Stay (Olson et al., 2014), the short-stay emergency payment system was developed for specific HRGs against A&E services in 2005 (Department of Health, 2005b).

The original intention to cover all inpatients, outpatients and A&E services was proved excessively ambitious, since PbR only reached the target of covering elective care, leaving the rest of the areas to 2006/07 (Department of Health, 2012b). In the fiscal year 2006/07, the coverage expanded across all NHS providers for admitted care, outpatients and A&E attendances with an increase in the number of HRGs from 48 to 550. Nevertheless, the errors of the 2006/07 tariff published by the DH in January 2006 raised the overall average tariff much higher than expected. Some PCTs reported an increase of 4% or more in the cost of service, which was more than double of the government's estimation (1.5% increase) (Boyle, 2007). Later on, the tariff was withdrawn and reissued on March 2006 after the DH recognised the mistake. An independent review

proposed a series of recommendations according to the existing system, including strengthening governance arrangements and promoting the involvement of stakeholders (Lawlor, 2006). The DH adjusted the organisational system according to Lawlor's (2006) review by revising the organisational structure and introducing the sense-check for tariffs.

During the transition period, the DH noted that some providers might receive less income than their actual costs while some PCTs may pay higher prices than they previously had when local prices moved to national tariffs. The Purchaser Parity Adjustment (PPA) was introduced to compare local prices to the corresponding national tariffs, which helped reduce the price gap while protecting the interests of providers. In the meanwhile, the PPA (phased out in 2008/09) protected PCTs from the negative impacts resulting from the changes in the payment mechanism (Audit Commission, 2008).

The release of the consultation paper *Options for the Future of Payment by Results: 2008/09 to 2010/11* (Department of Health, 2007) marked the end of the transitional period and placed the attention on the unbundling services, expanding the scope and strengthening the cost-efficiency of PbR. The proposal of the new version HRG v4 was set by the major revision of its predecessors from HRG v1 to HRG v3.5. As the first version to split unbundling services to promote more services provided by more providers, it expanded the number of groups from 550 under HRG v3.5 to over 1,500, covering 21 chapters for the whole body system (Department of Health, 2012b). At this stage, developing specific HRGs and the related tariffs for mental health became the priority (Fairbairn, 2007).

2.4.3 The major change phase 2008/09-2009/10

In 2008/09, the coverage of the national tariffs had been expanded to all independent organisations that provided services under free choice, which met the commitment to support patient choice by attracting more providers (Secretary of State for Health, 2002). The indicative or non-mandatory tariffs, which were set against those services that should have been set as an indication of price rather than mandatory prices, provided support to encourage appropriate alternatives to the traditional hospital bundling care since 2005/06 (Boyle, 2007). The unbundling of services allowed treatment procedures to be divided into several stages in which different providers take responsibility for different elements. Thus, commissioners could choose the providers with higher cost-efficiency for a specific care service (Maybin, 2007). As a supplement to unbundling service in HRG v4, a new MFF payment index was introduced to reflect the geographical differences among providers by taking into account the differences in costs caused by geographical variations (Monitor and NHS England, 2013b). For higher service quality, the final report of *High Quality for All: NHS Next Stage Review* (Secretary of State for Health, 2008) introduced the Commissioning for Quality and Innovation (CQUIN) scheme that based on best practice, committing to pay more for best practice rather than average cost.

In 2009/10, HRG v4 was officially implemented, including new unbundled HRGs for critical care, chemotherapy, radiotherapy and specialist palliative care, with the number of tariffs doubling from around 550 to over 1,000 (Department of Health, 2012b). Besides the expansion of coverage, the classification system was further refined to differentiate the special interventions from the routine ones, with a more detailed index including

comorbidities, complications, age and LOS. The detailed categorised index enabled the specialised services to be identified and supported with particular specialised supplement, which was a certain percentage of the relevant HRG tariff, known as “top-up” (Department of Health, 2010b). Starting from 2009/10, the CQUIN was implemented to supplement the financial incentives, committing to providers an additional 2.5% of incomes if they could meet the specified standards in any of the four services including two national determined services and two locally selected services (Department of Health, 2009a).

2.5 The implementation of PbR in mental health

Since 2010, the coverage of the PbR currencies was gradually expanded to mental health. However, it was also the time when the Coalition Government came into power, which indicated the changes in policies and objectives. Under such circumstances, various supplementary policies and targets have emerged since the implementation of PbR. The following subsections outline the political background to facilitate a deeper understanding of the development of PbR in mental health.

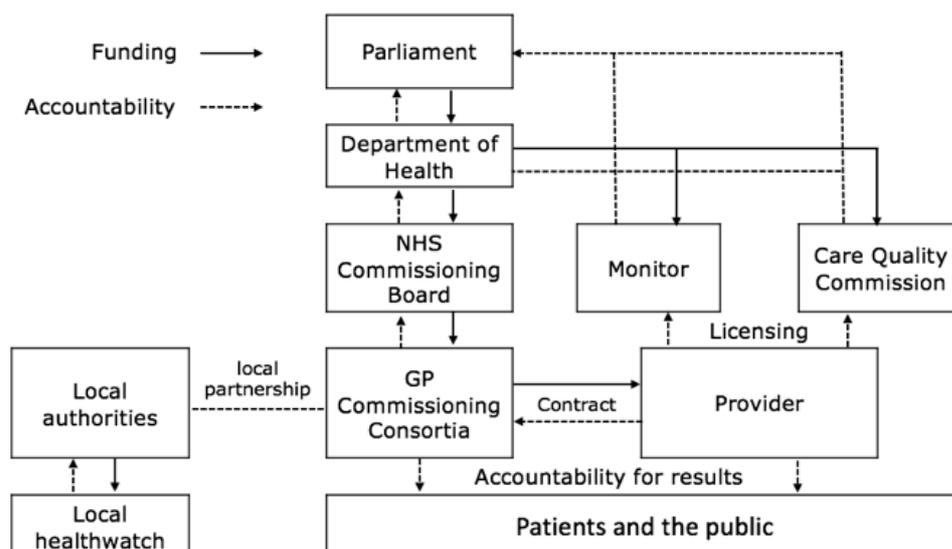
2.5.1 Liberating the NHS 2010-2015: Return to the market theory

The years since 1997 have witnessed a radical change in the NHS, which moved from being an organisation based on high-trust relationships to one operating based on nationally-set standards and targets (van Zwanenberg, 2003). Despite the attention paid to the bottom-up regulatory mechanism in the second phase of the NHS Modernisation, the targets and

regulatory policies were adopted as the main approaches for performance improvement. This raised concerns about the absence of attention paid to the actual outcome of services. Moreover, the launch of the QIPP, which set a target to save up to £20bn by 2014/15 (National Audit Office, 2011), indicated the financial pressure faced by the government. Under such circumstances, the election of a Coalition government comprised of Conservative and Liberal Democrat politicians in 2010, heralded an end to the process-oriented targets and top-down command-and-control style leadership, replacing it with a further bottom-up clinician leadership (Ham, 2010). The abolition of the miscellaneous arm's-length sectors was expected to save managerial expenditure for the investment in clinical issues. To retain the focus on patient choice and the provider-side competition, the Coalition government proposed a reform mainly focusing on increasing the investment in training and empowering clinicians to carry out their roles to control budget (Darzi, 2009). Seen as a continuation of the revolutionary change under Thatcher and Major, the Coalition government proposed a radical reform of a provider market with financial incentives to improve quality and regulation rather than mainly relying on performance management (Secretary of State for Health, 2010). The increase in market forces was expected to promote a rise in productivity as well as quality rather than simply meeting the targets (Black, 2010). In 2012, the *Health and Social Care Bill* (House of Commons, 2010) was passed to guide the reform in five main aspects: 1) devolving power to GPs, 2) establishing commissioning sectors, 3) setting up the independent NHS board, 4) enhancing economic regulation and inspection, and 5) abolishing SHAs, PCTs and a number of arm's-length bodies.

As Figure 2-6 shows, PCTs were replaced by 211 Clinical Commissioning Groups (CCGs) covering a smaller population. Commissioning and regulatory power of PCTs were passed to GPs. A new national NHS commissioning board overseeing 4 Regional Offices and 27 Local Area Teams was established (Holloway, 2012). With the involvement of the different types of providers, 80% of the total healthcare budget was paid to different free-market providers under contract (Reynolds et al., 2011). The Monitor, along with the CQC took responsibility for regulation. Acting as an economic regulator, the Monitor was entitled to regulate the prices paid to providers and to apply competition law to anti-competitive behaviours to ensure the continuity of high quality services. The CQC was established as an independent quango to integrate the responsibilities of the former three regulatory organisations including the Healthcare Commission, Commission for Social Care Inspection and the Mental Health Act Commission (Maybin and Harrison, 2008). Besides taking over most functions of the former Healthcare Commission, the CQC took responsibility to license providers including the NHS providers, independent providers and foundation trusts and to inspect their services since 2010 (Secretary of State for Health, 2010).

Figure 2-6 The structure of the NHS from 2013-2015



2.5.2 PbR changes for the future 2010-2015

Although under financial pressure, *Liberating the NHS* (Secretary of State for Health, 2010) outlined the commitment to concentrate on improving the quality of care in addition to expanding the coverage of PbR. Besides using patient choice to promote quality improvement, some adjustments on tariffs were set out to promote greater quality and enhance patient outcomes (Department of Health, 2010b). The 2010/11 national tariffs were adjusted to meet the commitment to best practice tariffs stated in *High Quality Care for All* (Secretary of State for Health, 2008). Accordingly, the best practice tariffs were initially implemented in four service areas with high volume and large variation in clinical practice including cataracts, cholecystectomy, fragility hip fracture and stroke (Department of Health, 2010b).

In *Options for the Future of PbR: 2008/09 to 2010/11* (Department of Health, 2007) the DH committed to setting national tariffs for mental health services. The introduction of mental health currencies for local use was the first step and also

one of the largest steps in the development process of PbR. According to the category methodology of the HoNOS, a national model for mental health currencies MHCT was adopted from the Care Pathways and Packages Project (CPPP) developed by Yorkshire and Humber (Whelan et al., 2011). The DH published three documents supporting the implementation of mental health currencies, which indicated a step towards promoting a comprehensive payment system in mental health (Department of Health, 2009b). The DH outlined the planned milestones of the development of MH PbR (NHS Confederation, 2011):

2010/11: the clusters and the related reference costs should be set based on clusters;

2011/12: all services, including post-GP and other referrals for both working age and older people's health care should be allocated to one of the 21 clusters by the end of 2011. The local prices should be agreed upon for use in 2012/13;

2012/13: the clusters with local prices should be adjusted to be mandatory for contracting purpose;

2013/14: the prototype of national tariffs for mental health should be generated.

2.5.3 Current implementation of PbR in mental health

Unlike other areas to which PbR expanded its coverage on time, the implementation of PbR in mental health has been delayed. A report from the Mental Health Network NHS Confederation in December 2012 stated that the local Block Contracts were still the dominant payment method, with 75% of the total investment spent through block contracts (Mental Health Network NHS Confederation, 2012). According to the survey

with 14 CCGs, the Block Contract has still been the primary payment method in daily commissioning in seven out of nine disease groups, within which the amount of investment via Block Contract shared over 70% of the total investment within the six clusters.

The overwhelming proportion of Block Contracts suggests the obstructions during the transmission to PbR in mental health. As mentioned in Chapter 1, the expansion of the PbR payment system into mental health was initially planned to begin in 2013. However, as Mayden (2013) reveals, it has now been delayed until 2014/15. Moreover, an article entitled *Updated: Monitor Questions Payment by Results for Mental Health* (Lintern, 2013) indicates that the mandatory rollout of national PbR tariff for mental health for 2014/15 has been recently dropped.

Until now, MH PbR has been applied in some trusts in England as pilot experiments. Central and North West London Trust has been appointed as the pilot trust implementing PbR since 2009. Over 500 patients have been clustered through the HoNOS, which indicated that 93% of all patients could be clustered into one of the 21 groups (Zoha, 2010). However, the lack of long-term evidence has led to a dearth of practical implications regarding the system and the policy. Thus, this indicates the significance of undertaking further research as proposed by this thesis, which is to examine whether it is feasible to apply PbR in mental health and what factors have caused the delay in implementing PbR in mental health?

Regarding examining the implementation of PbR in mental health, research carried out for this thesis focuses on two different levels: the macro-level and the micro-level. By

appreciating the importance of understanding political intentions behind this policy, the macro-level research aims to examine the theory foundations behind PbR regarding its theoretical viability, which sheds light on the direction of the micro-level researches. Guided by the macro-level findings, the micro-level research that combines theoretical analysis, semi-structured interviews and online surveys aims to investigate the formulation and implementation of this policy through exploring the ground-level evidence.

Summary

This chapter provided background information surrounding the development of PbR as a new payment mechanism replacing the previous Block Contract. Referring to Marshall et al.'s (2014) perspective that outlines the importance of the political context regarding understanding the implementation and value of one policy, the chapter discussed the initiation and development of PbR by contextualising it within a specific political environment.

To present an overview of PbR and the logic behind it, this chapter began by elaborating the general theoretical foundation of PbR. In the first section, the economic and mathematical theories behind PbR were discussed, which outlined how the financial incentives worked to encourage providers to manage their resources in a more cost-efficient way while promoting improvement in service quality. Accordingly, the second section demonstrated the working mechanism of PbR by focusing on two core elements: currency establishment and tariff calculation. Given the incomplete development of MH PbR and the fact that it shares the same development logic with that for acute services, Section 2.2 first illustrated the working mechanism of

PbR in acute services, followed by an illustration of the development of the clinical classification system in mental health.

Drawing on the importance of contextualisation to policy evaluation, Section 2.3 explored three major reforms of the NHS between the 1990s and the 2000s in order to understand the political intents behind PbR. The over-decentralisation resulting from the Internal Market together with the over-centralisation and excessively relying on standards under the New NHS, contributed to the establishment of the Quasi-market. According to its theory, in the Quasi-market, on the one hand, the government can reserve the regulatory and inspection power, and on the other hand, the introduction of PbR can stimulate the provider-side non-price competition and, therefore, facilitate an improvement in quality and efficiency. Based on the general political context, Section 2.4 described the development of PbR within the NHS Modernisation. Drawing on the change in the political context in 2010, which also was the time the coverage of PbR was expanded to mental health, Section 2.5 discussed the implementation of MH PbR in the political context of "Liberating the NHS". The return to the healthcare market with a particular attention to service quality was expected to be a motivation for the implementation of the PbR policy. Nevertheless, rather than following the planned schedule, the Block Contract was still the main payment method at the time of writing (October 2015). Despite the experiences of piloting MH PbR in acute services, there lacked strong evidence in terms linking PbR with quality and efficiency improvement.

Under such circumstances, this chapter shed light on the

development of the research aim – to investigate the driving factors that have caused the delay in implementing PbR in mental health and therefore, evaluate the policy-making process of MH PbR. The development of the NHS as introduced in Sections 2.3 and 2.4, pointed to the changes in the NHS political context, which paves the way for the following argument indicating that policy should be evaluated within the context (this will be discussed in Chapter 8). Simultaneously, the fast-changing policies outlined in these two sections will verify the fieldwork findings arguing that the intensively established policies resulted in frontline clinicians' reluctance to engage in the reform as well as the emergence of the "gaming" behaviours (this will be discussed in Chapters 6 and 7).

As mentioned in this chapter, PbR was developed based on a fundamental theory – the Quasi-market. The next chapter evaluates the application of the Quasi-market in health care to examine the initiation of the PbR policy.

3. The initiation of the PbR policy: The application of the Quasi-market

Introduction

As described in Chapter 2, the original aim of introducing PbR was to control costs and gradually lead to quality improvement through non-price competition among providers. When tracing back the idea of competition, it originated from the Quasi-market, which is a modified form of the fully competitive market model that has been introduced into the NHS since the 1990s.

Within the process of the NHS reforms, the introduction of the Quasi-market is of great importance to the design and implementation of PbR, since the political context and the accordingly established Quasi-market demonstrates the political intents behind PbR. In other words, the viability of applying the Quasi-market theory to health care acts as a crucial precondition for PbR to fulfil its functions. Drawing on Hogwood and Gunn's (1984) theory of policy evaluation as discussed in Chapter 1, this chapter aims to evaluate the initiation of the PbR policy by examining the theoretical viability of applying the Quasi-market theory. The first section introduces the definition and working mechanism of the Quasi-market by mainly focusing on its theoretical basis – the competitive market. The next two sections evaluate the viability of the application of PbR, considering its dual functions, which are cost control under the provider-side competition and quality improvement under government regulation. Section 3.4 presents some early experiences from implementing PbR in acute services, which comply with the previous arguments. By demonstrating the fundamental conflicts between the Quasi-market theory and

public services, together with the functional problems of applying standards, the preliminary findings outlined in Section 3.5 suggest that the Quasi-market does not fit health care, especially mental health, in theory. This indicates that the policy has been poorly set and thus sheds light on the research design for evaluating the formulation and implementation of the PbR policy.

The next section introduces the Quasi-market from three aspects: 1) the fully competitive market model, 2) the basic assumptions of the fully competitive market and 3) its theoretical mechanisms.

3.1 The Quasi-market

In light of the features of public services, the government has a clear responsibility for monitoring and regulating the system to meet public interest. However, as discussed in Chapter 2, the failure of the “New NHS” reform indicates problems resulted from over-centralisation under which the government tried to regulate healthcare services through establishing targets that lacked attention to service outcome and patient choice. To increase cost-efficiency under great financial pressure while maintaining government’s regulatory responsibility in healthcare services, Le Grand and Bartlett (1993) have developed the concept of the Quasi-market. As Kähkönen (2004) interprets, the Quasi-market, on the one hand, is a market that aims to reap the supposed efficiency gains through replacing the monopolistic public provider and thus embracing supply-side competition; on the other hand, it is “quasi” because it differs from the conventional free-market given the abandon on

the financial competition. In other words, it serves two purposes: the competitive market mechanism encourages competition to control cost and drive up efficiency for a better allocation of service, whilst the government can keep its regulatory responsibility and thus ensure the common good of public service. As Marquand (2004) points, central to this concept is the insertion of competition and the corresponding accountability, which the previous monopolistic system lacked. Therefore, this section begins with an introduction of the conventional fully-competitive market that illustrates the purchaser/provider interaction as well as the provider-side competition. This paves the way for the subsequent investigation of how the Quasi-market drives up efficiency.

3.1.1 The market mechanism

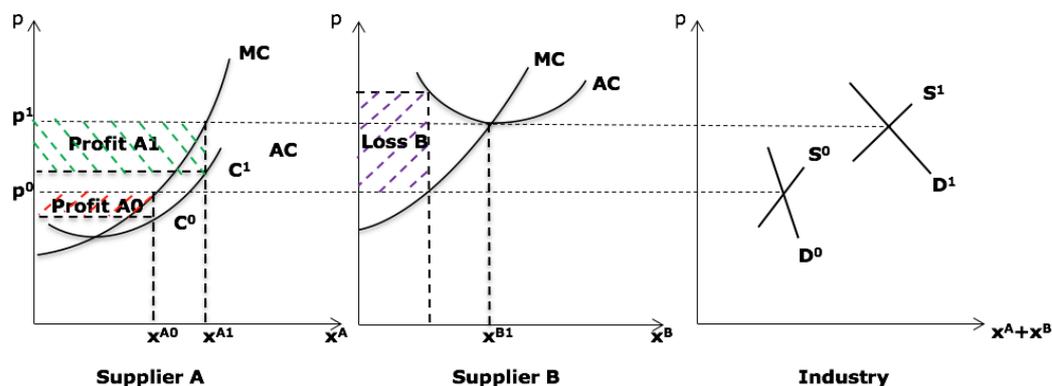
A market is a mechanism for resource allocation, which reflects the preferences of clients on the products offered by providers (West, 1998). The market mechanism is an economic term that describes the money-product exchange between clients and providers within an open and understood system. The interaction between these two leads to the equilibrium - the balanced price that supply and demand are brought into by the market's "invisible hand" (Exworthy et al., 1999).

Based on the assumptions that providers are profit-driven and provide homogeneous products (Nicholson, 2005), Figure 3-1 and Figure 3-2 present the theoretical basis of the PbR model to show how, and to what extent, the "market power" influences providers' behaviours.

Figure 3-1 displays an example of two different conditions

(profit and loss) of two different providers A and B. As stated above, each participant is a “price-taker” without the ability to affect the market price. In other words, the market equilibrium price is determined by the interaction between market demand and market supply. Therefore, the market price is constant for each identical product sold. Moreover, the price is determined when the market supply curve encounters the market demand curve when the Average Revenue (AR) becomes the Marginal Revenue (Baumol and Blinder, 2012). One supplier maximises profits when its MC (Marginal Cost) equals its MR (Layard and Walters, 1978). As Figure 3-1 shows, when the market supply is S^0 while the market demand is D^0 , p^0 is the market price. Under this condition, Supplier A produces X^{A0} amount of output at an average total cost (C^0) when it reaches the highest profit. Since p^0 is constantly greater than its average total cost, the red colour shaded area Profit A^0 represents the profit Supplier A makes in the short term. Unlike Supplier A, Supplier B has an AC curve above p^0 at every single point, which indicates that it experiences a profit loss at this market price (p^0). If Supplier B were to produce anything at this price, it would create a loss when each single output is made. The shaded area B denotes the loss Supplier B makes in the short-term. According to the assumption of profit maximisation, Supplier B would not produce any output at this price. Therefore, the total industry output is x^{A0} . When demand rises to D^1 , the relevant supply curve becomes S^1 , and the market price rises to p^1 . In such a condition, Supplier B starts to make a profit from producing output x^{B1} . At the same time, Supplier A increases its output to maximise its profit at x^{A1} amount as the green colour shaded area Profit A1 shows. Hence, the industry output is the sum of $x^{A1} + x^{B1}$.

Figure 3-1 Impacts of the demand-supply interaction on providers with different efficiencies

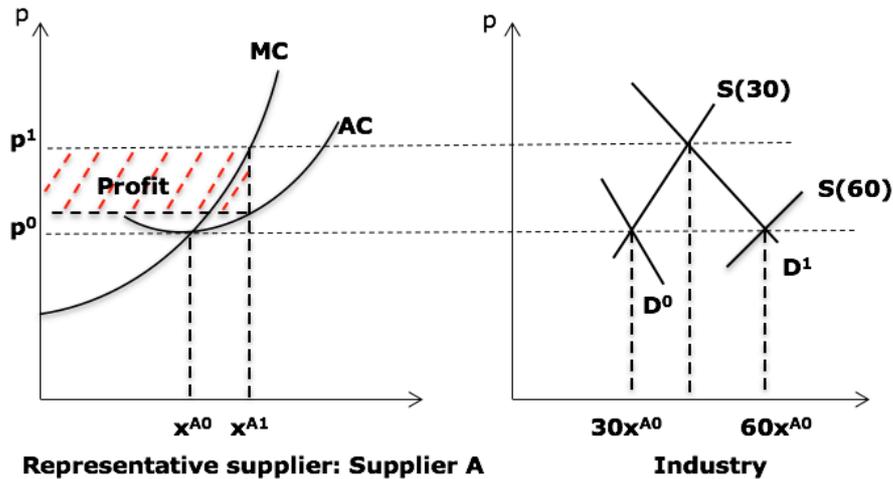


Based on the relationship between cost, price and profit as Figure 3-1 illustrates, Figure 3-2 explains how the supply-demand curve influences competition, which affects the market price in this fully competitive market.

Assume Supplier A is a firm that could represent the efficiency of most providers within this market, and there are 30 providers offering the same identical output. As the right-hand side graph shows, these 30 firms have a supply curve as S^{30} . When the market demand is D^0 , it indicates that the market price is p^0 . However, under such conditions, the average cost of these 30 firms is also at p^0 . In this case, there is no economic profit for these 30 providers. Therefore, there is a lack of incentives for other potential firms to enter this industry. When market demand rises to D^1 , the market price now locates at the crossing point of S^{30} and D^1 , which is p^1 . At this time, the existing 30 firms make an abnormal profit at this price as the shaded area shows. Based on the assumptions that providers are profit-oriented, each supplier produces the same quality products and there is no entry barrier for potential providers, new providers with the same efficiency will enter the industry until the price

falls back to the minimum average cost, which is p^0 . At this time, the supply curve of 60 firms intersects D^1 at p^0 , indicating that 30 more providers will enter the industry.

Figure 3-2 Impacts of the demand-supply interaction on providers having the same efficiency



In summary, in a perfectly competitive market, the market price is determined by the interaction between supply and demand. Profit varies according to the change in the demand and the supplier's costs. Competitions among providers lead to lower price and lower profit. Therefore, a supplier could only survive and make a profit when it minimises its cost, maximises its efficiency and at the same time keeps the same quality as other providers in the industry. In the end, the market price will be driven down until each firm in the industry only earns a normal profit and when the economic profit is zero.

3.1.2 Basic assumptions of the Quasi-market

As described earlier, the Quasi-market is developed based on the theoretical basis of the fully competitive market. In other words, the Quasi-market inherits some basic assumptions from

the fully-competitive market from which it develops its working mechanism by taking into account the essence of public services, specifically equity (this will be discussed in the next section). The five assumptions are as follows:

Large number participants: A large number of clients are willing and able to buy products at a certain price. There are a large number of providers with the willingness and ability to sell output at this price. Each participant is too small to the entire market to influence the price – each one in the market is considered a price-taker (Aumann, 1964).

Homogeneous product: Each supplier provides identical outputs that are perfect substitutes for others.

Elastic demand curve: The change in price will bring about a large change in demand. Therefore, the final market price is determined by the interaction between both demand and supply.

Transparent information and rational participants: All participants are assumed to have the same perfect knowledge of price, quality, utility of products and the nature of the market. Both clients and providers can make rational decisions according to the relevant information (Nicholson, 2005).

Free entry of the market: There are no entry or exit barriers for providers. Therefore, if the profit of a particular output is abnormally high in the short-term, potential providers will enter the market until the price falls to an equilibrium point. On the contrary, providers can exit the market when they are not able to make a profit in the long-term. The interaction between clients and providers does not affect third parties. Therefore,

there is no collateral social cost or benefit caused by the trade-off.

3.1.3 Working mechanisms of the Quasi-market

By taking into account the features of health care and the government's regulatory power, the Quasi-market develops its working mechanism by expanding the purchase/provider interaction to an interaction among clients, purchasers and providers. The subsequent subsections introduce the interaction relationship under the Quasi-market and thus the working mechanism of PbR.

Besides the above assumptions inherited from the fully competitive market, the Quasi-market further develops three features subject to the provider-side competition, as introduced below:

Provider/purchaser relationship: As previously discussed, the state becomes primarily a funder, leaving provider's responsibility to providers including private, voluntary and public organisations. Funded by general taxation, the state buys healthcare services on behalf of patients who receive the services. To further encourage competition, patients are granted the power to choose from at least four elective care providers for acute services, among which at least one is private (Brereton and Vasoodaven, 2010).

Non-profit-maximisation based competition: Unlike the fully-competitive market in which all providers are profit-maximisation oriented, publicly funded social service provision involves different types of providers, including for profit,

voluntary and public organisations. Providers, such as voluntary and public institutions, are not driven by profit. By taking equity and quality of service into consideration, the Quasi-market encourages a non-price competition. With the tariffs fixed, the competition system in the Quasi-market is based on quality rather than on price-cost relationships (Brereton and Vasoodaven, 2010).

Consumer/purchaser split: Unlike the conventional market in which clients pay for outputs as a precondition of consuming them, in health care, patients consume the services while the government acts as the purchaser.

Besides the above provider-side competition mechanism, the Quasi-market, and therefore PbR, employs government regulation to ensure the quality and equity of public services. Drawing on the features of public services, agencies such as Healthcare Commissioning Groups and Monitor have a broad range of responsibilities including contracting with providers and inspecting service provision (Allen and Hommel, 2006). According to the theoretical mechanism of PbR as discussed in Chapter 2, the information system under PbR will enable the regulatory organisations to compare service quality using the derived benchmarks. It also allows the price setter – DH, to gain more knowledge regarding the real demand for services and adjust prices to serve the purpose of increasing efficiency (Pate, 2009). In this respect, the government's inspection and regulation are expected to be an assurance that patients from different areas of the country receive the same quality services.

To examine to what extent the Quasi-market could fulfil its function in healthcare services, the following two sections

provide a theoretical evaluation of the viability of applying Quasi-market into healthcare services from two aspects: the market mechanism and the government's ability to regulate.

As discussed in Chapter 1, Hogwood and Gunn (1984) attribute the failure of a particular policy to three major reasons: bad luck, bad execution and bad policy. Regarding the implementation of PbR in mental health, the system can only achieve the political intents when the fundamental theory, which is the application of the Quasi-market, is solid and feasible. Considering the dual-function of the Quasi-market, its validity and viability are determined by the application of the market theory and governmental regulation, which will be discussed in Sections 3.2 and 3.3, respectively.

3.2 Theoretical evaluation of the market mechanism

The feasibility of applying the market theory depends on whether the fundamental requirements can be met as well as whether the trade-offs made by the implementation of this policy are rational. The following subsections evaluate its feasibility from two major aspects: the fundamental problems brought by the market mechanism principles and the corresponding functional problems of cost settlement.

3.2.1 Fundamental drawbacks of the market

The following four parts examine four basic assumptions that enable the competition principle to serve its function, including the homogeneity of products, the supply-side competition, clients' rational choice and the zero externality (Le Grand and

Bartlett, 1993).

3.2.1.1 Services vs. products

The homogeneity of output is the fundamental assumption of market theory: only when products in the industry are identical can clients make the choice among different providers simply based on the price and thus encourage supply-side competition. Although providers are not competing on prices in the Quasi-market, the idea behind the price settlement rests on the hypothesis that services can be standardised to be identical, and the adoption of the average value of the costs standardises the costs (this will be discussed in Section 3.2.2). This is a process to commoditise healthcare services. However, in health care, providers do not provide healthcare products, rather, they offer services. One obvious difference between “service” and “product” is that products could be produced according to certain standardised processes, while it is difficult, if not impossible, to standardise services given the individuality of recipients (Pratt et al., 2007). To distinguish services from products, Normann (2001) uses the word “offering” to describe the process for which service is delivered: offering is a process that is optimised regarding relevant actors, rather than a physical object. Services, such as health care, require a degree of collaboration between clients and providers, such as both psychotherapists and patients working together to reveal and make use of their personal experiences for treatment. This is particularly the case in mental health, due to its intangible aetiology, as well as the lack of reliable laboratory and other objective measures available in acute services. These factors, on the one hand, increase the difficulties in defining patients’ needs for care and therefore, the corresponding interventions

(Jones, 2004) while on the other hand, devalue the application of “standardisation-to-the-average” principle (this will be discussed in Chapter 5). Determined by the complex nature of mental disorders, besides the patient’s medical needs, clinicians also consider their social needs. In this respect, the treatment relies more on doctor-patient interactions rather than the laboratory indicators that are able to guide interventions for acute services. The process of mental health treatments normally involves building up a relationship of trust and intimacy, which requires clinicians to interact with patients and be flexible to the specific individual patient (Jones, 2004; Perry, 2000). In other words, these services are highly individualised and could not be completely substituted by others.

3.2.1.2 The provider-side competition

Another precondition of the provider-side competition is that there should be a large number of providers involved in the market, whereas the exit of one supplier would not affect the price or the operation of the market. If there are too few providers, the effects of market mechanism would be hindered by oligarch (Struyven and Steurs, 2005). However, in health care, due to its nature, it is not possible to break down monopolies for a variety of reasons (Lowery, 1998). Hospitals in the UK are largely founded based on the concept of District General Hospital. According to this concept, hospitals are founded on an expectation to provide a comprehensive range of services to the population within their district (Ministry of Health, 1962). Therefore, these organisations would have some extent of monopolistic power (Propper et al., 1998). However, unlike other industries in which monopoly and oligarchy are of more potential damage than the advantages they can bring, it is of

great importance to have some extent of monopoly in healthcare services. According to the nature of medical treatment, one specialty cannot be delivered without support from another (West, 1998). This is especially the case for mental health and A&E settings. If a provider is to offer a comprehensive range of services, it requires a broad variety of specialists to maintain a normal working order. Accordingly, it must have the capacity to serve a wide catchment area to have a sufficient caseload to keep these specialised teams working. In this case, the size of the supplier, and the range of service it provides, are essential to ensure the comprehensive service, which explains the necessity of developing one large general supplier rather than many small providers. Purchasing from distant providers is also seen as unattractive to both clients and purchasers due to the problems created by potential transport and communication issues, which further reduces the intensity of provider-side competition. The lack of a sufficient number of providers thus influences the contracting relationship between commissioners and providers: commissioners must develop a dependent relationship with the existing providers given the limited number of alternatives. (Petsoulas et al., 2011).

This subsection explained why it is not possible to break down monopolies in practice, which indicates the difficulties in establishing provider-side competition. Furthermore, clients' ability to make rational decisions has been questioned (Clarke, 2005), and is discussed in the subsequent subsection.

3.2.1.3 Clients' choices

In light of the consumer/purchaser split, consumers/clients who receive healthcare services are not the ones who pay for them.

Then, who chooses providers and how to make rational choice affect the degree of competition in the Quasi-market. Regarding the first question of who makes the choice, it is whether commissioners or patients are responsible for making the choice that matters. The fundamental social problem is seen as finite resources versus infinite human demands. When considering this issue at a general level, maximising the utility of resources is the goal of the commissioners (Bradby, 2012). By contrast, receiving best-individualised services is the goal of the patient when it comes to an individual level. Services that meet patients' demand, also known as patient satisfaction, may not always be efficient or even necessary, which echoes the potential conflicts between the "expressed need" and the "defined need" (Pilgrim, 2012) (this will be discussed in Chapter 5). The notion of "client" is even more complex in mental health since "consumer" and "client" are not interchangeable in this field. As Rogers and Pilgrim (2001) point out, besides patients themselves, under some circumstances, their relatives or even the police and the complaining public can be the clients when patienthood is imposed on a person. Agency theory suggests it is difficult to align these two mutually conflicting goals (Allen, 2002b). Studies undertaken by Fotaki (1999) and Dixon et al. (2011) support the idea that agents acting on behalf of patients have not been effective. Some trade-offs between efficiency and patients' preferences have occurred alongside the establishment of policies, such as encouraging patient choice (West, 1998).

Additionally, whether patients can make rational choices if they are willing to, or whether commissioners can make the right choices for patients, are crucial to the market mechanism. As previously discussed, health care is an area with complexity and high asset specificity, and patients do not always understand

what is the best or the most efficient treatment for them. Furthermore, in mental health it is common that patients with mental disorders do not ask for interventions themselves, rather the treatments are imposed on them against their will (Pilgrim, 2012). This leads to a lack of ability to make rational choices for themselves. Commissioners, as the agents for patients, also suffer from information asymmetry and power imbalance due to the existence of highly specialised professional groups (Croxson, 1999). West (1998) attributes the reason to the commissioners' lack of ability to accurately collect and analyse the relevant information (Vanstraelen and Cottrell, 1994). Furthermore, providers have doubts about the commissioners' ability to rigorously assess such highly professionalised services, since even the role of GP commissioners is considered "generalist" rather than "specialist", let alone other non-clinical commissioners. This is also supported by the research undertaken by Lewis et al. (2009).

Therefore, neither clients nor purchasers are considered able to obtain sufficient information and thus make rational choices based on efficiency/quality as the economic theory predicts. Moreover, some researchers even doubt the freedom of demand-side to choose services between providers due to externalities, such as political considerations.

3.2.1.4 Externalities

By using the defence department as an example, West (1998) illustrates the dilemma between pursuing cost-efficiency and considering national political pressure on public services. The defence department is the major sponsor of the national weapon industry. Thus, it is considered as responsible for

protecting domestic jobs by ensuring contracts with existing domestic providers. It can buy products from foreign providers when the products are not available from domestic manufacturers. Nevertheless, the defence department is under pressure to choose domestic providers when there are both domestic and foreign providers with the ability to provide products.

According to the competition mechanism brought about by the Quasi-market, providers with higher costs than the nationally - fixed prices will suffer from deficits. Under such conditions, they have no other choice but to reduce unnecessary costs and adjust administrative expenses, which may lead to job loss for the staff in those organisations. The entry of private providers is believed to intensify the provider-side competition, which may result in a less stable situation. Similar to the condition of the defence department, the DH is under the public pressure to protect jobs of the existing public organisations – the NHS hospitals when establishing any policy for reforms. Since health care remains a key general election issue, and the proposers who suppose employing market mechanism to promote competition and reduce costs will be easily labelled as “privatising” or “dismantling” the NHS (Greener, 2002), substantial reforms of the healthcare system, such as “bringing competition” and “reducing costs/budget”, are difficult to implement.

The above arguments demonstrate the gaps between the preconditions of market theory and the features of health care, which in turn devaluate the feasibility of applying market theory to manipulate provider-side behaviours. Besides the fundamental drawbacks, problems occur when considering it

from a functional perspective, among which the most obvious one is the cost settlement principle.

3.2.2 Functional drawbacks of the market theory

In addition to the initial drawbacks of the commodification of services as previously discussed, the use of nationally-fixed tariffs becomes less valid when taking account of the x-efficiency. The diversity of providers, especially the non-profit public organisations, determines that the demand-supply relationship in health care is different from that in a fully-competitive market, which in turn indicates that economic consideration (profit) is no longer sufficient for cost control and efficiency promotion. Considering the equity and quality, price competition has been ruled out, replaced by the fixed prices at the average level (West, 1998). Regarding the price settlement, critics have focused on two major aspects: the increase of x-inefficiency caused by the cost-based fixed tariffs and the financial risks brought about by the nationally-standardised prices.

According to the microeconomic theory, prices and price flexibility lie at the heart of the market mechanism. The price adjustment mechanism according to the demand-supply interaction, promotes the increase in efficiency and allocative efficiency (Le Grand, 1991). Without this price flexibility, the justification for employing the market mechanism begins to fall away (West, 1998). Moreover, the settlement of price may cause other difficulties. As Allen (2009a) reveals, on the one hand, if the fixed price is settled too high, there is a lack of incentives for providers to reduce cost and become efficient. While, on the other hand, if the price is too low, it will bring

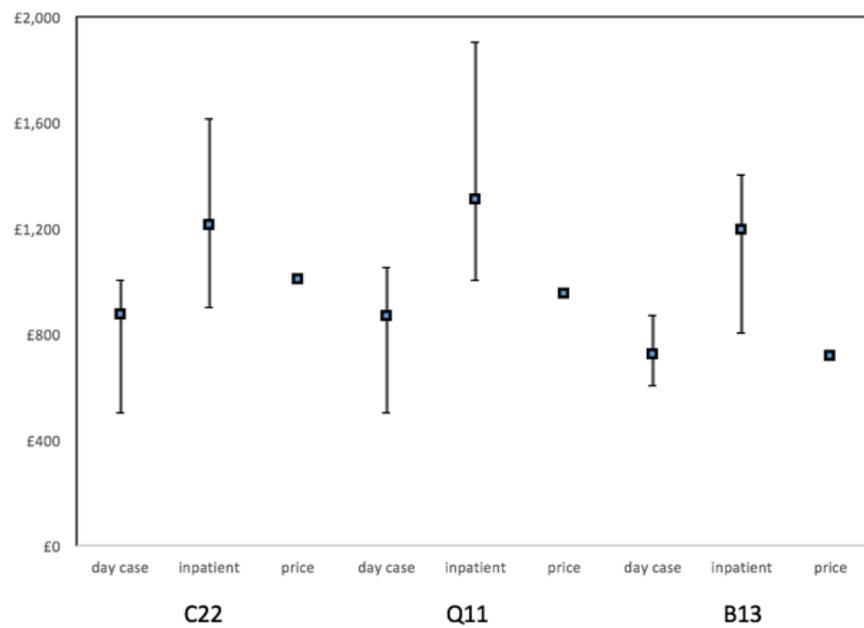
financial risks to providers, and they may start to skimp on quality as a reaction.

In fact, the price-settlement mechanism, which is based on average costs, has been questioned regarding the potential risks of financial instability and quality decline. Using elective services in acute services as an example, elective services consist of two elements: inpatient care and day cases. Therefore, the price for elective care is calculated in the following process:

- 1) Calculate the average reference costs for inpatient care and day cases as c^I and c^D , respectively.
- 2) Calculate the proportion of each type of service on a national basis, as p^I and p^D ($p^D = 1 - p^I$).
- 3) In the end, total average reference cost for the elective care is $C = c^I * p^I + c^D * p^D$.

Since the reference cost of the day case is significantly lower than that of the inpatient care, as Figure 3-3 shows, the nationally-fixed price covers less of the costs of inpatient treatment (Street and Maynard, 2007). Therefore, financial risks increase for those providers with a higher proportion of inpatient care services than the national average level. As NHS Institute for Innovation and Improvement (2006) notes, wide variations in service provision exist among providers, which indicates that the mandated price is unable to cover all common conditions. For other countries, average-based price calculation is rarely employed in healthcare services, rather for countries, such as Australia (Jackson, 2001) and Norway (Kjerstad, 2003) in particular, price settlement is deliberately separated from cost calculation.

Figure 3-3 Variations in costs among services (2005/06)



Beyond cost control, quality improvement is another goal for introducing the Quasi-market. This non-price competition system may allow providers to reduce their costs. Nevertheless, this may pose potential risks by undermining the quality of service delivery (Burgess et al., 2005). Moreover, Lipsky's (1980) research points to the conflicts between finite resources and infinite demand: the demand for services tends to increase alongside supply. In other words, if additional services are available, demand will increase to consume them, and the surplus demand still wait to be met. In other words, there is a lack of motivation for competition as long as demand is oversupplied, which explains the fact that the market mechanism lacks the ability to drive up the quality of healthcare services (Lipsky, 1980).

3.3 Theoretical evaluation of the government's regulation

The success of the Quasi-market also relies on the government's ability to regulate the quality of service delivery. The subsequent subsections theoretically evaluate this issue from two main aspects, including the appropriateness to regulate and the government's capability to regulate the market.

3.3.1 The appropriateness of standardisation

PbR employs clinical care pathways alongside other targets to standardise clinical behaviours. The theoretical effects of the standardised protocols are expected to enable different providers to deliver their agreed upon set of services, and therefore, money could follow patients across various types of providers (Greenhalgh et al., 2009). The following sections discuss the fundamental appropriateness of standardising healthcare services, which not only sheds light upon the subsequent arguments against the government's ability to regulate, but also paves the way for the evaluation of the working mechanism of PbR, which will be discussed in Chapter 5.

As discussed earlier, one prominent feature that distinguishes public services from another production industry is output, which requires frontline staff to continuously interact with clients and behave according to a particular context. Especially for healthcare services, the characteristics of individuals are more complex than bureaucratically relevant ones in other areas (Lipsky, 1980). Some of those could only be obtained through deep interaction with clients, which indicates that personal care services are highly individualised, and the co-

production plays a much important role in personal care services than in other impersonal services (Lipsky, 1980). As a result, the daily work frontline staff do is called "street-level bureaucracy" while frontline staff are called "street-level bureaucrats".

According to this feature, there are two major reasons to explain why it is difficult, or even inappropriate, to standardise frontline clinical activities. In one sense, individualised services could not be fully standardised. The essence of street-level bureaucracies is such that during the daily interaction with clients, street-level bureaucrats are responsible for making decisions about people based on individuals' characteristics and their personal situations (Lipsky, 1980). It is seen as inappropriate to rationalise or simplify these conditions. In contrast to the idea that standards represent fairness and equity, in healthcare services, and particularly mental health, treating individuals according to the predetermined standards but neglecting the actual differences, such as age, sex and income level is not seen as fair. These variations disable street-level bureaucrats' performances from fitting into a metric of correct responses according to the pre-determined guidelines. This complies with the ethos of the NHS regarding good practice. Regarding the term "patient-centred care" that has been highlighted by different governments since 1997. The Royal College of General Practitioners (2014) defines patient-centred care, or in another name "person-centred care", as a process in which professionals collaborate with patients and accordingly provide tailored services based upon their individual needs for care, personal priorities and individually defined outcomes. Therefore, the unique and fully appropriate responses could only be made by street-level bureaucrats' discretion rather than

being programmed by a simulation mechanism. In another sense, clients prefer individualised treatments. As Pratt et al. (2007) explain, patients want to be treated as an individual rather than a statistic, number or case. Receiving individualised treatment is the patients' demand and thus should be the core code for professionals. Therefore, the centrality of co-production in health care goes against the theory of care pathways, which is to standardise clinical treatments to provide standardised services to each patient according to their disease categories (will be discussed in Chapter 5).

This leads to a further question: to what extent is the government able to regulate such an area that is highly professionally-dominated even if services can be standardised to some extent? Therefore, the following section discusses the power balance between the government's regulation and professional autonomy.

3.3.2 The government's ability to regulate

Despite the political power of the government as the Quasi-market theory predicts, Propper et al. (1998) argue that the regulatory rules are not strictly followed by providers. Findings show the widespread trend of breaking regulatory rules, which indicates the weak influence of the regulatory rules. Besides the above arguments regarding the initial drawbacks of the price calculation mechanism, the imbalanced relationship between regulators and professionals is seen as another causal reason for the government's weak regulatory power.

The following sections demonstrate the government's weak regulatory power on cost and quality from three aspects: 1) cost

regulation versus professional codes, 2) quality regulation versus “real” quality, and 3) the government’s regulation versus the professional hierarchy.

3.3.2.1 Cost regulation vs. professional codes

In *Professionalism – Dilemmas and Lapses* (National Clinical Assessment Service, 2009), professionalism is defined as a broad concept covering competence, ethics, integrity, reliability and commitment to patients. As one feature of public services, providers are accountable for not only patients who receive services but also the public who pay for these services. Therefore, professionalism covers aspects within the service delivery process to meet patients’ and the public’s expectation – high standard healthcare services (Bradby, 2012). As Taylor (1996) indicates, maintaining and improving standards of services lies at the heart of professionalism in healthcare services. “Saving cost” does not appear as one of the criteria for “professionalism”. As previously outlined, conflicts between patients’ demands and the limited budget are evident and it is questionable whether doctors will still be professional enough to maintain patients’ best interests as their top priority when they are under pressure to control costs.

The economic principle indicates that competition leads to innovation, information transparency, efficiency and incentives (Jay, 2001). However, these effects are built upon a depersonalised product market rather than public services in which outputs are subject to individuals. If “people” is added in, it tends to become “people choose to innovate”, “people receive and analyse information”, “people choose to allocate resources

in exchange for services”, and “people’s demands (demand side) encourage providers”. The findings of Iles’s report (2011) suggest that the economic regulation is not able to produce these features. This is also the reason for British Medical Association’s strong opposition to the Health and Social Care Act 2012 regarding Monitor’s role, which was originally set to promote competition (Ham et al., 2015).

If the market theory fails to ensure service quality within the provider-side competition (Propper et al., 2008), will the other arm of the Quasi-market, which is government regulation, be able to promote high-quality standardised services and thus improve patient outcomes? The next section examines the relationship between quality regulation and “real” quality.

3.3.2.2 Quality regulation vs. “real” quality

As Iles (2011) illustrates, one can access information that is known or knowable to the public by searching the internet, whereas in complex situations that require professional knowledge, one needs to seek help from people with deeply held knowledge and expertise – the professionals. In the UK healthcare system, only the best-qualified young people can obtain access to medicine and receive comprehensive training before they devote themselves to this career. Seeing their established seniors as figures of moral authority, they are well-trained with professional codes, especially ethical standards, to provide services according to the best interest of patients (Iles, 2011). The establishment of quality regulation/measurement may risk breaking the trust between patients and doctors.

Apart from this ethical issue, from a practical aspect, the

viability to measure the quality of healthcare services is also questionable. The NHS has witnessed the process where the balance of power progressively shifted from clinicians towards regulatory agencies (Taylor, 1996). Key regulatory functions are carried out by agencies, such as the CQC and the Monitor (Lewis et al., 2009). In such circumstances, these non-clinical managers' abilities to accurately measure and regulate service quality have been questioned. The situation gets worse due to the reorganisation and high turnover of the managerial staff who generally lack clinical knowledge and skills on accurately analysing data (House of Commons Health Committee, 2010). It has already been reported that CQC makes errors in the use of data to assess performance (Ham et al., 2015). Moreover, in addition to the impersonal interventions, such as drugs that can be effectively assessed using a randomised control trial (RCT), there are interventions in mental health that involve complex personal processes, such as talking treatments (Rogers and Pilgrim, 2001). It is the complex nature of mental disorders that determines the difficulties in specifying and quantifying every move in individualised treatments and only activities that can be measured are enclosed into the measurement system. It is these measurable "facts" and activities that form the "performance" (Iles, 2011), which indicates that targets related to the measurable aspects do not encompass the whole picture of quality. According to the concept of professionalism, providing appropriate behaviours according to specific contexts is the essential skill that distinguishes professionals from others. However, these behaviours are usually difficult to capture. In such case, the most measurable, but not most representable, aspects get captured, leaving those essences missed out (Iles, 2011). The other risk created by quality measurement is the misleading of performance. When performance is measured

against objectives, the objectives are required to be specified in advance. In this respect, providers could simply focus on the targets in order to achieve “quality performance” in an easier and quicker way. The outcome-oriented system may easily lead to “gaming” behaviours (this will be discussed in Chapter 6). As Lipsky (1980) stresses, the actual performance of frontline activities is virtually impossible to measure. Therefore, the quality measurement system acts more like a means that policymakers respond to the public dissatisfaction, rather than a clinical instrument (Lees, 2013). Critics of healthcare quality measurement have questioned the extent to which patients benefit from these various forms of audit, data monitoring and quality initiatives (Taylor, 1996). Furthermore, parts of this administrative work have been decentralised to GP commissioners, with the possibility of distracting them from taking care of other patients (Smith, 2010).

The previous two sections, which investigated the initial problems of cost control and quality regulation, were based on the one assumption that the government is able to implement these regulatory rules. Therefore, the last part of this section explores the extent of the government regulatory power in health care.

3.3.2.3 Regulation vs. professionalism hierarchy

Strathern (2000) refers to audit as a power relationship between regulators and the observed. The balance of power is determined by the dependency relationship between the two parties. This part discusses how the imbalance of dependency leads to the government’s lack of power and results in its failure to control costs and, in the end, regulate quality.

As described at the beginning of this section, health authorities set the nationally-mandated rules, but they are not strictly followed by providers. As Enthoven (1985) notes, it is common for health authorities to have a heavy dependency on providers. Two main reasons contribute to this dependency: commissioners' lack of choice due to the geographic monopoly and the professional hierarchy due to the granted power of professionalism. According to economics theory, the former determines that commissioners lose their market power of price settlement in such a geographic monopolistic market. The second dependency relationship is determined by the degree of professional autonomy.

In health care, a highly professionalised area, the dominant power does not belong to the government, but to the professional bodies, such as medical and surgical Royal Colleges (West, 1998). Issues, including hospital planning at the macro level, and department establishment at the micro level are managed by the professional bodies. As discussed in the definition of professionalism, it is this professionalism that gives great autonomy power to the medical professionals. Especially the confidential relationship between doctors and patients brings unavoidable information asymmetry between regulators and providers. Thus, this inversely influences the accuracy of performance measurement (Greener, 2002). As a result of the information asymmetry, professionals' actions in diagnosis, treatment and referral become the policy of the system (Lipsky, 1980). As Exworthy et al. (1999) conclude, the NHS is centrally financed, since the politicians set the size of the budget, while it is run by professionals who also decide how to spend the budget.

3.4 Early experiences from acute services

As outlined in Chapter 2, the last decade has witnessed the development of PbR in acute services. The early experiences regarding the limited impacts of market theory show agreement with the above argument regarding the failure of the Quasi-market to reduce costs and to improve efficiency, as well as quality. Drawing on the fact that case-mix theory is more suitable to acute services than mental health services (this will be discussed in Chapter 5), the following unsatisfactory outcomes facilitate a better understanding of the delayed implementation of PbR in mental health.

1) Cost

The findings of Farrar et al.'s (2007) "difference-in-difference" comparative study suggested that PbR presented a stronger incentive for cost reduction compared to that of the Block Contract. The results of the Audit Commission's (2005) investigation indicated that the gap between trusts with higher and lower reference costs narrowed after the implementation of PbR. However, the increase in managerial costs was largely ignored by these studies. The report of Mannion and Street (2006) listed four main driving factors for the increase in administrative expenses under PbR: negotiation, data collection, monitoring and enforcement. This indicated that the implementation of PbR in mental health would increase transaction costs that should not be ignored. The downward pressure has also been found to be mitigated by cross-subsidies from other sources of income (Appleby et al., 2012).

2) Capacity

Unlike cost, the findings regarding capacity were not strong enough to support economic theory. In Farrar et al.'s (2007) research, little evidence was found to support the capacity enhancement plan. The findings of the Audit Commission's (2008) intervention and observation study stated that PbR had not yet significantly driven up providers' capacity due to the effects caused by other policies, particularly the unprecedented level of governmental investment (this will be discussed in Chapter 8) and the waiting-time targets. These targets made it difficult to evaluate the impacts of PbR since direct causal relationships were difficult to determine. Moreover, unintended consequences were noted: the attempts for LOS (Olfson et al., 2014) reduction raised concerns about the premature discharge and the subsequent increase in readmissions (Audit Commission, 2008).

3) Quality

The evidence for the relationship between the implementation and quality improvement of PbR was even weaker since the definition of quality in health care is complex and hard to quantify (Farrar et al., 2007). In Farrar et al.'s (2007) study, no significant differences were found between different groups in terms of the introduction of PbR.

Moreover, information asymmetry indicated the difficulties in detecting "real" quality through judging whether the provider undertook the proper intervention (Miraldo et al., 2006). In this situation, concerns were raised about the potential risks of the quality of care when the providers knew the way of "gaming", including over-coding and cream-skim (this will be discussed

in Chapters 6 and 7) (Cots et al., 2011). Specifically, the reduction in quality would occur in the providers who were considered better than average since they had to cut some additional, albeit effective, resources to meet the national financial requirement (Boyle, 2007).

3.5 Preliminary outcomes

In summary, the fundamental conflicts between market theory and healthcare services demonstrated the incapability of the competition mechanism to guide/manage providers' behaviours. Moreover, the conflicts between "professionalism" and the government's regulatory power resulted in a prediction that it is difficult, if not impossible, to standardise and therefore accurately monitor service quality. This corresponds with Struyven and Steurs's (2004) research indicating that the Quasi-market has delivered little benefit that met politicians' original expectations. The above discussions contribute to four preliminary outcomes as described below:

1) The market competition principle does not fit healthcare services

As Allen (2013) reveals, the reason public services are delivered through more hierarchical institutional structures rather than the market-like ones is that the fundamental principles of the market theory do not apply to public services, especially to healthcare services. On the one hand, the essential goal of the market mechanism is to reach the maximisation of resource allocation and utility through encouraging provider-side competition. Under such circumstances, equity is not

considered, whereas it is the crucial part of healthcare services. On the other hand, the requirement of co-operation between departments determines the range of services and the size of hospitals. Thus, this illustrates the necessity for a geographic monopoly and, at the same time, explains the reason it is unlikely to have intense competition (Wonderling et al., 2011).

2) Non-price competition's effects are limited

Rather than perfect competition under the market's "invisible hand", the Quasi-market brings non-price competition under the government's regulation. As Stigler (1968) argues, price competition is more effective in promoting efficiency and controlling costs than non-price competition. The possibility of efficiency driven up by non-price competition is likely to decrease when the nationally-fixed tariffs are inappropriately set. Additionally, the effectiveness of increasing the number of providers is overestimated, given the concerns about undesirable consequences (Allen, 2009b). The large organisational reform may destabilise the system and drive up transition cost. The increase in the number of providers requires higher transaction costs and other administrative costs (such as those incurred in information analysis, price calculation and quality monitoring), which will inevitably offset the savings achieved by the PbR mechanism.

3) The government lacks the capacity to contract and regulate

Policymakers expected a more sophisticated contract system to achieve higher efficiency and quality. However, the conflicts between individualised and standardised services, as well as between cost regulation and professional code, remain

questionable. These conflicts, together with information asymmetry, reject the precondition of the commissioners' ability to regulate costs and services, which is their ability to comprehensively acquire the relevant information (Greener, 2002). The finding corresponds with the report from the House of Commons Health Committee (2010) illustrating the commissioners' lack of ability to negotiate and analyse data. Moreover, the government's dependency on professional bodies reveals the gaps between theory and practice regarding government's ability to guide and regulate healthcare services.

4) Monopolistic managerial model is more effective on cost control

It is important to note that perfect competition is only the sufficient condition for allocation and productive efficiency, rather than the necessary one. As West (1998) illustrates, at the administrative level, prices for each component is not that important, rather, it is the total cost spent by the purchaser that matters. Compared to the Quasi-market, the monopolistic regulatory structure is seen as more capable of cost control, due to its ability to hold down wages through more effective bargaining with professional bodies (Le Grand, 1991). Since 40% of the NHS budget is spent on staff (King's Fund, 2010), the monopolistic administrative model is believed to be able to promote more savings, although at a price of cutting out local competition.

According to the initial problems of market theory and the government's regulation, Kähkönen (2004) points out that the Quasi-market is never a solution. In public services that require public regulation, control and financial support, emphasis

should be placed on government support and professional bodies' regulation, rather than simulating a market mechanism that is under the assumption of a profit-oriented motive.

These four preliminary outcomes at the macro level also lead to some further questions at the micro level: 1) since the market principle is considered not suitable for healthcare services in theory, how does it actually apply to daily activities regarding implementing PbR in mental health at the micro-level; 2) are the driving factors partly to blame for the delayed implementation; 3) besides the fundamental problems of the Quasi-market, what are other obstacles that have hindered its implementation; 4) what is the overall impact of PbR in mental health? To answer these research questions, this project conducted a three-step research design including theoretical analysis, semi-structured interviews and online surveys. The next chapter presents the methodology adopted in this research.

Summary

Based on the process of NHS's reforms presented in Chapter 2, this chapter has served as a bridge connecting the general background of the NHS's reforms and the implementation of PbR by focusing on investigating the theoretical foundation of PbR – the Quasi-market. Whether the idea of combining financial incentives and political regulation is viable to control costs and drive up quality in health care plays a significant role in evaluating the policy of implementing PbR in health care, specifically mental health. Therefore, this chapter took four main steps to evaluate the formulation of the PbR policy by examining the impact of the Quasi-market on cost control and quality improvement.

This chapter departed from presenting the forerunner of the Quasi-market: the fully competitive market model. This simplified model was employed to illustrate one core element of the Quasi-market as well as PbR - the idea of profit-driven competition. It then discussed how this theoretical basis was used and modified in the Quasi-market by outlining two core elements - the provider-side competition and governmental regulation. Subject to the theoretical functions, Sections 3.2 and 3.3 respectively conducted a theoretical evaluation of the validity and feasibility of the application of the Quasi-market through evaluating market theory and the government's ability to regulate. Section 3.2 argued that market theory does not fit with healthcare services by rejecting four fundamental preconditions: 1) high variation in healthcare services; 2) the existence and its necessity of geographic monopoly; 3) conflicts between the collective management; and 4) individualised services and externalities. Section 3.3 explored the feasibility of government regulation. Apart from the problems brought about by the variations in service delivery, it further investigated the government's ability to regulate healthcare services by discussing the relationship between the government's regulation and professional autonomy. The concept and the core characteristics of the professionalism explained the fact that strong professional autonomy exists in health care, which has led critical discussions regarding the government's lack of ability to control costs and regulate quality. The conflicts between measurable quality and "real" quality, together with the government's dependency on powerful professional bodies, demonstrated the difficulties in accurately regulating healthcare services. These fundamental and functional problems indicated the failure of the Quasi-market mechanism to serve its purposes in healthcare services, which complies with the experiences of

implementing PbR in acute services presented in Section 3.4.

Section 3.5 summarised all of the previous discussions into four main preliminary findings indicating that the policy was poorly designed. The initial problems of the fundamental theories behind PbR guided the research direction to explore the obstacles at the micro level, which are the formulation and implementation stages of this policy: how MH PbR is constructed and functions in theory and how it is implemented in practice. Therefore, the next chapter will illustrate the methods adopted by this study to investigate the issues surrounding the delayed implementation of PbR in this less explored mental health domain.

4. Methodology and methods: The use of mixed methods

Introduction

Under the general analytical framework discussed in Chapter 1, this chapter justifies the research design and presents the process of conducting fieldwork, through which this study further evaluates the formulation and implementation of the PbR policy based on the earlier evaluation of its initiation. Guided by the two-level theoretical analysis which outlines the fundamental and functional drawbacks of implementing PbR in mental health, the fieldwork discovered the frontline concerns regarding how the policy affected clinical everyday practice and how key players reacted to the policy. By appreciating the important role frontline staff play in policy implementation and their influence on the success of one policy, it makes this thesis different from a piece of desk research. Regarding the research methodology, the underpinning philosophical assumptions emerged from the development of the third paradigm mixed methods, which was developed based on the recognition of the drawbacks of using one single research paradigm. This implies a new epistemology in which qualitative and quantitative research compensate each other (Jick, 1979), and the integration of the two contributes to an in-depth and broad understanding of research phenomenon (Hussein, 2009). Accordingly, theoretical analysis and semi-structured interviews were adopted as the qualitative approaches while the online surveys were employed as the quantitative approach.

Regarding the investigation of the formulation of the policy, the theoretical analysis based on previous studies not only

evaluated the validity and reliability of the classification system of MH PbR (due to the absence of the tariff calculation system), but also shed light on the conduction of the fieldwork that involved semi-structured interviews and online surveys (this will be discussed in Chapter 5). Based on the theoretical evaluation at the fundamental and mechanical level, the semi-structured interviews are able to capture a relatively comprehensive understanding of the research objectives, while the online surveys mainly aimed to verify the findings derived from the qualitative research. To maximise the validity of the semi-structured interviews, the principles of GTM (this will be discussed in Section 4.2) were employed to collect and analyse data in a bottom-up order in order to capture useful information.

To elaborate on the reasons for employing the mixed methods (triangulation) and the GTM principles together with their applications as the methods for the fieldwork, this chapter is divided into three main parts: the mix-methods, the GTM principle and the fieldwork conduction. The first section provides reasons for choosing the mixed methods paradigm by presenting an overview of triangulation and its key components, discussing the potential risks of employing triangulation and illustrating how triangulation was applied in this study. Similar to the first section, the second section explains why and how the GTM principles were applied to the process of conducting the semi-structured interviews. Based on the justification of the methodology and methods presented in the previous two sections, the last section presents detailed information regarding how the empirical research was conducted, including a discussion on the interviews and online surveys used.

4.1 Mixed methods

By considering the analytical framework as discussed in Chapter 1, the combination of both qualitative and quantitative approaches was employed in the study to present a multi-level and multi-perspective understanding of the policy-making process. Qualitative analysis was employed in the theoretical analysis and semi-structured interviews to explore the formulation of MH PbR as well as the current stage of the implementation of MH PbR, investigate different perspectives towards the implementation from various angles. As the leading approach of the fieldwork, the semi-structured interviews aimed to capture the key driving factors for the delayed implementation through a small sample and, therefore, help construct the online surveys for quantitative analysis. Quantitative analysis was adopted to help verify and generalise the findings derived from the qualitative analysis. This section will explain the reasons for adopting mixed methods by presenting an overview of the mixed methods, illustrating the key elements, discussing the challenges and the corresponding solutions and outlining its applications for the research design.

4.1.1 Overview of mixed methods

The complementary characteristics of qualitative and quantitative strategies create the dilemma that when designing a single piece of research one always has to make a compromise: either to be intensive (in-depth study led by qualitative methods) or extensive (conducting a study using quantitative methods which allows for a larger sample) (Sayer, 1992). The generation of a new hybrid research strategy that combines qualitative and quantitative was believed to be an ideal solution to this dilemma. By concerning the aim to compensate the defects of each single

method, the combination strategy has been extensively employed in the social science area, with different names assigned to this growing research position. Names such as "triangulation" (Denzin, 1978), "multi-methods" (Brannen and Coram, 1992), "mixed methodology" (Tashakkori and Teddlie, 1998), "mixed-methods" (O'Cathain et al., 2007) and "multi-strategy" (Bryman, 2001) have been employed to describe this research strategy as to combine qualitative and quantitative methods in studying the same research phenomenon. In this chapter, "triangulation" was chosen as the name of this strategy since this metaphor precisely describes the process of conducting research. As an overview of the triangulation strategy, the following parts introduce the definition of "triangulation" and outline the values of triangulation.

4.1.1.1 Definition

The term "triangulation" originated from the navigation and military strategy, referring to the action of locating an object's exact position from multiple referent points (Smith, 1975). According to geometry principles, the action of "triangulation" improves the accuracy of the location. Broadly defined by Denzin (1978), "triangulation" refers to "the combination of methodologies in the study of the same phenomenon" (p.291) in the research area. Similar to its original purpose, the employment of multiple methods aims to better investigate the research objectives. Therefore, the word "triangulation" precisely presents the kernel of strategy, which is to reveal the convergence, complementarity and discordance of the findings through considering multiple viewpoints, perspectives and positions for a better understanding of research objectives (Erzberger and Prein, 1997).

In the area of social science, the application of triangulation could be traced back to the introduction of the idea “multiple operationism” (Campbell and Fiske, 1959). According to this theory, more than one method should be applied as part of the validation process to ensure the credibility of research design and the validity of the findings. In addition to this validation purpose, with the development of triangulation paradigm, the denotation of its purpose has expanded: for the completeness of understanding. Based on Campbell and Fiske’s theory, Denzin (1978) further distinguishes four forms of triangulation serving different purposes: data triangulation, investigator triangulation, theory triangulation and the methodological triangulation (this will be discussed in Section 4.1.2). Since then, it has been recognised as the third major strategy alongside the qualitative and quantitative paradigms (Johnson et al., 2007).

4.1.1.2 The significance of applying triangulation

Historically, quantitative methodology has been the dominant method for research in health care (Moffatt et al., 2006). Through statistical data analysis, quantitative research identifies the statistical relationship between variables, thus exploring the determining factors and the way they influence variables (Fossey et al., 2002). This linear model clarifies the relationships between variables by formula and data, which is generalizable and replicable. However, irrespective of the broad impact, transmitting the “macro” population-oriented issues to the “micro” everyday practice to guide individuals’ behaviours remains an issue. In the case of health care, people live their illness with their characteristics and within social contexts, which could not be seen as the components on the assembly line (Stimson and Webb, 1978). This is the reason that some

researchers doubt the validity of findings obtained from merely conducting statistical analysis in the social area: the potential risks of oversimplification due to its impersonal nature (Bhopal, 2000; Ryen, 2000). Thus, Yeasmin and Rahman (2012) remind us of the importance of taking into account the multi-dimensional social experiences and realities when conducting research in health policy.

The key benefit of qualitative research is its ability to depict the full picture (Barbour, 2008). Rather than pre-assuming relationships and pre-defining variables as done in quantitative approaches, the qualitative approach absorbs perspectives from different respondents to identify which factors influence their daily lives (Baum, 1995). As Shaw (1994) points out, in the social policy analysis process, both "macro" and "micro" aspects should be considered and reflected. It is through in-depth interviews that the "micro" picture of policy implementation is unveiled. However, as Silverman (2014) argues, individual's understanding of particular objects is based on their subjective lens of perception, and therefore, there is no way to pursue objectivity in qualitative research. Moreover, the validity of qualitative research also suffers from the limited amount of sample, which may lead to a situation that the findings generated from the study are remote from the "normality" of society. Subject to the risk of losing generalizability, Harding (2001) posits that the balance between subjectivity and objectivity could be approached through employing social statistics for extensiveness while interpreting them from a more critical and reflexive standpoint. In return, findings from qualitative approaches could facilitate the interpretation of statistical findings regarding validating the results and clarifying the puzzling findings (Sieber, 1973). Hence, by combining both

qualitative and quantitative approaches, the defects of each single method could be compensated by the counter-balancing strength of the other (Jick, 1979).

As Shih (1998) identifies, the values of triangulation are reflected from two main aspects: confirmatory and completeness purpose. However, splitting perspectives towards this issue are noted: some advocate this strategy by pointing out its effects on enhancing the study accuracy (Creswell and Miller, 2000; Golafshani, 2003). By contrast, some challenge its credibility and validity through questioning how two separate paradigms with different epistemological assumptions collaborate against convergence (Brannen and Coram, 1992). Aiming to illustrate to the reason for adopting this strategy and how to apply it, the following three parts provide further investigation by elaborating the key elements of triangulation, discussing the challenges and the corresponding solutions, and illustrating its application to the research.

4.1.2 Key types of triangulation

Identified by Denzin (1978), there are four main types of triangulation: data triangulation, investigator triangulation, theory triangulation and methodological triangulation.

Data triangulation refers to the action that retrieves data from different sources, namely, time, person and space (Denzin, 1978). It rests on the idea that data quality might vary according to the time of collection, the site of collection and the individual who is involved in the process of data collection.

Investigator triangulation refers to more than one researcher

with different backgrounds and working experiences collaborating on the same study. The different areas of expertise compensate each other and therefore, provide a broader and deeper understanding of the research objectives (Banik, 1993).

Theory triangulation refers to the action that interprets data by employing more than one theoretical scheme. It rests on the idea that involving different theories interpreting the same data improves the validity of the results: if theories interpret the outcomes in the same way and thus draw the same conclusion, it indicates that the result is valid and credible (Guion, 2002).

Methodological triangulation refers to the use of more than one method in one study, which is seen as the type of triangulation that has been most widely employed in the area of social science (Kopinak, 1999). It is believed that the employment of multiple methods in one study provides more detailed and multi-layered information about realities (Meijer et al., 2002). Regarding whether different methods come from the same paradigm, two types of methodological triangulation have been distinguished as within-method and between-methods triangulation (Denzin, 1978). Within-method triangulation refers to the use of different methods within either a qualitative or quantitative paradigm, whereas between-methods triangulation refers to collaborating both qualitative and quantitative approaches in one study (Thurmond, 2001). The adoption of within-method triangulation aims to test the internal consistency of the study. Between-methods triangulation closely parallels the meaning of the original "multi-methods" since it reaps the benefits of two different paradigms and complements the drawbacks of each paradigm to a large extent, rather than the previous one that fails to overcome the inherent weaknesses of one particular

paradigm (Denzin, 1978).

To reap the advantages of both qualitative and quantitative research, a combination of semi-structured interviews and online surveys were adopted as the research methods for fieldwork (this will be discussed in Section 4.1.4). Regarding the evaluation of the impacts of PbR on mental health services, it is a relatively less-explored area due to the delayed implementation. The complex nature of mental disorders together with the incomplete process, increases the complexity of the study. On the other hand, PbR has been implemented in acute services since 2003/04, which indicates that the studies on the impacts of PbR on acute services could contribute to the design of this study as presented in Chapter 3. Additionally, the theoretical analysis of the mechanism of the classification system of MH PbR, which will be discussed in Chapter 5, also contributes to the understanding of its practical impacts on everyday clinical practice. Therefore, qualitative methods, including theoretical analysis and interviews, were able to reveal relatively comprehensive perspectives on the research objectives from different levels and angles. Rather than employing another qualitative approach, such as focus groups, online survey research was seen as more appropriate to validate the qualitative findings by verifying them to a larger extent. For instance, in the social sciences, quantitative approaches are usually employed to validate the qualitative results (Flick et al., 2004). In addition, the statistical analysis may identify variations in perspective and attitude amongst stakeholders, which could facilitate further understanding of the conflicts between political considerations and mental healthcare delivery. Therefore, between-methods triangulation involving literature review, semi-structured interviews and online surveys was used

in this research to present a multi-level and multi-angle perspective regarding the policy-making process.

4.1.3 Challenges

Despite the strengths of this study, the theory of utilising triangulation indeed has its challenges. Concerns about the validity of triangulation could be categorised into two main aspects: the fundamental issues and the practical matters. Regarding the fundamental issues, the viability of combining qualitative and quantitative paradigms is questioned. In terms of the practical issues, the occurrence of divergent findings from different methods is seen as a risk that might compromise the effectiveness of triangulation. Therefore, the following two subsections illustrate the challenges and outline the corresponding solutions.

4.1.3.1 “The paradigm war”

As Hirschheim (1992) describes, epistemology is the foundation of true knowledge since it defines what knowledge is and how knowledge is obtained. The qualitative and quantitative paradigms represent two different types of ontology and epistemology. As a result, the process of combining these two paradigms has been challenged for its viability and validity (Hunt, 1991). However, the main utility of triangulation is to validate one instrument by adopting the other one. Therefore, whether or not triangulation itself is theoretically valid has a heavy influence on its effectiveness.

Some support has been found regarding this debate. As Reichardt and Cook (1979) argue, the paradigm should be

employed to facilitate the research rather than being a straitjacket that constrains the design and the conduction of study. The adoption of research methods and techniques should be process-oriented and outcome-oriented for either an exploratory or a confirmatory purpose. Particular for the evaluation study, Houts et al. (1986) indicate that it is a field of rapid development that requires joint analysis for multiple sources of evidence in order to make a comprehensive judgement. With the development of theory, Schwandt (2000) advocates triangulation by questioning the necessity and meaning of sticking to "paradigm". From his perspective, all studies are about interpretation. Indeed, different research methods are suitable for different understandings. Nevertheless, they are not necessarily in conflict with each other. Therefore, there is no point in questioning the validity of mix-methods just because of the existence of different paradigms.

4.1.3.2 "Divergent outcomes"

Triangulation enables researchers to validate qualitative results by conducting statistical analysis and comparing the results from both qualitative and quantitative approaches. If the outcomes are convergent, it is confirmed that the instruments adopted in the qualitative analysis are appropriate, and therefore, the results are valid. Nevertheless, it is noted that there may be outcomes other than corroboration emerging when applying different methods in one study (Hammersley, 2002): complementarity means that the findings from the qualitative analysis and quantitative analysis are divergent but complementing each other; while contradiction means that the findings from the different methods are not simply inconsistent but contradictory with each other.

These two possible outcomes raise questions regarding the triangulation strategy on how to deal with divergent findings. In this respect, assigning different weights to components is seen as an effective solution. However, the determination could be subjective since there is a lack of evidence-based guidelines to suggest how to weight the elements of a multi-method approach (Jick, 1979). The idea of Reichardt and Cook (1979) could be applied to addressing this challenge: research approaches should be used to facilitate the research itself. Therefore, the prioritisation of certain components could be subjectively based on researchers' understanding of the main epistemological position of research objectives (Foss and Ellefsen, 2002).

Practically speaking, the sequencing of the approaches is crucial to the determination of the leading method and the main findings (Kanbur, 2002). According to Kanbur (2002), there are two possibilities of the sequence arrangement: 1) the quantitative methods come after in-depth qualitative inquiry; or 2) the quantitative analysis is given the priority. Regarding the first possibility, quantitative methods, such as questionnaires, are devised based upon in-depth qualitative inquiries, such as literature reviews, focus groups and interviews (Marsh and Elliott, 2008). With the possible impact factors found and the general categories settled at the qualitative analysis stage, the questionnaire data could provide an extensive view of a broad range of cases to generalise the findings. Regarding the second possibility, findings concluded from the patterns of qualitative methods, such as interview and literature review, are used to exemplify them. Regarding selecting sequence and priority, on the one hand, as previously discussed, the validity of using the findings from statistical analysis to explain social reality might

suffer from its over-simplification since “correlation” could not represent the “causal relationship” (Dow, 2002). On the other hand, the first possibility is more suitable for the confirmatory purpose since the generalising process can confirm or complement the findings derived from the in-depth qualitative analysis.

Therefore, after considering the adoption of triangulation methods and the solutions of the possible divergent outcomes, the strategies of this study are: 1) adopt triangulation mainly for a confirmatory purpose; 2) choose the between-methods triangulation; 3) prioritise qualitative methods in a sequence of “qualitative + quantitative”; and 4) give more weight to the findings from interview. Regarding how to apply triangulation into the research, the following section provides a general introduction of the research design and then illustrates each approach adopted in the study.

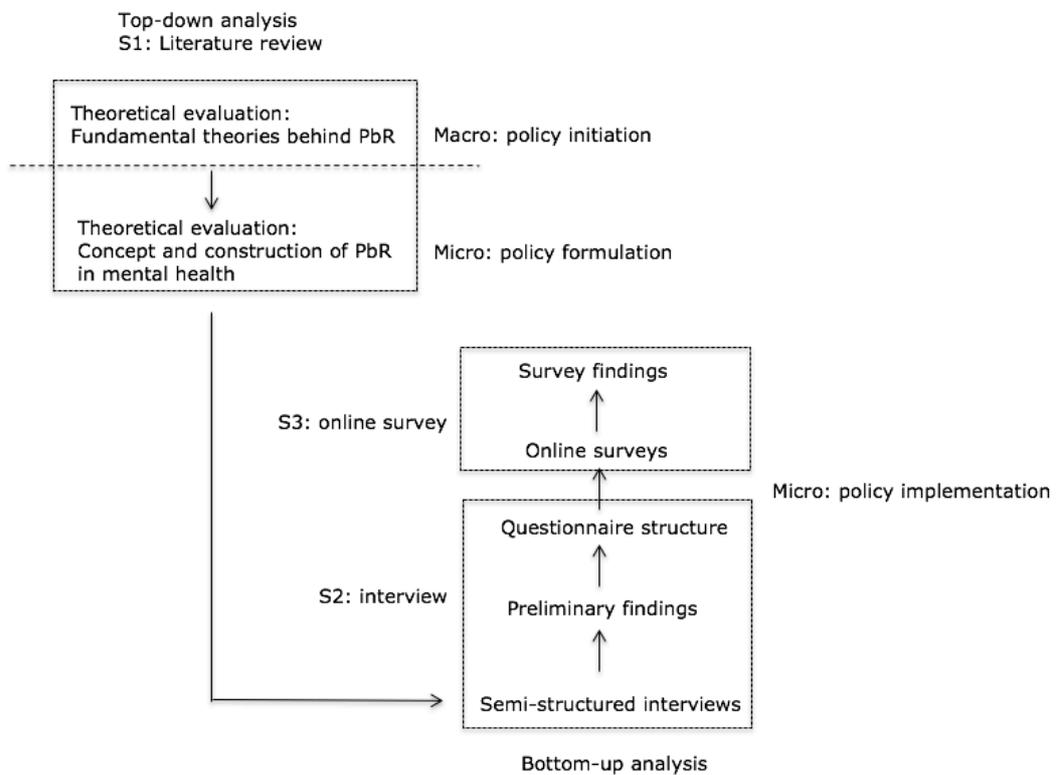
4.1.4 The application of triangulation

With a triangulation principle applied in this research, three main approaches were employed at different stages of the research, including literature review and semi-structured interviews as the qualitative approaches and online questionnaire as the quantitative approach. As Figure 4-1 shows, these three approaches were respectively introduced as progress developed. The top-down analysis of PbR in mental health began by evaluating the fundamental theories underpinning PbR, which led to the following evaluation of the constructional problems of the system. The latter identified the research objectives and the key issues surrounding MH PbR, which facilitated the design of the fieldwork. Next, the fieldwork

data collection and analysis followed the bottom-up principle. In the second stage, the face-to-face semi-structured interviews were undertaken to capture different perspectives towards MH PbR, including the effectiveness of key components, perceived problems, potential risks and the corresponding solutions. The preliminary findings derived from the interviews facilitated the design of the online questionnaires. In the third stage, the online questionnaires mainly verified the preliminary findings. In the end, all findings were gathered and analysed as a whole.

Regarding the fieldwork, the characteristics of the main approaches, including interviews and online surveys, are critically analysed, and the reasons for adoption are stated below.

Figure 4-1 Research design



4.1.4.1 Semi-structured interviews

The one-to-one interview is regarded as one of the most commonly adopted approaches in the qualitative “toolbox” (Barbour, 2003). Compared to the telephone interview, the participants in face-to-face interviews tend to be more cooperative and thus provide a deeper understanding of the research topics (Parahoo, 2006). Among face-to-face interview approaches, semi-structured interview research is the most popular and often favoured by qualitative researchers, due to the freedom given to interviewees and, at the same time, the ability to maintain order of the structure (Barbour, 2008). Rather than structured interviews, semi-structured interviews elicit data according to the salient perspectives of participants without strictly dictating the direction of the encounter. During the process of conducting the semi-structured interviews, Grounded Theory Methodology (GTM) was employed to construct theories and therefore, develop the structure for the online surveys.

In this study, the snowball principle was employed for the sampling, since professional individuals are difficult to access and whether or not the individual is suitable is hard to justify only if evaluated by other professionals (Rice and Ezzy, 1999). Additionally, snowball sampling is also considered optimal in this field since some degree of trust is required to initiate contact (Atkinson and Flint, 2001). In Saunders’s (1979) research, the snowball sampling method was adopted to reach urban politicians, who were considered to be a group of people “hard to reach”. This suggests the appropriateness and feasibility of applying the snowball sampling method in this study. By adopting the snowball principle, the sample started from a small group of individuals who are the key personnel of

commissioners, hospital managers or frontline staff. Through their social networks, potential participants who meet the eligibility criteria were nominated to enlarge the sample size (Atkinson and Flint, 2001).

Nevertheless, the drawbacks of interviews were noted. Firstly, the depth of the findings limits the amount of sample and thus hinders the representativeness of the study, since the sample of the interview has to be small otherwise analysis could turn out to be cumbersome, especially with snowball sampling principle (Ellis, 2010). Secondly, interviewed individuals are easier to be identified given their professional positions (this will be discussed in Section 4.3.1.1).

4.1.4.2 Online surveys

Regarding online survey research, its merits and drawbacks are almost a mirror image of the interview approach (Williams, 2003). Firstly, online questionnaires could be sent to a larger range of subjects. However, the "chain referral" is considered as one of the potential risks that may generate under snowball sampling (Atkinson and Flint, 2001). Given that referrals largely depend on the subjective perceptions of initial respondents, it may be biased towards the inclusion of individuals with interrelationships, especially when variations in social traits exist among individuals and the selected sample is not representative (Griffiths et al., 1993). In this respect, the increase in sample size can address this selection bias by expanding the coverage and representativeness using online surveys even though the response rate could be lower. Secondly, the potential risk regarding the confidentiality is much lower than for interviews. Therefore, the responses to sensitive topics

are more likely to be true and much less likely to cause respondents' stress (De Vaus, 2014). Therefore, using the results of a few interviews as the structure of online questionnaire could take both the depth of understanding and the representativeness into account while reducing ethical risks as much as possible.

To address the limitation in sampling stratified sampling was employed in this study (Williams, 2003). Unlike the randomised sampling method that might lead to under-representation of particular groups while over-representation of others, stratified sampling could better select objectives with appropriateness and adequacy (Morse and Field, 1995). Given the currently delayed status of PbR with a lack of an accurate information system, the study failed to employ statistical analysis to analyse medical records or financial data. Therefore, data from the questionnaires were used as the only resource for quantitative analysis. Microsoft Excel and IBM SPSS 20 were employed as the devices for quantitative analysis.

As previously discussed, the semi-structure interview was set as the primary strategy for this study. As a result, the process of conducting interviews and analysing the data has a heavy influence on the quality of the entire study. In order to efficiently undertake and analyse interviews, the principle of Grounded Theory Methodology (GTM) was employed. The next section presents the essential background of GTM and its applications in this research.

4.2 Employing GTM principles

The bottom-up research GTM was first introduced in the 1960s (Glaser and Strauss, 1967). In contrast to the conventional methodologies that depart from a literature review, GTM formulates new theories firstly, largely relying on systematically analysed data, which is seen as able to develop deeper understandings of individuals' perspectives, particularly within a new research domain. However, due to the constraints of reality, the procedures could only be met partially in this study according to the ideas of Glaser (1998). This study thereby employed the principles of GTM to generate themes in a bottom-up order. This section provides an opportunity to elaborate how the GTM principle was employed in the process of conducting the semi-structured interviews by introducing the principles and core elements of the GTM, explaining why this study did not employ the "pure" GTM while presenting the correspondent strategies.

4.2.1 The Grounded Theory Methodology

Seen as a response to the predominately top-down qualitative research, Glaser and Strauss (1967) make it clear that the GTM aims to generate new theories from deeply investigating data and categorising interrelated themes rather than testing existing theories. In contrast to the pursuit of statistical generalizability, GTM focuses on exploring different perceptions of various individuals and explaining specific phenomenon regarding a particular subject area. Therefore, what GTM indicates and prioritises is the sequence of conducting research: data collection comes prior to the literature review. To ensure the theory generation process remains uncontaminated from the preconceived theories from the literature review, data

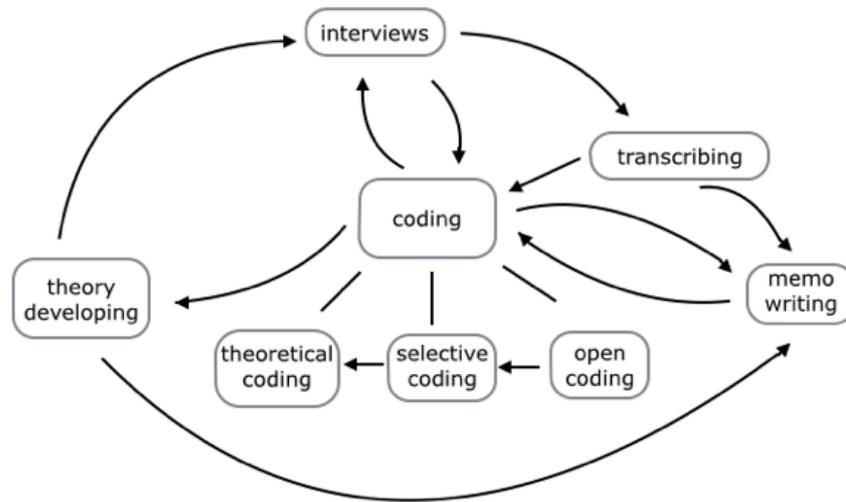
should be collected and analysed first to seek what the data truly indicates rather than shoehorning information into the pre-determined categories (Urquhart, 2012). Then, the ideas from existing literature could be referred to the theories built upon interviews. Bottom-up theory generation will be presented in the following data collection part. The following four sections outline the core elements of the GTM, including data collection, coding process, data analysis, and memo writing.

4.2.1.1 Data collection

As previously described, a successful GTM study relies largely on data collection and analysis. Figure 4-2 outlines the skeleton of conducting interview and data analysis, which could be described as an iterative cycle of both induction and deduction (Strauss and Corbin, 1990). Different from conventional methods of performing data analysis, the identification and categorisation of data are the key elements of the data collection process. As Figure 11 shows, coding, the process of identifying and preliminary categorising data, occurs immediately following the interview. Without any preconceived categories, identifying variable starts with line-by-line open coding. Through the following selective and theoretical coding, information segments are summarised and categorised into meaningful theme groups. The theme clusters are further extracted to develop new theories and to facilitate the sampling and interviews which follow. Without guidance from previous studies, the quality of information identification and analysis has a heavy influence on the quality of the study as a whole. Therefore, a constant comparison between results and new findings intra- and inter- interviews is employed alongside the memo writing strategy to ensure the quality of data and theory

(Miles and Huberman, 1994).

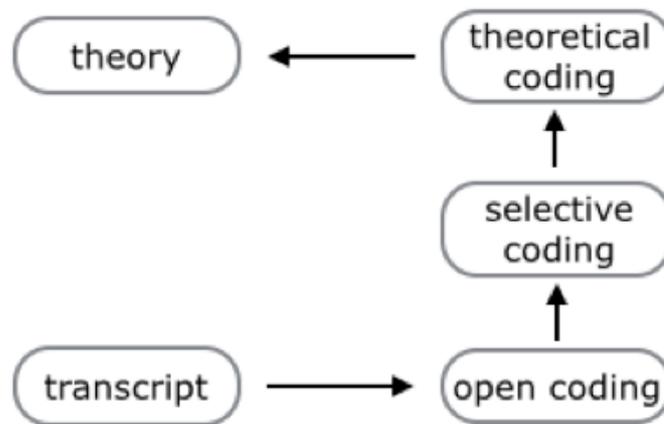
Figure 4-2 Induction and deduction process of data collection



4.2.1.2 Coding process

The coding process is seen as a process of capturing the interview data, grouping them into meaningful clusters and linking them together. Despite the splitting perspectives in terms of the specific steps (Glaser, 1992; Strauss and Corbin, 1990), three stages are widely accepted as the core procedures: open coding, selective coding and theoretical coding. Given that this study only involved the general principle of GTM rather than the “pure” GTM, the following section provides a brief overview of the general principle this study adopted informed by Glaser’s (1992) theory as shown in Figure 4-3.

Figure 4-3 Bottom-up coding process



According to Glaser (1992), the process of coding is a process of building up theory from the ground: material selection, structure construction and theory extraction. As the first step, open coding indicates the process of attaching codes to data through line-by-line reading of the transcripts. As Glaser (1978) points out, open coding with “free minds” calls for a theoretical sensitivity to capture all of the potential meaningful information. The outcomes of open coding are rough information about phenomena, such as events, objects and actions. Open codes are further grouped in the selective coding phase. The links between codes are then identified and these codes are then merged into different categories that are not mutually exclusive. Since different themes could be extracted from one sentence, different categories could share same properties (codes). As the last phase of the coding process, relationships and links between different categories are explored in the theoretical coding phase. In this stage, theories are extracted by investigating the relationships between categories.

4.2.1.3 Data analysis

Within the induction-deduction cycle, a constant comparison is seen as the key component of the data coding and analysing process. A constant comparison enables the coded data to accurately represent interviewees' initial ideas and the inducted categories to deduct reliable theories by constantly comparing the information segments and the whole context of the transcripts, the labelled data within and between categories, the ideas extracted from various interviews, and the data being coded now and the ones already coded (Urquhart, 2012).

As Charmaz (2006) suggests, multi-stage sampling and data collection enhance the effects of constant comparison through the reaction of emerging concepts and findings in the subsequent interviews and therefore, guiding the upcoming data collection. There is no specific rule regarding sample size in qualitative research. However, according to the principle of gathering information under GTM, sampling is suggested to end when data saturation is reached, in other words, there is no new concept or category to extract, and the results begin to appear redundant (Josselson and Lieblich, 2003).

4.2.1.4 Memo writing

Referring to Glaser's description of memo writing, it is considered the "bedrock of theory generation" (Glaser, 1978). The constant breaking of data collection, coding or analysis progress to write down fragments of thoughts allows ideas to be recorded (Bryant and Charmaz, 2007). The memos recorded from non-linear timing enable creative sparks to be captured and aids the process of abstraction. Constant comparing memos with the labelled data, the categorised clusters and the

emerging concepts reminds researchers of new ideas which may be reflected in the subsequent data collection and analysis.

4.2.2 The application of GTM principles

Referring to Glaser (1978), the concept of “theoretical sensitivity” explains the relationship between the literature review and data collection: literature review should only be employed as the guidance to understand how the theories are constructed if it is conducted before data collection and it is important to keep “an open mind” throughout data collection (Dey, 1993). As Urquhart (2012) indicates, whether or not using the concepts from the literature review determines whether or not the research method is “pure” GTM. As previously discussed, the literature review was conducted prior to the interviews, which indicates that the research method could not be called “pure” GTM. However, the general principles of GTM were employed during the interview phase. The following section explain the reasons for not using “pure” GTM”, present the reasons for applying GTM principles and present how they were applied in the interview phase.

4.2.2.1 Why not apply “pure” GTM?

As Rennie (1998) illustrates, besides the “open mind” without the “contamination” of literature, researchers should avoid using questions that are categorised for coding when designing an interview structure. However, the “open mind” is regarded as a strict criterion for studies, particularly for the ones in health care.

1) The potential risk of “pure” GTM

Purely relying on interviews could possibly lead to a result in which the theory generated and the researchers’ own versions of reality presented within the study are too remote from the “normality” of society (Heath, 2006). Additionally, when dividing data into individual words, the focus of the study and the meaningful concepts may become lost within the minutia of data (Allan, 2003). In other words, a comprehensive acknowledgement of background and context is crucial to the process of understanding and interpreting data (Patton, 2002). As Powell and DiMaggio (1991) argue, the research design should be examined within the research context regarding research problems and data collection strategy to prevent potential risks from occurring.

2) Structure overlay

This study attempts to evaluate the implementation of PbR in mental health, which is part of the government’s wider reform agenda and, therefore, is inevitably influenced by external factors. To objectively and comprehensively reflect the reality, codes from previous studies, which are the preconceived categories, should be considered before collecting additional data. Particularly, for the terms such as “Gaming”, “up-coding” and “cream-skim” and the abbreviations such as “HoNOS”, “MHCT” and “RiO”, the relevant information should be previewed prior to conducting the interviews in order to follow the conversation.

3) Ethical considerations

The study was conducted in health care, which is considered to

be a sensitive area. Any research subjected to the NHS will be carefully scrutinised before clearance is granted. The detailed research proposal specifying research problems, research design, methods adoption and sample obtainment, together with other relevant documents had been submitted to University Ethics Committee and NHS Research and Development before the interviews were conducted (this will be discussed in Section 4.3.1.1). Therefore, the literature review was performed to understand the research context, develop research questions, identify research objectives and subjects, and formulate research design to satisfy the requirements for the ethics clearance.

4) Difficulties for non-focused interviews

Regarding the “no preconceived idea” during the data collection, the researchers are expected to have no particular research schedules and be led by the participants in interviews (Glaser and Strauss, 1967). However, regarding the research subjects - commissioners, hospital managers and frontline clinicians, who are busy people in the commissioning circle, the non-focused investigation is difficult to carry out due to time constraints. As a result, the interview structure was included in the invitation email sent to target participants in order to attract their interest in participation.

4.2.2.2 The application to the research design

Regarding the research context, the application of PbR is not a new topic as PbR has been introduced in acute services since 2003/04 and indicates available studies on the impacts of PbR in this field. Within such studies, some outcomes could indicate

the influential factors for implementing PbR in mental health, such as the validity of the classification system, derived targets and frontline involvement. This is the reason for performing the literature review before conducting interviews. Additionally, since PbR has not been fully implemented in mental health yet, the inductive approaches could be adopted to explore the current stage of PbR implementation and the driving factors of its delay from the frontline. In the interview phase, focus was placed on participants' experiences and views towards the implementation of PbR in mental health and the emergent obstacles. Given the lack of existing primary studies regarding the implementation of PbR in mental health, under the super-categories settled by the previous literature, concepts could still generate from the ground, which was the reason for applying GTM principles in the interview phase. The following paragraphs explain how to apply these principles in the data collection and data analysis process: specifically, interview structure design, data collection, induction and deduction, and memo writing.

1) Interview structure design

Besides adopting the literature review to facilitate the formulation of the interview structure, the interview process could still have some generative components. Although pre-conceived categories were applied to some questions, such as: "What is your perspective on "gaming" behaviours?"; the concepts could still emerge from the open-ended questions such as: "What is your broad understanding of MH PbR?" The open-ended questions allowed participants to recall their experience regarding MH PbR and express their opinions freely. Semi-structured interviews also encouraged the interactions between the researcher and the participants while leaving the scope for

the participants to lead the interview (Bryman, 2001). The interviews were conducted as progressive repetitive cycles (this will be discussed in Section 4.3.1.3). The relevant information was extracted from the participant's responses, and then guided the next questions. The progressive repetitive cycle of flexible questions enabled the participants to express their perspectives to a larger extent under a broadly pre-outlined structure.

2) Data collection

As Urquhart (2012) elaborates, bottom-up concept generation can still happen to some extent under pre-defined categories, which is called the "thematic framework". In addition to being constructed from the literature review, the thematic framework was also underpinned by the concepts emerging from the interview data itself. Through constant comparison, the framework was tested and refined by being applied to the phenomenon. The transcripts were analysed in two ways: disassembled and reassembled following GTM principles. At the first stage, each transcript was reviewed, and any meaningful information related to the research questions and objectives was captured and coded. Next, the transcript was disassembled into small units by different codes that represented certain phenomenon. According to the codes, the interrelated information across all transcripts was sorted and shifted into the corresponding groups. The broader clusters of similar concepts were formed. Finally, all clusters were deduced into theories according to the research questions and objectives.

3) Induction and deduction

Against the potential risk that the integration of philosophy

expressed by participants could be destroyed by the disassembling codes (Spradley, 1979), a constant comparison was conducted between individual concepts, and the individual codes and the transcript as a whole, respectively. The generated themes were tested in the subsequent interviews guided by the theoretical sampling principle: at the end of an interview, one participant was asked to recommend key personnel in a particular group according to the content of the interview. For instance, a hospital manager was invited to recommend a colleague since the content of the interview had been mainly about managerial-level perspectives, while another manager was requested to recommend frontline clinicians since some judgements made on frontline clinicians' performance had been observed during the interview. The sampling process ended when there was no new information extracted from the interview, which is when the categories become "saturated" (Glaser, 1978).

4) Memo writing

During data collection and analysis, memos were kept in both handwritten and electronic form. Anything thought to be relevant, such as the name of code, relationship between codes, induction process or the modification of interview structure, was recorded throughout the entire process. Memos were used to outline the relationship between codes and the corresponding clusters, to constantly check the consistency between individual codes and the entire transcript and to help sort ideas to build themes.

4.3 Research design

As presented earlier, this study was conducted in three stages. The theoretical analysis of the fundamental theories and the construction of MH PbR determined the research subjects for the subsequent empirical studies involving commissioners, hospital managers and frontline clinicians. This section presents the detailed process of conducting the empirical study: the semi-structured interviews and the online surveys.

4.3.1 Qualitative study: Semi-structured interviews

Semi-structured interviews have the capacity to ensure the comprehensiveness of interview coverage by predetermined thoughtfully-worded questions while leaving some flexibility to explore certain subjects in greater depth (Patton, 2002). The process of conducting the semi-structured interviews is presented from five aspects: 1) gaining access, 2) sampling and ethical consideration, 3) conducting interviews, 4) transcribing and data importing, and 5) coding and developing theories.

4.3.1.1 Gaining access

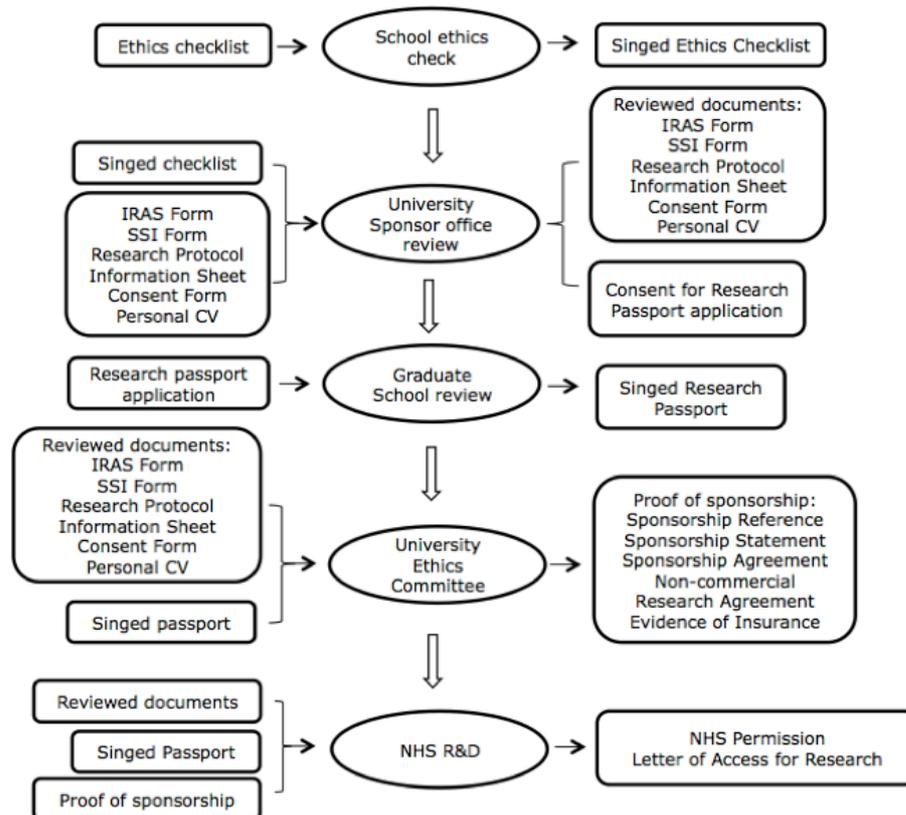
Given that this research is a case study of Nottingham, in order to present a multi-angle perspective on the implementation of PbR in mental health in Nottingham, the research sites were set as Nottinghamshire Healthcare NHS Foundation Trust, Nottinghamshire County CCG and Nottingham City CCG. According to The Ethics Code of the University of Nottingham, approvals from the Research and Development (R&D) office of each NHS Trust and CCG involved are required prior to the commencement of empirical studies. Acting as the research sponsor, the University Sponsorship Office reviewed all

documents relevant to the research in order to issue the sponsorship before the submission of R&D applications. Therefore, by considering the ethics issues, the following documents were provided as required: the Ethics Checklist signed by the School of Sociology and Social Policy, the Research Protocol that illustrated the research significance and presented the research design, the Integrated Research Application System (IRAS) form that provided detailed information related to the studies to be carried out, the Site-Specific Information (SSI) form that provided detailed information related to the organisations where the interviews were to be carried out, the Participant Information Sheet that provided interview-related information to help potential participants consider their participation in full detail, the Consent Form to be signed by the participants, the interview structure that provided a general structure of the interview (please see Appendix 1), Personal CV, Research Passport and Evidence of Insurance signed by the University.

Figure 4-4 illustrates the process of obtaining access to these organisations. After the School Ethics Committee approved the research proposal, the above documents were submitted to the University Sponsorship Office for review. After obtaining consent from the Sponsorship Office, the Research Passport was signed by the Graduate school. Next, the reviewed documents together with the signed Research Passport were submitted to the University Ethics Committee. Following its review of all relevant documents, the University Ethics Committee issued the Sponsorship Reference Number that was to be attached to the IRAS form, Sponsorship Statement, Sponsorship Agreement, Non-commercial Agreement and Insurance Agreement. The IRAS Form and the SSI form with the reference number

attached were submitted online, and other approved documents were submitted in hardcopy to the NHS R&D departments of each participating organisation. Lastly, access to these organisations was granted.

Figure 4-4 Flowchart of ethics-related document preparation and approval application



4.3.1.2 Sampling and ethical considerations

As previously justified, the small population of professionals in health care, together with the absence of access to the contact list, constrained not only the sample size, but also the methods available for sampling. Accordingly, snowball sampling was adopted in accessing “hard-to-reach” professionals in the healthcare commissioning cycle. This study followed Saunders’s

(1979) and Farquharson's (2005) strategy to use a "reputational method" to identify potential candidates by peer-nomination. The interviews began with the chief investigators' personal contact. The high-level managers from the three research sites (Nottinghamshire Healthcare NHS Foundation Trust, Nottinghamshire County CCG and Nottingham City CCG) showed their willingness to engage. According to their referrals, the potential participants who met the eligibility criteria were nominated. The snowball sampling process followed a repetitive learning cycle (this will be discussed in 4.3.1.3), according to which the interviewee was asked to nominate colleagues in relation to the key points derived from the interview. For instance, a hospital manager was requested to nominate a frontline colleague when their perspectives on daily clinical practice or frontline clinicians' involvement had been observed during the interview.

However, this study noted the potential risk created by the snowball sampling as it might compromise the confidentiality of key personnel (Faugier and Sargeant, 1997). Taking privacy into account, key personnel were informed about the study in great detail before obtaining their consents to participate. Potential participants were initially approached through a formal email introducing the research aims and objectives and explaining the reasons for inviting them. At the same time, the information sheet and interview structure were attached to each invitation email. The information sheet reminded the potential participants of their right to refuse to participate and, therefore, withdraw from the study at any time without consequence. Anonymity and confidentiality related issues were explained in the information sheet. The attached interview structure outlined the structure to attract their interests and to ensure them that

there would be no identifiable information asked in the interview. After obtaining their approval, interviews were arranged in their offices or seminar rooms at their location. To further protect participants' privacy, they were asked to read the information sheet again at the beginning of interview in case they had not done so previously. The recording issue was mentioned again and reiterated for their consent. They were then asked to sign three copies of the consent form before the interview officially started.

As explained earlier, qualitative research is more apt to increase the scope of data through purposive or theoretical sampling. Therefore, there is no exact sample size set (Lincoln and Guba, 1985). The interview process stopped after the 13th interview (including a follow-up with two participants) since no new information was found in the transcript.

4.3.1.3 Conducting interviews

As Rudestam and Newton (2007) state, despite ensuring that interviews should be loosely designed and flexible to allow participants to express their opinions freely, they should be conducted under a general framework constructed by the pre-conceived categories. In light of the differences in professional roles, the contents of interview structures shared the same general constructor but differed on the focal points subject to the three interest groups, including commissioners, hospital managers and frontline clinicians. For commissioners, questions were set relating to their current collaboration with providers and their understandings of contract negotiation and quality monitoring. Questions for managers aimed to obtain their understandings at the strategic level, while questions for

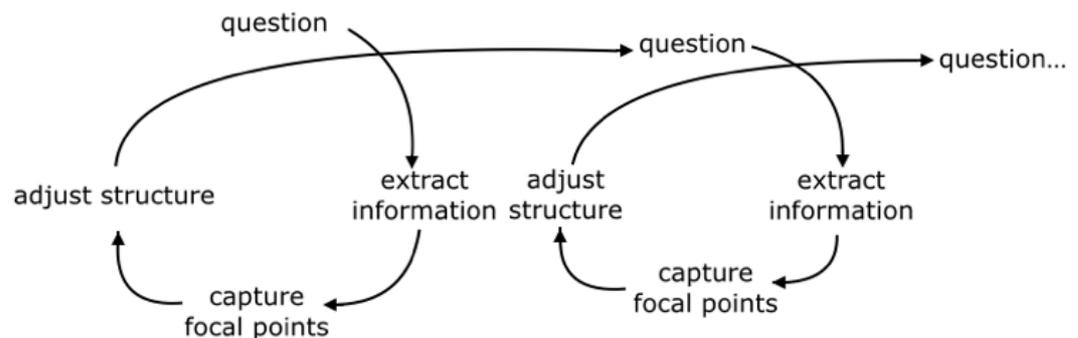
frontline staff sought to explore the practical implications of MH PbR and how it affected their daily clinical activities.

To encourage participants to recall their experiences and express their perspectives on the implementation of MH PbR as much as possible, the interview was designed in a four-stage structure. The interviews started with general questions, such as their current roles and responsibilities regarding MH PbR commissioning, in an effort to get participants think about the topic. Next, the open-ended question "What is your understanding of MH PbR?" was asked to allow participants to express their perspectives about MH PbR freely without any "contaminant" from the pre-determined categories. Subsequently, to help participants sort out their thoughts, questions about more detailed information were proposed from two aspects: the objective information about the current stage of the implementation of MH PbR and the subjective information about their understandings towards key elements (such as the MHCT, the HoNOS, quality measurements and training sessions) within the commissioning cycle. At this point, pro forma questions, or additional new questions, were adopted according to the participant's response. The pre-determined categories were employed to help the participants sort out their ideas and promote their emanative thinking. In the third stage, the focal point moved back to the general issues subject to the factors that caused the delayed implementation and the corresponding solutions. The previous questions subject to the key elements within the commissioning cycle were expected to help participants better summarise the driving factors and thus propose the corresponding solutions.

By applying GTM principles, the interviews were conducted

following progressive repetitive cycles, particularly in the second and third stage of the process. As Figure 4-5 presents, questions were proposed following an induction-deduction sequence. Firstly, the starting question was proposed, and then the relevant information was extracted from the participant's response, at which time the interview structure might be adjusted according to the specific information the participant provided, leading to questions designed for further exploration of the specific perspective of the participant.

Figure 4-5 Interview conduction



4.3.1.4 Transcribing and coding

The interviews were recorded with a digital audio recorder for fidelity. Meanwhile, written field notes were taken to capture the key points during the interview and help extract themes during the coding process.

After importing the recorded voice file to the PC, Microsoft Word was used for transcribing. When transcribing interviews, each participant was numbered and coded according to their posts: the commissioners were coded as "C", the hospital managers were coded as "M" and the frontline staff were coded as "S". Against the potential risk that the totality of philosophy

expressed by participants would be damaged by the disassembling codes (Spradley, 1979), transcripts were analysed in two ways: disassembled and reassembled following GTM principles, and reviewed entirely. After importing all transcripts to NVivo, each transcript was reviewed first and conceptual labels were attached to any information relevant to the research objectives within the theoretical framework following GTM principles. Since the Dialogue Analysis was not adopted as the analytic method, the sentences, such as "Do you know what I mean?" asked by the participants for a double-check were not coded. The codes were not strictly devised at the microscopic level, rather, more abstract concepts emerged at this stage: some labels consisted of the actual words of the conversation (e.g. "complicated system"), while other labels, such as "inconsistent training", were summarised from content.

While keeping the objectives and the theoretical framework in mind, as many interpretations as possible were made from the data (Charmaz, 2006) by asking myself: "What does this mean?", "What is its contribution to the research objectives?" and "What is the relationship between this and the pre-determined categories?". Since the pre-determined categories were not mutually exclusive and more than one concept could be extracted from one section of text, the same section of text could be assigned to more than one code and thus contribute to more than one theme.

4.3.1.5 Developing theory

After the transcripts were disassembled into small units, the process of theory development began, including organising and re-arranging codes, merging concepts and extracting theory.

Within the theoretical framework, the pre-determined categories were set as MH PbR overview, current stage implementation, the MHCT, the HoNOS, the MHCT care pathways, outcome measurement, "Gaming" behaviours, driving factors and solutions according to the theoretical analysis. According to the codes, the interrelated information was sorted and allocated into certain segments. Then, the broader groups of similar concepts were formed in one of two ways: from summarising similar concepts, and from examining the coded transcripts. At the same time, to ensure the accuracy of the emerging concept process, when forming the broader groups, the meanings of the specific concepts were examined by constantly comparing the individual codes with the transcript context. Facilitated by the memos, similar concepts were arranged in the corresponding, pre-determined categories. For those that could not be linked to the pre-determined categories, they formed new categories rather than being shoehorned into the pre-determined ones.

At last, all categories were concluded to themes according to research questions and objectives. Therefore, the themes were extracted as "moving from the Block Contract", "current stage of implementing MH PbR", "intra-system evaluation", "driving factors for the delay" and "suggestions for future improvement". Within the process as a whole, the accuracy of the data was confirmed by reviewing the entire set of individual transcripts before coding, categorising and concluding.

4.3.2 Quantitative study: Online surveys

As Patton (2002) indicates, quantitative measurements are adopted as the conventional means to minimise the subjectivity

in qualitative research and to maintain objectivity. Given that the semi-structured interviews have discovered what was happening, it is important to examine to what extent the preliminary outcomes fit into the general reality (Patton, 2002). However, the difficulties in obtaining research permission and approaching to sample population confined the generalizability of this study. The following sections elaborate how confirmation for the preliminary outcomes in a constrained situation were sought during the four main stages: 1) questionnaire design, 2) pilot testing, 3) gaining access and disseminating questionnaires, and 4) data collection.

4.3.2.1 Questionnaire design

As Bulmer and Warwick (1993) indicate, an in-depth qualitative enquiry of a research area is the foundation of a high-quality questionnaire. Therefore, the questionnaires were formulated based upon the preliminary outcomes derived from the semi-structured interviews. Questions, and the corresponding options, were primarily based upon the pre-categorised sections derived from the interview analysis. According to De Vaus's (2014) suggestions regarding the order of questions, one section of general questions about respondents' current posts and major responsibilities was added as to put respondents at ease. Given the different professions, three versions of the questionnaire were designed targeting commissioners, managers and frontline clinicians, respectively (please see Appendix 2). Regarding the contents of the three versions of the questionnaire, they shared the same structure comprising four main parts: "General questions", "Current stage of implementation", "Driving factors for the delay" and "General attitude". Regarding the content, for commissioners, questions

were set subject to the general issues surrounding the contract and political targets, such as the percentage of patients clustered and C1-C3 discharged. For managers, questions were set targeting both administrative level and clinical level. For frontline clinicians, more emphasis was placed on the daily workload and their perspectives of the feasibility of the sub-systems according to their experiences. Regarding the profession, details relating to the classification system, such as the validity of each instrument, were subject to managers and frontline clinicians, whereas commissioners were expected to express their broad understanding of it.

The majority of questions were set as forced-choice questions in consideration of viability and credibility. As De Vaus (2014) illustrates, forced-choice questions are quick to answer and thus useful when people's motivations to answer are not very high. This is particularly the case for the NHS staff who have tight schedules. Additionally, open-ended questions present potential risks for interpretation: researchers may misclassify the responses due to their misinterpretation of the answers. Force-choice questions remind respondents of different possibilities towards the asked issues and provide a range of options for respondents to choose the one closest to their answers. However, as Robson (1993) argues, a questionnaire that is mainly formulated by forced-choice questions is not able to provide respondents sufficient space to express their opinions and thoughts. To avoid providing respondents with a feeling that their answers are shoehorned into pre-determined options, much thought was put into the questionnaire design process and pilot testing was employed to further refine the questions.

Regarding the types of responses, numerical rating scales were

used to explore respondents' opinions towards the design of MH PbR and the driving factors that caused the delayed implementation. Other types of questions, such as multiple choice, checklists and ranking, were used to enable the application of a wide range of statistical methods. Given the possibility that the questionnaires came across some issues that respondents had not thought about or felt difficult to give an answer, "not known" was added as the last choice in some questions. To allow respondents to express their thoughts without being completely restrained by the closed-choice questions, "other (please specify)" was provided subject to some questions that sought respondents' attitudes.

4.3.2.2 Pilot testing

As Blaikie (2000) suggests, questionnaires should go through pilot tests before being officially disseminated. Pilot tests were undertaken to identify any ambiguous or misleading question and to refine response options to ensure that they provide a sufficient range of answer choices to cover all responses. Since the research subjects are highly professional, the sample population is very limited, which limited the number of pilot tests as well as responses. For the pilot tests, three questionnaires were sent to three people among whom, each represented one interest group. They were requested to complete the questionnaire and provide comments regarding content and length.

During the pilot tests, the feasibility and its compliance with the research objectives were verified while some changes were made to the questions and the order of the answer choices. For instance, Question 4: "Service quality should and can be

properly measured” was amended as two different statements: “Service quality should be properly measured” and “Service quality can be properly measured”. The reason for this change was that the previous statement comprises two different meanings in one sentence, which may lead to respondents’ confusion when they agree that service quality should be properly measured but disagree that service quality can be properly measured, or vice versa. Regarding Question 7: “Overall, do you think PbR should be implemented in mental health?”, the previous answer choices were in an order of “yes”, “no”, and “hard to say”. The order was adjusted to “yes”, “hard to say” and “no” to better reflect the display logic of the answer choices.

4.3.2.3 Gaining access and disseminating questionnaires

The process of obtaining permission for conducting the online surveys was the same as that for the semi-structured interviews. The application for expanding research activity was sent to the University Research Governance Office. After obtaining the approval, the amended SSI form and the IRAS form were submitted online, and other relevant documents were sent to the corresponding organisations in hardcopy. Given the possible low-response rate in researches involving NHS staff, Derbyshire NHS Foundation Trust was selected as a fourth research site. As Figure 4-6 shows, Nottinghamshire and Derbyshire share similar geographic characteristics regarding the health conditions, risk factors and level of mental health and illness of the population. The treatment and the corresponding outcomes provided by the trusts within these two areas are also similar. Therefore, no perceivable bias was expected to occur by adding Derbyshire NHS Foundation Trust into the survey sample,

although this research was conducted as a case study of the implementation of MH PbR in Nottingham.

Figure 4-6 Basic mental health information in Nottinghamshire and Derbyshire compared to the average level of England (Public Health England, 2013)

	Nottinghamshire value	Derbyshire value	England value
Wider Determinants of Health			
Working age adults who are unemployed, rate per 1,000 population, 2010/11	21.1	27.1	59.4
Rate of hospital admissions for alcohol attributable conditions, per 1,000 population, 2011/12	22.4	23.8	23
Numbers of people (aged 18-75) in drug treatment, rate per 1,000 population, 2011/12	5.4	4.1	5.2
Risk Factors			
Statutory homeless households, rate per 1,000 households, all ages, 2010/11	1.14	1.26	2.03
Percentage of the population with a limiting long term illness, 2001	19	19.2	16.9
Levels of Mental Health and Illness			
Percentage of adults (18+) with dementia, 2011/12	0.61	0.62	0.53
Percentage of adults (18+) with depression, 2011/12	10.73	12.62	11.68
Treatment			
Directly standardised rate for hospital admissions for mental health, 2009/10 to 2011/12	212	334	243
Directly standardised rate for hospital admissions for Alzheimer's and other related dementia, 2009/10 to 2011/12	148	187	80
Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders, 2009/10 to 2011/12	45	50	57
Numbers of people using adult & elderly NHS secondary mental health services, rate per 1000 population, 2010/11	2.2	2.1	2.5
Number of total contacts with mental health services, rate per 1,000 population, 2010/11	255	300	313
Outcomes			
Improving Access to Psychological Therapies - Recovery Rate, 2011/12	47.8	47.6	43.8
Excess under 75 mortality rate in adults with serious mental illness, 2010/11	962	1,149	921

Due to the sensitivity of the NHS, the access to a contact list was not granted together at the time of research permission. Without access to a sample population, randomised sampling was not an option. Therefore, the stratified snowball sampling method was used to approach potential respondents. Participants who had taken part in the semi-structured

interviews were regarded as the starting point of the snowball sampling. The sampling process shared the same process with that adopted in the interviews. Regarding the study with Derbyshire NHS Foundation Trust, due to the constraints of ethical clearance, no access to the contact list of the medical professionals was granted. In this respect, the officers in the R&D office were contacted with a requisition to circulate the invitation email among their colleagues.

As stated in the research protocol that had been used to apply for research permission, the deadline for the online surveys was set as September 30th, 2014. Under such circumstances, any response after the deadline was considered invalid. To increase the number of responses, the second stage of invitations were sent to the interview participants and the R&D officers at Derbyshire NHS Foundation Trust as a reminder in the middle of August. By the end of September 30th, 2014, a total of 51 responses were received and subject to data analysis as discussed below:

4.3.2.4 Data analysis

MS Excel was adopted to screen the data prior to the statistical analysis. During the screening process, different standards were set according to the participants' positions. The hospital managers and the clinical staff were assumed to have a deep understanding of the technical issues regarding the classification system and the driving factors for the delayed implementation. Therefore, any case with incomplete responses for these two parts was regarded as not valid. The nurses were assumed to know more about the daily frontline practice than the technical issues. As such, cases with responses regarding

workload were kept regardless of their answers to the intra-system evaluation and driving factors. After screening the responses, 38 were seen as valid and subject to data analysis. To accurately and comprehensively capture all of the information, a codebook was developed to define each variable and assign numbers to all responses. Given the different questions for the three interest groups, the missing values were coded in one of two ways: 99 represented values that should have been valid but were missing and 1000 represented those not applicable to the particular group.

IBM SPSS 20 was used to analyse the quantitative data screened and coded in MS Excel. Given the fact that most of the variables were either categorical or dimensional rather than continuous, descriptive statistics, such as frequencies, were used to explore the background information regarding the current posts of the participants, the collaboration between the managers and commissioners, managers and frontline clinicians, respectively. Cross-tabulations were adopted to explore the associations between variables based on interest groups. Chi-square tests further explored statistical differences in the distribution of variables based on contingency tables (Pallant, 2010). Regarding the ordinal variables that were used to test the importance of driving factors, considering the sample population and distribution, The Mann-Whitney test was used to explore the differences in perspectives between interest groups. $P < 0.05$ was adopted to detect the statistical significance (Bryman, 2001).

Summary

This chapter introduced and discussed the choice of the research design, with particular attention paid to the methods adopted for the fieldwork. The introduction of the types as well as the major benefits of triangulation, criticisms of the paradigm and the potential risks facilitated the research regarding the adoption of between-methods triangulation. The interview research was set as the primary approach, whereas the questionnaire research was adopted to verify the findings derived from the previous qualitative research.

Drawing on the importance of the semi-structured interviews, the second section explained how the quality of data collection and analysis at the interview stage would be insured: by employing GTM principles. Given the constraints of the study, only the bottom-up analysis principles of GTM were applied rather than “pure” GTM. This helped to formulate an iterative cycle in different stages of the interview research including structure design, data collection, induction and deduction, and memo writing.

Based on the design of research and the adoption of the leading strategy, the third section provided detailed information about the process of conducting the fieldwork. For a better understanding of the data collection and analysis in the interview stage, the first part described the process in a time-ordering sequence: gaining access, sampling and ethics consideration, conducting the interviews, transcribing and coding and developing a theory with a particular illustration of the application of GTM principles in practice. The second part discussed the key steps of conducting the online surveys, including questionnaire design, pilot testing, gaining access and

disseminating questionnaire, and data analysis with attention to the data analysis.

Based on the methodology and methods discussed in this chapter, the following three chapters present the findings from this three-step investigation. Chapter 5 firstly investigates issues surrounding the concept and construction of MH PbR to evaluate the validity and credibility from both the clinical and financial aspects, given its close relationship with the fieldwork. This chapter not only examines the formulation of the MH PbR policy, which is the process that transits the political intents to the detailed policies and targets, but also provides the knowledge basis and implications for the design of the interview structure. Chapters 6 and 7 analyse and discuss the findings from the semi-structured interviews and the online surveys, respectively, based upon the theoretical analysis in Chapters 3 and 5. Chapter 6 presents multi-level (managerial-level vs. frontline-level) and multi-angle (provider side vs. purchaser side) perspectives derived from the semi-structured interviews; and Chapter 7 presents and discusses the findings from the questionnaires to verify the findings from the previous qualitative analysis.

5. The formulation of the MH PbR policy: The application of standardisation

Introduction

As discussed in Chapter 3, it is difficult, if not impossible, to contract healthcare services in a standardised way. Not only is this a challenge in the price calculation aspect, but also in the clinical service management aspect. Based upon the evaluation of the fundamental theories, this chapter investigates the construction of MH PbR: specifically, in terms of commodification. By illustrating how MH PbR applies the “standardisation” principle to designing the classification system and the price calculation system, this chapter reveals the essence of the theoretical mechanism of MH PbR, through which MH PbR realises the political intents to commodify mental health services (this has been discussed in Chapter 3) into daily clinical practice in a form of categorising patients’ needs for care to inform the management of healthcare resources. Based upon the previous argument against the initiation of the policy, this chapter further identifies the functional drawbacks emerging in the formulation stage that have contributed to the delay. These identified drawbacks shed light upon the conduction of the subsequent fieldwork that focuses on the implementation of the MH PbR policy.

This chapter begins with a review of the development of PbR in mental health, with particular attention paid to the difficulties in classifying mental disorders with the same reliable laboratory measures used in acute services. This highlights the central importance of being able to distinguish illness type and the corresponding services, which depends upon a process of

“standardisation”. This also indicates that whether the MH PbR policy is well formulated depends upon the extent to which the classification system can accurately standardise mental health services and therefore the costs. The second section illustrates how this principle of “standardisation” is being applied in the MH PbR system. Sections 5.3 and 5.4 consider the mechanical shortcomings of the implementation of “standardisation” from the clinical and financial aspects, respectively. In Section 5.3, the MHCT classification system as a whole is evaluated in three steps: 1) is the identification of the ideal function of a quality needs assessment; 2) the investigation of the extent to which the MHCT/HoNOS achieves its goal; 3) an exploration of the problems caused by its shortcomings. The fourth section investigates the feasibility of applying the standardisation principle in the financial aspect, in which standardising a nationally-fixed tariff based upon average cost per need and treatment, together with the “gaming” behaviours derived from current financial pressures are also discussed. This chapter concludes with the perspective that the MH PbR policy is poorly formulated due to the failure to apply standardisation to the diagnostic classification system and thus the cost calculation system, which sheds light on the design of the following interviews and online surveys.

5.1 Mental health “diagnoses”: Processes requiring standardisation

As discussed in Chapter 2, the lack of clear diagnostic markers for mental disorders leads to greater reliance on professional judgement when appraising a patient’s mental condition, which is essentially a process of distinguishing “abnormality”. As

Rogers and Pilgrim (2010) illustrate, under the assumption that characteristics of any population conform to a normal distribution, frequently occurring behaviours are set as the standards of being “normal”, whereas the unusual behaviours, represented as extreme values in a the normal distribution, are regarded as “abnormal”. Practically, classification systems are designed as an attempt to capture “abnormal” phenomena from “normal” ones and thus identify the “shared characteristics” of the “abnormal” phenomena by arranging them into pre-determined categories to facilitate the provision of targeted treatments (Dalal and Sivakumar, 2009).

As discussed in Chapter 1, the ICD and DSM, two similar diagnosis-based classification systems, validate particular behaviours as abnormal and establish the privileged meaning for particular signs by a classification system (Foucault, 1977). This categorical model provides a “discrete entity” view of “abnormality”: pathology detected means “abnormal”, otherwise “normality exists” (Jablensky, 2009). This approach assumes that mental disorders can be meaningfully represented as distinct phenomena, and that variations among patients with similar needs can be reduced through standardising “shared characteristics” (symptoms). In other words, the development of the MH PbR policy is based upon the assumption that psychiatric disorders and their needs for treatment can be sufficiently described by a standardised framework reflecting “averaged” intensities and needs for treatment, and that the cost of providing such treatment can be appropriately estimated as the arithmetic mean of the current costs of providing comparable treatments incurred by comparable providers. The next section provides additional detail regarding how these related processes of standardisation have been operationalised.

5.2 PbR: Twofold standardisation

As discussed in Chapter 2, PbR uses a fixed price system that creates a direct link between the costs (calculated based on average unit costs) and the number of cases treated in any particular case group, called the “cost-and-volume” payment system (Farrar et al., 2009). Within it, payment is made towards a particular case and treatment (care package) regardless of provider. This is conducted under the classification systems of HRG in acute services and MHCT in mental health services, respectively (Whelan et al., 2011). As already outlined, the concept of PbR consists of two main components: a series of fixed prices mainly based on national average cost and a classification system in which cases would be categorised into corresponding treatment groups with associated costs.

5.2.1 National average cost: Tariffs

To act as a quality improvement mechanism, rather than encouraging competition based on price, PbR requires a national average unit cost for each condition and treatment. To accomplish this, for each category of cases seeking treatment a national average unit cost of providing treatment, is derived from the mean value of the average total costs from all NHS providers, which is the “average of average” (Self et al., 2008a). This assumes that the costs of treating a particular category of cases incurred by different providers follow a normal distribution so that the arithmetic mean is a meaningful average. It also suggests that “deviances” can be categorised as the extremes of both sides of the cost distribution curve and an effect of pursuing “standardised cost” would be to reduce deviance employing “standardisation-to-the-average” principle (Department of Health, 2012b).

This approach to establishing a national tariff depends upon reliable ways of categorising cases for treatment that will allow costs to be apportioned to them in the same way across providers. In acute services, the HRGs reflect a system whereby the diagnosis is linked to the cost of care provided to a patient. Coded in ICD, HRG distinguishes “disorder” by diagnosing physical problems and categorises patients into certain groups in which the members share similar diagnoses, medical interventions and resource consumptions. National tariffs can then be mainly based upon this classification system and the average unit cost against each group, formulating one fixed tariff to that particular group. Various adjustment tariffs are added to the reference costs to compensate for such things as local differences in costs, aiming to bring in incentive mechanisms for high-quality services (Farrar et al., 2007).

This approach is only valid if cases seeking treatment can be categorised in such a way that is both reliable and reflects relatively predictable resource implications. The implementation of PbR in mental health has hinged upon the development of a scheme of classification intended to achieve this, which has become known as the MHCT.

5.2.2 The MHCT classification system

Supported by the general information presented in Chapter 2, the following section illustrates the general process of classification, which is the process of applying the standardisation principle to clinical service management.

According to *Mental Health Clustering Booklet (2012/13)* (Department of Health, 2012a), the standard process of

classifying a patient follows a standardised three-step assessment:

1. Based on the information gathered through routine assessment, rate the patient's needs using the MHCT.
2. Referring to the Decision Tree, allocate the case into one super-cluster amongst "non-psychotic", "psychotic" and "organic" based on its origin of disorder. Then, narrow it down to one of seven secondary clusters attached to these super-clusters.
3. Identify the specific cluster guided by the MHCT rating grids (designed majorly based on the HoNOS). The rating grids with colour coded rules according to which different colours indicate how likely the certain symptom is expected to be scored subject to the specific cluster help to exclude prohibited clusters from the remainders under the same secondary cluster.

In terms of converting MHCT scores to a particular cluster, a series of mathematical calculations calculate the Discriminant Fischer Scores indicating the best-fit cluster based on MHCT scores and consequently determining eligible clusters supported by the percentage fit for each one (Monitor and NHS England, 2013a).

Acting as the process of attaching payments to clinical activities, the pre-determined standardised care packages decreases "inappropriate" variations in service provision between patients with similar needs categorised by the MHCT, promote multi-disciplinary teamwork thus improving the quality and outcomes of healthcare interventions (Cabana et al., 1999). In the

financial aspect, care pathways facilitate an efficient use of healthcare resources and therefore, an accurate calculation of costs for commissioning (Jones, 2004).

In this respect, the validity of care pathways is crucial for the feasibility of a cost calculation. At the same time, since the care pathways are attached to specific clusters, their validity is partly determined by the accuracy of the classification system. Unlike the MHCT and the HoNOS that have already been applied in everyday clinical practice, the care pathway system as a separate element is still under development. This situation reflects two major problems: the conceptual flaws of the MHCT as a needs assessment instrument and, on the contrary, the difficulties in effectively managing needs and treatments in a standardised way, which complies with the findings in Chapter 3. Drawing upon the importance of standardising needs and interventions in reference to the payment system, the next section assesses why the attempt to standardise mental health services in this way fails to serve the purpose by answering three essential questions: 1) is it valid to classify mental disorders and their corresponding treatments according to predetermined standards; 2) does the collaboration between the HoNOS and the MHCT fulfil the function of a quality classification system; 3) if it does not, what are the initial problems of the MHCT classification system?

5.3 The principles of standardisation in the clinical aspect

According to the findings in Chapter 3, significant variations in mental disorders among individual patients are widely

recognised and make standardising needs and their corresponding interventions difficult. However, it is still possible to measure patients' needs and predict interventions in a relatively valid, reliable and standardised way. This was first established in the form of the MRC Needs for Care Assessment Schedule (NFCAS) (Brewin et al., 1987). However, due to its complexity and dependence upon specific training if it is to be used reliably, it has not been widely used in everyday clinical practice. The MHCT was designed and employed as an alternative instrument that is simpler and easier to use. Nevertheless, its simplicity and explicitness come at the price of losing validity and reliability in the accurate assessment of patients' needs. In particular, as an alternative, the conceptual flaws and accordingly, the constructional flaws of the MHCT classification system caused the failure to apply the standardisation principle to mental health service management. Therefore, this section elaborates this issue in four steps in a top-down order: outlining the complex nature of mental disorders, evaluating the theoretical viability of managing mental health services in a standardised way by evaluating the NFCAS, and examining the conceptual flaws and the corresponding constructional shortcomings of the MHCT classification system.

5.3.1 Complex nature of mental disorders

In contrast to acute services (facilitated by easily quantified indicators in largely known diagnostic and treatment systems), mental health is an area with significant variations among individuals, a lack of objective tests and a wide range of other uncertainties. The absence of biological markers that might otherwise explain aetiology and the heavy reliance on

symptoms rather than signs undermine the validity of mental diagnosis, which has led some to argue that a mental illness itself is a myth (Nesse and Stein, 2012; Szasz, 1961). As Rogers and Pilgrim (2010) state, the judgement as to whether one person is mentally ill relies mainly upon the person's communication. Additionally, given that mental disorders are mostly chronic and easily affected by external social factors, clinicians are no longer treating diseases; rather, they are treating human beings as a whole closely connected with other social situations (Emmerson et al., 2004). Seen as a highly individualised problem involving different external uncertainties, diagnosis and treatment of mental disorders largely rests upon the point of view of the clinician (Jones, 2004). These singular characteristics of mental disorders indicate the difficulties in measuring the type and degree of needs and in turn, questions the validity of a classification system intended to define any one resulting care pathway (Jones, 2004).

The lack of medical or clinical markers makes classification difficult and leads to large variations in judgement among clinicians, even when considering the same symptom of the same patient (Houts, 2001). Sarrami-Foroushani's (2009) research findings echo this, specifically, the existence of variation in clinicians' perceptions and their preferences of approach in treating adults with Attention Deficit Hyperactivity Disorder. Even the "gold standards" in mental health classification, the ICD and the DSM, are based upon the assumption of "normality-as-absence of pathology" and largely rely on the professional's authoritative judgement (Houts, 2001). Critiques focus on whether the experiences and perspectives of frontline clinicians are sufficient to identify illness correctly without any support from objective tests, let

alone the more complex dimensional scale adopted by the MHCT regarding within-group homogeneity and between-group heterogeneity (this will be discussed in Section 5.3.4). There are issues regarding how to unify the standards of different disorders with subjective benchmarks (Crowe, 2000). As Wakefield (1997) argues, only when the conceptual validity of definition and criteria is achieved, will the classification system be fully feasible.

In addition to the initial complex nature of mental disorders, the following subsection reconsiders the needs assessment in greater conceptual detail, in which the technical viability of standardising mental health services to a certain extent is discussed with the recognition of the inappropriateness of rigidly standardising every activity (this has been discussed in Chapter 3).

According to *The NHS Plan* (Secretary of State for Health, 2002), the NHS would shape services according to patient needs and preferences and thus establish a needs-centred service provision system. Rooted in the NHS's value system, general health care and social service reforms require a needs assessment system for people with mental disorders. The underlying theory is that each patient should have individualised care service based upon the assessment of one's needs (Marshall, 1994). Therefore, the first question could be interpreted as whether there is a valid way to classify mental disorders based upon needs and to provide the corresponding target interventions, which has been set as one fundamental aim of the NHS Modernisation. In relation to this question, the essential element is a definition of needs.

5.3.1.1 Needs assessment: Definition of “need”

The foregoing discussion draws attention to the fact that it is more difficult to standardise clients’ needs for treatment and therefore, their resource implications in mental health than what tends to be the case amongst acute care patients. The NHS is committed to shaping services according to patients’ needs and preferences (Secretary of State for Health, 2000). This implies that each client should have an individualised care plan based upon an individualised assessment of needs (Marshall, 1994). Considered realistically, this has to be predicated by an acceptable understanding of “need” as it applies in this context. From a wider perspective, the definition of “need” is problematic. There is no broad consensus in reference to the concept of “need” in health and sociology literature (Asadi-Lari et al., 2004). In *Taxonomy of Social Need* (Bradshaw, 1972), Bradshaw categorises “needs” into four major clusters: felt need, expressed need, comparative need and normative need. In the context of mental health, Wing et al. (1992) suggest that “need” should be defined alongside potentially available “state-of-the-art” solutions. A healthcare “need” only exists when there could be a “treatment”. In parallel, the NHS defines “need” as the capacity to benefit from services (Asadi-Lari et al., 2004); the “need” for treatment and its resource implications cannot be separated from judgements concerning the type and amount of health care that clinical expertise believes to be beneficial in a particular situation (Magi and Allander, 1981). This definition builds a direct relationship between services and needs, consequently making it viable to provide services according to patients’ needs. Hence, an ideal needs assessment instrument should be able to: 1) detect the particular deviations (compared to standards or population); and 2) target the potentially appropriate health care services.

If the resource implications of providing for an individual are to be predicted, then the process of doing so must include, quite directly, the decisions made by clinicians about which course of action might be the most appropriate. In acute care settings, these are often implicit: providing for someone with an osteoarthritic hip could involve pain relief, physiotherapy, mobility support, rest or hip replacement. The course followed may well be determined by a detailed "diagnosis", including information about the state of the hip joint in question, the patient's degree of mobility, muscular tone and living conditions that would predict the course to be followed with little error. The nature of mental health difficulties is such that there is much broader scope for variations in "needs for care", even amongst those with the same diagnosis (Wing et al., 1992). In this case, diagnosis-related groups cannot indicate the corresponding target services. In other words, the ICD/DSM is not sufficient enough to be used in isolation to determine mental health needs. Brewin et al. (1987) also illustrate the limitation of a diagnosis-based classification system by highlighting the fundamental mismatch between needs and diagnoses: needs are defined around problems in individual functioning rather than around diagnostic labels. Indeed, sometimes diagnoses indicate needs for certain kinds of intervention, but they do not necessarily always lead to a particular type of intervention. They elaborate this argument by providing an example of severely depressed patients with delusions and psychomotor retardation. The patient may have at least three separate problems in functioning, against which at least three target interventions should have been specified. Nevertheless, the ICD/DSM could only provide one diagnosis. Therefore, the ideal needs assessment should be designed against functioning problems and be able to link them to the corresponding interventions.

5.3.1.2 The MRC Needs for Care Assessment

Attempts to standardise and quantify the care of mental health service clients antedate attempts to implement PbR by several decades. A significant step was the development of the NFCAS (Brewin et al., 1987). The NFCAS has not been routinely use because in its original form, it is detailed and dependent upon specialised training if it is to be used reliably. Nevertheless, those qualities can also be considered virtues, and conceptually it addresses many of the shortcomings already identified with the MHCT. In particular, it sets out to capture clinical judgements concerning the propriety or otherwise of different courses of action, and therefore, generates an assessment of needs that more closely reflects what is deemed to be the appropriate care pathway. As a result, it is worth considering as an approach that could still have a useful application.

The NFCAS was originally designed to measure the needs and provide structure to the provision of services for those with long-term mental health difficulties living in the community as large-scale mental institutions being phased out (Brewin et al., 1987). In essence, it determines the presence or otherwise of difficulties across nine domains of psychiatric symptomatology, such as positive psychotic symptoms, dangerous or destructive behaviour, or distress, and twelve domains of essential everyday living skills, such as the ability to use public transport, maintain personal hygiene or manage a weekly budget. Based upon explicit criteria, a judgement about the presence or absence of difficulties (Problem Status) is made in relation to each of these twenty-one domains; for each of the nine areas of symptomatology, "Problem Status" is classified as "None or Mild", "Recent or Threatened", "Current and significant" or "Unknown", and for each of the eleven areas of essential living

skills Problem Status is classified in the same way as "Competence plus performance", "Recent or Threatened Problem", "Lack of competence", "Lack of performance" or "Unknown".

Where there is evidence of threatened, recent or current symptomatology or a skill deficit, the potentially relevant treatments or interventions are evaluated accordingly. The interventions considered conceivably appropriate for each area of symptomatology and living skills are specified, which have been pre-determined by consensus from discussion with a broad range of mental health professionals. Therefore, where positive psychotic symptoms are or might be present, enquiries are made into whether or not any intervention such as medication, domiciliary visits, coping advice to the patient and/or relatives which might include alternative strategies, a family intervention or a sheltered environment might be appropriate and if so, whether or not they are being provided (Brewin et al., 1987). If any one of the relevant interventions is considered appropriate, but is not being provided, then a further enquiry is made into whether this is due to the fact that it has yet to be provided, has been offered and not taken up or has been tried and found to be ineffective. Where there is a problem with communication skills, for instance, similar judgements would be made concerning social skills training, practice in realistic settings or a sheltered daytime environment. Overall the NFCAS results in a detailed catalogue of clients' difficulties and a statement of their "needs" couched in terms of clinically-determined judgements concerning the suitability of consensually agreed interventions for each of them. This is clearly a more bespoke approach to identifying the resource implications of providing for a client and it incorporates the

outcome of clinical judgements. During the 1980s and 1990s, a number of studies confirmed both the reliability and validity of this approach (Brewin and Wing, 1993; Brewin et al., 1988; Marshall, 1994). This indicates that the NFCAS is a valid and reliable instrument to measure patients' needs and accordingly indicate resource allocation to facilitate cost calculation. However, the very detail that endows the NFCAS with these qualities also makes it cumbersome to use. To ensure reliability, judgements concerning the presence or otherwise of difficulties in each of the twenty-one domains and judgements about the applicability of numerous treatment options all have to be made based on explicit criteria. Although many of these judgements are also, implicitly, the same judgements that might be made by a competent clinician, the NFCAS imposes a structure upon clinical assessment that could only be applied after rigorous training. As a result, it has not found a place in routine practice. Attempts to popularise a shortened and simplified derivative were made (Phelan et al., 1995) but needs assessment in this form has remained a research exercise. Despite its conceptual and metric superiority over the MHCT (this will be discussed in Section 5.3.3.2), its reputation and the demands of training have hindered its adoption as a basis for PbR in mental health service settings.

In conclusion, the high validity and reliability of the NFCAS indicate that it is possible, although difficult, to measure patients' needs and consequently manage mental health services in a standardised way to a certain extent. This leads to the second question: To what extent does the collaboration between the MHCT and the HoNOS fulfil the function of a quality classification system?

5.3.2 The conceptual function of the MHCT classification system

The most obvious advantage of the MHCT and the application of the HoNOS are their suitability for incorporation into routine clinical practice. It only takes clinicians some 5-15 minutes to complete a HoNOS form (Jacobs, 2009) and it is reasonable to assume that most of the related judgements will have been made in the course of routine clinical activity. Mainly relying on the HoNOS scores, the MHCT serves as an instrument to assess the needs of patients who receive secondary mental health services and therefore collectively manages clinical resources accordingly (Monitor and NHS England, 2013a). Ergo, this section explores the effectiveness of the HoNOS and the conceptual function of the MHCT.

5.3.2.1 The effectiveness of the HoNOS

The HoNOS assesses general health and social functioning of people suffering from mental disorders and detects the severity of problems. Various studies have led to controversial results regarding the validity and reliability of HoNOS as an outcome measure (Lovaglio and Monzani, 2011).

Regarding the validity of the HoNOS, Wing et al. (1998) concluded that the HoNOS has moderate validity regarding its construction, content and criteria. McClelland et al. (2000) conducted a series of studies to test the sensitivity and criterion-related validity of the HoNOS. Their outcome indicated that the HoNOS had comparable dynamic properties as well as high sensitivity. Lovaglio and Monzani's (2011) study also investigated the internal structure validity of the HoNOS according to which the outcome of their research showed a

considerable acceptable internal consistency of the HoNOS. However, Brooks's (2000) study derived an opposite conclusion. The HoNOS scores (including those rated at admission and discharge) were compared with Symptom Checklist 90 Revised and the Short-Form 36. The outcome showed no correlation in the change of scores between the HoNOS and these two instruments, which questioned the validity of the HoNOS by highlighting the mismatches between the scores of the HoNOS and the existing widely used measures of mental health symptoms or health status. Regarding its reliability as an outcome measure, Orrell et al. (1999) and Wing et al. (1998) investigated its test-retest and item reliability. The results showed a moderate degree of reliability. Shergill et al. (1999) and Idaiani (2011) also tested the inter-rater reliability of the HoNOS. Their results indicated a good or adequate inter-rater reliability. In terms of its acceptability to the everyday clinical practice, McClelland et al.'s (2000) findings outlined its advantages, such as being "good for quantifying illness and change", to "indicate the level of risk and improvement" and "useful for monitoring purpose", however, they also noted the risks of misinterpretation and the inability to accurately reflect patient outcomes.

5.3.2.2 The conceptual flaws of the MHCT classification system

Gaps have been found between the theoretical function of the MHCT regarding assessing patients' needs and the actual process of classification under the MHCT. Referring to the definition of need as previously discussed, "need" is defined by the alternative interventions. However, the standard process of categorising a patient (this has been introduced in Chapter 2)

indicates that the clusters are derived from evaluating the severity of problems before potential interventions are taken into consideration. In other words, although the HoNOS serves as a valid instrument to measure patients' outcomes, the scores do not provide information regarding specific areas of patients' needs at an individual level (Teesson et al., 2000). Unlike the NFCAS, which enables decisions to be made concerning needs based on interventions, the MHCT categorises medical cases first and then attaches corresponding interventions to each cluster. The reversed order reveals one conceptual flaw: rather than providing a structured way of considering and cataloguing the difficulties and needs for treatment, each client presents in a bespoke manner, it "forces" classification of cases into one of the 21 clusters based upon their presenting difficulties, and assumes that this in itself is a sufficient measure of resource implications. Moreover, without taking the availability of intervention into consideration, on the one hand, there may be patients who are categorised into a particular cluster, but there is no potential effective intervention subject to their problems. On the other hand, there may be multiple interventions available to patients suffering the same problem in the same cluster, which leads to difficulties in unifying a standardised care pathway.

Furthermore, the content validity of the HoNOS when employed to guide classification is under question. In relation to the general level function of the MHCT in terms of managing medical cases and the corresponding resources collectively, limitations have also been found due to the applications of the HoNOS. As the core element of the classification system, the HoNOS was designed to be a brief assessment of functioning that measures clinical outcome changes, but not a classification instrument.

Collectively evaluating patients' needs and thus horizontally managing interventions is different from assessing changes in one patient's conditions at an individual level vertically. According to the content, the HoNOS is a multi-dimensional instrument to detect problems from different aspects. However, using only 12 items to detect one's physical condition and social functioning results in an inevitable loss of detail. For instance, item 3 "problem drinking or drug taking", may comprise four types of substance misuse, including alcohol only, one drug only, two substances and poly-substance. This would inevitably lead to a loss of information in rating and therefore, result in difficulties in making horizontal comparisons. Speak and Hay (2012) describe the difficulties in making a horizontal comparison on an item-by-item basis since certain items appear more sensitive to change within a particular population than others, which is one obvious shortcoming compared to the NFCAS that has been proved consistency in the score. As previously discussed, the scores obtained with the HoNOS do not comply with the existing wide-used instruments, which again brings its ability to comprehensively and appropriately evaluate patients' health conditions into question.

In conclusion, although the MHCT (mainly underpinned by the HoNOS) is a simpler measure with some advantages, such as being explicit and less time consuming, it suffers from the conceptual flaws of not taking account of potential interventions when making classifications. This in turn results in its failure to fulfil the function of an ideal needs assessment tool. The original purpose of the HoNOS limits its potential of facilitating classification. This also leads to scope for discordance between the HoNOS scores and the MHCT clusters.

5.3.3 The constructional drawbacks of the MHCT classification system

The constructional problems which have originated from these conceptual flaws further confirm the lack of validity and reliability of the MHCT facilitating the provision of accurate/appropriate treatments to patients in a standardised way, not to mention connecting interventions to payment. The subsequent subsections explore the constructional problems of each segment in managing clinical services in a standardised way and the inconsistencies among them, which lead to difficulties in incorporating the individual segments into a whole standardised management instrument.

5.3.3.1 The Mental Health Clustering Tool: Drawbacks of the classification mechanism

Advantages of the MHCT approach to classifying cases are the ease of use and its applicability to the contemporary information systems. The fact that PbR is proving difficult to implement in mental health service contexts suggests that the loss of detail (21 clusters compared to over 1,500 HRGs in acute services) and operational validity accompanying these conveniences are proving problematic. Furthermore, clinicians regularly complain that the clusters do not fit an individual's condition and this creates confusion for clinicians asked to ascribe people to "boxes" with no clinical sense behind them (Community Care, 2013). For instance, Cluster 11 may contain patients with stable schizophrenia or stable bipolar. The condition of "stable" does not necessarily predict details concerning patients' needs for care. In this case, one cluster may relate to more than one NICE guidance. Indeed, a diagnosis alone does not predict cost or prognosis for patients who suffer from problems such as

schizophrenia, but it is of value to guide clinical interventions for patients with problems such as dementia, OCD, phobic disorder, etc. (Solomka, 2011). Kingdon et al. (2012) stress that the abandonment of a diagnosis-based system makes it difficult to understand how clusters can work in MH PbR. Finally, with no prior consideration of services, the classification system MHCT itself has been criticised as a “labelling process” (Callard et al., 2013; Middleton, 2013) which may result in its adverse consequences. As Yeomans (2012) argues, the credibility of the MHCT and its validity regarding accurate and proper classification are still to be tested and to do so properly would take years. By contrast, the NFCAS, cumbersome though it may be, is conceptually more appropriate, clinically grounded and robustly tested. The decision rules, acquiring which makes up NFCAS training can be operationalized and it is possible that these could be formatted as an automated algorithm. There is some evidence suggesting that this approach can be applied in everyday practice (Middleton et al., 1996), and so it could be adapted for this purpose.

5.3.3.2 The HoNOS: Drawbacks of dimensional scales

The HoNOS attempts to introduce quantitatively graded transitions between the “normal” and the “abnormal”. In fact, a reliable classification system should be subject to a wider spectrum of symptoms in mental health and it is important to accurately situate the cut-off points (Patel et al., 2014). However, mental health care is such a complex area in which even the categorical approach with simple “cut-off” groups is under the attack due to the blurring of boundaries (Maser and Patterson, 2002). As Aboraya (2012) argues, most of the time the boundaries between minimal and mild symptoms are not of

clinical significance enough to result in a different clinical decision. At the moment, there is a lack of general agreement on the number of dimensions and empirical studies for evaluating the validity and credibility of this system (Busko, 2007). Hence, the lack of universal standards on dimensions requires more reliance on the clinicians' ability. Therefore, blurred boundaries make the dimensional scale more complex, which in turn compromises the between-group heterogeneity. As discussed earlier, the HoNOS was originally devised and adopted to measure clinical outcomes rather than assessing needs or grouping patients and there is scope for discordance between the HoNOS scores and the MHCT clusters. In practice, the degree of severity and the condition of stability are not mutually exclusive. A patient with prominent auditory hallucinations could be in a stable condition for a long period of time. According to the MHCT decision tree, this patient should be clustered into Cluster 11 (with an expectation of hallucination to be rated as "0-1"). However, the HoNOS rating for "Hallucinations and Delusions" could be 3, indicating that this patient should be clustered differently. The initial scope of application of the HoNOS could partly explain its shortcomings. The HoNOS ratings only test the general health and social functioning rather than measuring specific healthcare outcomes or clinical effectiveness (Harrison et al., 2004). Neither does it take account of one's culture, poverty, risk, bereavement, etc. Other specific scales, such as the Hamilton Rating Scale for Depression work more effectively than the more general HoNOS. As discussed earlier, the idea of "standardisation-to the-average", which identifies a range of phenomena with one representative standard may not be appropriate in such a highly individualised area. Merely relying on the HoNOS as the standardised outcome assessment attached to MHCT clusters

may not be a sufficiently reliable approach. More condition-specific outcome data are necessary if patients' needs, severity and responses to treatment are to be assessed with sufficient accuracy. For reasons such as these, critical organisations, such as the Royal College of Psychiatrists (2013), have questioned the validity of the MHCT, and these criticisms are also applicable to the notion of standardised care pathways.

5.3.3.3 The MHCT Care pathways: Difficulties in standardisation

As the basis of PbR tariff cost calculations, care pathways link clinical activity to payment. However, this connection remains aspirational. To date, there is no formal association between "cluster" and care pathway, and besides the conceptual flaws of the MHCT, reasons for this delay include the nature of patient-centred care and the coexistence of multiple treatments.

Conventional mental health services involve wide variations in the services provided, even in relation to very comparable cases. As the Royal College of Psychiatrists (2013) states, in consideration of the large variations in individual conditions, minimum standards are published but wide interpretation and different treatments are allowed. The complex nature of mental disorders determines that the focal point of mental health services should be the process of knowing patients and their needs (Jones, 2004).

Due to the personalised treatment in mental health, different therapeutic approaches and other types of treatment such as Cognitive Behavioural Therapy (CBT) and counselling can be offered to patients with similar needs (Cheshire and Pilgrim,

2004). It may be easier to standardise drug protocols and some biological approaches but it is difficult to identify a standardised procedure for developing a relationship with patients in treatments such as CBT. Furthermore, clear evidence of efficacy among a range of psychiatric treatments is hard to find, and so it is common for clinicians to provide psychiatric care according to their own value systems, which may be inconsistent with their fellow members (Jones, 2004). This conforms to Lipsky's (1980) "street-level bureaucracy" theory as discussed in Chapter 3.

In summary, patient-centred care and the coexistence of multiple treatments reveal the difficulties in standardising mental health services into one care pathway subject to a specific cluster. To make it viable, it requires a sophisticated and complex classification system that can accurately categorise patients into groups according to their needs. In this case, the alternative MHCT classification system is more a managerial strategy than a "real" clinical instrument that helps to identify the "root problem" and therefore, predict the corresponding treatment.

5.4 The principles of standardisation in the financial aspect

Alongside the difficulties in standardising clinical treatment under the MHCT, the feasibility of using "standardisation-to-the-average" principle to calculate a national tariff has also been questioned due to its mechanical drawbacks and corresponding risks.

5.4.1 Drawbacks of the “standardisation-to the-average”

Even if cases can be catalogued in such a way that meaningfully predicts resource implications, there is still work to be done before tariffs can be established and used as the basis of remunerating NHS provider organisations. The direct costs and other resources needed to support each of a broad range of activities must be defined. To act as a quality improvement mechanism, rather than encouraging competition on price, PbR requires a national average unit cost for each healthcare activity. Thus, for each set of treatment activities, a national average unit cost has to be estimated (Self et al., 2008b) and this depends on the availability of data that identifies costs of particular activities across a wide range of provider organisations. This in turn, assumes that the costs of treating a particular category of cases incurred by different providers follow a roughly normal distribution so that their arithmetic mean is a meaningful average. It also implies that “deviances” can be categorised as the extremes of both sides of the cost distribution curve and an effect of pursuing “standardised cost” will be to reduce deviance employing a “standardisation-to the-average” principle (Department of Health, 2012b).

However, the study by the PriceWaterhouseCoopers (2012) indicates that even for the same service, the unit costs reported by providers largely differ from each other. The causal reasons for this are attributed to the variations in costing methods and missing key information such as age and morbidity. The very nature of mental health difficulties means that the focal point of treatment should be the process of knowing patients and their needs (Jones, 2004). Insofar, as this has been the approach adopted by mental health services to date, there is very little quality data to draw upon which is able to identify the costs of

providing for this, that or a third category of client. Thus, there is little to draw upon in pursuit of unit costs that might be averaged to compute a national tariff. Therefore, from a statistical point of view, variations in the cost that providers attribute to each group results in a large standard error of the mean value in contrast to the assumption of “standardisation-to-the-average”, which assumes that all providers have similar cost structures. As a consequence, the employment of national tariffs derived in this way risks the financial stability of the outlying providers, something that is seen as a risk for the long-term implementation of MH PbR (Appleby et al., 2012). It is the consideration of these financial risks that encouraged Australian and New Zealand governments to deliberately separate their payment system from their classification system (Mason and Goddard, 2009).

It has also been argued that a consequence of the “standardisation-to-the-average” principle is that it encourages providers to become “average” rather than improving their performance (Llewellyn and Northcott, 2005). This payment system hinders innovation: providers are required to conduct practice in standardised pathways and get paid at the national average level unless they can provide persuasive evidence for a new service and its impact on cost reduction, capacity enhancement or quality improvement. However, the process of proving the effectiveness of a new product is often difficult, especially in this rigid system (Appleby et al., 2012).

5.4.2 Side effects: Financial pressure

Financial pressures brought about by limited resources result in tensions between the greater good of society and the

individual's needs, especially in the context of the "ethical duty" on doctors to reduce NHS waste (National Health Executive, 2014). Given that MH PbR brings resource management/cost control approaches into clinical services, some concerns have been placed on the potential risk, that it may undermine clinicians' obligation to put individual patient's interests first when these two interests do not overlap (Rosenbaum and Lamas, 2012). In such a circumstance, concerns have been raised that the fixed price payment system might compromise the quality of care when providers "game the system" through "up-coding" and "cream-skim" (Boyle, 2007) (this will be discussed in Chapter 6). Oyeboode (2007) argues that MH PbR may impose heavier incentives to "cherry-pick" since non-statutory organisations tend to pick patients with lower costs than the average and leave the more severe to the statutory hospitals. Therefore, statutory hospitals are likely to face more financial risks, which lead to higher risks of compromising quality, such as early discharge (Sainsbury Centre for Mental Health, 2004).

The complexity of the clustering system also results in errors in the clustering process with a classification system that has already suffered from constructional drawbacks. One chief executive of the consultancy on Health Strategies revealed that 40% of MH PbR clusters had been found incorrect in one large mental health trust (Lintern, 2012). The same study also revealed low confidence in the quality of cluster data and, therefore, a low state of readiness for implementing MH PbR care packages. In this respect, the insufficient and low-quality data in turn increases the risk of financial instability if payments are based upon them.

Summary

For a better understanding of how political intents are transformed into detailed policies/targets that influence everyday frontline practice, this chapter explored the formulation of the MH PbR policy by focusing on the construction of the MH PbR, including its clinical classification system and price calculation system. On the basis of the arguments in Chapter 3 that attributed the commodification as the essence of the design of MH PbR, this chapter explored the functional problems by analysing the conceptual and therefore, constructional flaws: the difficulties in applying the “standardisation-to-the-average” principle to managing mental health services and thus calculating nationally-fixed prices. As previously outlined, MH PbR is partly invoked as a classification system with the absence of a price calculation system in mental health. This on the one hand, implies the initial drawbacks of the classification system given its role as the foundation of the cost calculation, and on the other hand, indicates more attention being paid to discussing the construction of the MHCT classification system in this chapter. In this respect, this chapter analysed the construction of the MHCT system by answering three questions from a fundamental to a practical level: 1) is it feasible to manage mental health services in a comparatively standardised way; 2) is the underpinning concept of the MHCT valid in terms of predicting standardised treatment subject to the clusters; and 3) if not, what are the constructional drawbacks of the MHCT classification system?

This chapter began with contextualising the MH PbR policy by reiterating the importance of the norm “normality/abnormality” and thus suggesting the development of mental health services as a process of seeking “standardisation”. The introduction of

the NFCAS indicated that although difficult, clinical needs can be assessed in a standardised way and thus care/interventions can also be predicted and provided in a standardised, valid and reliable way. By comparing it to the NFCAS, this chapter demonstrated that the MHCT classification system suffers from, not only the conceptual flaws regarding the accurately and comprehensively assessing patients' needs, but also the constructional difficulties in standardising each segment and therefore, incorporating them as a whole. In comparison with the NFCAS, the MHCT has to be recognised as an expedient shortcut, and given the shortcomings that have been considered here, is perhaps too premature to serve its intended purpose. Based on the argument against the constructional flaws of the MHCT classification as a whole, Section 5.4 further discussed the potential risks of applying the "standardisation-to-the-average" principle in calculating nationally-fixed prices, including its lack of validity and side effects. This chapter did not intend to argue that it is not applicable to establish financial incentives for providing mental health services, given the cost control in acute service settings, but to point to the difficulties in fulfilling political intents given the poor quality data derived from such an incomplete classification system. In other words, this chapter attempted to argue that the implementation of MH PbR as a payment system becomes contentious since it is conducted in a hurried and inaccurate manner.

All of the criticisms from the theoretical evaluation described above, including the conceptual flaws and therefore, the constructional problems behind MH PbR, have contributed to its "low state of readiness". Hence, this sheds light on the empirical study, on its implementation in mental health and the corresponding problems in practice by outlining areas worth

particular attention, including the complex nature of mental disorders, the constructional drawbacks of the classification system, the mechanical problems of average-based cost calculation and “gaming” behaviours. The subsequent two chapters will present and discuss the findings from the semi-structured interviews and the online surveys. As previously elaborated in Chapter 4, the interview research was set as the primary approach while the online surveys were conducted mainly for a confirmatory purpose. In this respect, Chapter 6 will present the findings from the semi-structured interviews conducted with the key players in the commissioning circle, and in Chapter 7, the questionnaire data will be triangulated with the corresponding data derived from the previous qualitative analysis.

6. The implementation of the MH PbR policy: Interview results and findings

Introduction

Based upon the theoretical evaluation conducted in Chapters 3 and 5, this chapter aims to evaluate the MH PbR policy by investigating its implementation at the frontline, including current progress (by April 2014) and the perceived problems created by the implementation. To answer the research questions outlined in Chapter 1, the interviews involved 12 participants from three interest groups: two commissioners (coded as C); seven from the hospital managerial level (coded as M), including financial managers, clinical managers, interim managers and MH PbR trainers; and three frontline clinicians (coded as S). The participants revealed how the MH PbR system actually worked in practice, in particular, how the policies and targets derived from the MH PbR project influenced their routine work. They also expressed their attitudes towards the implementation of the MH PbR policy in mental health and elaborated reasons to support their arguments. The problems they perceived include some initial problems of the MH PbR classification system as well as external factors, such as the derived policies and side effects. These problems demonstrate the “bad execution” and “bad luck” of the MH PbR policy, and additionally reveal the gaps between theory and practice.

As illustrated in Chapter 4, the semi-structured interviews were conducted with key elements derived from the theoretical analysis, including MH PbR overview, current stage implementation, the MHCT, the HoNOS, the MHCT care pathways, outcome measurements, “gaming” behaviours,

driving factors and corresponding solutions. During the coding process, codes and groups emerged from the transcripts. By comparing codes with-in the transcript and between transcripts, the relationships between codes were identified (e.g., frontline clinicians' reluctance was attributed to the complex nature of mental disorders, the constructional flaws of the classification system and intensively established policies). The analysis process benefited from both top-down induction informed by previous literature and bottom-up induction guided by the GTM principles. This process, in turn, facilitated the establishment of the logic of this chapter, which investigates the implementation stage of the MH PbR policy in four steps: 1) explain the reasons for the reform; 2) present the current stage of the implementation of MH PbR; 3) analyse the factors that have caused the delay by evaluating the core elements of the MH PbR system and investigating the gaps between theory and practice; and 4) propose suggestions for further improvement. In this chapter, attention has been given to the different or even conflicting perspectives among participants from different subgroups or even within the same group. These perspectives are presented and organised to discuss the driving factors leading to the reform, factors that have caused the delay and corresponding suggestions.

Beginning with a summary of the mechanism of the Block Contract, the first section outlines the major drawbacks of the Block Contract and the trend of reform. Section 6.2 further elaborates upon the payment system reform by illustrating the major benefit brought about by MH PbR: the transparent information system. Section 6.3 outlines the current stage of the implementation of MH PbR from three aspects: clinical strategy design, contract negotiation and frontline practice.

Section 6.4 evaluates the core elements of the MH PbR system. The drawbacks of each element, together with the lack of coordination between them, are discussed, leading to further exploration of the driving factors behind the delay. Section 6.5 focuses on investigating the driving factors based on the previous two sections. This chapter concludes with some suggestions for future improvement.

6.1 Move from the Block Contract

In recognition of the initial problems of the Block Contract and the financial disadvantages for not being paid by MH PbR, it has become a political and a realistic trend to replace the Block Contract with PbR in mental health in a context where PbR has already been implemented in acute services for a decade. As the starting point of the payment reform, this section introduces the working mechanism of the Block Contract and explains its major drawbacks.

6.1.1 Working mechanisms of the Block Contract

At the time the interviews were undertaken, the Block Contract was still a dominant payment mechanism in mental health. It was considered suitable for mental health services due to its straightforward payment mechanism, which protects financial stability for both commissioners and providers in such an area with uncertainties and unknowns (due to the lack of a payment cap).

That (the Block Contract) is just very straightforward. The providers know what income they will be getting. We know what

we are paying for. So there is a lot less work in terms of time span on the provider-side and the commissioner-side in terms of the actual transaction of money. (C2)

Under the Block Contract, commissioners pay a lump sum of money for a whole bunch of services, employing general targets to measure work, such as Occupied Bed Days (OBDs) for inpatient services and face-to-face contacts for community services. As an activity-focused payment system, payments differ between the specified types of contact rather than different patients' diagnoses/needs. Regarding this system, the lump-sum payment reflects the purchase/provider relationship since the reached agreement ensures the trade between the amount of work and the amount of money. From the managerial-level perspective, the straightforward payment mechanism ensures provider-side financial stability, which is the mechanical drawback of the cost-calculation system under MH PbR as discussed in Chapters 3 and 5. Moreover, both the commissioners and managers noted the significant amount of collateral transaction costs that will come along with MH PbR payment: in order to make the money cost-effective, there would inevitably generate some ex ante costs, including information searching and cost calculation, and some ex post facto costs, including monitoring and enforcement (in the case of contractual disputes).

6.1.2 Major drawbacks of the Block Contract

However, concerns have been raised about this system due to the absence of a clear link between clinical services and payment. Due to the lack of detailed information about services, neither side has sufficient knowledge regarding the actual

quality of services or the outcomes in relation to the interventions.

Whether the Trust was delivering quality, good outcomes or not, it did not matter. They still got that amount of money. (M4)

The commissioners and providers both expressed their discontent about the payment mechanism, but from different perspectives. The tight budget has raised the commissioners' attention to maximising the utility of the limited amount of money. From the commissioners' perspective, the Block Contract is an income insurance for providers under which they get more reimbursements than what they have actually provided.

It means that we are paying more than we think it should be. (C2)

By contrast, the managers argued that they have provided more and higher-quality work than what the contract had required. From their perspective, the current payment calculation mechanism could accurately measure neither clinical input nor output.

One of the problems is that people do a lot of stuff and the state sectors do not always see that it costs money to do everything. (M5)

One of my problems in terms of the provision of mental health services is that there is such a mismatch between demand and supply. Because we've got no mechanism of measuring either demand or supply. (M3)

According to the contract mechanism, no other necessary work, such as preparation and phone calls, is counted except face-to-face contacts. Additionally, the frontline clinicians revealed that contacts are not counted unless the patient physically comes to the clinic or opens the door for the clinicians who provide home-consults regardless of the behind-the-scene preparatory work. Moreover, the targets were regarded as a burden for the frontline clinicians since they were made to accomplish the tasks rather than conducting practice for patients' interests (this will be discussed in Sections 6.5.3 and 6.5.4). As a result, 8 out of the 12 participants from different posts attributed the underlying reason to a lack of a transparent information system.

I think there is a problem with the Block Contract. In that, the commissioners cannot fully use their responsibilities for their commissioning because they are giving a whole money and do not know where it is going to. In fact, nobody knows where the money goes to. There needs to be a transparent system where it is clear how much money is for one particular thing and then there can be a system of feedbacks and audits to the commissioners about what is actually happening. (S3)

6.1.3 The trend to move to MH PbR

Mental health care has long been underfunded: mental health problems account for 23% of the total impact of ill in the UK while mental health services receive only 13% of the NHS budget (with over 67% of CCGs stating that they spend less than 10% of their budget on mental health) (All Party Parliamentary Group on Mental Health, 2015; Campbell, 2014). When compared with the funding invested in acute services, the commissioners and providers recognised the second-order

effect: the funding for mental health services has been diverted away to acute services since PbR is invoked in that field.

Our mental health services have been massively disadvantaged by not being under PbR. So in the context of everything else being in PbR, we need to be in PbR as well, because what is happening is that the acute trusts have their costs all being paid in PbR and we have to manage under block contracts. Sometimes the squeeze has been on us. It is not our overspending, but the commissioners have a finite pot of money.
(M6)

Moreover, it has been noted that the “cost-and-volume” payment system encourages hospitals to admit more patients into acute services, among whom, some should have been treated in community care or by secondary mental health services. In recognising the disadvantages of not being under PbR, the participants from both the commissioner and manager sides believed it necessary to introduce MH PbR to obtain enough funding from the limited budget. In other words, both the managers and commissioners considered moving to MH PbR as an approach to reach the equivalence of the care budget.

In the ideal world, it would be in a way to get a much fairer distribution of funding for mental health. (M6)

In consideration of the two obvious problems described above, all participants from both the commissioner and manager sides noted the necessity of replacing the Block Contract and regarded moving to MH PbR as a step in the right direction. The next section outlines the essential theoretical benefit of introducing MH PbR, which is the transparent information system.

6.2 The major advantage of MH PbR: The transparent information system

Regarding the broad understanding of MH PbR, the commissioners and managers considered MH PbR a breakthrough from the Block Contract at the strategic level by appraising the changes created by the market mechanism and the transparent information system facilitated by the attached subsystems, as the following subsections illustrate.

6.2.1 Changes created by the market mechanism

Chapter 2 elaborated the rationale behind PbR as it encourages non-price competition among different types of providers. As one manager illustrated, under PbR, the process of linking payments to healthcare services was expected to encourage providers and commissioners to develop an accurate evidence-based information system in an effort to avoid financial risks.

In terms of the clarity, they will know what they are buying, because in communicating not only the commissioners, but also to the frontline staff and service users and carers, if you fit Cluster 10, you can expect A, B, C, D... That's what the commissioners will be expecting us to provide them. (M7)

Both the commissioners and managers appreciated the economic mechanism of PbR that encourages providers to pay attention to costs and efficiency and thus allocate resources more strategically, which is particularly important in a context of austerity.

PbR would force providers to look at their costs. ... Now obviously you are being paid by activity. It should make things

more efficient in terms of the costs. (C2)

One consequence of the provider-side competition is to encourage providers to focus on patients' outcome to attract more patients, which was regarded as a step in the right direction by both the managers and commissioners.

I really like it because we will actually be looking at the quality of outcomes and money will follow that. (C1)

6.2.2 The specific benefit: Transparent IT system

Besides the drawbacks of the Block Contract and the disadvantages of not being under PbR, the core reasons for moving to MH PbR were attributed to the transparent information system and the corresponding theoretical benefits, which will be discussed from two aspects: the clinical aspect and the financial aspect.

6.2.2.1 The clinical aspect

As discussed in Chapter 5, the MHCT categorises a patient into one of the 21 clusters according to their symptoms using the HoNOS. Consequently, by applying the scales to classify patients, the categorising mechanism indicates that providers would develop better knowledge of patients' problems and corresponding treatments, according to the participants from the managerial level.

PbR itself and the whole thing are providing us with lots of information. So we know how many people in certain clusters, therefore we know the levels of need. ... So it is helping the

Trust to look more strategically at what it is doing. (M2)

Additionally, as the first time introducing the outcome measurement, it enables both commissioners and providers to focus on service quality. From a managerial perspective, the outcome measurement adopted to re-assess the patient at the end of a treatment period was seen as an effective approach to help frontline clinicians make decisions for next-stage interventions according to their needs for care. It was also regarded as able to help commissioners and providers dig down to specific cases to check whether the patient has been provided effective interventions or why the patient has not received appropriate treatments at the administrative level.

Within the cluster transitions, which is after the end of period care, you can discharge someone back to primary care, or you can move them to a different PbR cluster. I would say that we will be able to see who is doing well and who is not doing so well. We could see which service is effective and which service is less effective and we can ask questions. (M3)

The managerial level participants also regarded the provider-side competition as another collateral theoretical benefit brought about by transparency. They appreciated the transparent information system by outlining the prospects for commissioners and patients: commissioners would be able to compare different providers based upon outcomes and quality, whereas patients would be able to choose the providers with higher quality as described by the *Money Follows the Patient* (Secretary of State for Health, 2002).

Trusts would be compared with each other. So the outcomes

and the quality at some points would be transparent. We will be able to see which trusts are performing well, which trusts are not. For the public and service users, they will be able to choose now. (M4)

6.2.2.2 The financial aspect

From the financial side, the managers and commissioners appreciated the fair payment system under MH PbR, which is facilitated by the predetermined care pathways as discussed in Chapter 2. Compared to the Block Contract, the “payment against care pathways” model outlines the type and amount of services providers will be expected to deliver and the amount of payment they will receive from commissioners.

At the same time, MH PbR provides a chance for providers to evaluate the services they deliver but have not been included in the contract. Providers would be able to look into these interventions and make decisions on whether to stop providing them or to negotiate with commissioners by taking account of both necessity and efficiency. From the manager side, the evidence-based negotiation was considered beneficial since it would offer providers a chance to pay more attention to patients’ needs.

When we look into the things, we are actually delivering some elementary cares that we are not commissioned to. We need those conversations with the commissioners “Do you want these services?” (M1)

Nevertheless, potential risks derived from the financial incentives have been noted by the managerial-level participants.

They were aware that providers may be encouraged to attract more patients and do more work, which will make it harder to realise the strategic plan regarding transferring patients to primary care. In this respect, it has become a potential risk or even an inevitable outcome that MH PbR would become a finance-led system that it was not supposed to be. As the quote below indicates, the managerial-level participants have recognised the potential risk that this finance-led system may eventually compromise patient-centred care in a context where financial issues attract more attention.

I think the bad thing about it is that it seems like a finance-led project and probably shouldn't be, cause actually it is about patient outcomes and patients' needs. (M1)

This reveals that the managers and commissioners were aware of the potential risks brought about by MH PbR besides appreciating its theoretical benefits. This also paves the way for the subsequent comparison of the splitting perspectives between the managerial-level and frontline-level participants (this will be discussed in Chapter 7). The next section describes the progress of the implementation of MH PbR at the time the interviews were conducted from three aspects including clinical strategy, contract negotiation and frontline practice.

6.3 Current stage of implementation

At the time when the interviews were undertaken, commissioners and providers had set up a transitional process leading to the MH PbR system. To ensure a smooth transition, a series of new projects such as the MHCT, the MHCT care

pathways and the RiO information system were either under development or being undertaken as the preparatory work. Drawing upon the importance of the clinical structure design to the cost calculation system as discussed in Chapter 2, as well as the importance of the policy formulation to the implementation as discussed in Chapter 1, this section illustrates the current progress in an order of clinical strategy, contract negotiation and frontline practice.

6.3.1 Clinical strategy design

By acknowledging that there would be no new money coming into the system, the managers considered both patients' needs and the resources at their disposal to maximise resource utilisation. Financial issues were discussed horizontally between financial managers and clinical managers without vertically going down to the frontline level. By noting that Nottinghamshire Healthcare NHS Trust (NHT) was underperforming, financial managers worked closely with clinical managers to develop more cost-effective clinical strategies to minimise any possible financial risk. The fortnightly meetings involving the financial team, clinical directors and the senior general management team went through service design and service transformation at the strategic level. Regarding specific responsibilities at the current stage, clinical managers were responsible for reducing inpatient beds, building up care pathways, training frontline clinicians and sharing information, whilst financial managers started to cost up the pathways and negotiate with commissioners.

6.3.1.1 Efficiency

As both the managers and commissioners noted, the NHT currently had low efficiency of service delivery, which reminded the managers to pay attention to costs and efficiency in an effort to avoid financial risks, as the quote below describes:

They are starting to realise that if certainly there is a national price coming along that they would be really out of pocket because they have too much inpatient care. (C2)

At the moment, the long OBDs were seen as the major reason for the NHT's high costs and low efficiency. Both the financial and clinical managers were aware of the financial risks brought about by the high percentage of inpatient services, especially by those provided to the patients with lower-level needs.

We have got lots of patients we are treating actually should probably be treated in primary care by GPs because they have got minor depression and in Clusters 1, 2 and 3. (M1)

Regarding the policy to close secondary beds, the managerial-level participants (managers and commissioners) advocated the policy by regarding it as a good way to improve efficiency as long as the services between divisions were integrated to ensure patients proper treatments, although they had noted the news reports regarding the adverse consequences (this will be discussed in Chapter 8).

I would support beds being closed as long as those patients could be safely and well managed in the community. (C1)

Therefore, the managers were looking at integrating resources

between primary and secondary services based on care pathways. As the managers were aware, the clinical strategies, such as discharging patients out of secondary care, are not new, but MH PbR reminds providers of the importance of efficiency, thus encouraging multi-disciplinary collaboration involving different mental health professionals for higher efficiency. To accurately distinguish the patients whom could be discharged, the managers noted the importance of clustering. Therefore, priority has been placed on getting every patient accurately clustered and coded. At the moment, frontline clinicians were required to cluster every patient whilst discharging patients in Clusters 1-3, Cluster 7 and Cluster 11, or re-assigning them to a higher cluster.

6.3.1.2 Training

Meanwhile, the managers realised the importance of training to the accuracy of classification and the establishment of an integrated information system. In this respect, the NHT has launched a series of training sessions since 2013 to help frontline clinicians better understand how the subsystems work and how to use them properly in this integrated system. By the time the interviews were conducted, training sessions had been provided to nearly 400 out of 800 frontline staff who are the priority ones responsible for clustering patients.

For the frontline clinical staff, they are going to be clustering the patients. So they need to know that they are going through the right process and also to make sure that they understand why they are doing it and the changes are happening. (M4)

In the training sessions, specific scenarios were provided to

show frontline clinicians how to detect patients' needs, when to cluster patients and how to use the information to cluster them. To facilitate decision-making for frontline clinicians, the RiO information system was being developed to record patient medical information and the treatments provided by frontline clinicians. The algorithm provides suggested interventions in a drop-down menu after frontline clinicians input the patient's assessment results. The managers and commissioners expected the RiO to provide frontline clinicians a clear sense of quality and efficiency by comparing what they are delivering with what they should deliver.

Regarding this new system, participants from all interest groups realised the necessity and the importance of training by acknowledging the fact that frontline clinicians generally lacked understanding of the new project, as well as the large variations in clinical skills among frontline clinicians.

You just realise how many frontline people just did not understand. They did not understand the general understanding of the clustering, although there were different opinions. They (the trainers) gave some scenarios, and people had to cluster based on the information. Everyone from the table went out slightly different, which was worrying. (C1)

That is very evident from my personal experience that the Trust and the staff themselves are completely inconsistent. (S2)

In recognition of the frontline clinicians' lack of understanding of the system, in particular, their reactive working patterns, the managers expected the clustering system to improve service efficiency by promoting a change in their way of thinking.

It is getting people to think about the clustering as part of their daily practice. For the review periods at the moment, our staff are working on a reactive basis rather than a preactive basis. ... But actually if they start thinking on the lines, if they meet somebody they look and see when the next review period is, and base their appointments on that, it would be more streamlined, wouldn't it? (M4)

6.3.1.3 The MHCT care pathways

Due to the uncertainties of mental health conditions and the existence of different alternative treatments, the MHCT care pathways were in the piloting stage. In recognition of the value the care pathways in terms of making sense of the classification system, the managers regarded it as a priority to establish the MHCT care pathways.

We are trying to develop the care pathways reaching clusters so they (frontline clinicians) can get a sense of who fits where as well as what they are doing. (M6)

At the moment, the NHT was also developing quality outcome measurements to facilitate the MHCT care pathways. During the pilot of the MHCT care pathways, the NHT conducted two clinical audits in April 2013 and October 2013. During these two audits, the managers assessed the effectiveness of the care pathways using the newly developed outcome indicators, such as patient transition, the frequency of review, the time point of review and review outcomes. Besides these rough indicators, the commissioners expressed their expectations for more measurements to quantify and qualify clinical services.

Alongside the information gathering process, the managers also paid attention to sharing information with participants within the service delivery circle. The NHT was providing information on three levels according to the level of needs. For carers and service users, the NHT kept information concise and approachable. Detailed clinical information was provided to staff but no longer to carers or service users. The information behind the scene, such as financial issues was only available to commissioners and managers and not to frontline clinicians.

6.3.1.4 Linking service to payment

In order to better facilitate attaching tariffs to clinical activities, financial managers were cooperating with clinical managers to ensure the efficiency of clinical strategies. From a strategic point of view, financial managers emphasised more on the productive efficiency of the organisation. By working closely with clinical managers, the financial managers' responsibility was to prevent the NHT from experiencing any financial instability under the newly established payment system. Meanwhile, the managers of different divisions met twice a month to work through financial and clinical issues relating to MH PbR. By communicating with the clinical managers on a regular basis, the financial managers considered themselves able to obtain frontline-level information in order to ensure that the frontline clinicians were conducting practice according to the clinical strategy.

6.3.2 The contract negotiation

As discussed in Chapter 2, the MHCT and the corresponding care pathways are the foundation of the cost calculation system. As

this stage, the care pathways had just been developed and were being piloted. Without a fully established information system, both the commissioners and providers expressed their willingness to remain temporarily under the Block Contract. During the transition period, commissioners set a double-running system: on the one hand, they kept contracting based on OBDs for inpatient services and face-to-face contacts for outpatient services, on the other hand, they began to monitor clinical services using MH PbR targets.

6.3.2.1 The current progress

The awareness of the trend of implementing MH PbR was seen as a driving factor for providers to have a closer collaboration with commissioners and to establish a joint plan to minimise financial risks. Meanwhile, commissioners and providers have initiated a different conversation about the contract, one that focused on outcomes and quality. Commissioners and managers held weekly meetings from December 2013 to March 2014 to negotiate the contract for the financing year of 2014/15. In the meetings, the managers and commissioners discussed a range of strategic topics such as how the contract was going, how services were delivered, what currency they were going to set up and how to make the payment. From a managerial perspective, the collaboration with commissioners enabled them to better develop strategies by considering both internal factors and the commissioners' requirements.

We have been developing our clinical strategy internally but also trying to bring that in line with what commissioners would want and get everybody in line with the national policy. (M6)

Regarding 2014/15 as a transitional year, both the commissioners and managers felt pressure regarding the upcoming MH PbR system that is filled with uncertainties. The managers admitted their lack of confidence about the new “payment-by-cluster” method and attributed the reason to the absence of credible data. One financial manager pointed to the importance of exempting the NHT from financial risks during the contract negotiation, given the potential risks of destabilising the financial system led by MH PbR. Under such circumstances, the commissioners and providers reached an agreement to share financial risks using a financial envelope in the financing year of 2014/15. Therefore, although the Monitor has set up the rules on contracting between commissioners and providers, the price would still be set locally in 2015.

Although the Monitor have been so step-up for the implementation of PbR, what has gone quite is talking about like the national prices. So if it is always on local price, I suppose that is less risky. (C1)

6.3.2.2 The double running system

Both the commissioners and managers recognised the lack of accurate frontline data in relation to clinical services at the NHT (this will be discussed in Section 6.5.6), which led to the low readiness for payment-by-volume implementation.

I do not think we have got any assurance of our own data, and that is making the commissioners quite uncomfortable. They need the assurance because they need it to provide to their parties as well. (M1)

Given the series of clinical reforms that were being undertaken simultaneously, it was considered difficult to accurately cost up clinical inputs for each cluster without these fundamental subsystems established to ensure a bottom-up collection of the frontline clinical data. Therefore, the commissioners questioned the credibility of paying against clusters based upon the current incomplete information system, particularly in the absence of the MHCT care pathways. Under such circumstances, the commissioners and the providers preferred to stay in the Block Contract.

During this transitional period, the implementation of MH PbR began with establishing new indicators to monitor providers' performance. Meanwhile, providers were required to set action plans and submit reports according to the CQUIN indicators to facilitate commissioners' strategic plans although with no financial incentive attached. As a result, after the demand-supply side negotiation, commissioners and managers came to an agreement that the NHT was to submit quarterly dual-reports, including the information in relation to OBDs and contacts subject to the Block Contract and other indicators following the new action plan. In other words, the NHT had their services monitored by clusters, but were bought in the old way, which was called a "double-running" system.

We are running almost a "double-running system". So we have got the Block Contract and then we are also running a kind of "shadow PbR" contracting system. (M2)

To facilitate further quality measurement, the NHT has developed some approaches, such as cluster movement but they were not even at a testing stage. Regarding 2014/15 as a

transition year, the commissioners expected the new system to further improve quality by developing more quality related measurements to assess clinical performance using “cluster” as the unit.

They are going to report on the recommended requirement, which is probably some part of the Mental Health Minimum Dataset, and then they are not nationally mandated. A lot of them are quality related, like the number of people seen within their review period, the number of people on CPA or clustered. So these are quite a few quality indicators that we are getting them broken down by each cluster. (C1)

After reaching this broad agreement, the commissioners focused on getting GPs to understand the new contract system while the managers paid more attention to refining the service delivery process, costing up the clusters and submitting the quarterly dual-reports.

6.3.3 The frontline practice

As frontline clinicians, their daily practice is affected by both clinical and financial strategies. In other words, in this double-running system they were asked not only to meet contact targets set under the Block Contract and implement clinical strategies, such as clustering/re-clustering patients, but also to change their working patterns in order to adapt to MH PbR following the NHT’s new action plan.

According to the targets set under the Block Contract, frontline clinicians revealed that since 2013, they had been required to have four successful face-to-face contacts with patients each

day regardless of the severity of the patient. Both the managers and frontline clinicians were concerned about the fairness of the contract unit since only the contacts that last over 20 minutes are regarded as successful ones. Clinical work and other supplementary work, such as blood tests that contribute to the contacts, was not counted. In addition, the types of contact with different payments attached are roughly set as inpatient serves and outpatient services, first contact and follow-up contact, without taking account of other external factors, such as time span and patient severity.

They are looking at the activity, so the face-to-face contacts. They do not count the clinical work as the work counted. There is also a lot of work we do but not counted. (M7)

At the time of writing, frontline clinicians were required to use the HoNOS to cluster every patient. Another target for the frontline clinicians was to review patients in Clusters 1-3, Cluster 7 and Cluster 11 to decide whether to re-assign them or discharge them back to primary care as the NHT would no longer receive money for patients in these clusters under the MH PbR system. However, some managers and frontline clinicians questioned the appropriateness of these targets by pointing to the lack of within-group homogeneity of the classification system (this will be discussed in Section 6.4.1). The findings from interviewing frontline clinicians revealed the fact that when the political intents come to the forefront, they become detailed policies/targets, but these targets do not always fit into the frontline reality. In this respect, the implementation of MH PbR at this stage was seen as a top-down dictation that lacked viability (this will be discussed in Section 6.4). Consequently, it has been noted that managers were

struggling to get frontline clinicians involved in this payment system reform at this stage.

We have to cluster all the patients and the time taken to do that takes us away from caring for the patients and looking after them. The main thing is that we get emails sent to ask why we have not clustered everybody. That is all. We get emails asking why we only have 96%. (S3)

6.4 Intra-system evaluation

Regarding the subsystems that are involved in the MH PbR scheme (the HoNOS scoring system, the MHCT clustering system, the MHCT care pathways and the quality measurement system) all but the HoNOS were newly developed for the MH PbR system. Whether or not these core elements fully perform their functions, and whether or not they effectively coordinate with each other, heavily influences the viability of the project as a whole. Therefore, this section evaluates these elements to facilitate the investigation of the driving factors for the delayed implementation in the next section. To provide better readability, the findings subject to the internal elements are summarised in Tables 6-1 and 6-2. These two tables show the similarities and differences in perspective between the managerial-level and the frontline-level participants, which indicate two obvious problems of MH PbR at that stage: the conflicts between a top-down management style and a bottom-up health service provision as well as the gaps between theory and practice. The subsections will analyse the findings in the following order: the MHCT, the HoNOS rating scales, the MHCT care pathways, the HoNOS outcome measurement and the patient-rated outcome measurements.

Table 6-1 Summary of perspectives on the MHCT, the HoNOS and the MHCT care pathways

	The managers and the commissioners		The frontline clinicians	
	Perspectives	Themes	Perspectives	Themes
The MHCT				
Advantages	More manageable than the ICD/DSM; Streamline interventions; Facilitate cost calculation	Ideology: the top-down management is more effective		
	The symptom-based classification is more valid and effective	Advantage of the symptom-based classification	The symptom-based classification is effective when diagnoses are not clear	Advantage of the symptom-based classification
Drawbacks			The diagnosis-based classification is more valid; The ICD/DSM encourages comprehensive consideration of root problems; The ICD/DSM provides coherent treatments based on disease evolution	Ideology: the bottom-up individual-centred care is more valid
	Low within-group homogeneity; Low between-group heterogeneity	Constructional drawbacks	Low within-group homogeneity; Low between-group heterogeneity	Constructional drawbacks
The HoNOS rating scales				
Drawbacks	Subjectively given by assessors; The scores lack consistency	Constructional drawbacks	Subjectively given by assessors; The scores lack consistency; Limitation: other measures are more effective against particular disorders; Historical flaws: only examines past 2 weeks	Constructional drawbacks
	Mismatches between the HoNOS scores and the corresponding MHCT clusters	Poor collaboration	Mismatches between the HoNOS scores and the corresponding MHCT clusters	Poor collaboration
The MHCT care pathways				
Advantages	Facilitate classification: help frontline clinicians make decisions; Facilitate cost calculation; Facilitate the provider-side competition: use as benchmarks	Ideology: manage healthcare resources collectively	Facilitate clinical decision-making	Practical utility
	More manageable than the NICE guidelines; Limitations of the NICE guidelines	Constructional advantages		
Drawbacks	Insufficient to merely rely on symptoms in the absence of diagnosis/NICE guidelines	Practical drawbacks	The NICE guidelines are more valid: diagnosis-based classification; Interventions should be based on disease evolution	Ideology: the bottom-up individual-centred care is more valid

Table 6-2 Summary of perspectives on the HoNOS outcome measurement and the patient rated measurements

	The managers and the commissioners		The frontline clinicians	
	Perspectives	Themes	Perspectives	Themes
The HoNOS outcome measurement				
Advantages	A step in the right direction: payment should be made based on patient outcome	Ideology: patient-centred care		
	4-factor model; Cluster movement is valid to indicate service quality	Validity	4-factor model	Validity
Drawbacks			Unfair to exclude clinical input	Ideology: biased
The PREM and PROM				
Advantages	Valid to reflect patients' opinions: ultimately lead to quality improvement	Theoretical benefits	Valid to reflect patients' opinions	Theoretical benefits
Drawbacks	Biased: patients' opinions are subjective	Biases	Biased: patients' opinions are subjective	Biases
	Waste of resources: over focus on quality check	Potential risks	Increase workload	Practical burden

6.4.1 The classification system: The MHCT & the HoNOS

Drawing on the importance of the MHCT classification system to the project as a whole, the following section evaluates the MHCT by comparing it with the diagnosis-based ICD/DSM classification system. Together with the detected problems of the HoNOS, this section explains the initial drawbacks of the MHCT classification which devaluates its validity and feasibility.

6.4.1.1 The MHCT vs. the ICD/DSM

Serving as a reference, the ICD/DSM sheds light upon the advantages and disadvantages of the MHCT. It has been noted that when compared with the long-established ICD/DSM, the effectiveness of the MHCT depends on the standpoints chosen by the participants.

In comparison with the diagnosis-based ICD/DSM, the symptom-based clustering mechanism was seen to have higher predictive validity from a strategic level perspective. As

introduced in Chapter 2, the MHCT works as a hub gathering information from different angles and distributing patients into one of the 21 clusters, which is simpler than the ICD/DSM considering a large amount of groups. In this respect, six out of seven managerial participants appreciated its theoretical benefits created by the transparent information system. From a managerial perspective, the series of standardised treatments attached to the clusters would make it possible to predict the treatment process at the practical level and to monitor the activity in a transparent way at the strategic level, which may in turn facilitate the calculation of unit costs. By contrast, neither the ICD nor the DSM is able to predict costs of delivering mental health services. From the perspective of the managerial-level participants, this is the reason they regarded the MHCT with higher validity than the DSM in terms of serving as a basis for the payment system, as the quote below demonstrates:

I think it is much better than using the DSM or the ICD cause diagnosis does not really predict the costs or needs. Then the clustering tool is simpler than using ICD-10 or DSM diagnostic criteria, cause there is a much more limited number of clusters. It is a so much simpler thing. (M6)

Regarding clinical practice, the managers pointed to the fact that frontline clinicians sometimes cannot make an “accurate” diagnosis the first time they meet the patient due to the complex nature of mental disorders. From a managerial perspective, another benefit of the MHCT is that this symptom-based classification system allows interventions to be provided without being firstly informed by a detailed diagnosis.

It allows you to categorise patients into groups when you have

not got infinitive diagnoses, which is often very appropriate. (M5)

However, the outcome of this comparison is different when evaluating the effectiveness from the perspective of providing individualised interventions rather than collectively managing resources. From a clinical perspective, frontline clinicians have established their working patterns based on diagnosis. Rather than providing interventions based on symptoms, the ICD/DSM encourages an incremental process of understanding the fundamental problems of a patient, and provides flexible adjustments to interventions according to the individual's disease progress, which was considered essential in mental health by the frontline clinicians.

If you treat somebody as depression and later on they have a manic episode, so the diagnosis is bipolar disorder. It is not necessarily that you get things wrong by not getting the full picture immediately. It needs time for things to evolve or become clear. (S3)

By contrast, if psychiatrists only deal with one's symptoms, help them overcome crisis and then discharge, patients are more likely to experience a relapse. Nevertheless, the frontline clinicians admitted that when the diagnosis is not clear at the first time meeting with a patient, they have to make decisions based on clinical presentations. In this situation, they regarded the MHCT clustering system more helpful.

If somebody is a new patient and the diagnosis is not clear, then certainly you have to go on with the clinical presentation. In that sense, generally it can be very helpful. (S2)

However, it has been noted that the idea of separating a treatment that should have been an individualised/personalised process into several stages goes against the frontline clinicians' understanding of patient-centred care. In this case, the frontline clinicians did not agree with the idea to break a coherent progress down into several stages that share the same core pathogen and similar interventions.

There is a difference in the clusters drawing between depression and psychosis, but in nature there is no difference there. People are often progressing through severe depression to psychotic depression. So why then they have to jump into a different cluster? That does not make any sense for them. The management is still about the depression. So there is a problem there for me about cutting across that natural problem. (S3)

Besides the ideological drawback, the MHCT was criticised for its blurred boundaries that lead to low within-group homogeneity and low between-group heterogeneity. Regarding the within-group homogeneity, the frontline clinicians perceived difficulties in defining "stable", which is the criterion of Cluster 11. Some patients stay in a high level of auditory hallucination or other variances in mood for a long period of time whereas the variations for them are normal and stable. The frontline clinicians questioned whether they are in the same "stable" condition as what is expected in Cluster 11. Under such circumstances, the variations lead to a low level of within-group homogeneity. Regarding the between-group heterogeneity, the frontline clinicians pointed to the fact that comorbidities make cases difficult to fit precisely into one particular cluster. Facing a patient with two possible diagnoses, such as bipolar disorder and organic dementia, the frontline clinicians perceived

difficulties in making the decision between Cluster 12 for bipolar and Cluster 18 for organic dementia. The managers also noted some grey areas between the neighbouring clusters, such as Cluster 3 and Cluster 4. These issues could be attributed to a lack of accuracy of the HoNOS scales, which will be discussed in the following section.

Is it easy to say Cluster 3 is the one and Cluster 4 is the other or are there some grey areas between the two? We do need to be more sophisticated to look at the differences between Clusters 3 and 4. (M7)

The ideology of classification and the initial problems of the MHCT raised the frontline clinicians' concern about the reliability and viability of this new classification system. The managers expressed their understanding of frontline clinicians' lack of confidence when the diagnosis-based system the ICD/DSM, which has been invoked in the sophisticated NICE guidance, was replaced by an entirely new system. However, one manager questioned the validity of the latest version of DSM by referring to the interferences from pharmaceutical companies. As one manager concluded, there is no absolute black or white in this area, therefore, merely comparing these two systems and picking one from the other is not seen as appropriate.

There is nothing totally not credible or totally credible. There are scales and shades of credibility and I think one is always working with a compromise. (M5)

The managerial-level participants also highlighted the collaboration between the symptom-based classification and the diagnosis-based classification under the MHCT. This complies

with the theoretical process of clustering under the MHCT classification system as discussed in Chapter 2. According to the standard process of clustering, clinicians should firstly allocate a patient into one of the three super-clusters, including “non-psychotic”, “psychotic” or “organic”, which are set based upon preliminary diagnoses. Based upon the preliminary classification, frontline clinicians are expected to further allocate the patient by their symptom severity. In addition, the managers revealed that frontline clinicians were encouraged to use the NICE guidelines as a reference in the clustering process in order to improve the accuracy of clustering.

Besides the design of clusters, whether the clustering system can fully perform its function also depends upon the coordination with the HoNOS rating scales, as discussed below.

6.4.1.2 The HoNOS rating scales

As discussed in Chapter 5, the HoNOS was not designed for the classification system, and this would inevitably generate some discordance. Both managers and frontline clinicians indicated that the initial drawbacks of the HoNOS rating tool impede it from being able to capture symptoms and to help make an accurate classification. Similar to the findings in Chapter 5, all frontline clinicians and two out of four clinical managers pointed to the drawback of being subjective, which hinders its validity to a large extent. It has been noted that the results may vary by factors, such as the patient’s mood and conditions at the time meeting clinicians.

I think there is quite a lot of subjectivity in the rating tools and they vary by patients’ mood, what type of diet potentially, their

situation, what's going on the ward, what they have been told about and their home situations. (M5)

Therefore, concerns have been raised about its ability to accurately reflect the severity and patients' needs and thus accurately assign them to the corresponding clusters. Hence, this rating scale was regarded flawed for only considering the severity of symptom rather than measuring patients' needs. Furthermore, participants from both the manager and frontline groups stressed that the HoNOS rating tool only tests the general health and social functioning of patients rather than measuring the specific health care outcomes or clinical effectiveness of treatments. Frontline clinicians considered other specific scales, such as the Hamilton Rating Scale for Depression, more effective and accurate against a particular disorder field than the HoNOS, which echoes the findings in Chapter 5. Therefore, it was considered insufficient to connect symptoms to clusters and the corresponding interventions by merely relying upon the HoNOS.

The only question is that does it really make sense to use the HoNOS for everybody as an outcome scale? Should we not be using Depression Outcome Scale for people with depression or Bipolar Scale for people with bipolar? (S3)

As a measurement, the HoNOS has also been criticised for only focusing on the patients' symptom history for two weeks prior. Against chronic diseases, such as mental illness, the frontline clinicians regarded it as inappropriate and dangerous to only look at symptoms over a two-week period.

The HoNOS is a way for what is going on in the last two weeks.

We think it a joke that if you killed somebody 15 days ago, it would not show. (S1)

Despite the improvement made by adding the historical indicators, it has been noted that frontline clinicians had established their own working patterns before the adjustments were made. Moreover, as both the managers and frontline clinicians were aware, there existed large variations in working patterns among frontline clinicians, which indicates that the outcomes could further vary among clinicians, particularly in the absence of support from clinical laboratory tests.

What we are finding is people clustered very wrongly just using it, cause they are just looking at the last two weeks and the historical scores do not necessarily reflect the long-term difficulties. (M6)

There is no clinical item. There is no blood test, is it? There is no blood test for schizophrenia. I cannot go "His Schizophrenia rating is 6 because where he goes is blood sugar is 8". (S1)

When linking the HoNOS scores to the MHCT clusters, the RiO algorithm was criticised for the discordances between the two and a lack of flexibility. Regarding the discordances, one manager illustrated the conflicts between the actual HoNOS score and the expected the HoNOS score in a particular cluster (Cluster 13/14). The example given involved patients with a bipolar diagnosis but in a low level of hallucination and delusion (the must score is expected to be 4). One frontline clinician provided an example of one patient with severe hallucination in a stable condition to explain the conflict between the MHCT cluster (Cluster 11 in which the must score for hallucination is expected to be less than 3) and the HoNOS must score

(hallucination score 3). These discordances made the frontline clinicians prefer to choose the attached interventions as the determining factors for clustering when conflicts emerged. Objectivity was noted as another conflict between the MHCT and the HoNOS: the MHCT is about to categorise patients into specific clusters and provide target treatments, which is supposed to be objective, whereas the HoNOS was seen as a subjective tool. In this respect, the managers were aware of the difficulties frontline clinicians met in categorising patients into clusters based upon the HoNOS scores, since no one could perfectly fit into a particular cluster. This shows agreement with Lipsky (1980) who argues that the individualised needs require individualised services.

All they have been doing is basically allocating somebody into a number that does not mean anything and trying to fit them into boxes. So as far as they are concerned, they are just being asked to fill someone into that box and in reality nobody fits into the box. (M4)

As the managers realised, the poor validity of the HoNOS brings its feasibility and viability into question. In recognition of the fact that frontline clinicians were clustering patients based upon the possible treatments attached to each cluster rather than the HoNOS scores, the managers were concerned about the potential risk that such backwards classification would cause the HoNOS to become a separate task. Therefore, the lack of accuracy of the HoNOS and its direct adverse results, such as the difficulties in getting accurate clustering data, were seen as the two major casual reasons for the current situation. Specifically, frontline clinicians clustered patients somehow arbitrarily according to the workload, which in turn

further reduced participants' confidence in the accuracy of data (this will be discussed in Section 6.5.5).

To begin with, we just put everybody in Clusters 11 and 12 if they are in psychotic clusters cause we only need to review them once a year. (S1)

6.4.2 The MHCT Care pathways

Similar to the investigation of the classification system, this section discusses the validity of the MHCT care pathway system by depicting its theoretical benefits and comparing it to the existing NICE guidelines based upon the diagnosis-based classification system.

6.4.2.1 The theoretical benefits

The managers attributed the ability to facilitate effective classification and predict the corresponding interventions as the two most obvious advantages of the MHCT care pathway system. Regarding its influence on resource management, the managerial-level participants appreciated its ability to facilitate providers and frontline clinicians in foreseeing the whole process of service provision from a perspective of a multi-disciplinary collaboration with social care.

If someone is allocated to a particular cluster, there will be a particular pathway attached to each cluster and that pathway will outline all of the interventions that could be offered to that person as part of that pathway. (M4)

If you are looking at delivering a care pathway, along that care pathway is inevitably social care which deals with people's social

care needs. (M2)

At an administrative level, the detailed information in relation to resource consumption would help providers gain better knowledge of patients' needs and the corresponding health resources needed, which would facilitate the contract negotiation with commissioners.

Prescribing an activity and prescribing the care, you are actually ultimately prescribing how much entitlement you have. (M6)

Regarding its influences on clinical practice, by predicting all relevant resources needed for the treatment process, clinicians and providers were expected to change the way they operated and no longer merely focus on their own responsibilities. The managerial-level participants also appreciated its ability to provide frontline clinicians with the suggested interventions when they were not sure of the most effective intervention. Serving as benchmarks, the standards were expected to help frontline clinicians improve their skills, particularly in mental health where professional skills vary greatly among clinicians.

They are offering the same service. But depending on where you live what you may get varies. But hopefully, the pathways will reduce that as well because wherever somebody lives in the division, they should be offered the similar pathways of care as well. (M4)

The information was also considered beneficial to patients in terms of providing them a clear picture of the services they could expect to receive.

I think the fact that we have got the care pathways now written down and something we can give to the patient. They are not sitting down and thinking about how the next, what's the next thing to happen. (M1)

However, despite the fact that the NHT was still piloting the MHCT care pathways, some concerns were already raised in relation to its discordances with the NICE guidelines, which will be discussed in the subsequent subsection.

6.4.2.2 The MHCT Care pathways vs. the NICE guidance

Since the NICE guidance was developed based on ICD codes, the discordance between MHCT care pathways and the NICE guidelines is similar to that between the MHCT and the ICD/DSM. From a clinical perspective, separating the treatment process into several stages (clusters) and connecting them with standardised review periods is more of a managerial strategy than a “real” clinical mechanism that helps improve clinical quality. From the frontline clinicians’ understanding, treatment should be a process of seeking the root problems and solving the emerging problems by trial and error. In other words, frontline clinicians considered it clearer and more reasonable by appreciating that it outlines the whole process of an integrated treatment according to the development of the patient’s condition.

Care pathway should be based on the core problem. As far as I understand, the care pathway for the depression and the care pathway for the Obsessive Compulsive Disorder (OCD) should manage the evolution of that process and the recovery from that process, rather than somebody jumping from Cluster 6 to

Cluster 12 and then back. (S3)

As previously discussed, the managerial-level participants advocated the adoption of the MHCT care pathways by appreciating its theoretical mechanism of predicting costs. From their perspective, care pathways should take account of resource allocation, particularly in an area with limited resources. Similar to the comparison between the MHCT and the ICD/DSM, the NICE guidance does not provide information in relation to costs.

The cluster care pathways need to incorporate some of the economic reality. (M3)

Additionally, the managers also pointed to some limitations of the NICE guidance such as its lack of evidence base other than Clozapine for Schizophrenia. After all, in recognition of the gaps between the MHCT care pathways and the NICE guidance, managers were trying to incorporate NICE guidelines into the MHCT care pathways to further improve their validity.

We are trying to align the potential diagnoses within the clusters to the NICE guidance and to any other guidance that relates to what we should do to certain groups of patients in symptom clusters. (M5)

6.4.3 Quality measurements

The improvement of quality was regarded as another important theoretical benefit by both the managers and commissioners. One manager illustrated the definition of “quality” by referring to the NHS standard matrix: “quality” could be broadly defined

from three aspects.

Quality is easy to define if you use the NHS standard matrix, which is: quality is about the patient safety, clinical outcome and effectiveness, and patient experience. (M5)

Regarding their personal definitions of “quality”, seven out of nine managerial-level participants independently referred to “how much people get”, which echoes the idea of providing patient-centred services from the strategic level. Therefore, the implementation of measurements subject to patient outcomes was also seen as a highlight.

I think it is good because its whole emphasis is on outcomes, the outcome improvement and the outcome for the patients. So that is the right emphasis. (C2)

However, the managers also realised the difficulties in measuring the effectiveness and the validity of these quality measurements. One manager pointed out that only when the whole range of impacts regarding one specific intervention is known could the corresponding scales be accurately set, which affects the validity of the measurement. Nevertheless, it has been noted that such research is lacking in mental health.

We have to understand more about to what extension do the interventions we put in place affect outcomes as supposed to the natural history of the condition... A lot of development work is needed there because I do not think that we have any idea at all outside the randomised control trials. (M5)

Drawing upon the difficulties in measuring the qualitative

outcomes and the incapability of one single measurement to reflect the whole picture of service quality, providers were in the process of developing a series of measurement instruments and trying to form a single, integrated measurement system.

One isolated is not enough. It has to be a number of things putting together. (M2)

Therefore, the following sections mainly examine the newly developed clinical quality measurements. Besides the CQUIN targets, the HoNOS was adopted as an outcome measure to support the clustering process. Other approaches such as the Patient-Reported Outcome Measurement (PROM), the Patient-Reported Experience Measurement (PREM) and cluster movement adopted to measure service quality were tested during the pilot. However, due to the lack of tangible laboratory tests, measurements for mental health services were subjectively completed by either clinicians or patients, which brings its effectiveness into question.

In this respect, the participants were asked about their opinions concerning whether these measurements can accurately reflect “real” quality, including: a) can outcome measurement reflect the full picture of the effectiveness; and b) are patient-rated measurements reliable?

6.4.3.1 The HoNOS outcome measurement

Both the commissioners and managers regarded the HoNOS outcome measurement as a step in the right direction by pointing out that it was the first time that both providers and commissioners refocused on service quality, in particular,

patient outcomes rather than clinical input. The managers regarded the outcome measurement as evidence for cluster transition, which reflects the effectiveness and quality of clinical interventions.

According to the managerial-level participants, patient outcomes could present the quality and effectiveness of mental health services following the patient-centred principle. The newly developed 4-factor model summarises and describes the original HoNOS items in a more meaningful way, which helped to better evaluate patients' outcomes in four aspects including personal wellbeing, emotional wellbeing, social wellbeing and severe disturbance. The movement between clusters was seen as a valid indicator to facilitate managing performance collectively.

We are expecting to see a certain percentage of people moving down from the high intensive clusters. We have never measured the quality like that before. We have never really been able to measure on a contract base where the interventions that we pay for actually made people better. (C1)

Nevertheless, a conflicting perspective regarding the validity of the HoNOS has been noted at the frontline level. From their perspective of view, the "narrowed-down" definition of "quality" was not seen as sufficient or even appropriate when considering the complex nature of mental disorders. Due to the complexity of mental disorders, sometimes patients do not improve after efforts have been put in place, but this is not equal to no input or the wrong input. Therefore, the frontline clinicians expressed their concern about adopting patient outcomes without considering clinical input, especially recognising efforts behind

the scene.

The problem is that there is no way of testing the quality of my interaction with the patients outside this building. Actually, how well you are does not bear on how much work put on you to get you that well. (S1)

6.4.3.2 The patient-rated measures

Regarding the patient-rated measures, they were seen as valid from both the managerial and frontline perspectives, since the PREM and the PROM would provide a chance for patients to express their needs and feedbacks for the clinical services they have received. By realising the insufficiency of the understanding of patients' feelings under the previous system, frontline clinicians considered patient-rated measurements necessary and beneficial to facilitate a better interpersonal relationship, which is essential for mental health services. Regarding financial effectiveness, the PREM was believed to be able to provide evidence when negotiating with commissioners by outlining the gaps between the services patients want and the ones currently paid for.

I would welcome their feedbacks, cause if we are not providing the service, if you get ended up with a number of patients saying the same thing that we are not providing, then we will turn back to the commissioners and say "Your patients want this and you are not actually paying us to do it. If they want it and you want to provide a complete service, then you got to listen to your patients the same as we got to listen to your patients." (S2)

Despite their advocacy of the idea of considering patient feedback, the clinicians were aware of the initial drawbacks of the questionnaire design. Some clinicians did not agree with some questions such as “Do you feel optimistic about the future” (in Warwick-Edinburgh Mental Wellbeing Scale) by questioning the appropriateness of asking a patient with dementia in their early 40s about their attitudes towards the future. Additionally, both the managers and frontline clinicians were concerned about biases resulting from patients’ subjective attitudes. Unlike acute services where patients are keen to cooperate with interventions, frontline clinicians sometimes have to serve people who do not want to be treated in mental health services. Additionally, frontline clinicians have to deal with patients’ excessive demands, which sometimes cause their dissatisfaction when clinicians are not able to meet these excessive demands. Consequently, some clinicians doubted the accuracy of patients’ subjective opinions regarding reflecting the “real” quality of service.

That (the quality measurement) becomes a subjective report from the party. So it is very difficult to actually measure that level of effectiveness. (M7)

In recognition of the biases within the patient-rated measurements, the managers suggested treating them as the representation of one specific part of quality.

However, one manager explained a potential risk of establishing a series of different quality measurements is the excessive attention paid to checking the system. In theory, the system is supposed to be efficient and effective enough to not require constantly checking for fraud. In this case, the excessive effort

put into checking for fraudulent activity was seen as a waste of resources that could have been used in patient care.

My biggest worry is that the both the commissioners and the providers will put effort, management resources and time into checking that while that is wasted essentially. (M5)

In light of the theoretical benefit of driving up quality, the managerial level participants were keen on the establishment of quality measurements, even though they were aware of the potential risks.

I think we should just be careful about the evaluation of the guidelines that put in place. I think it is important to have a mix of qualitative and quantitative information, so we can not only display the trends but also to put a good narrative on that as well. (M7)

Based upon the above discussion about the subsystems, the problems captured in this section facilitate the exploration of the factors that have caused the delayed implementation in the following section.

6.5 Driving factors for the delay

The interview findings indicated that the commissioners and managers supported MH PbR by considering its prospects whilst the frontline clinicians were more concerned about its feasibility. In turn, when it comes to the driving factors for the delay, the commissioners and managers attributed part of the reasons to the difficulties in getting frontline clinicians involved. The factors

that made frontline clinicians reluctant to engage and how these factors led to the delayed implementation will be discussed in this section. The factors are primarily categorised into seven interlinked parts: 1) the complex nature of mental disorders; 2) the constructional flaws; 3) the intensively established policies; 4) frontline clinicians' involvement; 5) the "gaming" behaviours; 6) the information system; and 7) the negative attitude towards change.

6.5.1 Complex nature of mental disorders

In the interviews, eight out of twelve participants attributed the major reason for the delay to the complex nature of mental disorders, given the individualised conditions and the lack of tangible tests that cause difficulties in categorising patients. According to their perspectives, in mental health, clinicians are no longer treating diseases, rather, they are treating human beings as a whole under the influence of social conditions. Consequently, patients with the same diagnosis could end up with completely different outcomes, as the quote below indicates:

This is a difficult area in mental health. There are so many macro and micro issues that affect people in mental health services apart from what you are doing for them. (M5)

These unpredictable external factors made all frontline clinicians aware of the difficulties in predicting patients' behaviours and thus concerned about the large variations in the outcomes, even among patients with the same diagnosis. In this respect, frontline clinicians expressed their concern about the uncertainties that may compromise the effectiveness of

managing medical interventions in a standardised way in this largely under-explored area.

I think Payment by Results is a difficult thing in physical health care, and it is almost impossible in psychiatric health, because how can you possibly know what a human being is going to do? (S1)

6.5.2 Constructional flaws

The constructional drawbacks were noted at both the frontline and managerial levels. From a clinical perspective, the drawbacks were contributed to the complexity of mental disorders. The frontline clinicians pointed to the problems they met when categorising highly-individualised patients. As both the managers and frontline clinicians were aware, the vague distinctions between the neighbouring clusters, the variations within one cluster, the mismatches among the subsystems and the lack of a comprehensive quality measurement system required more sophisticated adjustments to the structure. As the managers realised, trying to streamline different practices and thus map them into care pathways was the most difficult target at that stage.

We have got different practices within the Trust. So trying aligning our practices with other trusts is difficult. I think the implementation of the care pathways is going to be the hardest thing that we can set up. (M1)

As previously discussed, the NHT was still piloting the MHCT care pathways. Nevertheless, the mismatches between the designed pathways and the practical realities had already been

noted.

We are piloting care pathways in one area at the moment. ... The care pathways that we have set at the moment are quite aspirational. It is not necessarily what is happening in practice.
(M1)

The limited suggestions provided after clinicians entered the assessment results raised clinicians' concern about the flexibility of the RiO system as the limited suggestions could not cover all possible conditions. Therefore, the process of inputting information into the RiO was described as a process of "feeding the machine".

You can click a button and you can put what you have rated somebody as and then it will tell you which cluster. Usually, it comes up 83% this one of whatever and left 17% this one. So you have got two choices really. But it has to be a menu of options. (S1)

We are doing it now because we are expected and we have to do it. So again, I am keeping using the phrase "still like feeding the machine". (S2)

Regarding the payment calculation mechanism, the payments subject to severity failed to reflect the real frontline workload. According to frontline experiences, what they can do for the patients in higher clusters, such as Clusters 15 and 16, is very limited, whereas they need to make a significant amount of behind the scene effort to keep the patients in Cluster 11 in a stable condition. Thus, it gave the frontline clinicians an impression that the idea of "higher clusters with higher costs" only came from the calculation of the costs of medication,

whereas other types of clinical inputs were largely ignored due to the difficulties in quantification, which was seen as unfair to them.

I do not think the cluster reflects the costs. How well you are is got nothing to do with how much time (it takes). I can only demonstrate it with the medication, and I am sure that is the same thing goes on with my talking therapy. But it is almost impossible to prove the services on an individual basis. (S1)

6.5.3 Intensively established policies

In the meantime, the government has established a series of policies with different emphases ranging from improving quality by measuring outcomes to establishing performance-based payment and incentivising the provider-side competition in the market within a very short period. When these top-down policies come to the frontline, they come in a form of different targets and paperwork, particularly in such a scenario where all sub-systems are being established at the same time. This inevitably resulted in the frontline clinicians' lack of understanding of the policies and the MH PbR policy as a whole. This became more evident when some targets were not considered as properly set due to the lack of rigorous tests prior to implementation, as the quote below indicates:

They did not say "Let us assess what each service does". Instead, they said "Let us make four contacts each day". There is no "Let us measure where we are" or "Let us have a think about it". (S1)

Since 2013, one policy has come into effect that requires

frontline clinicians to have four successful face-to-face contacts with patients each day regardless of the severity of disorders. Drawing upon the high variations in the time span for community contacts, frontline clinicians regarded the policy as set without a careful consideration of the realities of their work. This is due to the lack of consideration of the time and effort required for a successful contact, which varies in across patients' conditions, doctor-patient relationships and the type of service. To support this argument, one frontline clinician elaborated the heavy workload by giving an example: it may take up to four hours to see four new patients and it may take another three hours on traffic for home-visits. Even if they can manage to make all contacts within one community, it would still take five hours of fieldwork. Regarding the workload, all frontline clinicians expressed their discontents about the target-driven policy due to a lack of rigorous calculation of clinical inputs. Moreover, one clinician pointed to a potential consequence that the unnecessary contacts driven by the target may make patients overestimate the medical severity of their condition.

You feel like that the pressure has been put on you to create opportunities to see people you do not actually need to see them. If you need to do four contacts a day, you see them a bit extra, more than they actually need. Possibly more than that is good for them. It is actually damaging because they start to think why should I turn up more? Does she think that I am ill? Does she think that I am not coping? (S1)

Besides the inappropriately set policies in this double-running system, conflicts were observed between policies and clinical realities regarding the MH PbR payment system. From a strategic perspective, moving patients back to primary care is

necessary and helpful regarding improving efficiency through a better utilisation of resources. Nevertheless, this policy has brought a sudden dramatic change in the long-term doctor-patient relationship. This is particularly the case for the patients who have become dependent upon the staff. The conflict between the clinical strategy and the practical human feelings put frontline staff into a dilemma, let alone the potential risks that have resulted from the gaps between secondary and primary care.

When they (the patients) were brought into the service, they would have been told "You have support for life" back to the 60s and 70s, possibly in the 80s. When we are bringing people out of the hospital to the community, we could not imagine that we could never ever come to at a time, where these people are managed without the Trust. (S1)

The feasibility of another policy that requires all patients in Clusters 7 and 11 to be discharged to primary care has been questioned by the frontline clinicians, particularly given the gaps between secondary care and primary care. In contrast to the assumption that patients in Cluster 11 are stable enough to not require secondary care, both the managers and frontline clinicians were aware of the fact that the NHT has to accept some patients in Cluster 11 because GPs have no authority to prescribe Clozapine or perform blood tests. This leads to the condition that the NHT is made to offer services that are not counted in the end. In this respect, the extra, but unpaid, workload exacerbates their level of discontents. Discharging patients in Cluster 7 also raised the managers' concern about the appropriateness of this policy, given their complicated conditions and particularly the gaps between primary and

secondary care. In this respect, the managers pointed to the existence of the political elements of this reform as well as the fact that sometimes there are mismatches between political intents and clinical realities.

There is a political element for all of it as well. It is about the politicians want us to be seen safe, effective and efficient service, and sometimes there can be a little bit mismatch between the politician's objectives and the very immediate objectives for the service users. (M7)

The potential damage to service quality has been noted as the main side effect caused by this target-driven policy. From the frontline perspective, the poorly set targets took away time that could have been spent in treating patients and improving skills. Moreover, to prevent fraud/lie, one policy requires two clinicians to see one patient together, which was not seen with much clinical utility except the financial benefit resulting from double counting the clinical work. Therefore, frontline clinicians considered these target-driven, but not clinically meaningful, policies a political imposition with the potentials to undermine good clinical services

How do you improve the quality? You can improve the quality by training staff or by giving them opportunities to explore and have good supervision. All these things go if you said "We have got to see four people a day", because they have not got time to think. If every minute of every day they are being monitored, that does not create a thinking, does it? (S1)

Additionally, as one manager argued, the changing political environment made whether MH PbR would be implemented an

open question, which further reduced clinicians' willingness to engage, as the quote below demonstrates:

One of the problems with the government initiatives is that half of them fail or disappear when the political colour changes or you get a new manager in the Department of Health. They are a waste of time, and I have wasted many hours on paperwork that has been no use at all because of the national dictation. The frontline clinicians are even less incline to do that because they cannot see the patients. (M5)

6.5.4 Frontline clinicians' involvement

Similar to what managers were aware of, all frontline clinicians expressed their unwillingness to engage by arguing that what they saw were targets and changes to their long-formed patterns of daily practice but with no clinical benefit attached.

6.5.4.1 Increasing workload

Regarding the increasing workload to the frontline, managers noted the inevitable increase in workload given the effort required to understand the new system and to facilitate quality assessment. In fact, they highlighted a number of disadvantages as described in the following subsections.

At the moment, I probably would guess that they (frontline clinicians) would say they prefer the Block Contract because it (quality monitoring) is part of the new PbR. It requires more work to look at it. In the initial stage, I think there will be more work. So as to the staff, they will think it as a negative thing. (M4)

However, this extra workload and constant checking for fraud raised some managers' concern about the validity of MH PbR since one of the original intents is to ensure quality by competition. The experiences from frontline clinicians echoed managers' concern: some checklists were considered long and redundant, or even inappropriate. The dictatorial clauses made the frontline clinicians feel uncomfortable.

I got forms to go "Have you discussed this and this with the service user? Have you discussed this and this with the service user's partner?" and you think "Oh my god, this is just like a baby". (S1)

The requirement of detailed evidence was regarded as heavy burden for the experts, and at the same time it failed to promote those less skilful clinicians to improve service quality, since the skilful clinicians would provide high-quality treatment without such redundant guidelines, whereas those clinicians who are not good at clinical treatment would go through the checklist perfunctorily. Moreover, the heavy workload took away their time that could have been used to truly improve their skills, thus confusing them by the dilemma between the idea of increasing efficiency and the policy of increasing paperwork. Particularly, in such a context where subsystems together with the supporting policies were being intensively established, the inappropriately set policies triggered their resentments, although they understood the ultimate goals as efficiency and transparency.

They (the commissioners) just pick some targets at their way not aware of that they are not achievable. They are not doable. ... I am not saying that we should not try and look ways

for public services and reduce the spending. I am sure that we are wasting money. But it comes too quickly. (S1)

6.5.4.2 Unfair payment

As previously stated, the current payment mechanism was not seen as appropriate by frontline clinicians. It is common for patients not to show up for appointments while clinicians have already put a lot of effort into preparation, or alternatively, patients do not open the door when clinicians have travelled a long time to their homes. Due to the idea of focusing on clinical output rather than clinical input, effort was neither rewarded by the contact-based system nor the patient outcome-based system. The frontline clinicians revealed that the work behind the scene, which should also have been measured as part of service quality, is often neglected.

I think the word of "Result" is ambiguous. "Payment by Results", it should be "Payment by Effort". I do not feel that the commissioners appear to be aware of the amount of effort it takes. (S2)

By realising the unfairness of the payment system, managers were negotiating with commissioners to improve this mechanism by adding the behind-scene activity into the paid work.

6.5.4.3 Training

As discussed earlier, the sequence of developing the key subsystems indicates that frontline clinicians had established their working patterns before they were offered the

standardised training sessions, let alone the initial problems of the MHCT algorithm as previously examined. In contrast to expectations, the training sessions have not turned out to be effective. One manager attributed part of the reasons for this to the lack of continuity by pointing to the several years' gap before the re-launch of the training sessions. One of the problems created by the inconsistent training programme is the absence of opportunities to deliver up-to-date information to the frontline in a direct and accurate way: the same message delivered by different managers became different versions when it arrived at the front line. One manager admitted that training sessions would provide frontline clinicians another new version of information, which would result in more confusion.

In meetings with senior managers, they would be given messages that probably go down the chain. But by the time they get to the frontline, they are probably not the accurate messages, or there might be the panicking messages. So the staff have been given lots of mixed messages. So they feel very confused about it. When we first started to do the training, there were all sorts of bizarre mixed messages out there about how they should be doing things. Obviously, they will be coming to my session and then I will be telling them something different again. (M4)

Moreover, the frontline clinicians also criticised the initial drawbacks of the RiO and the trainers' failure to solve the practical problems that further compromised the effectiveness of the training.

In conclusion, the intensively established policies, the heavy but unhelpful workload and the unsuccessful training sessions

provided negative information rather than incentives to frontline clinicians. Therefore, at that stage, it is not surprising that the frontline clinicians and even some managers were not willing to embrace MH PbR.

The staff managers and medical staff have not embraced this as a good thing. (M2)

6.5.5 The “gaming” behaviours

Regarding the potential risks of “gaming” behaviours emerging in the implementation process, the commissioners and some financial managers showed their concern by referring to the experiences of implementing PbR in acute services.

“Gaming” is a worrying. You see how many (“gaming” behaviours) in the acute trusts and you see a real distrust between commissioners and providers. (C1)

However, rather than the “game for money” behaviours as the economic theory predicts, the frontline clinicians referred to their “gaming” behaviours as a means to deal with the heavy, but clinically unhelpful, workload. Drawing upon the lack of national guidelines to evaluate the accuracy of the previous clustering outcomes, the managers pointed to the inappropriateness of attributing all up-code decisions to “gaming” behaviours in the current situation.

6.5.5.1 “Game for money”

Seven out of twelve participants (among whom five were managers) made it clear that “gaming” is completely

unprofessional and there should not be any “gaming” behaviour. According to the economic mechanism as discussed in Chapter 2, profit is determined by the comparison between the actual costs and the corresponding national tariffs. As one manager indicated, it was more difficult to game at that stage, given the lack of accurate information about the actual costs of each cluster. Even if providers have identified the more profitable clusters by comparing the average value of the actual costs and the national tariffs, they could turn out to be unprofitable once the patients with high costs were allocated in those clusters, especially since the current information system could not accurately predict possible costs at an individual level. Furthermore, the commissioners argued that the “up-coding” behaviours it would not necessarily lead to more income since “higher cluster” does not equal “more profit” when taking account of clinical input.

Besides the technical infeasibility to “game”, the majority of managers did not think the financial environment would necessarily affect frontline clinicians’ daily practice in terms of developing “game for money” behaviours since their salaries are separate from their activities. They believed that frontline clinicians do not have a sense of earning money for providers, especially by putting someone into a cluster where they do not belong, as this goes against their professional values. From their perspectives, as long as the financial issues can stay at the managerial level as it was at the moment, frontline clinicians would not “game” for financial reasons, as the quote below indicates:

They do not really have a sense of earning money for putting someone into different clusters because they are not bothered

by that amount of money. The problems with the medication in the Medicare, the American insurances, are that their incomes which go up depending on the work they are doing. Our salaries are set separately. (M3)

In terms of the managers' understanding of frontline clinicians' value systems, this complies with the concept of "professionalism" as discussed in Chapter 3. One commissioner supported this viewpoint by pointing to the fact that the frontline clinicians were more likely to score patients into lower clusters than they should have been due to their sympathy about patients' feelings.

6.5.5.2 "Game for workload"

Nonetheless, rather than "game for money", the frontline clinicians admitted that they had participated in "game for workload" behaviours. Due to the development sequence of MH PbR, frontline clinicians had been clustering patients without care pathways underpinning the decision-making process. This not only points to the lack of accuracy of the clustering process, but also indicates the situation where frontline clinicians were allocating people into boxes with no clinical meaning attached. Therefore, it resulted in a situation where some frontline clinicians clustered patients arbitrarily for less workload, especially within a context of heavy, but clinically meaningless workload and information asymmetry between regulators and the observed.

To begin with, we just put everybody in Cluster 11 and 12 if they were in psychotic clusters cause we only needed to review them once a year. (S1)

Drawing upon the inappropriately set targets, the managers also noted the mismatches between the politicians' objectives and the very immediate objective for the service users. In this regard, all frontline participants admitted that they regarded "gaming for workload" as a means of dealing with some targets, which are government dictations without much clinical benefit.

I would not call that "gaming" and I would say that is a way of trying to cope within and trying to bend the orbit within the constraints of this system that sounds imposed on you. (S3)

Besides those movements that have been attributed to "game for workload" behaviours by the frontline clinicians, the managers regarded some movements such as some "up-coding" behaviours, as a correction of the wrong decisions that were previously made. For instance, the managers noted a huge shift from Cluster 3 to Cluster 4 and from Cluster 11 to Cluster 12. In recognition of the lack of national guidelines at the beginning and the grey areas between the neighbouring clusters, the managers considered it impossible to distinguish "gaming" behaviours from a correction of previous decisions.

6.5.5.3 "Gaming": Still a risk

Despite the dispute regarding the actual motive for the "up-coding" behaviours, it is not surprising for five out of twelve participants to regard it as a potential risk and another three even considered it as something about to happen under the marketised healthcare system. From a commissioning perspective, the financial risks put on providers and the poorly set targets made "gaming" an expected result.

At the minute, you take away the confines of the Block Contracts, and then you are opening up both sides to potentially "game". (C1)

Referring to the situation in acute services, the managers noted the ambiguity between "up-coding" and "cluster correction" in the situations where acute hospitals developed computer programmes to spot codes and help managers to double check the accuracy of the codes. Unlike the natural inclination of frontline clinicians, managers were considered more likely to use this mechanism to "game" in the current context of austerity.

Whether it is considered to be "gaming" or just double-checking for accuracy is a moving point. I guess you could say the same about the clusters, but I think the natural inclination of the clinicians is not to game, and the natural inclination of the managers is to balance the bucks. (M5)

6.5.6 The delay in establishing an accurate IT system

According to the above arguments, the initial drawbacks of the classification system including the constructional problems of the MHCT, the limitations of the HoNOS, the mismatches between the two and the lack of care pathways devaluated the classification results. Moreover, the possible "gaming" behaviours resulted from both clinicians' "game for workload" and managers' "game for money" further reduced the accuracy of the frontline data. The constructional drawbacks of MH PbR and the practical obstacles as a result of the target-driven policies reveal a low accuracy of the current information system. These factors raised concerns from both the providers and commissioners about the accuracy of the clinical data.

Moreover, the commissioners were aware of the lack of sufficient investment in IT and data collection. Drawing upon the theoretical mechanism of PbR as discussed in Chapter 2, without an accurate information system established, it is impossible to cost up services for each cluster/care package accurately. As the quote below indicates, the commissioners considered the lack of investment an impact factor that caused the delayed implementation of MH PbR.

There hasn't been the same level of investment in the data collection. ... I think we cannot go to PbR system until mental health trusts invest enough money on their IT. (C1)

This complies with the current situation where both commissioners and managers preferred to stay under the Block Contract temporarily to avoid financial risks due to their lack of confidence in data quality.

6.5.7 Negative attitudes towards change

Apart from the above objective factors, subjective factors such as the natural objection against change, have been noted. Five out of twelve participants regarded the naturally tendency for people to not want to change (on both the provider and the commissioner sides) as one of the factors that have caused the delay.

They now have to change the way they are doing things. For a lot of people, they do not like to change, do they? (M4)

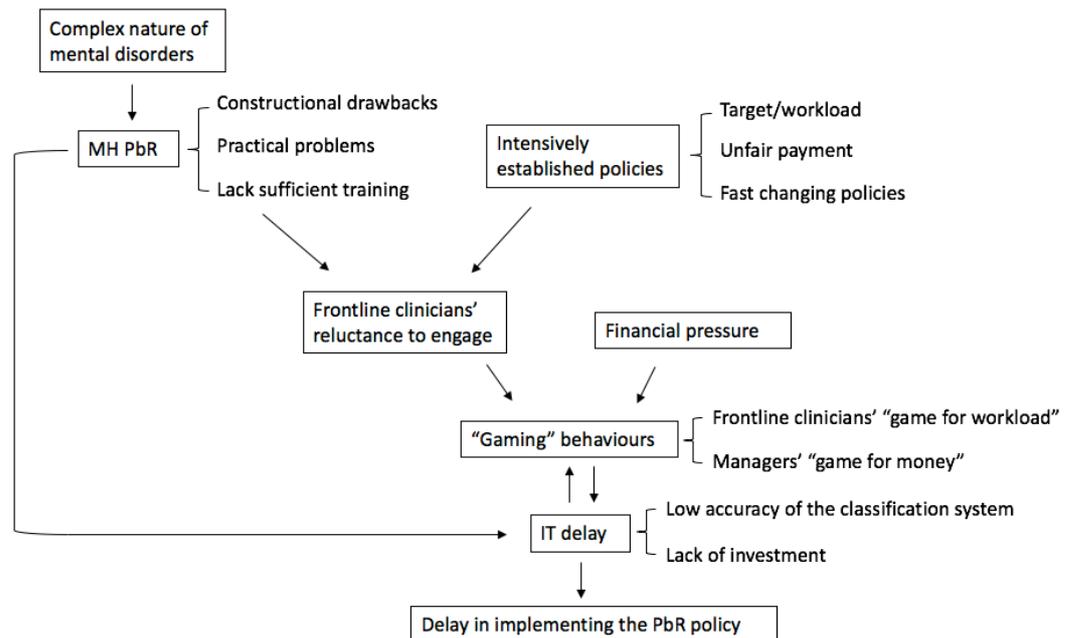
In some cases, the trusts has been a lot more willingness to implement PbR while the commissioners have not been so keen. (C1)

With respect to unwillingness to change, participants provided two types of examples. For the providers, the frontline clinicians were unwilling to implement the new policy, such as discharging patients who had developed a dependency on secondary care. One manager attributed this to people's fear of change in the culture and the ways they have been conducting services. On the commissioner side, the managers attributed the commissioners' unwillingness to change to their lack of understanding of the new payment mechanism, given a large number of commissioners who were still thinking in the old way of contracting.

I think what I want the commissioners to try to move towards is thinking about they are commissioning in a care pathway for a cluster. At the moment, they are still thinking in terms of services. (M6)

In conclusion, as Figure 6-1 illustrates, the complex nature of mental disorders increased the difficulties in accurately classifying patients and therefore calculating costs. The current double-running system focused more on targets than the establishment of a fair payment system. The fast changing policies resulted in uncertainties that reduced frontline clinicians' confidence in this project. All of the above factors contributed to frontline clinicians' reluctance to engage, which therefore resulted in the "gaming" behaviours. A lack of accurate bottom-up data together with the government's insufficient investment, caused the delay in building up an accurate information system, which is the foundation of MH PbR. Together with people's natural objection against change, these factors hindered the process of implementing PbR in mental health.

Figure 6-1 Interrelations among the driving factors



6.6 Suggestions

As some participants indicated, it is difficult to predict the risks before actually putting money attached to the system and having it officially implemented. It was considered still early to disclose how and to what extent this policy would affect people. In this case, one manager suggested implementing the whole system as postponing the project until everything is ready would be inappropriate.

You could probably say that we will never be ready, and I think that in the system you just get them on that. We have always got to make changes, haven't we? (M4)

Only when this system gets fully implemented for a period of time can participants obtain a better idea of its value and drawbacks. In other words, only a limited number of potential

suggestions for the problems that had already emerged were available in this early stage of implementation. These preliminary suggestions for the process improvements are categorised as refining the clinical system, developing closer collaboration among participants, adjusting the focal points and seeking more support from the government.

6.6.1 Refine the system

Nine out of twelve participants suggested refining the clinical system, including refining the classification algorithm, prioritising the care pathways and investing the IT system, as potential solutions to the previously discussed problems.

6.6.1.1 Refine the classification algorithm

Regarding the MHCT classification system, the credibility and validity of the care pathways and the tariffs would be largely compromised when the validity of the clustering mechanism is brought into question. According to the previous findings, the appropriateness of adopting the HoNOS as the outcome measurement for clustering and re-clustering has been raised. Both the frontline clinicians and managers were aware of the potential risks of compromising the within-group homogeneity by merely relying upon the HoNOS scores. Hence, both the managers and frontline clinicians suggested adopting more elements/supplementary means to make an accurate clustering decision.

If you just use the clustering tool you get a lot of people in the wrong clusters. We encourage people to use clustering tool but also use the clinical descriptor. We also encourage people to use

the care pathways. (M6)

The managers also admitted that the lead clinician at the NHT did not agree with the current algorithm, whereas the members of the benchmarking group also had concerns over its validity. Under such circumstances, managers have set the schedule to revisit the algorithm.

Our lead clinician for PbR does not like the algorithm. He does not actually think that it gives the outcome that we should have given as the feedback. Now I have asked it to be revisited actually. (M1)

6.6.1.2 Prioritise Care Pathways

One of the reasons why the frontline clinicians felt it difficult, or were even unwilling, to cluster patients has been attributed to the absence of the officially established care pathways. At the financial level, the commissioners noted that in the absence of the care pathways, providers could not accurately calculate the costs for each cluster. However, the managers were also aware of the difficulties in standardising care pathways and the fact that the currently designed care pathways did not represent what was happening in practice.

The care pathways that we have set at the moment are quite aspirational. It is not necessarily what is happening in practice. We put things in the care pathways that we think should be done, but we are not necessarily doing. (M1)

The managers also noted the lacked of sufficient resources for the development of the care pathways, despite its evident

importance to the implementation of the entire project. In this respect, it is important and urgent to prioritise the development of the care pathways.

6.6.1.3 Test the clinical system

When comparing the MHCT with the ICD/DSM, the frontline clinicians expressed their preference for the ICD/DSM partly due to the long existence of the diagnosis-based system and the support from the NICE guidelines. The initial shortcomings of the clustering algorithm have also been noted. Additionally, concerns were raised regarding the content of the quality measurements during the pilot. As one manager indicated, letting problems occur is the purpose of conducting a pilot test, which provides opportunities for refinement. However, despite the series of pilot tests that were launched, the frontline clinicians still considered the system lacking viability due to the lack of rigorous tests, as the quote below describes:

It all comes too quick. They did not say "Well, all right, let us assess what each service does first". No one asked me at any point "Can you do this? Is this doable? What do you do now?" So whom did they ask? I do not know. But I have been here 20 years, no one asked me. (S1)

As for the construction of MH PbR, the validity of each element within the clinical system are the preconditions for high-quality data, which in turn ensures the accuracy of the payment settlement. Therefore, the frontline clinicians suggested that each element should be refined, and the whole system should be tested at a local or national level first before the official implementation of the entire project.

6.6.2 Build closer collaborative relationships

As previously discussed, although managers were conducting pilot tests, the frontline clinicians still felt the new system lacking viability. Together with the inconsistent training sessions, the gaps between the administrative strategy and the frontline understanding indicated a lack of collaboration between the two. In the financial aspect, the current status of the commissioners' lack of willingness to adopt the new payment mechanism, together with experiences of lack of trust between providers and commissioners in acute services, called for closer collaboration.

6.6.2.1 Manager-frontline collaboration

To solve the frontline clinicians' reluctance to engage, the managers were aware of the importance of building a closer collaborative relationship, particularly from three aspects: prove MH PbR effective, further develop training sessions and involve frontline clinicians in the decision-making process.

Meanwhile, the frontline clinicians complained about the targeted practice that took away too much time that could have been used to provide treatment to patients. However, from a managerial perspective, the routine activities are meaningful regarding collecting the frontline information to facilitate the resource management and thus the price calculation at the strategic level. In this case, the managers and commissioners attributed one of the reasons for the frontline clinicians' complaints to a lack of opportunity to obtain a broader picture of the system. As some managers admitted, the administrative targets are necessary and useful, but it is managers' responsibility to make them as explicit as possible for the frontline clinicians.

I think it (the manager-frontline collaboration) gives them (providers) a greater understanding of the project, and makes them easier to be part of it rather than they are told to do something. (M7)

Participants from all groups were aware of the importance of training, due to the variations in clinical skills to cope with the MHCT. As discussed earlier, the managers attributed one of the factors that adversely affected the validity of the training sessions to the mixed messages coming from either different training sessions or different middle managers. The mixed messages devaluated the training sessions by confusing frontline clinicians about the accuracy of information provided during the sessions. By noting the side effects of the disjointed training sessions, the commissioners suggested a consistent and high-quality, up-to-date training to ensure that frontline clinicians understand what to do and how to do it.

Although noting the difficulties in implementing collaboration, the managers acknowledged the insufficiency of the current top-down dictation, which indicated the necessity and importance in having a different relationship with frontline clinicians. In this respect, the managers appreciated the importance of establishing a collaboration process where frontline clinicians could share the information in greater detail and even engage in the decision-making process in order to encourage their participation.

By engaging them in the process, they will understand it and become more a part of it and they become part of the potential solution as well because it is a process we have looked up them at the moment. (M7)

6.6.2.2 Provider-commissioner collaboration

Regarding the current situation where GPs were new to commissioning and many commissioners were still thinking about commissioning in service rather than in cluster/care pathway, ways to help GP commissioners understand the new payment mechanism were also considered important. Drawing upon the importance of getting signatories to understand the new mechanism, the participants from the commissioner side attributed one of the reasons for requiring the dual-report to helping signatories comprehend the differences between commissioning in service and commissioning in clusters.

They (providers) did not want to do the dual-reporting. They wanted to stop reporting on OBDs and contacts, and they only wanted to give us PbR data based on the PbR plan. So we argued "No, we have to have the report on contacts and (Occupied) Bed Days because we need to get signatories understand the differences between the two." (C1)

Besides getting commissioners on board, the managers realised their working relationship with commissioners was, and should be, collaborative rather than conflicting. The current collaboration progress highlighted the areas where the providers had been ineffective, which may in turn bring more financial risks under the MH PbR system. Similarly, on the commissioner side, the commissioners were inclined to collaborate with more directors besides the senior managers in order to obtain more detailed information regarding the actual frontline practice.

I think what we need to do is actually talking about the implementation of PbR a lot more at those higher-level contract

meetings, and also at the contract set board which is attended by the directors because I think we need to have a really honest dialogue of where we are. (C1)

In light of the side effects caused by the target-driven policies, the managers pointed to the importance of keeping the routine clinical practice in a stable condition and not to be destabilised by the potential increase in workload resulting from the establishment of the collaborative relationship.

I suppose the other thing is to make they called "collaborative relationship with commissioners" not producing huge clinical instability in the mental health system, which clinicians do not want either. (M6)

6.6.3 Adjust the focal point

Additionally, the frontline clinicians argued that the information they received was all about money and targets. Simultaneously, the managers and commissioners were also aware of the potential risks or the fact that it was already happening: indeed, MH PbR became a finance-led system while it should not have been. In this case, the participants suggested an adjustment to the focal point from two aspects, including moving the attention from controlling costs to improving clinical services, and focusing on establishing an integrated mental healthcare system.

6.6.3.1 Reduce the emphasis on targets and costs

As both the managers and commissioners noted, the emphasis of MH PbR should be placed on "leading a better quality service".

In other words, the standardisation of mental health services, the integration of service delivery and the quality of mental health services should be the priorities whilst less attention should be paid to the payment mechanism. However, at that moment, the change in the payment mechanism together with the establishment of supporting sub-systems attracted more emphases. This raised participants' concern over the current condition, where MH PbR became a finance-led system that it should not have been.

I think the bad thing about it is that it seems like a finance-led project and probably should not be, cause actually it is about the patient outcomes and patient needs. (M1)

Regarding the solution, one commissioner and one manager suggested changing the misleading name and thus re-attracting people's attention to patient needs to facilitate the development of better mental health services.

Obviously because of the financial implications, that is called "Payment by Results" that people tend to focus on the finance. (C2)

We need to change the name, don't we? (M1)

The frontline clinicians regarded the current the MH PbR system as lacking sufficient attention to comprehensively measure quality. When referring to the quality measurements, indicators, such as the successful face-to-face contacts or even the payment by cluster and the PREM, were considered to focus mainly on outcomes and only present part of the overall quality of services. One manager argued that service should be defined by "quality" and "perceived quality". Regarding the "perceived

quality”, they believed it should not be defined merely by service users, rather, it should also be defined by frontline clinicians. In other words, the behind the scene effort should also be taken into consideration. As one clinician suggested below, to avoid an over focus on results and thus a lack of attention on other aspects of service, more attention should be paid to improving the service delivery process.

I think it is too concentrated on results. I think what people need to pay a bit more heat to is the quality of care that is provided. (S3)

6.6.3.2 Focus on establishing an integrated care system

In terms of providing better services to care users, it has been noted that the current policies in relation to discharging patients to primary care required a closer collaboration between primary and secondary care. According to the statement below, there are some grey areas between the two that need to be clarified for a better coordination.

I think there is always going to be a disconnection between primary care and secondary care. ... We do need to be more sophisticated to look at the differences between Clusters 3 and 4. (M7)

With the development of different treatment approaches, managers were planning to make more investment in the community, such as allocating more resources to community care in order to improve the efficiency of secondary services. In other words, the reforms brought by MH PbR would not only affect the NHS system, but also influence social care services.

One manager revealed that the changes in secondary care would have a broader impact on other services due to the heavy impact of the external factors and the close relationship between secondary care and primary care, as well as with social care.

This impacts on other sectors by introducing these changes in secondary mental health care, because it cannot be seen as an isolation since there is always an impact on other areas. (M2)

In this respect, the success of MH PbR not only depends upon the changes in secondary care, but also requires the development of primary care and social care in sync. The commissioners also suggested reallocating some resources to primary care in order to improve efficiency. Furthermore, they considered the establishment of an efficient mental healthcare system as the prerequisite for the accurate calculation of mental health care costs. Only when the integrated system is established, can commissioners be assured of the effectiveness of the payment.

Under such circumstances, the commissioners suggested focusing on establishing an effective service provision system first and postponing the implementation of the payment system.

6.6.4 Government support

In reference to these difficulties, the participants requested for more support from the government regarding the establishment of national guidelines and the provision of more financial support.

Besides the frontline clinicians' complaints about too many targets, the managers and commissioners were also concerned about getting too many orientations from the government without being provided a clear direction on how to conduct the project. The lack of national guidelines not only led to a low accuracy of clustering, but also resulted in large variations in treatments, which conflict with the original goal of implementing MH PbR.

I think the problem in mental health is that it is the area probably with the least national guidance, national standards. So what happened is that massive of codes in the country and what you can get in one area can be completely different from the other, and it should not have been. (C1)

Under such circumstances, participants from both the manager and the commissioner groups expected more useful information from the government to guide the implementation process.

I think the biggest thing is that there should be more information coming down from the top on how we do this and sharing information. (C1)

From a managerial perspective, one benefit of care pathways is the integration of the mental healthcare system. This indicates that the system would inevitably involve social care and it has to address social needs. However, the managers also noted that the relationship between secondary care and social care was not close and even disappearing, given the fact that social care had been pulled back to the centre and the Nottingham City Council was planning to cut investment in social care.

If you are looking at the delivery of the care pathway, along that care pathway is inevitably social care. ... Ideally, you would have social working in multi-discipline teams working within secondary mental health care. But that kind of model is, unfortunately, disappearing as social work is pulled back to the centre. (M2)

The commissioners were also concerned about the limited budget since the money saved from closing inpatient beds had not been used to invest community services, rather, it had been taken out.

I think sometimes beds have been closed, and the money has just been taken out. (C1)

This made the implementation more difficult since that the establishment of fundamental facilities requires a considerable amount of initial input. Consequently, the managers asked for more financial support from the government to establish an integrated mental health system and to facilitate the reforms in secondary care.

Ideally, we need a bigger financial envelope. (M6)

Summary

Chapters 3 and 5 explored the fundamental theories behind PbR and the technical mechanism of MH PbR design, respectively. The preliminary findings suggested that the Quasi-market, the fundamental idea underpinning PbR, lacked feasibility in health

care services and that the MH PbR suffered from the mechanical flaws due to its failure to apply the standardisation principle. Based on those macro-level findings, semi-structured interviews were undertaken to investigate the micro-level issues surrounding the implementation of the MH PbR policy. Subject to the research questions, this chapter attempted to explore the current stage of implementing PbR in mental health and to identify the driving factors that have caused the delay of implementation by summarising and analysing the findings from 12 interviews.

To facilitate a better understanding of the driving factors, this chapter depicted the background of the payment system reform, outlined the current stage of MH PbR implementation, evaluated the core elements of the MH PbR system, investigated the driving factors for the delay and proposed suggestions for improvement. The first two sections outlined the reasons for the reform from two aspects: the initial problems of the Block Contract and the theoretical benefits of MH PbR, particularly the transparent information system. By presenting the current stage of MH PbR implementation, Section 6.3 outlined the difficulties in applying the MH PbR system and the corresponding targets to daily clinical practice, which revealed the gaps between strategy and practice. To further investigate the reasons for the delayed implementation, particularly the reasons for frontline clinicians' reluctance to engage, Sections 6.4 and 6.5 looked at the MH PbR system itself and the external factors. The flaws in each sub-system, together with the lack of coordination among them, partly explained the frontline clinicians' negative attitudes towards this project and thus causing the delay in putting it into practice. Accordingly, Section 6.5 further summarised the driving factors into seven inter-

linked aspects. The first three driving factors led to the frontline clinicians' being reluctant to engage in the reform: the complex nature of mental disorders and the initial problems with the classification system made the classification system lack accuracy, and the inappropriately set targets brought heavy, but meaningless workload. This together with the information asymmetry, resulted in the "gaming" behaviours such as clinicians' "game for workload". The negative attitude towards change has also been noted as one supplementary reason for the delay. According to these factors, suggestions were proposed in the last section, although it was still too early to predict them.

To verify the interview findings, the next chapter is organised in the same structure while paying greater attention to the detail information regarding the variations in perspectives among different interest groups.

7. The implementation of the MH PbR policy: Questionnaire results and discussion

Introduction

As discussed in Chapter 4, the semi-structured interviews and the online surveys were conducted to investigate the implementation process of the MH PbR policy. Regarding the relationship between these two methods, the interview method was set as the leading approach, while the online surveys were employed to verify and generalise the findings. Referring to the findings presented in Chapter 6, the participants confirmed the delayed implementation of MH PbR and introduced the current implementation progress of the sub-systems, including the MHCT clustering, the HoNOS scales, the MHCT care pathways and the quality measures. Regarding the delay, the driving factors have been categorised into seven inter-linked aspects with variations in attitude found between different interest groups. In particular, the interview findings highlighted the splitting perspectives among different interest groups. In this respect, three versions of the questionnaire were designed specifically for commissioners, managers and frontline clinicians, respectively, in order to verify and generalise the findings in relation to the implementation of MH PbR in practice, with particular attention paid to the splitting perspectives among the participants. IBM SPSS 20 was used to analyse the questionnaire data sorted by Microsoft Excel 2010.

To better verify the findings from the semi-structured interviews, the questionnaire data were analysed and triangulated with the findings derived from the previous two-level theoretical analysis. In this regard, this chapter presents and discusses the

questionnaire results from four main aspects: 1) the background information regarding the demographic information and the current stage of implementation; 2) the evaluation of the core components; 3) the perspectives on the driving factors and the participants' general attitudes towards MH PbR; and 4) the suggestions for further development.

7.1 General background of implementation

This section provides general background information including the demographic information of participants, the collaboration between the participants and some factual information regarding the implementation progress. By introducing the background information of the participants, this section will facilitate a better understanding of the results derived from the statistical analysis, in particular, the results that indicate the splitting perspectives among the participants.

7.1.1 Demographic information

The 38-participant group comprises 14 managers, 20 frontline clinicians and 4 commissioners. Due to the difference in sample population between the three groups, nurses, clinical the managers and psychiatrists are the top three groups with the highest proportion of the sample population, respectively accounting for 43.1%, 21.6% and 13.7% of the total sample, as Figure 7-1 shows. Figures 7-2 and 7-3 depict the distribution of post in the first two groups: within the managerial group, over 73% are clinical the managers; amongst the frontline participants, nurses and psychiatrists together account for over 90% of all participants. As a reflection of the limited number of

commissioning participants, two participants are financing officers and two are GP commissioners.

Figure 7-1 Distribution of the participants' posts

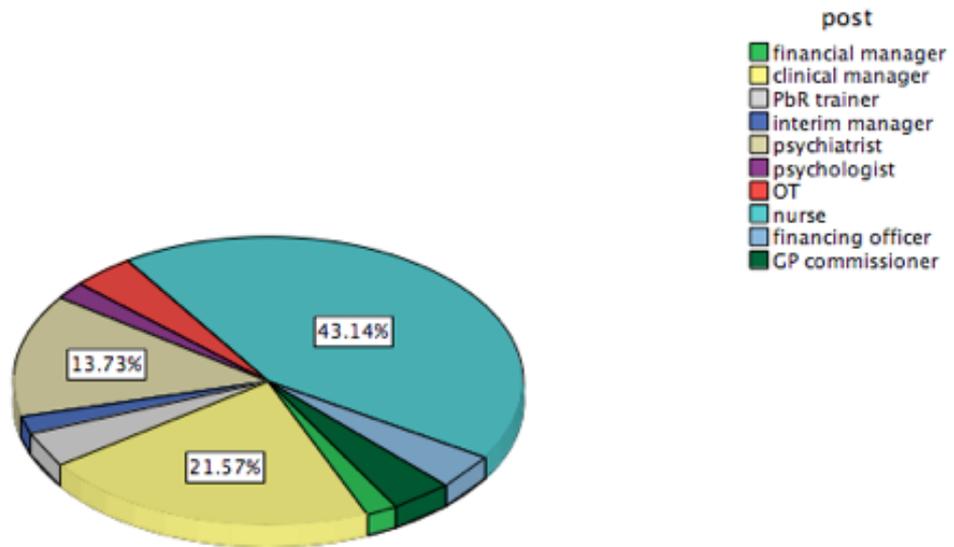


Figure 7-2 Distribution of the managerial posts

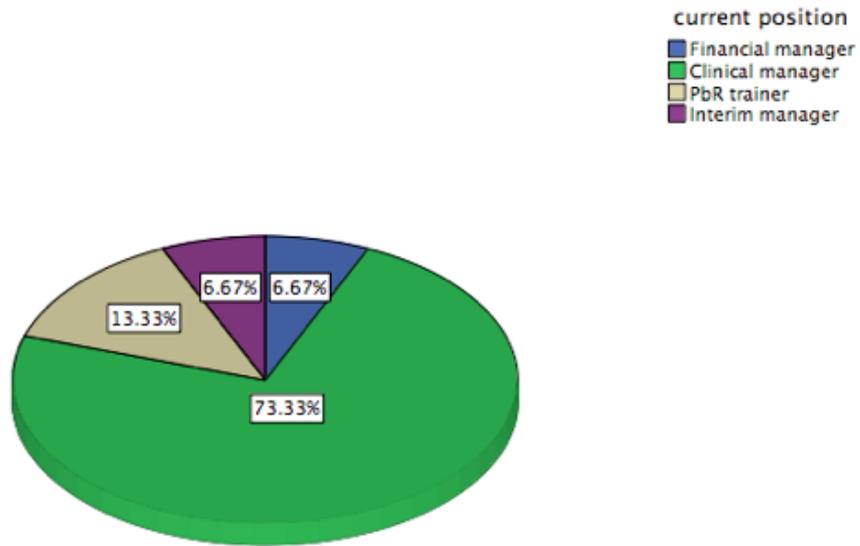
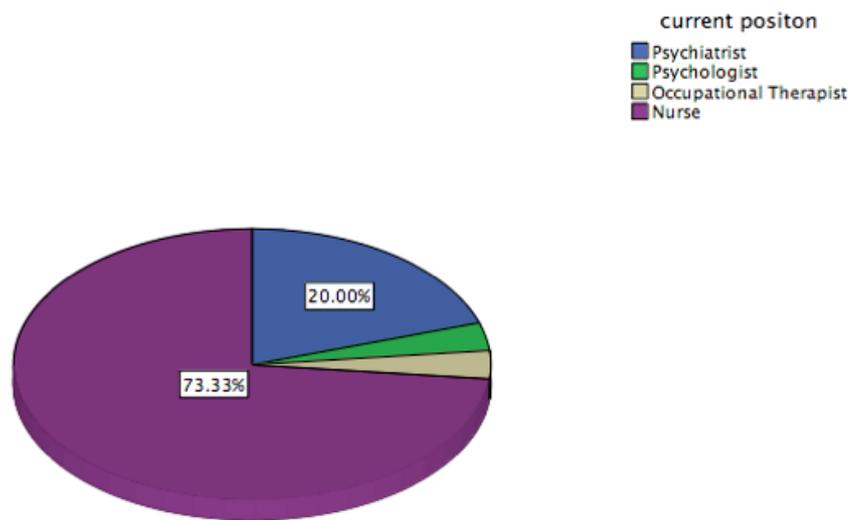


Figure 7-3 Distribution of the frontline posts



As described in Chapter 6, the managers as a whole team have dual responsibilities: to collaborate with commissioners regarding financial and clinical issues and to direct frontline clinical practice. As Figure 7-4 shows, the collaboration between the commissioners and managers mainly involved multi-disciplinary coordination and payment negotiation. The meeting frequency was normally less than 2-3 times/month, as shown in Table 7-1. For the managers who have no direct collaboration with commissioners, they took more responsibility for designing and providing the clinical strategy. Figure 7-5 explores the core elements/priority of the manager-frontline collaboration in daily practice. As it illustrates, the majority of both the managers (75.0%) and frontline clinicians (47.27%) attributed the direct clinical practice as the primary element of their daily collaboration. It shows that only a small amount of participants considered training as part of the collaboration, which shows agreement with the findings in Chapter 6 that revealed a lack of training at the frontline level. Regarding the meeting frequency between the managers and frontline clinicians, over 45% of the participants had more than one meeting per week with their corresponding supervisors/supervisees. Over 80% of the participants had at least one meeting per month to discuss clinical issues. The meeting frequency is higher than that between the commissioners and managers, although without statistical significance.

Figure 7-4 Collaboration types between managers and commissioners

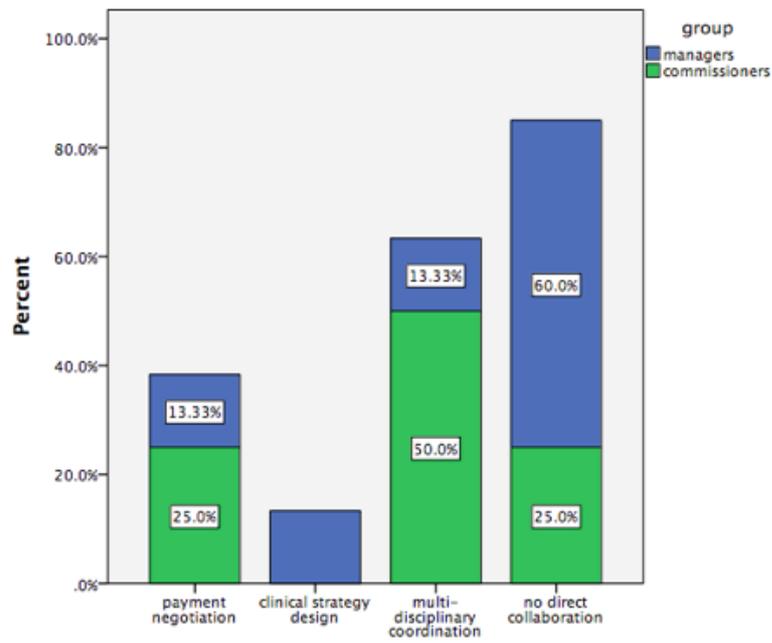
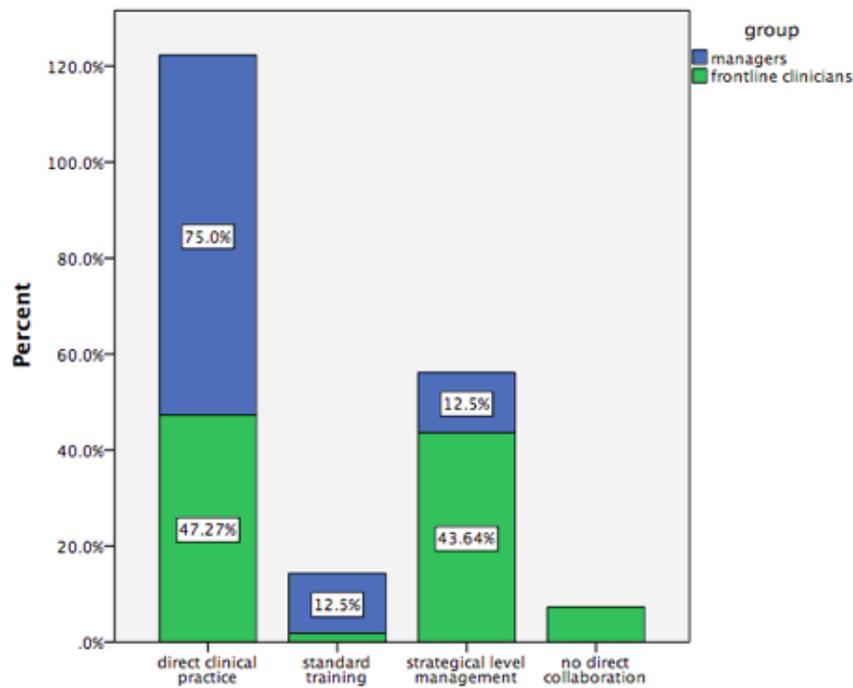


Table 7-1 Meeting frequencies of the commissioner-manager collaboration and manager-frontline collaboration

			>= 1week	2-3/month	1/month	<1/month
Meeting frequencies	Commissioner-Manager	Count	1	2	2	3
		% within group	12.5%	25.0%	25.0%	37.5%
	Manager-frontline	Count	20	5	14	5
		% within group	45.5%	11.4%	31.8%	9.6%

Figure 7-5 Core elements of the manager-frontline collaboration



7.1.2 Current implementation

Table 7-2 introduces the implementation status of MH PbR. Over 73% participants confirmed the dominant position of the Block Contract, which indicates the delayed implementation of MH PbR. However, over 57% of participants were aware of the political trend to implement PbR in mental health. According to the outcomes of the semi-structured interviews presented in Chapter 6, the care pathways have been developed for preliminary testing in a selection of pilot hospitals. Over 68% of participants confirmed that care pathways were being implemented, although without being officially established. For 42% of the participants, at least some quality measurements were being used in their daily clinical practice. This echoes the findings in Chapter 6 indicating that the quality measurements such as CROM, PROM and PREM were under preliminary testing. Concerning the implementation of financial incentives, the

percentage of the participants who voted “yes” equals those who voted “no”. According to the information obtained from the semi-structured interviews, the CQUIN targets had been adopted as clinical targets with some financial incentives (2.5% of the total budget) attached. However, commissioners decided to cease paying CQUIN financial incentives in 2014/15, considering the financial support they had already provided. This decision may explain the equally splitting opinions in reference to the implementation status of financial incentives.

Table 7-2 Current status of the implementation of MH PbR

Implementation status	Yes	No	Not known
Block Contract currently implemented	73.5%	3.9%	13.7%
Deadline for moving to PbR settled	57.9%	15.8%	23.6%
Care pathway implemented	68.6%	17.1%	14.3%
Quality measurement implemented	41.9%	35.5%	22.6%
Financial incentives implemented	38.9%	38.9%	22.2%

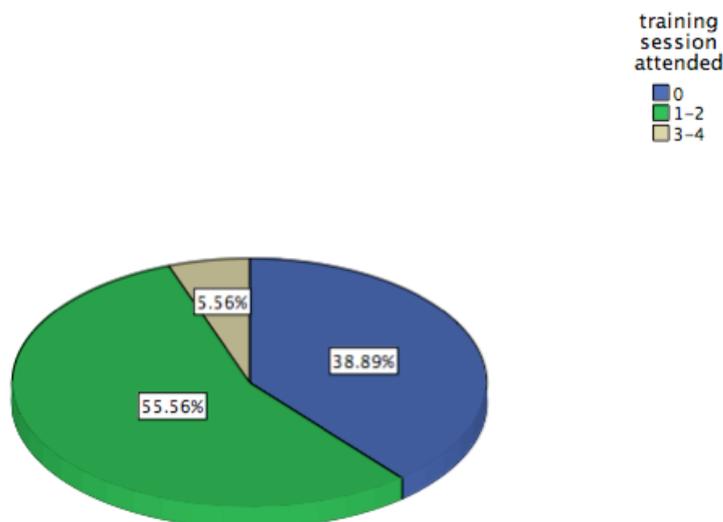
Table 7-3 below shows the current progress of implementing MH PbR. Over 89% of the participants confirmed the high percentage (>75%) of patients already clustered, which meets the government requirement regarding clustering every patient as described in Chapter 6. Subject to the target of discharging C1-C3 patients, the result shows high variation in the percentage of C1-C3 patients who have been discharged. The causal factor may be attributed to the variation among frontline professionals regarding service provision, especially considering the insufficient training as discussed in Chapter 6. This deduction may be verified by the corresponding interview findings where the managers noted a considerable number of patients being transferred from C3 to C4 rather than being discharged. Another possible reason may be the variation

among providers. Despite the difference-minimisation rule considered during the site selection process, service-user characteristics and service outcomes (this has been discussed in Chapter 4), the progress of implementation may still vary between these two hospitals. According to Figure 7-6, over 38% of the participants have never been to any training session. Amongst those who have attended training sessions, the majority (90.92%) have attended once or twice. This may imply that the insufficient training sessions failed to correct some frontline clinicians' misunderstandings, which led to its failure to improve service quality by minimising variations in clinical practice (this will be discussed in Section 7.3.5).

Table 7-3 Current progress of the implementation of MH PbR

Implementation progress	<=50	50%-75%	>75%	Not known
Patients clustered	5.3%	0%	89.5%	5.3%
C1-C3 patients discharged	27.5%	11.1%	33.3%	27.8%
Training sessions provided	5.6%	11.1%	61.1%	16.7%

Figure 7-6 Number of training sessions attended by frontline clinicians



7.2 Sub-systems evaluation

Referring to the findings derived from both the theoretical analysis and the semi-structured interviews, the MHCT, the HoNOS, the care pathways, the quality measurements and the IT system were seen as core elements within the MH PbR system, while the accuracy of the IT system largely is dependent upon the validity of the other four systems. Considering the differences in the profession, questions in relation to the detailed information about the MHCT, the HoNOS and the care pathways were only available to the managers and the frontline clinicians. In terms of the commissioners' perspectives on the classification system and its corresponding care pathways, they were asked to express their perspectives at a general level. Questions exploring general issues, such as the validity and credibility of quality measurements, were asked to all participants. To verify the findings of the semi-structured interviews, this section evaluates the sub-systems from four main aspects: the MHCT, the HoNOS, the integration of the classification system and the quality measurements.

7.2.1 The MHCT

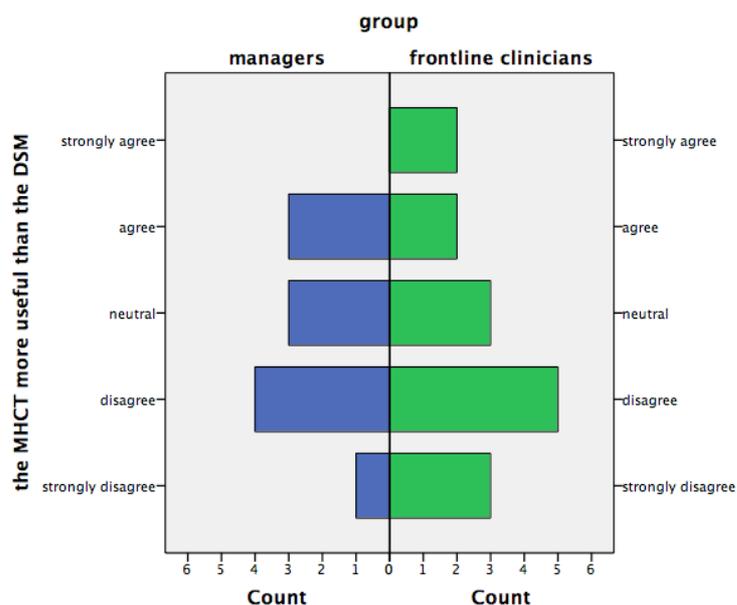
Drawing upon the findings from the interviews, the comparison between the MHCT and the DSM reflects the differences in the standpoints of providing healthcare services, which complies with the corresponding findings in Chapter 6. As Table 7-4 displays, the majority of the participants (50.0%) regarded the MHCT as less valid than the DSM. A considerably large amount of participants had a "neutral" opinion (23.1%). This echoes the corresponding finding in Chapter 6: "there is no black and white, and it always comes with a compromise". Similar to the interview findings, Figure 7-7 indicates that compared to the

manager group, there is a higher proportion of the frontline clinicians who disagreed with the statement “the MHCT is more valid than the DSM”. This shows agreement with the corresponding interview findings that the frontline clinicians were more likely to be concerned about the validity of the MHCT than the managers, whereas the managers were likely to value its advantages besides its initial drawbacks and thus preferred to answer “neutral”. In general, there is no significant difference ($p= 0.51$) in perspective between the managers and the frontline clinicians.

Table 7-4 Comparison between the MHCT and the DSM

			Strongly disagree	Disagree	Neutral	Agree	Strongly agree
The MHCT is more useful than the DSM	Managers	% within group	9.1%	36.4%	27.3%	27.3%	0%
	Frontline clinicians	% within group	20.0%	33.3%	20.0%	13.3%	13.3%
	Total	% of total	15.4%	34.6%	23.1%	9.2%	7.7%

Figure 7-7 Differences in perspectives on the validity of the MHCT between managers and frontline clinicians

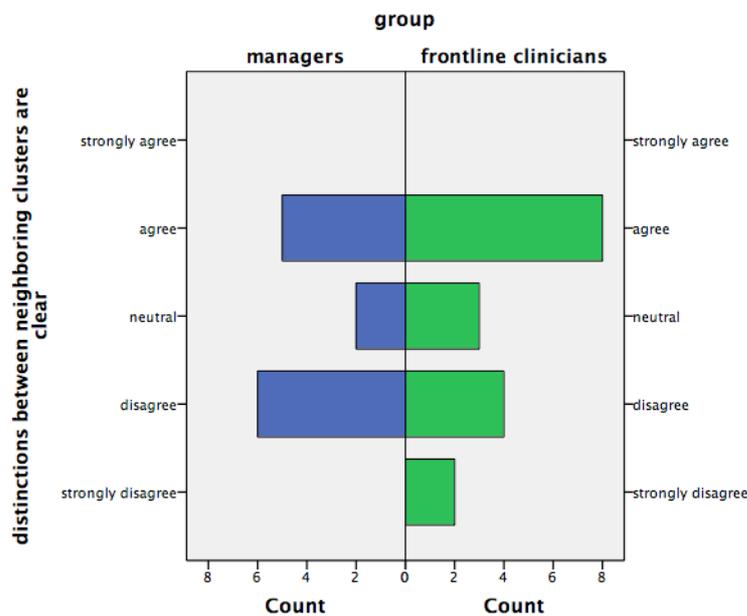


The interview data indicated that for those who held negative views towards the MHCT, the poor within-group homogeneity and between-group heterogeneity were their major concern. In order to investigate the relationship between the two statements: "The MHCT is more useful than the DSM" and "the distinctions between neighbouring clusters are clear", descriptive analysis and correlation analysis (Spearman non-parametric analysis) were used for two purposes, : 1) to explore the participants' opinions towards the clarity of the neighbouring clusters; and 2) to explore the correlation between the two variables.

As Figure 7-8 below illustrates, splitting perspectives have been found towards this issue. Specifically, 40% of the participants selected "disagree" regarding the hypothesis: "The distinctions between neighbouring clusters are clear", and while 43.3% of the participants agreed with the statement, no one strongly supported this claim. Unlike one corresponding finding in Chapter 6 stating that the managers were more likely to advocate the MHCT over the DSM, 46.15% of the managers considered the distinctions between neighbouring clusters not clear, compared with 38.4% who advocated it. This echoes another finding from Chapter 6 where managers noted the initial problems regarding the within-group homogeneity and the between-group heterogeneity. This in turn complies with the finding that the managers were more likely to weight more on its theoretical advantages in reference to connecting clinical activity and payment system. As one manager concluded in Chapter 6: "There is no absolute black and white. It always comes with a compromise." By contrast, a considerable percentage of frontline clinicians considered the distinctions clear, which is consistent with one viewpoint observed in

Chapter 6 concerning the mismatch between the MHCT clusters and the HoNOS scores: the MHCT classification system is supposed to be objective while the HoNOS scores are subjectively given by clinicians. Supported by Spearman non-parametric analysis, there is no significant correlation ($p=0.113$) between the validity of the MHCT and the clarity of distinctions. Therefore, it suggests that further investigation into the HoNOS and the interaction between the two is needed.

Figure 7-8 Splitting perspectives on the distinctions of neighbouring clusters



7.2.2 The HoNOS

According to the findings derived from the interviews, the validity of the HoNOS scale in terms of accurately capturing patients' symptoms and the collaboration between the HoNOS scores and the MHCT clusters are the two factors that significantly affect the validity and credibility of the classification system. The online surveys investigated the participants'

perspectives towards two statements, including: “The HoNOS is well-designed” and “The HoNOS scores lead to correct clusters”.

As Table 7-5 displays, in general, over 60% of the participants disagreed with the first statement that “The HoNOS is well-designed regarding its validity and reliability”. However, the distributions of perspective differ between two groups. 38.5% of the managers considered the HoNOS well-designed whilst only 7.7% voted “strongly disagree”. By contrast, 64.7% of the frontline clinicians regarded the HoNOS as poorly designed, among whom nearly half held a strong negative opinion. This result shows agreement with the corresponding interview findings that revealed its limited coverage and historical problems. Although it has been revised by adding criteria to detect historical symptoms, the long formed viewpoint and the lack of guidance could explain why the frontline clinicians either disagreed or strongly disagreed with this statement. When analysing this issue from a general perspective, the outcome that 38.5% of the managers considered the HoNOS well-designed partly conforms to the findings discussed in Chapter 5, which revealed the splitting opinions towards the validity of the HoNOS. This also complies with the interview findings indicating that the validity was viewed as largely improved due to the refinement of the historical symptoms.

Table 7-5 Perspectives on the validity of the HoNOS

			Strongly disagree	Disagree	Neutral	Agree	Strongly agree
The HoNOS is well-designed	Managers	% within group	7.7%	46.2%	7.7%	38.5%	0%
		% of total	3.3%	20.0%	3.3%	16.7%	0%
	Frontline clinicians	% within group	29.4%	35.3%	23.5%	50.0%	0%
		% of total	16.7%	20.0%	13.3%	6.7%	0%
Total		% of total	20.0%	40.0%	16.7%	23.3%	0%
The HoNOS scores lead to correct clusters	Managers	% within group	14.3%	71.4%	14.3%	0%	0%
		% of total	6.5%	32.3%	6.5%	0%	0%
	Frontline clinicians	% within group	35.3%	35.3%	23.5%	5.9%	0%
		% of total	19.4%	19.4%	12.9%	3.2%	0%
Total		% of total	25.8%	51.6%	19.4%	3.2%	0%

Despite the splitting perspectives regarding the design of the HoNOS, the majority of the managers and frontline clinicians noted the poor collaboration between the HoNOS scores and the MHCT clusters. According to Table 7-5, 51.6% of the participants chose "disagree" while 25.8% even chose "strongly disagree", compared to 3.2% who chose "agree" and no one chose "strongly agree". By comparing the distribution of perspectives between the manager group and the frontline clinician group, the questionnaire data shows that among the participants who disagreed with the statement, there is a higher percentage of the frontline clinicians who voted "strongly disagree" (50%) than that of the managers (16.7%). In other words, compared to the managers, the frontline clinicians were more inclined to be concerned about the poor connection between the HoNOS scores and the MHCT clusters. This matches the corresponding findings from Chapter 6 which indicates that the frontline clinicians tended to have a deeper understanding of the initial problems resulting from allocating patients to particular clusters according to their MHCT/HoNOS scores. Regarding the perspectives on the MHCT, the HoNOS and the collaboration between the two in the manager group, the results indicate that the managers had splitting opinions regarding the validity of the MHCT and the HoNOS as two individual elements, but the majority (85%) were aware of the mismatches between the two. This complies with one finding discussed in Chapter 5 indicating that the HoNOS has considerably good validity in terms of comparing the changes in outcome at an individual level. Nevertheless, it does not serve the function of a rating scale that was expected as part of the MHCT classification system.

In consideration of the commissioners' understanding of the

classification system, they were asked about the validity of the MHCT in terms of accurately categorising patients as a classification system at a general level. 50% of the commissioners considered the MHCT incapable of accurately classifying mental health disorders. This outcome echoes the perspectives that the managers and frontline clinicians held towards the validity of the MHCT. It also conforms to the corresponding findings that the initial problems of the MHCT clusters, the HoNOS scales and the gaps between the two undermined the ability of the MHCT to accurately categorise patients as a classification system.

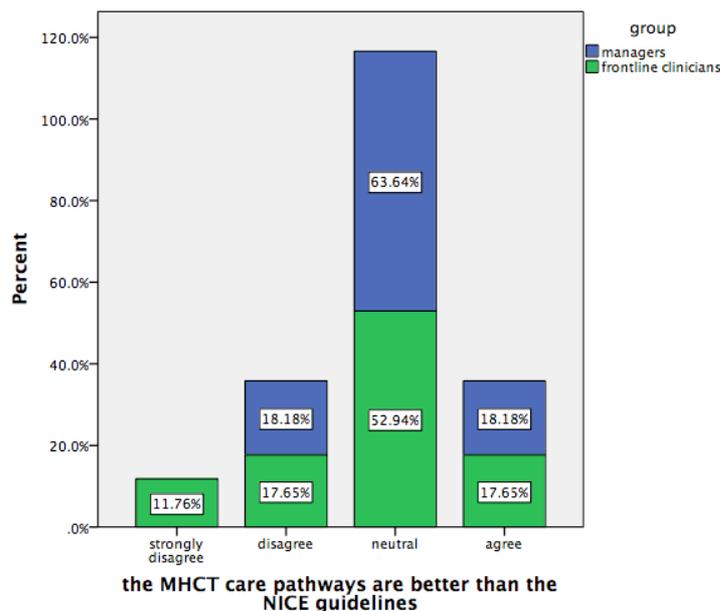
7.2.3 The integration of the classification system

As discussed in Chapter 6 and Section 7.1.2, the MHCT care pathways were still under preliminary testing without being officially invoked in daily clinical practice. Drawing upon the experiences of using the pilot care pathways up till now, the managers and frontline clinicians were asked to compare them with the NICE guidelines regarding its validity to predict target treatments for the patients in the corresponding clusters. The commissioners were asked about its validity to provide proper guidance at a general level. In the end, for the integration of a MHCT classification system, all participants were requested to express their opinions on the MHCT care pathways and the integrity of the system as a whole.

According to Figure 7-9 below, the majority of participants answered “neutral”, which echoes the corresponding interview finding that both the MHCT care pathways and the NICE guidelines have their advantages as well as limitations. Slightly more participants preferred the NICE guidelines than those who

supported the MHCT care pathways. In particular, the results show that 11.76% of the frontline clinicians strongly disagreed with the statement. This reflects the splitting perspectives resulted from different considerations: from their perspectives, the NICE guidelines are more useful since they are based on the diagnosis that seeks the root problem of mental disorders. By contrast, 50% of the commissioners preferred the MHCT care pathways to the NICE guidelines, which reiterates their attention to its financial benefit regarding indicating resource allocation and, therefore, cost calculation.

Figure 7-9 Comparison between the MHCT care pathways and the NICE guidelines



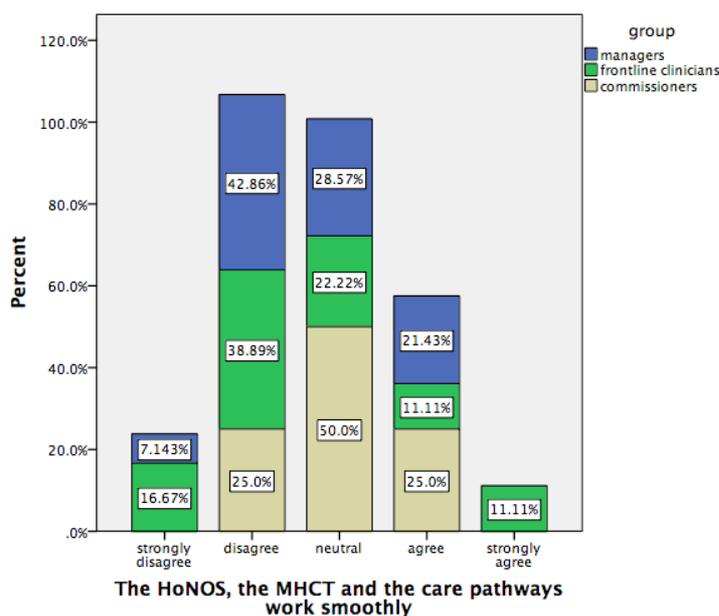
Regarding the integration of these three elements (the HoNOS, the MHCT and the MHCT care pathways), Table 7-6 displays the participants' viewpoints as an entire group, as well as three separate groups. As a whole group, a total of 50% of participants were concerned about the poor collaboration among these three elements, leaving 27.8% regarding it as neutral and the remaining 22.3% supporting it. Figure 7-10

shows the splitting perspectives among subgroups: the commissioners tended to be neutral while the managers and frontline clinicians held a more negative attitude, which conforms to the corresponding interview findings. One of the possible reasons may be the limited information available to the commissioners due to the incomplete system, which made them prefer to hold a more cautious and thus neutral opinion. By contrast, the clinical professionals, especially the frontline clinicians were more likely to note the discordances between these three elements. Compared to the managers, the frontline clinicians tended to hold a higher degree of concern about the interaction between these three elements, which is found in line with their perspectives on other issues in relation to the classification system as previously discussed.

Table 7-6 Perspectives on the integration of the classification system

				Strongly disagree	Disagree	Neutral	Agree	Strongly agree
The HoNOS, the MHCT & the care pathways work smoothly	Managers	% group	within	7.1%	42.9%	28.6%	21.4%	0%
	Frontline clinicians	% group	within	16.7%	38.9%	22.2%	11.1%	11.1%
	Commissioners	% group	within	0%	25.0%	50.0%	25.0%	0%
	Total	% of total		11.1%	38.9%	27.8%	16.7%	5.6%

Figure 7-10 Perspectives on the integration of the HoNOS, the MHCT and the care pathways



7.2.4 Quality measurements

Findings from the interviews demonstrated the importance of a transparent information system to service/quality regulation. Nevertheless, Chapter 6 also raised questions about whether quality could be comprehensively and accurately measured and whether the currently established measurements can detect the “real” quality, complying with the corresponding argument discussed in Chapter 3. To explore the participants’ viewpoints towards the quality measurement system in theory and how these different measures work in practice, questions were asked in an order from more general to greater detail: 1) Should service quality be measured? 2) Can service quality be measured? 3) Can the PREM reflect service quality? 4) Can the HoNOS accurately present outcomes?

Table 7-7 depicts the distribution of responses regarding the necessity and the feasibility of measuring service quality. A

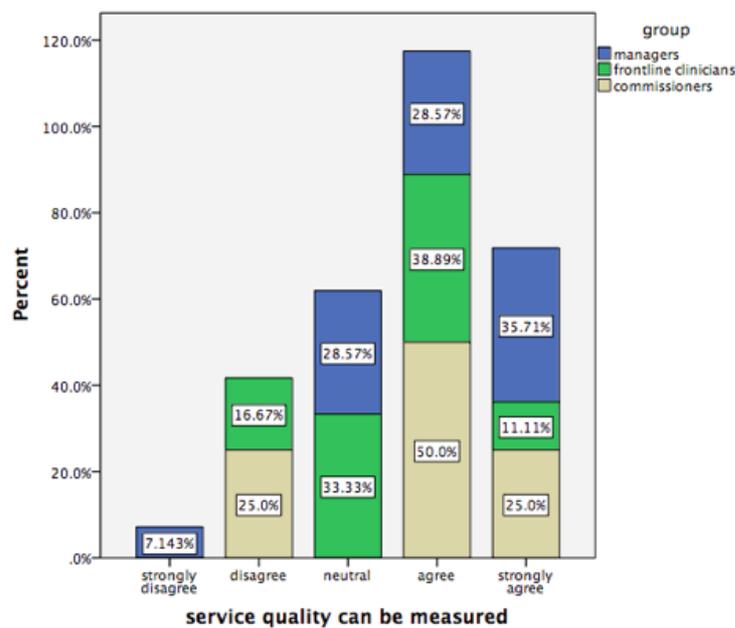
majority of the participants considered it necessary to measure service quality. Particularly, 69.23% of the managers strongly supported quality measurements, which echoes the interview findings that the managers considered themselves disadvantaged under the Block Contract since they provided more and better service than they was required. This may also contribute to the explanation of the fact that the managers still advocated for MH PbR despite their awareness of the initial problems of the classification system and the side effects created by this project. From their perspective, the establishment of a transparent information system equipped with a comprehensive quality measurement system has the potential to facilitate an evidence-based health resource management.

Table 7-7 Perspectives on quality measurements

			Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Quality should be measured	Managers	% within group	0%	0%	7.7%	23.1%	69.2%
	Frontline clinicians	% within group	0%	0%	5.6%	61.1%	33.3%
	Commissioners	% within group	0%	0%	25.0%	25.0%	50.0%
	Total	% of total	0%	0%	8.6%	42.9%	48.6%
Quality can be measured	Managers	% within group	7.1%	0%	28.6%	28.6%	35.7%
	Frontline clinicians	% within group	0%	16.7%	33.3%	38.9%	11.1%
	Commissioners	% within group	0%	25.0%	0%	50.0%	25.0%
	Total	% of total	2.8	11.1%	27.8%	36.1%	22.2%
The PREM can accurately reflect quality	Managers	% within group	0%	18.2%	36.4%	36.4%	9.1%
	Frontline clinicians	% within group	7.7%	23.1%	30.8%	30.8%	7.7%
	Commissioners	% within group	0%	75.0%	0%	0%	25.0%
	Total	% of total	3.6%	28.6%	28.6%	28.6%	10.7%
The HoNOS scores can accurately reflect outcomes	Managers	% within group	7.7%	46.2%	7.7%	23.1%	15.4%
	Frontline clinicians	% within group	6.2%	37.5%	31.2%	25.0%	0%
	Commissioners	% within group	0%	50.0%	0%	50.0%	0%
	Total	% of total	6.5%	41.9%	19.4%	25.8%	6.5%

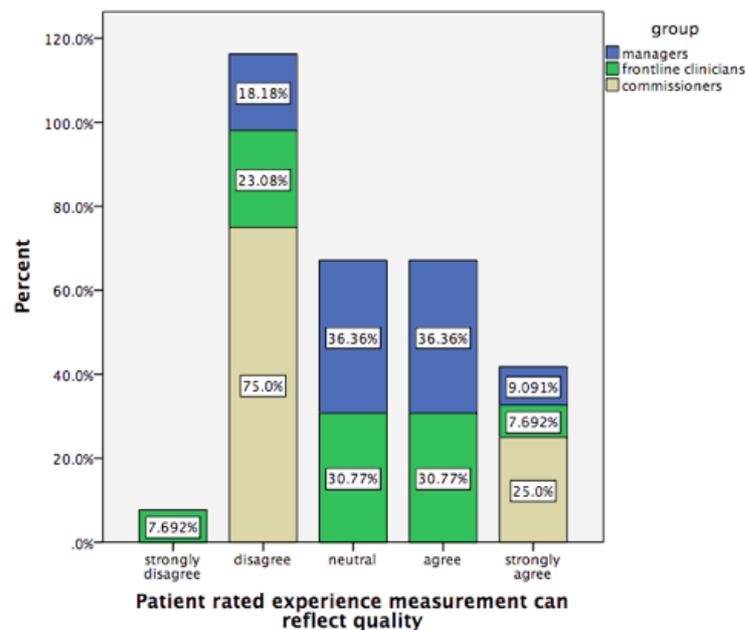
Compared with the theory of measuring service quality, the opinions of measuring quality in practice were not as optimistic, although the majority of participants still advocated the statement: "Service quality can be accurately measured", as shown in Figure 7-11. Comparing the perspectives by subgroup, the managerial side (including the managers and commissioners) was more likely to show confidence in quality measurement proxies. Whilst similar to the previous finding, the frontline clinicians tended to be more concerned about this system. The initial problems of the existing measures such as the HoNOS and the PREM might be the reasons that made them feel more conservative about the quality measurement system. For those who voted either "strongly disagree" or "disagree", the theories in relation to quality measurement discussed in Chapter 3 may be one reason: it is difficult if not impossible to comprehensively and accurately measure the quality of the frontline practice.

Figure 7-11 Perspectives on measuring quality in practice



In terms of the validity and reliability of the PREM, a significant within-group variation has been observed as shown in Figure 7-12. According to Table 7-7 above, a total of 32.2% of the participants who had concerns about PREM, versus 39.3% who considered PREM’s outcomes able to reflect service quality, and the remaining 28.6% who held a neutral opinion. The splitting opinions match the findings in Chapter 6, according to which the clinicians, on the one hand, valued patients’ thoughts and regarded them as valid in evaluating clinical services, while on the other hand, they realised the gaps between the “good services” and patients’ subjective opinions.

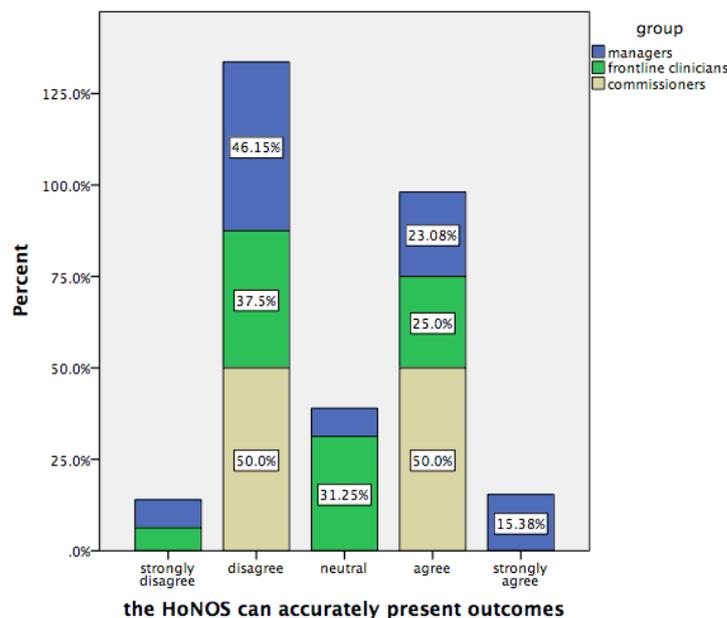
Figure 7-12 Perspectives on the validity and reliability of the PREM



Similar to their opinion of the PREM, the participants tended to be negative towards the effectiveness of the HoNOS as an outcome measure, while splitting opinions have been noted in Figure 7-13. 53.9% of the managers regarded the HoNOS with low effectiveness for presenting patients’ outcomes. Similar to the managers, more frontline clinicians held a negative

viewpoint, although with larger variation in responses to the statement: "The HoNOS outcome measurement can effectively present outcomes". The general preference matches the main finding against the HoNOS's validity in Chapter 6 – the HoNOS lacks the ability to detect symptoms and to present outcomes due to its subjectivity, limited coverage, function as a general assessment and its historical problems. Nevertheless, as stated in Section 7.2.2, the improvement of the HoNOS makes it more valid and more credible, which may explain the responses allocated in the "agree" or even "strongly agree" categories.

Figure 7-13 Perspectives on the validity of the HoNOS as an outcome measurement



7.3 Driving factors

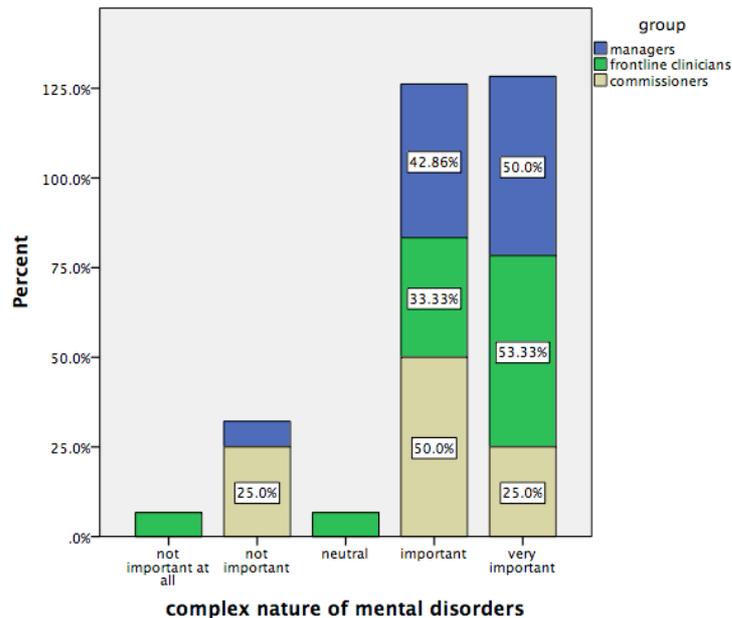
As outlined in Chapter 1, the core objective of this thesis is to identify the driving factors that have caused the delay in implementing PbR in mental health. Drawing on the corresponding findings derived from the interviews, questions

were set to explore the participants' perspectives on seven factors in relation to their impacts on the delayed implementation. These included the complex nature of mental disorders, the ideology of "standardisation" and the Quasi-market, the initial drawbacks of the classification system, government policies, clinicians' involvement, "gaming" behaviours and the experiences from acute services. Among these seven factors, six were asked to all participants, whilst the questions about clinicians' involvement were set in a different way for the frontline clinicians from that for the other two subgroups.

7.3.1 Complex nature of mental disorders

As Figure 7-14 indicates, a large majority of participants (87.9% in total) attributed the complex nature of mental disorders as an important driving factor leading to the delayed implementation of MH PbR. Among the participants, more than half considered it crucial. This result confirms the finding from Chapter 6 where the complex nature of mental disorders was considered as the foundation of resource management and the following cost calculation. This also echoes the arguments in Chapters 3 and 5 that suggested the individualised needs for care resulting from the complex nature of mental disorders rejects the fundamental idea of commoditizing mental health services and therefore, the application of the "standardisation-to the-average" principle. Figure 7-14 also indicates that the managers and frontline clinicians were more likely to regard it as a crucial reason than commissioners, which once again, reveals the gaps between theory and practice.

Figure 7-14 Impact of the nature of mental disorders on the delayed implementation of MH PbR



7.3.2 The ideas behind MH PbR

Table 7-8 below demonstrates the impacts of two fundamental ideas on the implementation of MH PbR from two levels: the feasibility of the general ideas underpinning the clinical system and the feasibility of MH PbR as a payment system underpinned by the Quasi-market theory. The outcomes reveal two general phenomena: on the one hand, these two factors were regarded as important to the delayed implementation, and on the other hand, rather than the previous findings according to which the frontline clinicians had more negative perspectives, the managers and commissioners expressed more concern about the ideas behind MH PbR.

Regarding the impact of the ideology of clustering, the majority of participants (52.9%) regarded the clustering ideology as one of the reasons leading to the delayed implementation, as Table 7-8 shows. This may be explained by one finding in Chapter 5:

the MHCT classification system is fundamentally flawed for not taking account of the possible interventions during the decision-making process. The lack of fundamental validity has therefore been attributed as a factor that caused the delay. In light of the current progress of implementing MH PbR, the majority of participants (51.6%) believed that it has become a finance-led system, and it is the finance-led system that has hindered the implementation process. Similarly, the managers and commissioners tended to realise the problems of MH PbR in terms of being a finance-led system, which echoes the corresponding interview findings. This result complies with the arguments in Chapter 3 where the MHCT and the corresponding care pathways were developed to serve cost calculation rather than clinical practice, which had raised concerns about its ability in terms providing patient-centred care.

In regard to the splitting perspectives between the administrative-level and the frontline-level participants, this could be explained by one finding from Chapter 6: the clinical and financial strategies were only discussed at the managerial level rather than including the front line, which led to frontline clinicians' lack of comprehensive understanding of the ideas behind MH PbR. A viewpoint observed in the interviews could also explain this concept: frontline clinicians tend to focus on their duties regarding providing service to clients and, as a result, they are not likely to think about more general issues, such as ideology and finance-related issues. This explanation could be supported by the findings discussed in Section 7.3.3 in terms of their opinions on the particular objectives of the MHCT.

Table 7-8 Impacts of the clustering ideology and finance-led system on the delayed implementation of MH PbR

			Not important at all	Not important	Neutral	Important	Very important	Not known
Ideology of clustering	Managers	% within group	0%	14.3%	14.3%	57.1%	14.3%	0%
	Frontline clinicians	% within group	6.2%	18.8%	31.2%	25.0%	6.2%	12.5%
	Commissioners	% within group	0%	0%	25.0%	75.0%	0%	0%
	Total	% of total	2.9%	14.7%	23.5%	44.1%	8.8%	5.9%
Finance-led system	Managers	% within group	7.7%	15.4%	15.4%	46.2%	15.4%	0%
	Frontline clinicians	% within group	6.2%	25.0%	31.2%	18.8%	18.8%	0%
	Commissioners	% within group	0%	25.0%	0%	75.0%	0%	0%
	Total	% of total	6.1%	21.2%	21.2%	36.4%	15.2%	0%

7.3.3 Sub-systems

Based upon the findings discussed in Section 7.2 which evaluated the validity of the sub-systems including the MHCT decision tree, the HoNOS scores and the MHCT care pathways, this section further explores the relationship between the development of these subsystems and the delayed implementation of the MH PbR policy.

Table 7-9 displays the impacts of the MHCT and the HoNOS as two separate elements as well as an entire classification system on the delayed implementation of MH PbR. A total 67.7% of participants regarded the design of the MHCT clusters as having negative impacts on the implementation of MH PbR. Similarly, 67.6% of participants chose either “important” or “very important” to describe the impacts of the poor-design of the HoNOS on the implementation of MH PbR. However, the distribution of responses varies. According to Table 7-9, among the participants who considered that the poor design of the MHCT had an impact on the delayed implementation of MH PbR, 30.0% considered it of high importance. Among the participants who rated the design of the HoNOS as either “important” or

“very important”, there is a greater percentage of participants (40.3%) who rated the design of the HoNOS as “very important” to the delay. Mann-Whitney test confirms this result: the mean rank of rating for the HoNOS is higher than that for the MHCT. In other words, the initial problems of the design and application of the HoNOS have a greater impact on the delayed implementation of the MH PbR policy than those of the MHCT. This result also matches the corresponding findings discussed in both Section 7.2 and Chapter 6.

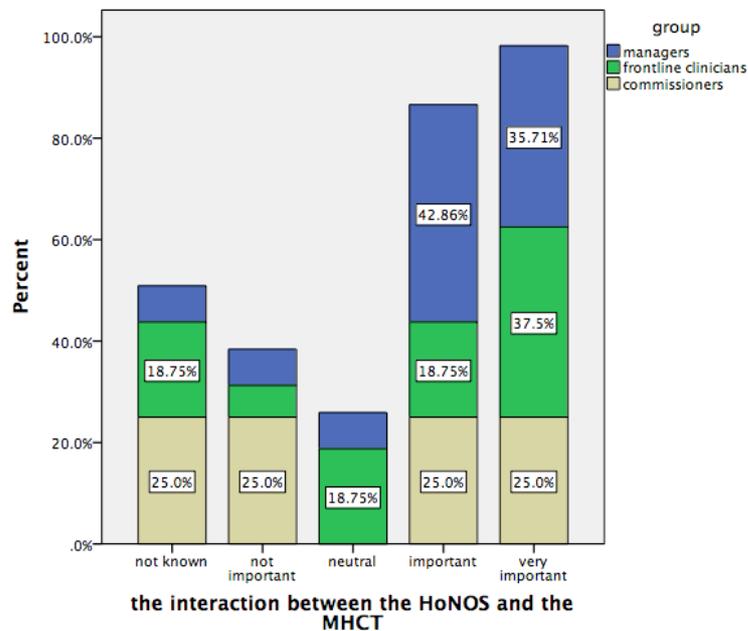
Table 7-9 Impacts of the MHCT, the HoNOS and the entire classification system on the delayed implementation of MH PbR

			Not important at all	Not important	Neutral	Important	Very important	Not known
Design of the MHCT	Managers	% within group	7.1%	7.1%	14.3%	50.0%	14.3%	7.1%
	Frontline clinicians	% within group	0%	12.5%	0%	50.0%	31.2%	6.2%
	Commissioners	% within group	0%	0%	50.0%	25.0%	0%	25.0%
	Total	% of total	2.9%	8.8%	11.8%	47.1%	20.6%	8.8%
Design of the HoNOS	Managers	% within group	7.1%	21.4%	7.1%	21.4%	35.7%	7.1%
	Frontline clinicians	% within group	0%	6.2%	6.2%	50.0%	31.2%	6.2%
	Commissioners	% within group	0%	0%	25.0%	50.0%	0%	25.0%
	Total	% of total	2.9%	11.8%	8.8%	38.2%	29.4%	8.8%
Interaction between the MHCT and the HoNOS	Managers	% within group	0%	7.1%	7.1%	42.9%	35.7%	7.1%
	Frontline clinicians	% within group	0%	6.2%	18.8%	18.8%	37.5%	18.8%
	Commissioners	% within group	0%	25.0%	0%	25.0%	25.0%	25.0%
	Total	% of total	0%	8.8%	11.8%	29.4%	35.3%	14.7%

Regarding the collaboration between these two elements, 64.7% of the participants rated the weak interaction between the MHCT clusters and the HoNOS scores as an either “important” or “very important” factor for the delay. Splitting opinions have been found although there is no significant difference found in the Chi-square test. As Figure 7-15 shows, divergent opinions have been found inside the commissioner group, which could be due

to their professions and also due to the lack of high-quality information. Another phenomenon worth discussing is the splitting opinions among the frontline clinicians, particularly the 18.75% who selected “unknown”. This conforms to one finding from the interviews: due to the incomplete classification system and the inconsistent training, the HoNOS scores and the MHCT clusters were viewed as two separate issues to some frontline clinicians. Therefore, some of clinicians did not have a clear idea of how the MHCT and the HoNOS incorporate with each other.

Figure 7-15 Impacts of the interaction between the MHCT and the HoNOS on the delayed implementation of MH PbR



According to Table 7-10, 67.7% of the participants rated the impacts of the incomplete care pathways as an “important” or “very important” factor that affected the implementation of MH PbR. Compared with the splitting opinions in the commissioner group, a clear preference of “important” and “very important” has been found in the manager group and the frontline clinician group, since 78.6% of the managers and 62.2% of the frontline

clinicians expressed concerns. This result confirms the findings discussed in Chapters 5 and 6 indicating that the impact caused by the absence of care pathways depends upon the roles the care pathways play in the classification process. Drawing upon their professional experiences, the managers and frontline clinicians are more likely to appreciate the importance of the care pathways. According to the interview findings, due to the initial mismatches between the HoNOS and the MHCT clusters, some frontline clinicians' preferred to rely on the possible treatment. This indicates the adverse impacts on the clustering process brought by the incomplete care pathway system, let alone its subsequent impacts on cost calculation and therefore the implementation process of the entire project.

Table 7-10 Impacts of the incomplete care pathways and the incomplete IT system on the delayed implementation of MH PbR

			Not important at all	Not important	Neutral	Important	Very important	Not known
Incomplete care pathways	Managers	% within group	0%	7.1%	7.1%	50.0%	28.6%	7.1%
	Frontline clinicians	% within group	0%	12.5%	12.5%	43.8%	18.8%	12.5%
	Commissioners	% within group	0%	25.0%	25.0%	50.0%	0%	0%
	Total	% of total	0%	11.8%	11.8%	47.1%	20.6%	8.8%
Incomplete IT system	Managers	% within group	7.1%	0%	14.3%	35.7%	42.9%	0%
	Frontline clinicians	% within group	0%	12.5%	25.0%	43.8%	12.5%	6.3%
	Commissioners	% within group	0%	25.0%	25.0%	25.0%	25.0%	0%
	Total	% of total	2.9%	8.8%	20.6%	38.2%	26.5%	2.9%

Similarly, the important role a transparent IT system plays demonstrates the adverse consequences that result from not having it properly established. In Table 7-10, a total of 64.7% of the participants considered it as an important factor that caused the delay in implementing the MH PbR policy. This result is in agreement with the corresponding findings from Section

7.2 and Chapter 6 which indicated that without a fully established clinical system supported by a well-designed information system, frontline clinicians can neither make an accurate classification, nor see the general picture of the new system as a whole.

7.3.4 Government policies

Inconsistent with the corresponding interview findings, the participants from all three interest groups expressed their concern about the intensively established government policies and regarded them as a driving factor for the delay. To test the influence of government policies as effective guidance and thus explore its impact on the development of MH PbR, Likert rating scales were used to test the clarity of government policies and their impacts on the delayed implementation of MH PbR.

As Table 7-11 displays, the majority of participants (50.4%) considered government policies unclear. On the one hand, particularly stronger concerns have been found from the manager and the commissioner groups. This conforms to the corresponding finding in Chapter 6 arguing a lack of clear national guidelines to guide local activities. Figures in Table 7-12 also underpin this finding by indicating a total of 47% of participants (particularly the managers and commissioners) attributed the unclear government policies as one of the driving factors. On the other hand, splitting viewpoints between the frontline clinicians have been noted. This may be explained by the findings from Chapter 6: the frontline clinicians focused more on their duties rather than thinking about the government's general strategy. Policies became targets when they came down to the frontline, which (e.g. "clustering every

patient” and “having four successful contacts every day”), which were considered clear, however, not in a helpful way. This complies with frontline clinicians’ perspective of the impacts of workload on the delayed implementation of MH PbR. The questionnaire figures show that 75.0% of the frontline clinicians attributed the heavy workload as either an “important” or “very important” factor that adversely affected the application of PbR in mental health. This corresponds with the interview finding arguing that the increasing targets not only increased the frontline workload, some even conflicted with the clinical realities and thus threatened good quality care.

Table 7-11 Perspectives on government policies

			Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not known
Government policies are clear	Managers	% within group	15.4%	38.5%	23.1%	23.1%	0%	0%
	Frontline clinicians	% within group	5.6%	33.3%	33.3%	27.8%	0%	0%
	Commissioners	% within group	25.0%	75.0%	0%	0%	0%	0%
	Total	% of total	11.4%	40.0%	25.7%	22.9%	0%	0%

Table 7-12 Impacts of government policies on the delayed implementation of MH PbR

			Not important at all	Not important	Neutral	Important	Very important	Not known
The lack of clear government policies	Managers	% within group	0%	7.1%	35.7%	35.7%	14.3%	7.1%
	Frontline clinicians	% within group	0%	6.2%	43.8%	18.8%	18.8%	12.5%
	Commissioners	% within group	0%	0%	25.0%	50.0%	25.0%	0%
	Total	% of total	0%	5.9%	38.2%	29.4%	17.6%	8.8%

7.3.5 Clinicians’ involvement

According to the findings in Chapter 6, the participants from all three groups were aware of clinicians’ lack of willingness to be involved in the reform. In order to explore the factors that caused frontline clinicians’ reluctance to engage, participants

were asked to rate the factors, which were identified from the interviews, according to their importance to the delayed implementation. Factors, including “training lacks effectiveness” and “variation in skill among clinicians”, were available to participants from all three groups. In consideration of profession, the factor “clinicians’ lack of understanding” were only available to the participants from the manager and commissioner groups. Instead, the frontline clinicians were asked to rate the factor “mixed messages to the front line”, which is an explanation of frontline clinicians’ lack of understanding of the whole system, according to the interview findings.

According to Table 7-13 below, it has been found that commissioners tended to answer either “not important” or “neutral” to all questions. By contrast, the managers and the frontline clinicians were more likely to hold similar viewpoint towards these three aspects. This shows agreement with the interview findings that demonstrated the fact that the importance of clinicians’ lack of understanding, variation in skills among clinicians and training’s lack of effectiveness resulted in frontline clinicians’ reluctance and their lack of ability to engage in the reform. Separating the inter-linked three aspects, 92.9% of the managers regarded clinicians’ lack of understanding as an important factor that affected their involvement and thus adversely affected the implementation of MH PbR. This matches one corresponding finding in Chapter 6 where the frontline clinicians mistook daily contacts as part of the targets of MH PbR, whereas it was the target for the current double-running system. From the perspective of frontline clinicians’, they attributed the mixed messages coming down to the frontline as an important factor given that 62.6% rated it as either “important” or “very important”. This result also matches the

corresponding finding from the interviews, which demonstrated the impacts of the mixed messages on frontline clinicians' misunderstanding and even their negative attitudes.

Regarding the causal relationship between the insufficient training and frontline clinicians' lack of understanding discussed in Chapter 6, the figures in Table 7-13 confirm the insufficiency of training by showing that 92.9% of the managers and 68.8% of the frontline clinicians had serious concerns about the effectiveness of training sessions. This finding echoes one frontline clinician's argument expressed in the interviews in terms of the training's lack of flexibility in the training and the trainer's lack of ability to solve the practical problems. For the managers, it reflects that the managerial level has realised the importance and urgency of conducting high-quality and targeting training, which is consistent with one commissioner's observation that the managers had realised that training should be a rolling session to update information constantly, rather than the previously disjointed segments. Table 7-13 also confirms the variations in clinicians' skills and, therefore, their impact on the delay: 93.8% of managers and 62.5% of frontline clinicians regarded it as a crucial factor for the delayed implementation.

In conclusion, this section confirmed the corresponding interviews findings indicating that the mixed messages in terms of the policies and the targets coming down the frontline, the variation in clinical skills resulted from the complex nature of mental disorders, the lack of national guidelines and the lack of effective training sessions led to the frontline clinicians' reluctance to engage in the implementation stage of the MH PbR policy.

Table 7-13 Perspectives on frontline clinicians' involvement

			Not important at all	Not important	Neutral	Important	Very important
Clinicians' lack of understanding	Managers	% within group	0%	0%	7.1%	50.0%	42.9%
	Commissioners	% within group	0%	50.0%	50.0%	0%	0%
	Total	% of total	0%	11.1%	16.7%	33.3%	33.3%
Mixed messages to the front line	Frontline clinicians	% within group	0%	6.2%	31.2%	43.8%	18.8%
Training lacks effectiveness	Managers	% within group	0%	0%	7.1%	50.0%	42.9%
	Frontline clinicians	% within group	0%	18.8%	12.5%	43.8%	25.0%
	Commissioners	% within group	0%	75.0%	25.0%	0%	0%
	Total	% of total	0%	17.7%	11.8%	41.2%	29.4%
Variations in ability among frontline clinicians	Managers	% within group	0%	7.1%	0%	57.1%	35.7%
	Frontline clinicians	% within group	0%	18.8%	18.8%	37.5%	25.0%
	Commissioners	% within group	0%	25.0%	50.0%	25.0%	0%
	Total	% of total	0%	14.7%	14.7%	44.1%	26.5%

7.3.6 The "gaming" behaviours

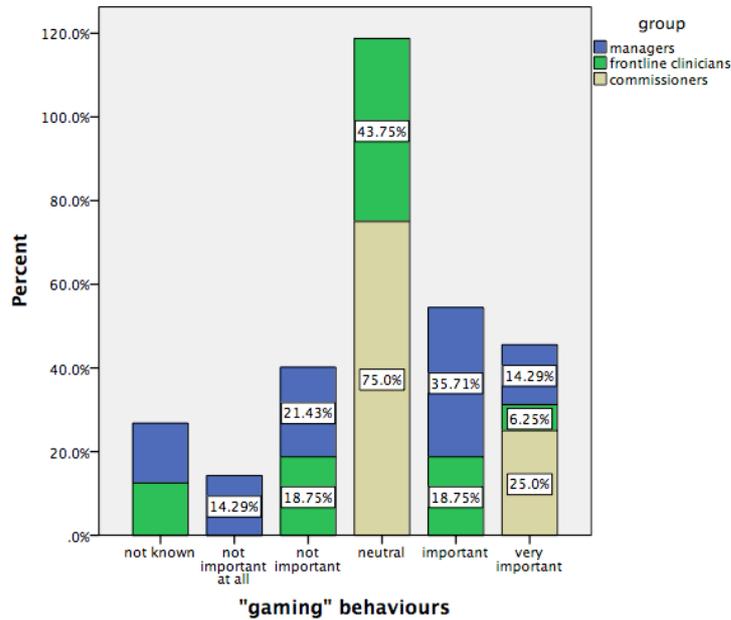
Similar to the c findings derived from the interviews discussed in Chapter 6, splitting opinions have been found regarding the impacts of "gaming" behaviours among the participants from these three groups. As Table 7-14 displays, 23.5% of the participants considered "gaming" behaviours as either "not important at all" or "not important" to the delayed implementation of MH PbR, 29.4% held a neutral opinion, leaving 35.3% considering these behaviours as an important factor. According to Figure 7-16, although the majority of the managers were concerned about the "gaming" behaviours, a high within-group variation has been found, given that 35.7% of the participants regarded it as either "not important at all" or "not important". This echoes the corresponding interview findings indicating that on the one hand, some managers considered frontline clinicians as generally honest and not to be influenced by financial issues; whereas on the other hand, some managers noted the possible consequences brought about by

financial risks. Similarly, most frontline clinicians rated this factor as “neutral” but the percentage of the frontline clinicians who indicated as “not important” equals those who selected “important”. For those who selected “not important”, one fact observed from the interviews could explain this: frontline clinicians tended to score patients into lower cluster than they should have been due to their sympathy towards patients’ conditions rather than conducting “up-coding” according to the theoretical prediction. This also complies with the “professionalism” theory that appreciates the professional sense of value, which is to provide patient-centred care. For those who answered “important”, this could also be explained by the fact that all frontline clinicians in the interviews admitted the existence of “game for workload” due to the poorly set targets and the conflicts between policies and clinical activities. Regarding the commissioners’ perspectives, Table 7-14 shows the commissioners’ conservative concerns about “gaming” behaviours, which corresponds to what has been found in Chapter 6.

Table 7-14 Impacts of “gaming” behaviours on the delayed implementation of MH PbR

			Not important at all	Not important	Neutral	Important	Very important	Not known
“Gaming” behaviours	Managers	% within group	14.3%	21.4%	0%	35.7%	14.3%	14.3%
	Frontline clinicians	% within group	0%	18.8%	43.8%	18.8%	6.2%	12.5%
	Commissioners	% within group	0%	0%	75.0%	0%	25.0%	0%
	Total	% of total	5.9%	17.6%	29.4%	23.5%	11.8%	11.8%

Figure 7-16 Impacts of the "gaming" behaviours on the delayed implementation of MH PbR

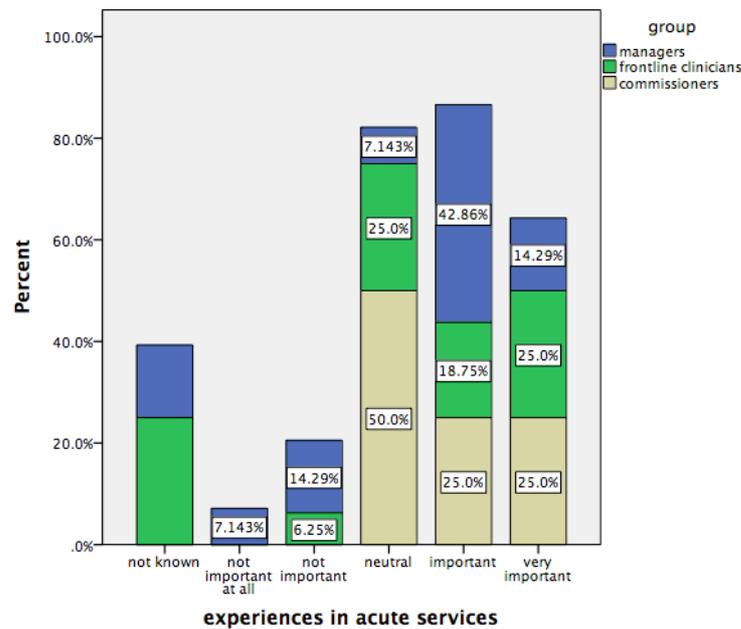


7.3.7 Experiences in acute services

Figure 7-17 displays the opinions on the impact of the experiences in acute services on the delayed implementation of MH PbR. According to the findings in Chapter 6, some participants doubted the feasibility of MH PbR by questioning the outcomes from implementing it in acute services where it was supposed to fit most appropriately. Figure 7-17 shows that the majority of the participants regarded the experiences in acute services as an important factor that caused the delayed implementation of MH PbR. By comparing the responses by subgroups, the data shows that the managers and the frontline clinicians tended to be more concerned about the feasibility of applying PbR in mental health. This conforms to the corresponding findings in Chapter 6, which indicated that the managers and frontline clinicians had a deeper understanding of the complex nature of mental disorders and the difficulties in classifying patients due to the lack of laboratory tests. Since

they were aware of the differences in nature between mental health services and acute services, the lack of solid evidence in relation to the practical impacts of PbR on acute services may easily result in their lack of confidence in implementing it in mental health.

Figure 7-17 Impact of experiences in acute services on the implementation of MH PbR



7.4 General attitudes and suggestions

According to the previous evaluations, participants were asked to express their general attitudes towards the implementation of PbR in mental health. To those who objected to the implementation, they were requested to attribute it to one reason that influenced their negative attitudes the most. Given the delayed status, the participants were also requested to rate approaches with potential to help improve the current system according to the findings in Chapters 5 and 6. In the end, the

participants were asked to list one most obvious benefit brought about by the implementation of MH PbR from their own perspectives.

7.4.1 General attitudes towards the implementation of MH PbR

Table 7-15 displays participants' concerns about the feasibility of implementing PbR in mental health, with 44.4% of the participants showing objection to the implementation. However, splitting opinions have been found within all three subgroups. The distribution of responses of the frontline clinicians conforms to the corresponding interview findings that indicated their concern about the actual impacts on everyday clinical practice, particular in light of the current situation where frontline clinicians were required to achieve various targets, some of which were not considered clinically helpful. Similarly, the distribution of responses of the commissioners complies with the corresponding interview findings that some GP commissioners were found reluctant to engage in this reform due to their lack of understanding and general negative acceptance of change. Regarding the considerable percentage of the managers who agreed that MH PbR should be implemented, it corresponds to their positive attitude toward the prospect of MH PbR as expressed in the interviews. According to the findings from Chapter 6, the managers were the group of professionals who recognised the initial drawbacks of the Block Contract and the unfairness created by the lack of a transparent information system. Under such circumstances, they were more willing to embrace the reform, although they were also aware of the initial drawbacks of the MH PbR system.

Table 7-15 General attitudes towards the implementation of MH PbR

			Yes	Hard to say	No
MH PbR should be implemented	Managers	% within group	35.7%	21.4%	42.9%
	Frontline clinicians	% within group	22.2%	33.3%	44.4%
	Commissioners	% within group	25.0%	25.0%	50.0%
	Total	% of total	27.8%	27.8%	44.4%

As Table 7-16 below shows, objections towards the implementation mainly focused on three aspects: a finance and target led system, the complex nature of mental disorders and the clinical effectiveness of MH PbR, which echo the corresponding findings in Chapters 5 and 6. According to interview findings, a finance-led system was seen as an inevitable outcome of the implementation of MH PbR. Nevertheless, the commodification of mental health services was seen as having a high risk of compromising patients' interests given the individualised symptoms and needs for care. In this situation, it makes sense for the frontline clinicians to be more concerned about the finance-led system underpinned by the Quasi-market. Thus, the questionnaire outcomes confirm the key players' concern about the fundamental theory. According to Table 7-16, the complex nature of mental disorders was the second most-rated problem that led to the participants' objection. This outcome also conforms to the corresponding findings in Chapters 3 and 5: the individualised symptoms and multiple alternative treatment approaches challenge the classification and standardisation of the corresponding treatment, thus making PbR less suitable for the mental health domain. In addition, 18.8% of the frontline clinicians regarded poor clinical effectiveness of MH PbR as another reason, which corresponds to the MHCT's initial problems as discussed in Chapters 5 and 6.

Table 7-16 Reasons for objecting to the implementation of MH PbR

			No objection	Finance and target-led system	Ideology of clustering	Complex nature	Lack clinical efficacy	Subjective system
Factors caused objection	Managers	% within group	100.0%	0%	0%	0%	0%	0%
	Frontline clinicians	% within group	0%	37.5%	6.2%	31.2%	18.8%	6.2%
	Commissioners	% within group	0%	75.0%	0%	25.0%	0%	0%
	Total	% of total	41.2%	26.5%	2.9%	17.6%	8.8%	2.9%

Regarding the unified perspective of the manager group, all managers indicated that they had “no objection” to the implementation of MH PbR. Considering their split opinions on whether they believed the implementation of MH PbR is feasible, (for which 6 out of 14 answered “no”), this outcome may be due to the balance between the attitude from a clinical perspective and that from the general picture. According to the findings from Chapters 5 and 6, the managers realised the existence of a “second-order effect” and the “be in PbR or less privileged”. Although PbR does not fit mental health well, it was both a political trend and their second best choice to have PbR in mental health to avoid further financial pressure. It once again reveals that the managers tended to weight more on the potential benefits resulting from a transparent information system, which was expected to facilitate better collective resource management. Meanwhile, this dilemma did not affect the commissioners’ and frontline clinicians’ concerns given their positions.

7.4.2 Suggestions

In order to improve the validity and feasibility of applying the PbR policy in mental health, the participants were asked to rank six suggested approaches, derived from both Chapters 5 and 6, according to their importance. After assigning 10 to the priority,

7 to the second most important, 5 to the third most important, 3 to the fourth most important, 1 to the fifth most important and 0 to the least important, the total value of each approach was calculated and ranked from the highest to the lowest. To minimise the errors generated from the process of evaluation, Kruskal-Wallis Test was adopted to double check the sequence of ranking.

According to the evaluation of ranking, the effective sequence was considered to be the following:

Action 1: "prioritising the development and application of care pathways";

Action 4: "publishing clear national guidelines and standards";

Action 2: "improving the clustering system";

Action 5: "defining more effective quality measure instruments";

Action 3: "improving training";

Action 6: "improving the collaboration between primary and secondary care".

However, as Table 7-17 shows, Kruskal-Wallis Test resulted in a slightly different ranking sequence as Action 1, Action 2, Action 4, Action 5, Action 3 and Action 6. Taking these two outcomes into consideration, they both ranked Action 1: "prioritising the development and application of care pathways" as the priority, Action 5: "defining more effective quality measure instruments" as the 4th suggestion, Action 3: "improving training" as the 5th suggestion and Action 6: "improving the collaboration between primary and secondary care" as the least important suggestion, with Action 4 and Action 2 in the opposite positions. In regard to Action 1, it corresponds with the findings from Chapters 5 and 6, in which the importance of care pathways was highlighted. Regarding Action 2 "improving clustering system"

and Action 4 “publishing clear national guidelines and standards”, the differences were caused by different analytical approaches. However, due to the difficulties in scaling the intervals between two grades, it was difficult to identify a better approach from these two. Since the allocations of responses are similar between these two actions (this is shown in Table 7-17), these two actions should therefore be considered equally important to the refinement of the MH PbR system at the current stage.

Table 7-17 Ranking of the suggested actions

Action groups	Total value	Mean rank
1 Prioritising the development and application of care pathways	167	60.67
2 Improving the clustering system	111	76.19
3 Improving training	91	91.44
4 Publishing clear national directions and standards	113	79.83
5 Defining more effective quality measurement instruments	107	80.09
6 Improving the collaboration between primary and secondary care	84	100.78

7.4.3 General benefits

Drawing upon the findings from Chapters 5 and 6, the questionnaire summaries six major benefits of MH PbR, including “standardised treatment”, “outcome and service measurements”, “better information system”, “the idea of cost-efficiency”, “quality promotion mechanism” and “great understanding of variation”. Among these benefits, the participants were asked to vote for the most prominent one according to their own perspectives. According to Figure 7-18, “outcome and service measurement” and “quality promotion mechanism” are the two most rated factors. Table 7-18 further outlines the detailed information about the distribution of responses, according to which a significantly higher percentage

of the participants (41.2%) considered “outcome and service measurements” as the most obvious benefit reaped by the implementation of PbR in mental health. This echoes the corresponding findings from Chapter 6 in term of a better knowledge of service quality and therefore, the fairness of payment. In particular, 37.5% of the frontline clinicians were also pleased with the outcome measurements. This conforms to one interview finding that pointed to their awareness of the importance of having patient feedback, which can help clinicians adjust their clinical practice as well as serve as evidence in the negotiation with commissioners for patient-centred care. Therefore, this indicates that the arguments about the currently available quality measures only point to their lack of validity to represent a comprehensive view of “quality”, rather than indicating them invalid as individual measures. This result shows agreement with one manager’s opinion that a comprehensive measurement incorporates measurements from multiple dimensions to ensure patients receive appropriate care, while at the same time, appreciate the input of clinicians. The second most rated benefit was “quality promotion mechanism”. The participants from all groups were pleased to see quality promotion, which matches the corresponding findings in Chapters 3 and 6 where the establishment of non-price competition incentivises providers to compete on quality, which had not been paid attention to under the Block Contract. This also explains the underpinning reason for managers’ advocacy of the transparent information system: the IT system under the new system was expected to facilitate the development of care pathways that would help to reduce the variation in clinical skills among frontline clinicians. The data, together with those from the quality measurement, were expected to facilitate providers’ management of health care services and resource allocation.

Figure 7-18 Perspectives on the most obvious benefit reaped by MH PbR

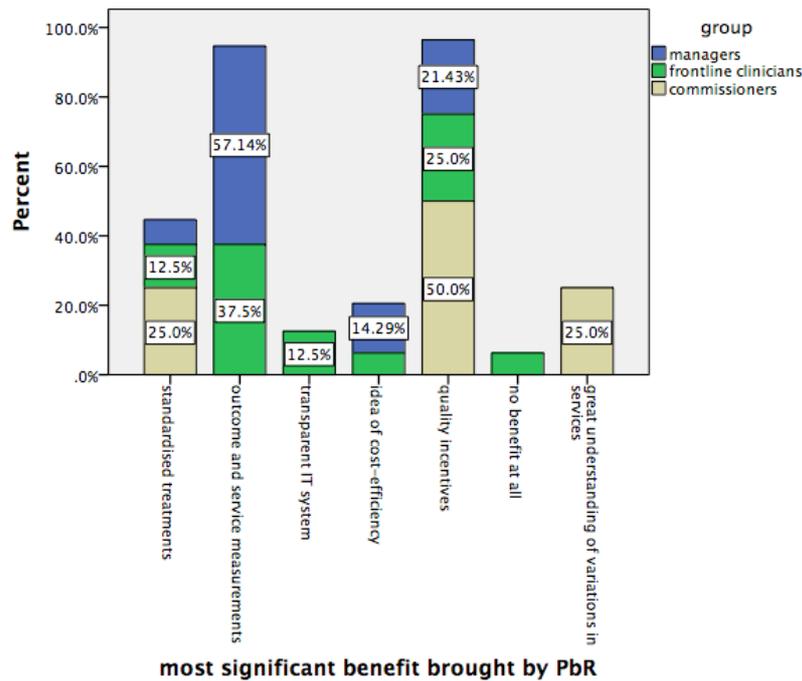


Table 7-18 Perspectives on the most obvious benefit reaped by MH PbR

			Standardised treatment	Outcome and service management	Transparent IT system	Idea of cost-efficiency	Quality incentives	Understanding of variation in services	No benefit at all
Most obvious benefit reaped by MH PbR	Managers	% within group	7.1%	57.1%	0%	14.3%	21.4%	0%	0%
	Frontline clinicians	% within group	12.5%	37.5%	12.5%	6.3%	25.0%	0%	6.3%
	Commissioners	% within group	25.0%	0%	0%	0%	50.0%	25.0%	0%
	Total	% of total	11.8%	41.2%	5.9%	8.8%	26.5%	2.9%	2.9%

Summary

This chapter presented the data obtained from online surveys that aimed to verify the findings from the previous qualitative analysis, particularly the interview findings. As discussed in Chapter 4, the design of the online surveys conformed to the logic sequence resulted from the semi-structured interviews. A total of 38 responses were considered valid after screening the original data according to different expectations/assumptions of

the specific knowledge. Analytical approaches, such as graphs, descriptive analysis, crosstabs, Spearman correlation test and Mann-Whitney non-parametric test, were adopted to analyse the questionnaire data. The outcomes were triangulated with the corresponding findings from Chapters 3, 5 and 6 and presented from four main aspects: the general background of implementation, the subsystem evaluation, the driving factors of delay and general attitude and suggestions.

Section 7.1 outlined the Block Contract's dominant position and some milestones of the implementation of the MHCT classification system. Section 7.2 evaluated the validity and reliability of the clinical classification system. The findings generally matched the corresponding findings derived from the interviews: the managers tended to note the advantages of MHCT classification regarding predicting resource allocation and costs although they realised the initial drawbacks while the frontline clinicians tended to hold negative opinions towards the subsystems as well as the collaboration between each, since their judgements were made mainly according to clinical efficacy. The splitting viewpoints towards the PREM and the HoNOS outcome scales generally conform to those obtained during the semi-structure interviews. Section 7.3 investigated the driving factors that caused the delay from seven main aspects, including the complex nature, ideas behind MH PbR, subsystems, government policies, clinicians' participation, "gaming" behaviours and the experiences from acute services. The statistical analysis showed a high level of agreement with the corresponding findings in Chapter 6. In the end, Section 7.4 reflected the variation in the general attitude towards implementing PbR in mental health: although a high percentage of participants held a negative attitude towards the

implementation, a considerable percentage of the managers regarded it as the right move. The primary suggestions were sorted by importance. The outcome echoed the findings in Chapter 6 by attributing the care pathways and the national guidelines to the two aspects awaiting more attention.

Besides confirming the corresponding findings in Chapter 6, the major finding in this quantitative analysis was the splitting perspectives among different interest groups, or even within the same group. In particular, the splitting perspectives between the managerial group and the frontline group reflected the differences created by various standpoints, which also demonstrated the fact that one size does not fit all systems (this will be discussed in Section 8.3.2). The negative perspectives the frontline clinicians held pointed to the mismatch between the MH PbR project (including the classification system and the supporting policies) and the frontline realities. This highlighted the important role frontline clinicians play in the implementation stage while suggesting careful considerations of the trade-offs between political objectives and the inevitable consequences in practice (this will be discussed in Section 8.3.3). In general, the splitting perspectives not only reflected the variations in participants' understanding at this early stage, but also indicated the information asymmetry that awaited more collaboration and communication.

In the next chapter, the findings and insights gleaned from the four analytical chapters will be reviewed and discussed. The triangulation of findings from different levels and angles will facilitate further discussion of the utility of this study concerning policy evaluation and future policy-making.

8. General discussion and conclusion

Introduction

As a policy evaluation, this study has focused on the evaluation of the driving factors that led to the delayed implementation of the PbR policy in mental health in England. Based upon the analysis of the fundamental theories, the theoretical mechanism and the practical issues surrounding the implementation of the policy, this study thereby argues that PbR, in general, is a system with more theoretical significance regarding the prospect of establishing a transparent information system and therefore, a fair payment system than a policy facilitating high-quality clinical services and cost containment. Regarding the implementation of PbR in mental health, the fundamental flaws of the Quasi-market lead to a lack of validity and feasibility of the policy, which adversely affects the corresponding formulation and implementation of this misconceived policy. The difficulties become more prominent in light of the complex nature of mental disorders that compromises the validity and credibility of the clinical classification system, thus adversely affecting the accuracy of the tariff calculation. This study thereby argues that the fundamental problems of applying the Quasi-market theory, the conceptual and constructional flaws of the clinical classification system, together with negative external factors have hindered the implementation of PbR in mental health.

This chapter reviews the findings and insights to facilitate further discussion regarding the relevance and utility of this study. This chapter is divided into six main sections. The first section summarises the findings gleaned from the four analytic

chapters by reviewing the research questions and therefore, presenting the main findings with respect to the current implementation of MH PbR and the driving factors responsible for the delayed status. The second section highlights the significance of the study by analysing its relationship with prior research conducted in this area. The subsequent two sections further demonstrate the implications of this study from different levels and angles for policy analysis and research design. The third section discusses the study's insights and contributions to policy evaluation. Section 8.4 highlights the implications for research design, including the utility of the analytical framework and the GTM principles, respectively. In Section 8.5, the limitations of this study are discussed, which lead to implications for future research. Considering policy evaluation as a learning process, Section 8.6 further illustrates the contribution of the findings to future policy-making in the healthcare domain. This chapter concludes by summarising and reiterating the underpinning motivation, findings and contributions of this project.

8.1 Summary of main findings

This section serves as a brief summary of the research framework of this study. It revisits the research aim and questions, the latter is in turn considered by presenting the current stage of the implementation of PbR in mental health, outlining the major factors that have caused its delay, and simultaneously proposing suggestions for further improvement.

8.1.1 Research questions and design

As a policy evaluation, this study aimed to evaluate the MH PbR policy from three stages, including its initiation, formulation and implementation. In regard to these three core stages in the policy-making process, this study thus set four research questions that guided the research conduction:

- 1) What is the fundamental basis of PbR? Is it theoretically feasible to be implemented in healthcare services?
- 2) To what extent is PbR theoretically valid regarding fulfilling the function of a clinical classification system as well as a payment system in mental health?
- 3) What is the current stage of the implementation of PbR in mental health?
- 4) What are the obstacles that have hindered its implementation in mental health?

To answer these research questions, this study employed the “administrative anthropology” theory and therefore, conducted a three-step research, including theoretical analysis, semi-structured interviews and online surveys. Theoretical analysis was adopted for evaluating the policy initiation and formulation (subject to research questions 1 and 2) whereas semi-structured interviews and online surveys were used in the fieldwork investigating the implementation of this policy. For the empirical research, a series of semi-structured interviews were conducted between November 2013 and April 2014 at NHT, Nottingham City CCG and Nottinghamshire County CCG. Online surveys were carried out between June 2014 and September

2014 subject to the staff at the above three organisations as well as Derbyshire NHS Foundation Trust mainly for a confirmatory purpose. The subsequent sections summarise and present the principal findings derived from all three approaches in respect to the research questions.

8.1.2 Main findings

Through analysis of the underpinning theory of PbR, the Quasi-market theory, this study found that MH PbR was poorly designed due to the fundamental conflicts between the market theory and the complex nature of health care, especially mental health services. Moreover, investigation of the theoretical validity of the MHCT classification system revealed that this classification system as a whole is fundamentally flawed and therefore, leads to constructional drawbacks as well as the inevitable difficulties in accurately classifying patients on the frontline. Both fundamental drawbacks and mechanical drawbacks influenced the implementation of the MH PbR policy. In this case, the following two subsections answer the above four research questions from two major aspects: the first subsection answers Question 3: "What is the current stage of the implementation of PbR in mental health?" and the second subsection summarises the fundamental drawbacks of this policy, the mechanical drawbacks of the classification system (Questions 1 and 2) and the practical obstacles, and attributes them to the "driving factors" behind the delayed implementation of MH PbR. Finally, the last subsection summarises suggestions for future improvement of the MH PbR policy, which were derived from the fieldwork results.

8.1.2.1 Current implementation

The literature review in Chapter 2 indicated that the past two decades have witnessed a series of disjointed reforms in health care. Having experienced four major reorganisations, the NHS has currently moved towards a local-based health care system guided by the market mechanism that encourages supply-side competition. Particularly, the previous decade has witnessed the development of PbR; refining the classification and payment system and enlarging its coverage to mental health replacing the previous Block Contract (Department of Health, 2002b). Based upon this background information, this study attempted to investigate the policy implementation progress until September 2014, when the interviews and the online surveys were undertaken. In this respect, the expression “at that moment” refers to that particular point in time, namely September 2014.

In the context of PbR being implemented in acute services since 2003, it has subsequently become a political and realistic trend to replace the Block Contract with PbR in mental health. Nevertheless, despite the wide recognition of the drawbacks of the Block Contract, such as the lack of a transparent information system to support budget calculation and service monitoring, or even the “PbR or less privileged” pressure, this study found that the Block Contract is still widely used in mental health. The questionnaire findings revealed that over 73% of the participants confirmed it as the dominant contracting method in mental health. This demonstrates an agreement with the interview findings: although the commissioners and providers were working together to set up a transitional process leading to the MH PbR system, the delay in establishing a comprehensive classification system and therefore, the lack of

reliable data for tariff calculation determined the prevalent use of the Block Contract. This corresponds to the published report stating a delayed status of the implementation of MH PbR (Lintern, 2013). This study observed that to avoid financial risks posed by the incomplete system, the commissioners and managers adopted a more cautious double-running system to maintain contracting in a lump-sum format using OBDs and direct contacts as indicators while simultaneously monitoring clinical services using MH PbR indicators.

As indicated in the interviews, within this transitional period, the emphasis was placed upon implementing the subsystems and collecting accurate data regarding the use of service, as well as refining the current classification system from the managerial level. The findings from both the interviews and the questionnaires outlined a number of milestones of the implementation process: under the pressure of deadline for contracting by MH PbR, over 75% of patients have been clustered by the MHCT, frontline clinicians were reviewing the patients in C1-C3, C7 and C11 in order to decide whether to upgrade or to discharge, while care pathways were in preliminary testing.

Since the information collection is a bottom-up process, the involvement of frontline clinicians is vital to the implementation of the system as a whole. This study found that in relation to the new classification system, training sessions were being offered to frontline staff. The outcomes of the interviews and questionnaires indicated that half of the frontline staff had received one to two MH PbR training sessions. Only approximately 5% of the frontline clinicians have attended more than two sessions. Regarding this insufficient training, the

interview findings attributed the reason for this to the discontinuity of the training programme, due to the NHT's lack of attention to the importance of training. Furthermore, with limited training provided, clinicians were assigned targets such as clustering every patient and reviewing previous clusters with no clinical meaning attached due to the lack of care pathways. In this context, frontline participants involved in the interviews confirmed their reluctance to engage with the new system, which has also been noted by both the commissioners and managers. The commissioners and managers, therefore, regarded it as the most obvious problem in the current implementation stage.

8.1.2.2 Driving factors

By summarising the findings from the theoretical analysis, interviews and online surveys, the delayed implementation of MH PbR can be attributed to eight major obstacles: 1) fundamental flaws of applying MH PbR; 2) the complex nature of mental disorders; 3) drawbacks of the MH PbR system; 4) intensively established policies; 5) frontline clinicians' involvement; 6) "gaming" behaviours; 7) incomplete information system; and 8) negative attitudes towards change.

1) Fundamental flaws of applying MH PbR

The design of a PbR system is based upon the Quasi-market theory, which highlights the utility of the market mechanism in regard to controlling costs, increasing efficiency and improving quality through provider-side competition. It also assumes that the government has the power and skill to accurately regulate clinical behaviours and measure service quality.

Market theory is underpinned by the hypothesis that the service provision process can be standardised and the incurred costs can thus be standardised. However, the theoretical analysis identified the fundamental differences between healthcare services, especially mental health services, and typical products that can be produced on the streamline to be identical. By illustrating other conflicts between the healthcare system and preconditions of a typical market, Chapter 3 argued that a market competition principle is not suitable for health care services, especially mental health services, and that the effects of the non-price competition are limited in regards to cost containment.

The investigation of the government's ability to regulate revealed: 1) Concerning the individualised conditions and needs, it is difficult, even if not impossible, to standardise frontline practice; 2) Controlling costs may result in conflicts with good clinical practice, which is meant to only concern patients' needs rather than costs; 3) Given the presence of information asymmetry as well as the limitation of profession, commissioners, who are non-clinical staff, are disadvantaged in regulating clinical behaviours and monitoring service quality.

By rejecting the preconditions of the Quasi-market, Chapter 3 pointed out that the Quasi-market theory does not fit healthcare services, especially mental health services. In other words, PbR is fundamentally flawed, which inevitably impeded the implementation of this policy.

2) The complex nature of mental disorders

Complying with the theoretical analysis, which pointed out the

radical differences between mental health services and ordinary merchandise, the empirical findings show that the complexity of mental health disorders is the factor that has been most highly rated by participants from all subgroups. The rating scale shows that clinical professionals are more likely to be concerned about this issue given its importance to the viability of measuring patients' needs and thus managing interventions in a standardised way. This corresponds to the findings in Chapter 5, which have indicated that the individualised conditions, the intertwined relationship between the definition of "normal" and "abnormal", together with multiple alternative interventions, made it difficult to standardise interventions due to the lack of clear evidence of efficacy. Drawing upon Lipsky's (1980) street-level bureaucracy discussed in Chapter 3, this study argued that this low degree of within-group homogeneity resulted in the difficulties in commodifying services into identical products.

3) Drawbacks of the MH PbR system

In reference to the drawbacks of the MH PbR system, this study found that the conceptual flaws of the MHCT regarding measuring needs and the initial functioning drawbacks of the HoNOS caused mismatches observed between the HoNOS scores and MHCT clusters when making clinical decisions. In terms of conceptual flaws, the findings in Chapter 5 argued that the care pathways were shoehorned into each cluster that indicated patients' "needs" rather than being considered as the criteria for defining needs. The sequence revealed that it was not adequately assessing patients' needs, which should be defined in conjunction with potentially available interventions (Wing et al., 1992). In this respect, the theoretical analysis in Chapter 5 attributed this finding as one important reason for

the low validity of the classification system. Furthermore, this was echoed by the questionnaire results, which revealed that over 71% of the participants regarded the clustering ideology as a factor that had caused the delayed implementation. This study detected the major constructional flaws of the MHCT as the low degree of within-group homogeneity and between-group heterogeneity. Conflicting perspectives in respect to the validity of the HoNOS were noted from the questionnaire outcomes: the frontline clinicians were more likely to be concerned about its poor effectiveness whereas a considerable number of managers (38.5%) regarded it as a valid and reliable instrument. These findings are consistent with the findings of research by Lovaglio and Monzani (2011) regarding the existence of controversial perspectives about the validity of the HoNOS. McClelland et al. (2000) conclude the HoNOS offers good sensitivity, validity and clinical acceptability, whereas Brooks (2000) questions its validity by pointing out that the HoNOS scores do not comply with other existing, widely-used measurements. The relationship between the conflicting opinions in relation to the validity of the HoNOS and the convergent opinion of the poor validity of this classification system is evident: the HoNOS is a considerably valid measure regarding assessing changes in outcome at an individual level rather than facilitating a rigorous evaluation of one's condition for a classification system. The original purpose of designing the HoNOS determines the gaps between the HoNOS scores and the MHCT clusters, which in turn devalue the validity of the MHCT classification system as a whole. As a result of the lack of officially implemented care pathways, this study found that participants tended to hold conservative, negative attitudes towards the effectiveness of the MHCT care pathways, mainly considering its ideology of standardisation. In this respect, the

questionnaire outcomes observed a total of 50% of participants who disagreed or strongly disagreed with the statement that “The HoNOS, the MHCT and the MHCT care pathways work smoothly as a whole system”. With respect to the financial aspect, this study verified that the poor data quality caused the delayed implementation of the cost calculation system. However, despite its delayed implementation, the appropriateness of the tariff calculation mechanism was noted in this study given the low within-group homogeneity in terms of patients’ conditions and needs, which conforms to the findings of the Price Waterhouse Cooper’s (2012) report. Other side effects of setting the national tariffs at an average level of costs were noted as: 1) the average cost based price encouraged providers to be “average” rather than improving performance; and 2) a higher possibility of “gaming” due to information asymmetry. Hence, this study argued that it is risky to apply the “standardisation-to-the-average” principle in calculating nationally fixed prices in the absence of accurate data from the classification system. Consequently, the Block Contract emerges as a more suitable payment method for mental health services in this particular context.

4) Intensively established policies

This study noted the simultaneous implementation of a series of reform-related policies with various targets in this transitional period. Amongst these policies, some targets were seen as confusing. Some others like “discharge all C7 and C11 patients back to primary care” and “have four successful contacts every day” were even seen as inappropriately set or not applicable to practice. Therefore, 47% of the participants regarded it as either an “important” or “very important” factor that led to the

delay. Additionally, the interview findings indicated that the heavy, but not clinically appropriate paperwork took up time that could have been used to improve patient-centred services or develop new techniques. This is confirmed by the questionnaire data, which states that 75% of the frontline clinicians regarded the heavy workload as either an “important” or “very important” factor contributing to the delayed implementation.

5) Frontline clinicians’ involvement

The questionnaire data revealed the frontline clinicians’ negative attitudes towards the implementation of MH PbR and their corresponding unwillingness to engage in reform. The corresponding findings from the questionnaires confirmed clinicians’ unwillingness to engage by pointing to their negative perspectives on whether MH PbR should be implemented. Moreover, the interviews found that the idea of MH PbR conflicts with the idea of good practice. As concluded in Chapter 3, concerns were raised in regards to professionals being sufficiently professional to keep patients’ best interests in mind when taking financial issues into consideration. This concern became more evident when the validity and reliability of the classification system were brought into question. Regarding frontline clinicians’ lack of understanding, the questionnaire data showed that over 90% of the managers considered clinicians’ lack of understanding as either an important or very important factor for the delay. This shows agreement with the corresponding interview finding that the frontline clinicians judged the effectiveness of a clinical system only by clinical validity and credibility in terms of facilitating quality services. Moreover, the insufficient training not only failed to help

frontline clinicians to better understand the policy as a whole but it also failed to reduce the significant variation in clinical skill among frontline clinicians, which is essential to better appreciate the classification mechanism. In this case, this study argued that the frontline clinicians judged the effects of MH PbR only from a clinical utility perspective, and lacked understanding of its administrative value in providing better management of health care resources.

6) "Gaming" behaviours

With findings derived from the interviews and the online surveys, the study found that "gaming" was not only a potential risk, but also an activity that existed in daily frontline practice, although not in the way predicted by previous studies according to economic theories. The lack of accurate quality measures, together with the information asymmetry, created the potential for providers to "game", especially given the current heavy workload. As demonstrated by the questionnaire figures, patient-rated measures were seen as subjective, or even misleading, given that a considerable proportion of the participants (32.3%) were concerned about the validity of PREM as a proxy to reflect actual service quality. It was argued that the current quality measurement system functions more like a means that policymakers use to respond to public dissatisfaction rather than an effective clinical instrument at the current stage. Similarly, Lipsky's (1980) theory argues that the actual performance of frontline activities is virtually impossible to measure. Therefore, this study attributed it as one reason for the current situation in which frontline clinicians "game" for less workload, although not for money. Under such circumstances, this study deduced that an outcome-oriented system easily

leads to such “gaming” behaviours.

7) Incomplete IT system

Considering the constructional problems of this classification system, the data collected in this manner failed to meet the fundamental assumption of the case-mix principle that patients in the same group share similar conditions and health care needs. Moreover, the study found that both the managers and frontline clinicians noted variation in clinicians’ ability to use the new classification system in an appropriate way, as over 70% of the participants rated it as either an “important” or “very important” factor in the delayed implementation. This study also found that the training sessions were discontinuous with several years’ gap before being re-launched. In light of the poor effectiveness of training sessions as shown by the questionnaire figures, they failed to improve data accuracy through providing support to improve frontline clinicians’ ability to use the new classification system.

8) Negative attitudes towards change

Besides the internal and external factors that raised concern about the validity and feasibility of implementing PbR in mental health, a natural opposition towards change was noted in this study. The interview findings also revealed GP commissioners’ reluctance to engage and attributed their natural opposition as part of the reasons for the delay.

8.1.2.3 Suggestions for further improvement

In this respect, this study concluded with six suggestions for the

further improvement of MH PbR. These suggestions were arranged in an order according to the level of urgency and importance, including prioritising improving and applying care pathways, improving the clustering system, publishing clear national directions and standards, defining more effective quality measurement instruments, improving training and improving integrated care.

Both the commissioners and managers noted the potential financial risks created by moving to a cost-and-volume payment system. Nevertheless, at this stage, the interview findings indicated that more attention was paid to the change of the payment mechanism and therefore, the efficiency of service provision and targets rather than clinical services. Compared with the financial aspect, the theoretical benefits brought about by the establishment of a transparent information system in the clinical aspect were more prominent. Although moving to an evidence-based system was seen as a step in the right direction, the conceptual and constructional flaws of the classification system have been noted, which were believed to be the direct causal factors for the delayed implementation. Under such circumstances, the study suggested devoting more attention to refining the classification system in the clinical aspect and postponing the implementation of the payment system.

Both theoretical and empirical findings argued that the absence of care pathways not only devalued the MHCT as a needs assessment instrument, but also reduced the accuracy of classification outcomes especially in a system with constructional flaws. The empirical findings corresponded with the theoretical analysis, confirming that the initial problems of the HoNOS and constructional drawbacks of the MHCT resulted

in gaps between the HoNOS scores and the corresponding clusters, particularly with the absence of care pathways. To improve the validity and reliability of MH PbR, study findings suggested prioritising the development of care pathways and further refining the MHCT classification system.

As shown in both the interview and questionnaire findings, on the one hand, too many top-down policies made the frontline clinicians confused and stressed in daily practice. On the other hand, the frontline clinicians had not been provided with nationally standardised guidelines regarding how to cluster patients and what services should be provided. Therefore, the empirical findings revealed that the participants expected clearer and more supportive policies with viable targets attached and more quality measures to build a comprehensive quality measurement system that can facilitate clinical practice. The participants in the study expressed their expectations of governmental financial supports as the starting fund for essential elements, such as the information system.

The interview outcomes reflected the managers' and commissioners' awareness of the importance of building a closer collaboration between managers and frontline clinicians by improving training sessions and involving frontline clinicians in the decision-making process. This study also noted the importance of establishing the purchaser-provider collaborative relationship to address the potential financial risks generated from the new payment system. Additionally, the interview findings echoed the corresponding findings from the theoretical analysis by arguing that the complex nature of mental disorders determined the focal point of mental health service as the process of knowing patients and their needs on an individual

basis. This study therefore, suggested the establishment of collaboration between primary and secondary services to establish an integrated service delivery structure.

8.2 Relation to prior research

As previously discussed in Chapter 3, the complex nature of mental disorders indicated that PbR was less suitable to mental health than acute services in which the classification system (HRG) has a comparatively high degree of within-group homogeneity and between-group heterogeneity. The findings from this study are consistent with the unsatisfactory outcomes of the implementation of PbR in acute services presented in Chapter 3. Based upon the experiences of implementing PbR in acute services, this section compares the research findings from this study with other studies subject to analysing the implementation of similar classification systems in mental health in other countries, due to the paucity of systematic evaluations on the impacts of PbR on mental health in England.

It was found that it is feasible, though difficult, to manage mental health interventions in a standardised way, given the validity and credibility of the NFCAS. The transparent process of identifying patients' problems and assessing needs according to the target interventions proved fruitful regarding providing comprehensive information and facilitating clinical decision-making. Previous studies investigating the application of similar classification systems in mental health in other countries confirm the theoretical viability of applying the case-mix principle to classifying patients with mental disorders. In Australia and New Zealand, the classification system was

explored in categorising and managing case records without being subsequently implemented for payment purpose given their concern about the impacts of the case-mix mechanism on reducing cost variation (Mason and Goddard, 2009). This shows agreement with the theoretical analysis of this study arguing the validity of the attempt to use the standardisation principles to reduce cost variation. The classification system and the payment system have been applied in the Netherlands and Canada (Ontario). In the Netherlands, psychiatric medical services have been under the coverage of a DRG-based system since 2009, but the payment is only subject to first-year admissions (Mason and Goddard, 2009). In Canada, the System for the Classification of In-Patient Psychiatry (SCIPP) categorises mental health patients into seven super-clusters according to the intervention phases and the resource intensity (Murphy, 2008). However, for these four countries, few details of the systematic evaluation of the case-mix based systems have been identified. Therefore, the lack of long-term research has led to a lack of practical implications to the system as well as the policy. This demonstrates the contribution of this study – the introduction of the English experience in regards to the early outcomes of applying a DRG system in mental health. Additionally, the previous research outcomes reveal a vague impact of the case-mix principle on cost control, which echoes the findings from the studies evaluating the impacts of PbR in acute services.

Regarding the early results of implementing PbR in mental health in England, Murphy (2014) evaluated the relevant policies regarding MH PbR in England by conducting interviews with nine trust managers and triangulating the interview findings with the relevant literature. In his study, the barriers to

implementing the policy were attributed to the inadequate time frame, inaccurate data, lack of quality training, poor reliability and variability of the MHCT, lack of care pathways and national guidance, insufficient IT system and changes in commissioning patterns. These findings show significant agreement with those of this study.

However, Murphy's (2014) study only adopted interviews, which makes the study suffer from a lack of comprehensiveness and generalizability. Therefore, it reflects the methodological significance of this study that considered splitting perspectives among different interest groups and employed questionnaires to generalise interview findings. Unlike Murphy's (2014) study that only involved trust managers, this study sought different, or even conflicting, perspectives from three angles, including commissioners, managers and frontline clinicians, to expand the comprehensiveness of understanding. Furthermore, unlike Murphy's (2014) empirical research that only relied upon interviews, online surveys were adopted in this study to verify and generalise the findings derived from the previous qualitative analysis. The questionnaire findings showed high agreement with the corresponding interview findings. The empirical findings were then confirmed as valid due to their compliance with the theoretical predictions.

8.3 Implications for policy analysis

By combining the findings from investigating the fundamental theories, evaluating the constructional mechanism and analysing the empirical evidence, this study develops three major implications for the policy analysis of the implementation

of MH PbR, including: policy should be evaluated in the context, one size does not fit all systems and objectives always come with trade-offs.

8.3.1 Policy should be evaluated within the context

As previously discussed, this study found that the fast changing policies with different targets hindered the implementation of PbR in mental health. This echoes Marshall et al.'s (2014) insight that points to three factors that determine the success of a policy, which includes the previous system it is to replace, the political context and other external factors. These three factors highlight the importance of contextualisation, whereas it is particularly the case in mental health (Walt et al., 2008). In this respect, this study argues that the feasibility and value of PbR should be evaluated within its context.

8.3.1.1 The context is changing

As illustrated in NHS England's *Five Year Forward View* (NHS England, 2014), despite the fact that the kernel of NHS services, which is to provide quality and efficient health care, has not changed over the past decade, the outside world has changed. Whether PbR is feasible depends not only on its theoretical validity and credibility, but it also relies upon the current situation. This study considers it insufficient and inaccurate to predict the feasibility of implementing PbR in the current situation by merely considering the previous experiences of implementing it in acute services, especially considering the fundamental differences between the two.

There have been dramatic changes in the NHS since the “NHS Modernisation”, as demands have increased since people live longer, medical technology has developed, and new medical interventions have emerged. Among the changes, the most obvious one is the change of the government’s capacity to pay for services given the rising demands (NHS England, 2014). When PbR was first introduced in 2003, the reform took place in the context where a firm financial investment was made into the NHS. The government has ensured an average of 6.4% (in real terms) per year increase in funding for the NHS during the period between 2003/04 and 2007/08 (Harker, 2012) It was this funding that supported NHS to conduct a series of reforms surrounding the payment system. However, since 2009, the launch of the QIPP programme set a target to save up to £20bn by 2014-15 (National Audit Office, 2011), which later increased to £30bn by 2020 (NHS England, 2014). Although the final decision is to be made by the new Conservative government and may need to be adjusted, it signals the austerity that the current NHS is facing, particularly since the King’s Fund claims that there may be a “cliff edge” for some providers and this may lead to the shut down of A&E services (Appleby et al., 2014). In other words, there is a lack of current financial support compared to what was available in 2003/04.

Additionally, inequalities have been noted between acute services and mental health services from interviewing the managers and commissioners. This is further supported by the figures indicating that mental health services receive only 13% of the NHS budget to address problems that account for 23% of the total impact of ill in the UK (All Party Parliamentary Group on Mental Health, 2015). Besides the fact that mental health services have always been underfunded in comparison with

acute services, research conducted by Community Care and BBC News revealed that NHS trusts' income for mental health services has dropped by 8.25%, or approximately by £600m in real terms between from 2010 to 2015 (McNicoll, 2015). Moreover, according to BBC News, three-quarters of mental health trusts have predicted another 8% (in real terms) in income cuts in the next five years commencing in 2014/15 (Hutchinson, 2015). By contrast, the past decade has witnessed a growing demand for mental health services (NHS England, 2014). The number of people subject to Mental Health Act has increased by 32% since 2008/09 and by 6% since 2012/13 (Care Quality Commission, 2015). Under great financial pressure, the NHS has acknowledged the unprecedented challenges brought by the change of context, which has required them to take action on three fronts, including demand, efficiency and funding simultaneously (NHS England, 2014).

In this respect, this study points to the insufficiency or inappropriateness to predict the success of PbR in mental health based upon the experiences in acute services. In light of the constrained budget, this study questions whether it is realistic to develop and implement such a radical financial system reform in mental health (this will be discussed in Section 8.3.3.2). Whether it is feasible to achieve cost-saving, while simultaneously ensuring quality by implementing PbR in mental health, depends upon external factors.

8.3.1.2 Feasibility depends upon the general environment

This study found that the Coalition government failed to fulfil its original intentions, which include to stop top-down

reorganisation of the NHS (NHS England, 2014) and to promoted a market-like competition system (Secretary of State for Health, 2010). The *Health and Social Care Act* (Secretary of State for Health, 2012) reiterated the importance of applying the market mechanism in health care by adopting approaches such as privatisation. However, until now, the private sectors only earn a small amount of the NHS budget while the NHS slowly transforms into a more bureaucratic system.

This study found the government's top-down squeeze restricted the development of market competition and therefore, hindered it from serving its function regarding driving up efficiency. The fixed tariff is seen as a top-down price squeeze that resulted in intense financial risks for providers. Drawing upon the fact that the data used to calculate nationally-fixed tariffs are only derived from NHS providers without taking private providers into consideration (O'Reilly et al., 2012), the lack of accuracy and the variation in costs results in a considerable financial instability for the NHS providers. Hence, this leads to difficulties in getting private providers into the market considering the difficulties in making a profit. This corresponds to Krachler and Greer's (2015) critiques about the uncertainties for private providers created by the price calculation together with its direct consequences. The interview outcomes comply with the theoretical evaluation since the commissioners admitted the collaborative relationship with NHS providers rather than a purchaser/supplier relationship in an ideal market. Without the provider-side competition, which is the fundamental assumption, MH PbR could not serve its incentivising function.

Moreover, the government's failure to depoliticise the market has also been noted as one reason that hindered the

implementation of MH PbR, especially in mental health. The findings in the interviews pointed to the risk of wasting resources, as a result of paying excessive attention to quality checking. Indeed, service quality should be monitored to be accountable to both commissioners and patients. However, greater attention has been paid to care regulation since Jeremy Hunt became Health Secretary (Ham et al., 2013). On the one hand, the overlapping responsibilities regarding regulating service quality have been noted between the CQC and the Monitor. On the other hand, less emphasis has been given to competition and patients' choices as a direct consequence, which leads to the condition in which providers are under intense scrutiny, in addition to financial pressure.

The financial burden has been further increased by the radical reorganisation of the NHS. The original intention of the Coalition government's reform was to contain the large expenditure resulting in the miscellaneous governing bodies by simplifying the structure. However, Figure 8-1 compares the structure before and after the Coalition government came into power. Chapter 2 found an evident increase in the number of the NHS bureaucratic bodies after April 2013, from a total 162 bodies to 244 bodies, including 4 regional offices, 27 local offices, 211 CCGs and 1 NHS commissioning board (BBC, 2013). According to Figure 8-2, the example of the relationships among the health bodies in London is an epitome of the whole NHS, which indicates a complex and confusing bureaucratic structure (Ham et al., 2013). When it comes to Lind's (2015) perspective, practice funding will suffer from the increase in management costs. In other words, the reorganisation has made the NHS more bureaucratic rather than creating a supportive environment for the provider-side competition.

Figure 8-1 Structures of the NHS before and after the Coalition government came into power

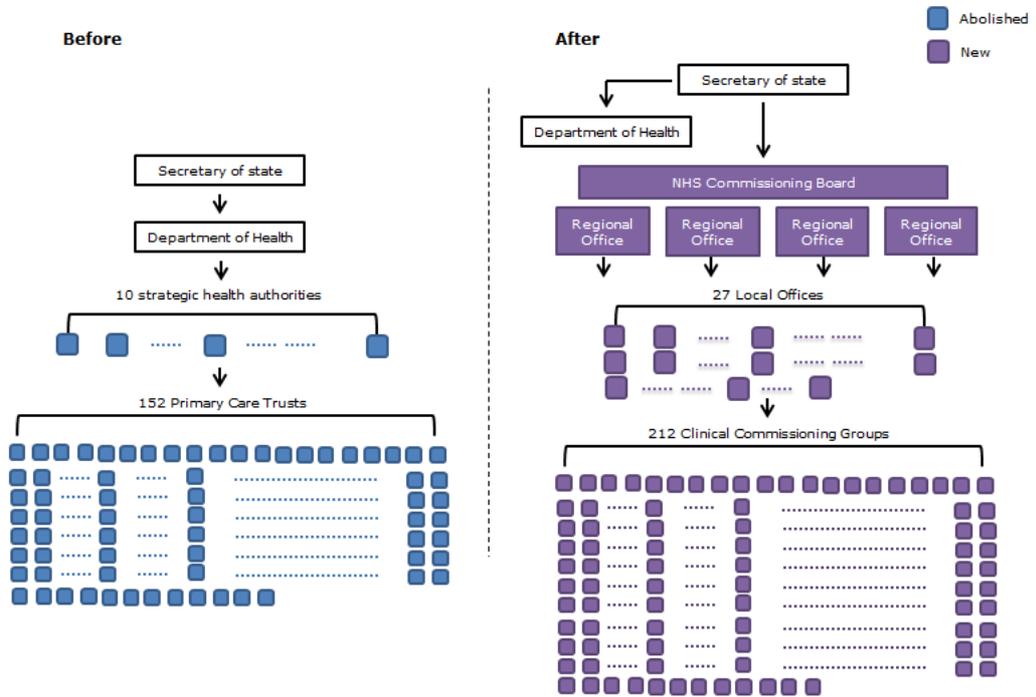
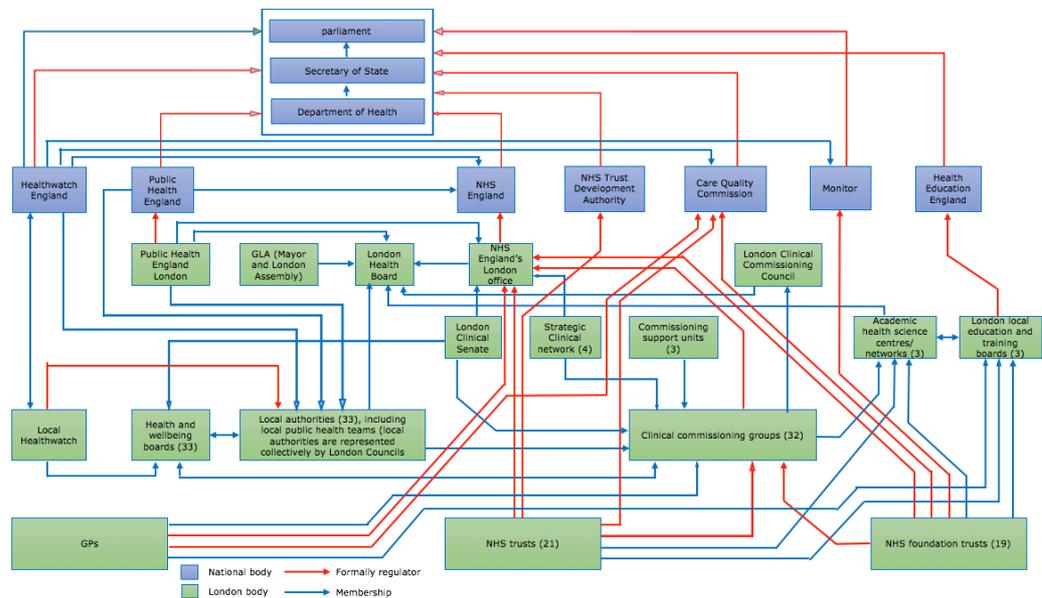


Figure 8-2 Relationships among healthcare bodies in London



In this respect, there is neither intensive provider-side competition nor economic efficiency created by purchaser/provider relationships as the market theory predicts. Moreover, the tariff calculation mechanism creates entry barriers for third party providers. Therefore, the weak incentives to involve providers and the government's political interventions make the system a more bureaucratic one rather than a proper market-oriented one. Rather than the political environment in the 2000s, under which the priorities were set as to promote the diversity of providers by a steady growth in funding, this study argues that the current situation is no longer a supportive environment for the development of MH PbR. However, besides the external constraints, whether PbR is worth implementing depends more upon the specific clinical context. This study argues that there is no one-size-fits-all system within the healthcare system, particularly within mental health services as discussed in next section.

8.3.2 One size does not fit all systems

Combining the development sequence of PbR in health care and the specific evaluation of PbR in mental health, this study found that one size does not fit all systems. PbR is only one of the tools responsible for promoting cost-effectiveness and quality improvement. As such, it functions well only in a certain environment rather than covering all aspects of service perfectly. This is supported by Appleby et al.'s (2012) research that attributes the complex nature of mental disorders and the unpredictability of disease progress to the factors that have caused difficulties in applying PbR in mental health.

As the interview findings indicated, one obvious reason for introducing PbR into mental health, a domain with much more challenges for PbR, is the “second-order” effect. In this respect, both the commissioners and managers noted the vulnerable situation for not being paid by PbR. Therefore, this study argues that the situation “being under PbR or in the “second-order” made PbR the second best choice for providers in mental health instead of an ideal payment system that fits in well.

8.3.2.1 PbR faces more challenges in mental health

This study demonstrated that mental health care is very different from other general health domains due to the nature of mental disorders. The latter emerges as rather complex in light of the variation in disease symptoms and treatment methods as well as the chronic characteristics that require complex multi-organisational co-operation. When it comes to the development sequence of PbR, it was firstly introduced to the elective inpatient care, given the existence of clear diagnostic markers and the high degree of within-group homogeneity. Thus the study argues that compared to acute illnesses, mental disorders are more complex and vague, which makes PbR less suitable to this arena. Moreover, compared with over 1,500 HRGs in acute services, there are only 21 clusters under the MHCT, which raises concern about the low within-group homogeneity and therefore, the inevitable high variations in patient needs and interventions within one cluster.

Additionally, this study also found that there is a high variation in interventions and clinical skills among different geographic areas or even among organisations within one area. Confirmed by *Five Year Forward View* (NHS England, 2014), there exist

variations in intervention and cost between areas, which indicates that England is too diverse for a “one-size-fits-all” system to apply in all locations. This is particularly the case for mental health due to the coexistence of other variations in the classification system and therefore, the cost calculation system. The interview findings confirmed this argument by reflecting the participants’ preference for having a locally negotiated price rather than national tariffs to avoid financial risks.

Accordingly, this study shows that the complex nature of mental health services and the large variations in service provision brings challenges to the development of MH PbR as a policy, which was designed with an intention to stimulate efficiency and quality by nationally fixed tariffs and unified standards. In other words, the decision to replace the Block Contract with PbR in mental health emerges as more of a political financial consideration in lieu of one with much greater practical effectiveness. However, this study was also aware that this does not necessarily lead to “a thousand flowers bloom” situation. It is still important to have a standardised system to indicate evidence-based treatments (Miraldo et al., 2006). As such, this study argues that the move from the Block Contract to a more transparent system is one step in the right direction, although the initial problems need addressing, and a combination of the two is needed.

8.3.2.2 The mental health payment system should be both standardised and flexible

According to the research findings, the Block Contract is safer as a payment method regarding cost control and financial stability when compared to MH PbR at the current stage.

Nevertheless, the study also appreciates the indirect advantages brought by MH PbR to the clinical aspect: the transparent information system.

This study reviewed the political intent to replace the Block Contract with PbR during the Modernisation, based upon which it attributed the establishment of evidence-based health care as the highlight of the NHS evolution. The interview findings comply with the theoretical evaluation that MH PbR helps to build a transparent information system in acute services, which is ultimately beneficial to good quality services. This corresponds to Marshall et al.'s (2014) report that the non-price mechanisms improve service quality regarding data collection, coding and reporting. The fieldwork findings showed that both the commissioners and providers regarded the transparent information system as the most obvious advantage of implementing PbR in mental health in light of the current absence of measurement instruments subject to both the demand side and the supply side. Underpinned by the NHS's strategy (Department of Health, 2010a), this study found that the establishment of a standardised process was believed to be of theoretical benefit regarding promoting resource utility. Drawing on the evaluation of the NFCAS in Chapter 5 that indicates the feasibility of managing mental health services in a standardised way, this study argues that the case-mix principle is feasible and helpful to facilitate healthcare delivery in mental health and thus worth implementing, although the conceptual and constructional flaws of the current classification system await addressing.

In summary, on the one hand, the PbR payment system offers the potential to fit acute services while simultaneously proving

less practical in relation to mental health, at least by the time this study took place. On the other hand, the Block Contract neither serves the purpose of creating a health care system that is sustainable nor it is aligned with the demands of today's population. Therefore, this study proposes a mix of both the Block Contract and MH PbR: using the refined MHCT classification system to guide clinical services while keeping the Block Contract as the payment method.

8.3.3 Consider trade-offs between objectives and the inevitable consequences

Based upon the empirical findings, this study contends that one policy always comes with a compromise. In particular, by comparing the centralisation and decentralisation models, it shows that the top-down management and the bottom-up decision-making strategy have both pros and cons; the targets intended to help drive up efficiency turned out to be lacking feasibility; the reorganisation of the NHS and implementation of PbR intended to address austerity, but has raised concern about the increase in total costs; and the empowerment of patients' rights raised some concern about the potential side-effects that devalue its validity to accurately measure healthcare services. This shows agreement with Dunsire's (1978) idea of "the implementation gap" that reveals the wide existence of gaps between theory and practice. Hence, this study demonstrates that it is important to consider trade-offs between objectives and the inevitable situations.

8.3.3.1 National guidelines vs. local autonomy

Similar to the concern regarding the mismatches between nationally fixed tariffs and individual providers' actual costs, the balance between the centralised guidelines and the local autonomy calls for attention.

Chapter 2 reviewed the development of the NHS reforms and demonstrated the NHS's oscillation between the centralised regulatory strategy and the decentralised regulatory strategy. By the time this study took place, the Coalition government had returned to the internal market with emphasis on local commissioning. The interview findings confirmed that contracts were set based upon local negotiation and the commissioners suspected the price would continue to be determined locally. However, the interview findings attributed the lack of centrally set guidance to one reason responsible for the low accuracy of data and the difficulties in commissioning. This study thereby points to the potential risk of a decline in quality resulting from the poor quality data derived from an inaccurate method of collection and calculation. Specifically for some areas, a lack of support from accurate data, together with the local commissioners' lack of capacity of commissioning, might lead to a situation that the locally negotiated prices are based upon poor data (not based upon the national pooled data) that do not reflect current or efficient costs, which risks a decline in service quality (Marshall et al., 2014).

This study also appreciates the importance of the bottom-up management strategy, especially in a field where there exists significant geographic diversity. In this respect, this study highlights the importance of considering regional differences and thus providing localised mental health services. The

interview findings demonstrated two main reasons for frontline clinicians' reluctance to engage, consisting of the gaps between policies and local realities and the intensively-changing policies. This shows agreement with the findings of *Five Year Forward View* (NHS England, 2014), which attributes the negative consequences of a highly-centralised national management strategy to a lack of local involvement and a lack of sensitivity to local circumstances.

Under such circumstances, this study suggests a balance between top-down management and bottom-up decision-making processes: the government provides general guidelines for local authorities' reference simultaneously empowering local authorities to set rules according to local realities. This complies with the reform direction proposed in *Five Year Forward View* (NHS England, 2014).

8.3.3.2 National targets vs. frontline realities

This study found mismatches between targets and the frontline practice, according to which it argues that targets with good intentions may lead to a decline in service quality leaving patients to suffer the consequences.

Besides the targets, such as "four successful contacts per day" for the double-running system, some targets set as preparatory work for the forthcoming PbR were regarded as lacking feasibility in daily practice. For instance, with the intention to improve efficiency to address the bed shortage in secondary care, frontline clinicians were required to review the patients in C1-C3, C7 and C11 in order to decide an upgrade or discharge. The interview findings pointed to two problems that make these

targets less feasible at the current stage: 1) the long stay patients have developed a dependency on the clinical staff and the system that had promised them a lifetime of care, which makes the discharge difficult and problematic given the importance of mutual trust between doctors and patients to mental health services; and 2) the fragmented services between primary and secondary care impedes the delivery of integrated care. The splitting perspectives between the commissioners and frontline clinicians reflect the mismatches between the political intents and the practical realities. Moreover, this is not a single case during the implementation of PbR in mental health. Considering the fact that the mental health inpatient system was running over capacity, the interview data revealed that both the commissioners and managers regarded closing beds as a way to protect providers from deficits. This complies with the figure indicating there has been an 8% reduction of mental health beds since 2010 (O'Hara, 2015). However, this further intensifies the bed shortage in a context of increasing demands. A report from the Royal College of Psychiatrists (2014) presents the results derived from conducting a survey with 575 trainee psychiatrists. The report reveals that 80% of the participants have sent a patient outside the local area for a bed, and 28% have sent a critically unwell patient home because of the bed shortage. The Care Quality Commission (2015) echoes this by arguing that the delays in admission and the high level of occupancy negatively affect the quality of mental health services. Mark Winstanley, the chief executive of the charity Rethink Mental Illness, further discloses the fact that people choose to go to A&E when they are in a crisis as a means in response to the bed shortage in secondary mental health services (O'Hara, 2015). This, in turn, increases the burden to A&E as a collateral consequence.

Beyond mental health, there has been great concern about other targets during the implementation of PbR in acute services as well. As previously discussed, this study questions the extent to which the efficiency improvement could be attributed to the implementation of PbR in acute services given the external incentivising targets, such as maximum waiting times. In other words, the strength of the national targets has been credited to their effectiveness on efficiency promotion. This complies with Connolly et al.'s (2011) research comparing four countries in the UK (England, Scotland, Northern Ireland and Wales) between 1996 and 2006. However, distorted behaviours have been noted under such political pressure. As reported by the Telegraph (Donnelly, 2009), patients were forced to wait in ambulances outside the emergency department to meet the targets of treating patients within four hours.

By noting the emergence of the "game for workload" behaviours, this study points to two side effects resulting from the mismatches between targets and frontline realities. Moreover, the "box-ticking" exercise does not only happen in the implementation of MH PbR, but it has also emerged during the implementation of CPA. Rogers and Pilgrim (2001) attest to the existence of the "box-ticking" behaviours by attributing it to a similar reason that there is a mismatch between the broad strategy and the vagaries of actual practice. These behaviours reveal that the mismatches have compromised service quality by creating the wrong attitude under political pressure. Furthermore, the excessive emphasis on efficiency goes against frontline professionals' value, thus resulting in their reluctance to engage. In this respect, in recognition of the fact that the government's political targets often concentrate on one area at the expense of others, this study calls for attention to these

unintended consequences to improve frontline clinical services rather than focusing on hitting targets.

8.3.3.3 Cost saving objectives vs. initial instalment

Chapter 2 discussed the reasons for the Coalition government's return to market and privatisation by highlighting the significant financial risks and the increasing demands the government was facing. However, by taking account of the financial pressure, as well as the requirement of initial investment, this study reminds policymakers to make a cautious decision by considering additional costs alongside the implementation of MH PbR.

By reviewing the development of PbR in acute services under the Labour government, this study revealed the significant costs resulted from the large-range reorganisation of the NHS, the initial instalment of the PbR system and the subsequent transaction costs. This conforms to Paton's (2014) argument that the one-off and start-up costs are high for establishing a market in the previous four major reforms. This study revealed that it was this unprecedented level of governmental investment that facilitated the successful implementation of PbR in acute services. Nevertheless, it also found that these additional transaction costs were largely ignored in the previous studies that evaluated the impacts of PbR on acute services. The official estimate of the cost for the latest reform has reached £3bn since 2010 (Paton, 2014). This is consistent with Walshe's (2010) estimation of the expense of the NHS reorganisation (between £2bn and £3bn). Notwithstanding the significant amount of investment in the NHS, the implementation of PbR in mental health has been delayed. Furthermore, by identifying the driving factors for its delay, this study argues that more

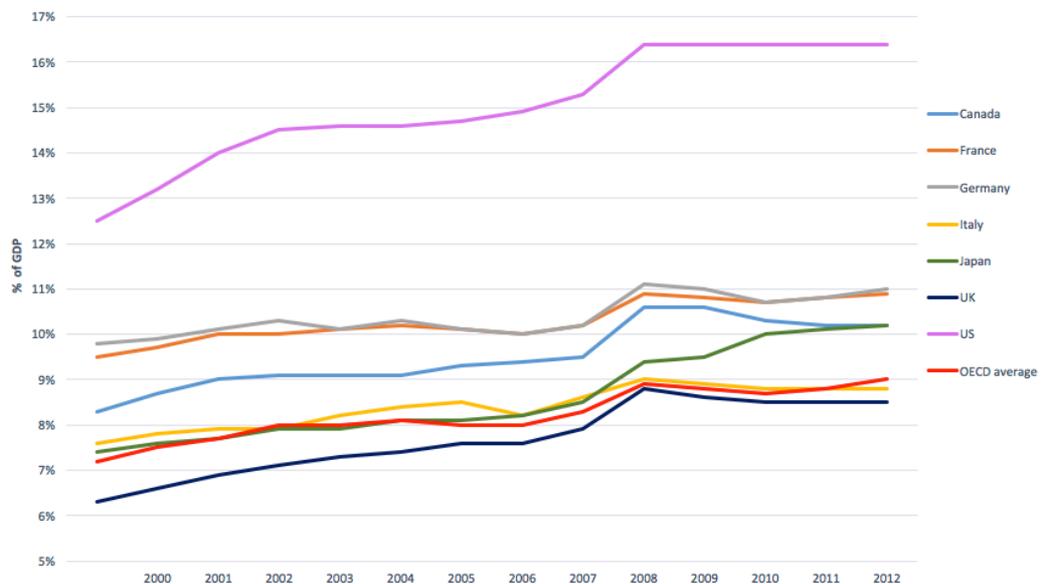
investment is needed for the development of the classification system and therefore the project as a whole.

This study demonstrated that the complex nature of mental disorders determines the difficulties in developing a valid integrated clinical classification system. The interview findings highlighted that some subsystems, such as the HoNOS and the quality measures, need further testing and refinement. The development, test and refinement of the system in turn requires greater start-up financial input. The establishment of external support systems, such as quality monitoring and IT system, also require a considerable investment. Even after establishing the MH PbR payment system, the complex transaction costs derived from data collection, commissioning, monitoring and enforcement have been estimated (in 2005) as £40m to £60m a year (Marshall et al., 2014). All of these estimations contribute to the fact that the development of MH PbR as a part of the further reform, requires more financial input than what has been invested in acute services, which conflicts with the political intent to cut total expenditure in this area.

It is also worth noting that the amount of the expenses used for the NHS reforms becomes more significant when compared to the total limited budget. Figure 8-3 displays the total health expenditure as a share of Gross Domestic Product (GDP) across all seven G7 countries and the average of 34 OECD countries between 2000 and 2013. As the figure displays, despite the Labour government's significant investment in the Modernisation of the NHS, the British government had been spending the least on health care as a share of its GDP among the G7 countries. It had also been lower than the OCED average level in this period. Furthermore, the expenditure has started to

drop after it peaked in 2009 when the QIPP was released. Based upon *Five Year Forward View* (NHS England, 2014), Shaw (2015) points to a continuing drop to under 7% by 2021, which is also seen as miserly when compared to the EU average.

Figure 8-3 British healthcare spending compared to G7 countries and the OECD average (Organisation for Economic Co-operation and Development, 2015)



Therefore, this study questions the political decision to conduct a radical financial reform in mental health, which requires a significance amount of investment under such a limited budget for health care. It raises questions about whether there is a more cost-effective way to increase the utility of the limited budget, particularly considering the lack of solid evidence of the impact of PbR in acute services. In this regard, this study suggests that additional costs should be considered alongside the potential efficiency gains from implementing PbR in mental health, particularly considering a more complex system it targets in a context of austerity.

8.3.3.4 Patient choices vs. quality improvement

This study found that devolving power to patients failed to serve its theoretical intention to promote service quality, considering the conflicting interests of clients, purchasers and providers, in addition to some patients' lack of ability to make rational choices.

According to the theoretical analysis in Chapter 2, another fundamental assumption of the market theory is that clients have comprehensive information regarding products and thus can make rational decisions considering both quality and price. Nevertheless, in health care, patients act as service users to choose services according to their best interests, while commissioners act as purchasers to buy a service on behalf of patients. According to Fotaki et al.'s (2008) report, patients are more willing to rely on a trusted practitioner to choose the organisation and the treatment on their behalf. However, conflicting goals have been noted between patients and commissioners, since commissioners focus on maximising the utility of resources at a general level, while patients consider receiving best-individualised treatments as the priority. It corresponds to Dixon et al.'s (2011) perspective that agents acting on behalf of patients have not been effective when considering patient preference and price separately. Moreover, in contrast to the precondition of the market mechanism that a wide range of providers compete for purchasers' contracts as discussed in Chapter 3, the interview findings presented a collaborative relationship between commissioners and NHS providers in mental health. In other words, even if commissioners take patients' best interests as the priority, they are not able to use the economic mechanism to choose the providers with higher quality. Thus this contradicts the presumption of *Money Follows the Patient* (Secretary of State

for Health, 2002) that requires a sufficient amount of candidate providers. Moreover, the interview findings indicated that the information asymmetry between providers and commissioners make it difficult for commissioners to accurately evaluate healthcare services and thus make rational decisions, which shows agreement with the findings of Greener's (2002) research. The difficulties in evaluating service quality further increases the risk of compromising patients' interests under financial pressure. As concluded in Chapter 3, the fundamental idea behind PbR risks a decline in quality since it has been brought into question whether professionals are professional enough to maintain patients' best interests when taking financial issues into consideration, especially under the current austerity. Under such circumstances, this study concludes that the patient-commissioner relationship, the current purchaser-provider relationship in mental health services, together with the initial flaws of MH PbR, have impeded *Money Follows the Patient* (Secretary of State for Health, 2002) from performing its function as an incentive for improving service quality.

Moreover, this study considered the relationship between patients' opinions and their best interests, according to which the study questions to what extent patients' opinions should be valued. The interview findings confirm that participants from all three interest groups valued patients' opinions by indicating the importance to understand patients' feelings in mental health services. However, this study also notes the concerns about the validity of patients' opinions given the special nature of mental disorders: there are always some patients who do not want to be treated with mental health services, while others would overestimate their severity and thus require excessive care which is not the standardised interventions. This study thereby

draws attention to the gap between patients' opinions and their real needs, particularly in mental health.

In this respect, this study reveals the biases of patient opinion and thus suggests taking account of both the objectives of devolving rights to patients and the inevitable consequences of doing so.

8.4 Implications of the research design

Besides the implications for policy analysis as discussed above, the research design and the adoption of the GTM principles also have proved fruitful. The adoption of "administrative anthropology" as the analytical framework has yielded a multi-angle perspective towards the MH PbR policy in terms of its initiation, formulation and implementation. In the fieldwork stage, the employment of the GTM principles has harvested rich information in relation to the implementation of the MH PbR policy. In this regard, the subsequent subsections discuss the utility of the research design.

8.4.1 The utility of the analytical framework

This study utilised Glennerster et al.'s (1983) "administrative anthropology" as the analytical framework. Hogwood and Gunn (1984) highlight the importance of understanding policy-making as a learning process and appreciating each stage of the process when conducting policy evaluation. Referring to the previous research, Hunter and Wistow's (1987) study pays more attention to the initiation and formulation stages of the policy-making process whereas Lipsky's (1980) "street-level

bureaucracy" theory appreciates the importance of frontline situations to implementing a specific policy. Therefore, to evaluate the MH PbR scheme in a comprehensive way, this study investigated the initiation, formulation and implementation stages using a combination of forward-mapping and backward-mapping approaches. This also conforms to Hogwood and Gunn's (1984) categorisation of the general reasons for the failure of a particular policy – bad policy, bad execution and bad luck.

By looking at the fundamental theory, the Quasi-market, the findings have served two major functions. Firstly, they demonstrated the political intents behind PbR, which facilitate the following comparison between the political intents and the frontline realities. Secondly, the findings demonstrated the fundamental flaws underpinning the policy, which indicated the insufficient understanding of the problems to be solved and the over-optimism of the cure. Therefore, the evaluation of the underpinning theories suggests that the PbR policy is poorly designed at the fundamental level.

The theoretical evaluation recontextualised PbR in mental health by concerning the concept and construction of the classification system. The analysis findings demonstrated its failure to serve the purpose of accurately assessing patients' needs for care to ensure the within-group homogeneity and between-group heterogeneity of the classification system. The initial problems of the MHCT and the HoNOS together with gaps between the two indicated a low validity and reliability of the derived frontline data. The theoretical flaws of the cost calculation mechanism revealed its inability to serve the initial intentions to save costs and increase efficiency. This in turn

reflected the system designer's failure to accurately translate the general intents into workable forms. In this regard, the evaluation of the application of the commodification/standardisation of mental health services indicates the MH PbR policy is poorly formulated.

The fieldwork findings showed agreement with the arguments from the theoretical evaluation. The findings, on the one hand, discussed the practical obstacles in executing the classification system in mental health and, on the other hand, outlined the external constraints that adversely affected its implementation, which could be attributed to "bad luck" according to Hogwood and Gunn's theory (1984). The empirical evidence revealed the gaps between the political intents and the frontline realities, which highlighted the importance of field-level workers to policy delivery, as well as the importance of the political context in which frontline staff operate.

The combination of forward-mapping and backward-mapping approaches has offered a multi-level and multi-angle investigation of the process whereby the political intents were translated into clinical outputs through the formulation and implementation of the MH PbR scheme (Hunter and Wistow, 1987). By exploring the policy-making and service-delivery process, this study has identified the variables and factors that have hindered the implementation from three different levels, facilitating the understanding of the gaps between the initial intents and the practical outputs. Besides analysing the drawbacks of this particular system, this study has also highlighted the impacts of the central-local collaboration upon MH PbR in general, which may contribute to the future policy evaluation.

8.4.2 The utility of GTM principles

The study applied the principle of Grounded Theory Methodology in conducting and analysing the semi-structured interviews, the primary approach for the fieldwork. In light of the previous theoretical analysis of the initiation and formulation of the MH PbR policies, some key issues were identified in a top-down order in advance to guide the design of interview structure. Nevertheless, although the analytical model could not be called “pure” GTM, it employed the principles of GTM, including bottom-up concepts construction, constant comparison, theoretical sampling and memo writing. Open questions were adopted to encourage participants to express their perspectives freely in order to assist in the generation of new concepts. The application of the principle of Plan-Do-Check-Adjust (PDCA) loop in conducting interviews reflected a flexible bottom-up data collection process, which provided sufficient information from the individual participants to foster a deep understanding of their perspectives.

The GTM principles were utilised in the bottom-up process of data analysis. Since the interviews targeted key participants from three different interest groups, the process of breaking transcripts into nodes and subsequently merging nodes into concepts facilitated both a vertical and horizontal comparison of data. Themes generated from the collected data guided adjustments to the content of the subsequent interviews, although the general structure remained unchanged. The themes were further tested in the subsequent interviews according to the PDCA principle. Given the bottom-up nature, the codes, or even concepts, arranged at the beginning may not be accurate or making sense, therefore, the constant comparison between results and new findings intra- and inter-

transcripts served as a backtracking mechanism to ensure the validity of the interview contents and findings. In particular, regarding the comparison of the perspectives of participants from different interest groups, the different, or even conflicting, perspectives enlarged the comprehensiveness of findings subject to a specific objective.

The bottom-up data analysis followed the evidence-based principle. The relationship between codes and the corresponding concepts in addition to the theories, provided a transparent way of illustrating how theories were generated, making the findings more valid and reliable. Drawing upon the nature of the NHS ethics requirements, it was not viable to conduct a “pure” GTM study that would have allowed for a more flexible information collection process and deeper understanding. However, the combination of top-down theoretical analysis and bottom-up interview analysis has proved fruitful in terms of expanding the practical knowledge in relation to the target issues, which is more efficient under tight time constraints.

8.5 Limitations and future implications

In this section, the limitations and future implications of the study are discussed from four main aspects: the imperfection of the research design, the limited sample selection, the limited generalizability and implications for future research.

8.5.1 The imperfection of the research design

Mixed methods were employed in this study, combining both

qualitative and quantitative approaches. Within the three-step investigation, the theoretical analysis and the semi-structured interviews were employed in the first two stages, whereas the quantitative approach of using online surveys was adopted in the last phase mainly for a confirmatory purpose. As discussed in Chapter 4, the benefit of employing triangulation is to compensate for the defects of each single method by counterbalancing the strength of the other in order to achieve intensiveness (in-depth findings derived from qualitative methods) and extensiveness (generalisable outcomes derived from quantitative methods) (Jick, 1979). In health care, the statistical analyses of experiments or secondary data are the methods most prevalently adopted to identify the statistical relationship between variables, or explore the determining factors and the way they influence the variables (Fossey et al., 2002). However, due to the delayed status and the lack of sufficient data, it was not feasible to conduct statistical analysis of medical records or finance-related data. In this respect, the study was not able to evaluate the impacts of PbR on cost, volume and quality in a direct way. Rather, impacts on cost and quality have been mainly evaluated based upon rating scales according to participants' own subjective value systems.

Indeed, the ideal way to precisely quantify outcomes is to conduct a longitudinal analysis comparing the differences in cost, volume and quality before- and after- implementing MH PbR. Nevertheless, the systematic analysis of a particular policy requires a collective assessment of policymaking outcomes, which can only emerge over an extended period (Schön and Rein, 1994). As discussed in Chapter 2, the past decade has witnessed four radical reforms in health care. One of the reasons for the frontline clinicians' reluctance to engage in the

implementation of MH PbR has been attributed to the quick disappearance of policies. This study pointed to the fact that there are many policies disappearing before they had an impact on healthcare services. Williams et al. (2002) attribute one of the reasons that evaluations are often ignored by policymakers to the desynchronisation between policy-making and evaluation. As Hogwood and Gunn (1984) suggest, the appropriateness of a methodology is determined by the purpose of the evaluation. In this respect, this study serves as a real-time evaluation to present early outcomes of the implementation of PbR in mental health and therefore, offers the corresponding suggestions for the incremental adjustment subject to the mechanical flaws of the system. The evaluation this study conducted in the early stage may provide implications for future rigorous statistical analysis when high-quality data is available. The comparison awaits the full implementation of the payment system and the establishment of a comprehensive quality measurement system.

8.5.2 Limited sample selection

This study involved 12 participants for the semi-structured interviews and 51 participants (38 were considered valid after screening the responses) for the online surveys. Regarding the interviews, as Ellis (2010) reveals, the sample of the interview has to be small, or analysis could turn out to be cumbersome, especially with the snowball-sampling principle. In this respect, the small sample has inevitably affected the representativeness of the study, given the requirement of depth. Additionally, considering the current condition that PbR has not been officially implemented in mental health as of yet, it is a comparatively less-explored area. The nature of mental disorders, together with the newly established classification system, increased the

complexity of the study, especially considering the lack of sufficient training at the current stage. It therefore, restricted the entire sample population, which refers to those highly-professionalised with a deep understanding of the new system. Moreover, the research subjects, including commissioners, hospital managers and frontline clinicians, have busy schedules due to the demands of their professions. These factors impeded the study from obtaining a larger sample.

As discussed in Chapter 4, without access to the sample population, randomised sampling was not an option. In this respect, the only viable way was to apply a stratified snowball sampling method to obtain access through contact with the participants previously engaged in the semi-structured interviews. Despite setting the form of the survey as an online questionnaire rather than posted questionnaire considering the low-response rate of posted questionnaire, the sample of online surveys was small. Given the complexity of the research topic, the questionnaire results found that some key participants, especially GP commissioners and frontline clinicians, lacked a deep understanding of MH PbR implementation, which was reflected in the missing values and “not known” options. In this regard, this study noted that those key players with brief or even little understanding of this system are more likely to ignore the email invitation at the time they received it, which in turn limits the number of response. Therefore, subsequent studies may obtain a larger sample when MH PbR is fully implemented, and key players will be more likely to have a deeper understanding of MH PbR.

8.5.3 Limited generalizability

The depth of the study limited the amount of the engaged participants and thus hindered the representativeness of the study. To increase the number of responses, Derbyshire NHS FT was set as the fourth research site in addition to the three institutions in Nottinghamshire. The reason for choosing Derbyshire NHS Foundation Trust was the consideration of comparability. In light of the existence of geographical and organisational variations in performance discussed in Chapter 2, comparability is important to the validity and reliability of survey outcomes. Nottinghamshire and Derbyshire share similar geographic characteristics regarding health conditions, risk factors and the level of mental illness of their local populations. The treatment and the corresponding outcomes provided by the trusts within these two neighbouring areas are similar and at the average level of trusts throughout England. In this respect, the survey outcomes were considered able to represent the current condition of Nottinghamshire and Derbyshire. In other words, the findings were not able to represent the current condition in other areas of England, particularly in a general context of power devolution according to which actions such as contract negotiation and care pathways are undertaken locally. Generalizability would be increased if permission to conduct a nation-wide online survey and the access to contact appropriate participants could be granted. However, since research permission was signed by each organisation, under the pressure of the time constraint, the study was designed to focus on investigating the current implementation in Nottinghamshire as a case study rather than seeking nation-wide generalizability. In this respect, the study provided implications for future investigations on a nation-wide level.

8.5.4 Implications for future research

For now, the available evidence indicates that the government tends to replace the market with the integrated service management while continuing to devolve power to local authorities (NHS England, 2014), although detailed reform strategy still awaits further information. As previously discussed, this study suggests a rigorous evaluation of new policies/targets beforehand and a cautious consideration of any further reform to avoid destabilising the NHS. In this respect, alongside the implementation of support policies, such as reorganisation, further devolution and reallocation of the resources and responsibilities, more research is needed on the application of PbR in mental health, considering the current political context.

The devolution of power to local authorities may further reduce the theoretical significance of MH PbR regarding facilitating collective data management by applying the nationally set tariffs and standards. How the government will balance between localised management and nationwide standardised services (equality) awaits further investigation. Further study may reap different findings regarding issues such as how and to what extent the establishment of new policies will affect the implementation of MH PbR; how and to what extent the combination of the health budget and the social care budget will affect the payment system; whether the local-based management will lead to a “thousand flowers bloom” situation or whether the integrated care will promote further standardisation of mental health services; whether and how the refined MH PbR will help to control costs, improve efficiency and quality in the new political context; and how and to what extent granting power to GPs and patients will help improve mental health services.

8.6 Implications for future policy development

By considering policy-making as a learning process and appreciating the utility of policy evaluation for providing implications for future policy-making (Hogwood and Gunn, 1984), the findings gleaned from the three-stage investigation, particularly those derived from the interviews, served to inform further messages in regard to the general lessons from launching the MH PbR policy. Despite recognising that the process of decision-making is a rapidly changing, flexible and chaotic process (John, 2012), there are at least two general lessons for developing a more realistic policy, which include: the policy-making process should be consistent, and policy should be tested first.

8.6.1 Policy should be consistent

This study revealed that the disjointed reforms with continuously changing policies not only slowed down the development of healthcare services, but also, more importantly, they destabilised the NHS and reduced the confidence of frontline staff. As illustrated in Chapter 2, the Thatcher and Major government adopted a decentralisation strategy to encourage provider-side competition under the Internal Market. The establishment of “modernisation of the NHS” implies that everything in the previous reform was of dubious value (Pilgrim and Ramon, 2009). In this respect, the Blair government took a third way to build an evidence-based health care system relying on centralised management supported by steady investment. However, the Liberalisation of the NHS returned to the Internal Market logic by regarding the centralised managerial strategy no longer suitable for a system under financial pressure. This study noted that these reforms came

with four reorganisations and intensively changing policies. The establishment of the GP fundholder strategy was abolished under the Blair government and PCGs were replaced by PCTs. The star-rating system aiming to reward Foundation Trusts was abandoned only six years after it was introduced at the beginning of the Modernisation. Despite the commitment the Tory party made the decision to not initiate another radical reform prior to the election (Timmins, 2012), the Coalition government returned to the "market": abolished the miscellaneous arm's-length sectors and replaced PCTs with CCGs to promote the provider-side competition. However, this study recognised a lack of hard evidence to support the Coalition government's turning back to the market besides the significant financial investment put into these radical reorganisations. This shows agreement with Hood's (2011) argument regarding the absence of compelling evidence indicating the relationship between returning to the market and the improvement of outcomes. Again, the recently released policies have dropped the idea of competition and refocused on providing integrated care (Monitor, 2014, 2015).

This interview findings revealed that the fast-changing political strategies brought different and fast changing policies/targets to the frontline. Given the lack of sufficient and up-to-date training, the fast-changing policies resulted in two main adverse outcomes. On the one hand, policies/targets were implemented before being tested. Among them some policies, such as completing four successful contacts every day and discharging all C7 and C11 patients back to primary care, did not comply with clinical realities and therefore, created a heavy burden for frontline clinicians. On the other hand, policies had disappeared before they came into effect. As a result, frontline clinicians

wasted time completing paperwork that finally turned out to be meaningless. Consequently, this has resulted in an increasing workload brought about by fast-changing reforms, which took up time that could have been spent on treating patients or improving professional skills. This weakened their willingness to be involved in another radical reform, especially considering the significant gap between theory and practice. This finding conforms to Ham et al.'s (2013) study regarding the distraction of attention that should have been paid to quality improvement as an inevitable adverse consequence of reorganising the NHS on such a frequent basis.

Therefore, this study argues that the oscillation between hierarchy and market led to disjointed reforms with fast changing policies that hindered the development of the healthcare system. This is particularly damaging given the current context of austerity in which the government may not be able to afford another radical reform. As Lindblom and Woodhouse (1993) suggest, policymakers should make incremental adjustments to the existing policies based upon sufficient foreknowledge of the context rather than taking a giant step into an unknown future. In this respect, this study suggests ceasing the permanent NHS revolution and focusing on refining the existing healthcare system.

8.6.2 Policy should be tested first

The interview findings revealed the existence of a cautious attitude from both the commissioner and the provider sides towards this newly developed system upon considering the constructional flaws of the subsystems. It has been observed that the providers had an impression that policymakers were

making decisions based on gut feelings with a lack of sense of the practical reality, which complies with O'Hara's (2015) perspective. Relevant policies such as choosing the HoNOS as the standardised measurement to assess every patient, filling complex checklists as mandatory work subject to every patient and discharging all C11 patients from secondary care, were seen as more harmful than beneficial. This study noted that the care pathways and quality measurements were under preliminary testing, which was seen as helpful regarding discovering problems and making targeting revisions. However, the interview findings indicated the absence of strict tests: RCT is the only known method that could effectively evaluate the validity and reliability of one intervention/measurement in the healthcare domain, however, there often lack rigorously designed RCTs in mental health. This study therefore, argues that the government was too optimistic about the implementation of PbR in mental health with insufficient consideration of the undesirable, but inevitable consequences based upon the arguments, or even complaints, from the frontline. The inadequate understanding of the problems to be solved and the over-optimism of the cure resulted in the lack of theoretical validity of the policy, which indicated its inevitable failure to deliver the intended outputs (Bardach, 1977).

As discussed in Chapter 1, the success of implementing PbR in mental health also relies upon external support settings, which also require tests. It has been noted that the government tends to design policies and conduct reforms before carrying out rigorous pilot tests to evaluate their validity and feasibility (Public Administration Select Committee, 2009). According to Walshe (2010), the reform of replacing PCTs with CCGs has not been piloted. The assumption that the NHS would save more

than 45% of the management costs by abolishing PCTs and SHAs was not seen as a result derived from a rigorous evaluation. The results of the NHS Confederation's (2011) interview study indicated that by then, less than 20% trusts had undertaken clustering, and more than 80% trusts could not meet the 2011 deadline for clustering all service users into diagnostic categories. Besides testing clinical service quality using a rigorous assessment, this study appreciates the importance of having valid and reliable inspection approaches. Only when the validity and utility of the inspection and regulation approaches are evaluated and confirmed, can the government have a clear understanding of the extent to which one policy contributes to improving service quality and what the unintended consequence may be. This complies with Lindblom and Woodhouse's (1993) idea about the importance of having sufficient knowledge of the practical experiences in addition to future consequences.

8.7 Conclusion

There has been a historical split between acute services and mental health services regarding the nature of illness and the methods of providing treatment. The complex nature of mental disorders also determines the difficulties in accurately predicting interventions and therefore, the corresponding costs, which makes a DRG system less suitable for mental health. As a result, most developed countries have applied DRGs systems in acute services, but only a few have developed DRGs systems to manage mental health services. For countries such as Australia and New Zealand, although the governments have developed DRGs systems to classify mental illness, the payment systems are deliberately separated from the classification system due to

concerns over the potential financial risks resulting from poor data. In consideration of the lack of empirical evidence regarding the implementation of a DRGs system in mental health, this study set out to explore the English experience by unveiling some early outcomes of applying the PbR policy in mental health.

Since MH PbR has only been partly invoked as a classification system with the price calculation system under development, there was a lack of sufficient investigation to rigorously examine either the current problems of implementing MH PbR as a whole scheme in mental health or PbR's general impacts on this area. Moreover, there was a lack of compelling evidence of the impacts of PbR on cost, efficiency and quality, even in acute services where PbR fits most appropriately. Therefore, this study raised concern about the validity and feasibility of PbR itself, which further increased when taking account of the complex nature of mental disorders and the current climate of austerity. In consideration of the incomplete MH PbR system that hindered the use of longitudinal comparisons, this study mainly relied on qualitative approaches to investigate the driving factors that have caused the delay.

This study employed mixed methods to present multi-level and multi-angle perspectives on issues surrounding the design and implementation of PbR in mental health. The literature review provided background information regarding the development of PbR in the general context of a series of NHS reforms and thus outlined the research aim. The following theoretical analysis focused on evaluating the fundamental theories behind PbR at the macro level from which the research questions were derived. A three-step analysis was carried out to provide multi-angle

perspectives regarding issues surrounding MH PbR at the micro level. The outcomes were categorised and analysed separately in each chapter. Based upon the findings, the values and flaws of applying PbR in mental health, together with the significance of this study, were further discussed in this chapter.

8.7.1 Formulation of research objectives

Chapter 2 provided background information surrounding the development of PbR as a new payment mechanism replacing the previous Block Contract. It indicated that PbR is based upon the Quasi-market theory that employs the non-price competition mechanism to promote efficiency and quality, while using governmental power to oversee healthcare services. The introduction of four radical reforms indicated the disjointed policies, based upon which this study highlighted the importance of political context to the implementation of MH PbR. The introduction of the implementation process outlined the two core elements of PbR, which include the clinical classification system and the tariff calculation system. At the end of this chapter, the status quo of the delayed implementation of MH PbR is outlined, which indicated the research aim of investigating the driving factors for the delay.

Based upon the background information, Chapter 3 evaluated the application of the Quasi-market in healthcare services, particularly in mental health, by referring to fundamental theories such as professionalism and street-level bureaucracy. The theoretical analysis demonstrated that the Quasi-market failed to achieve the intended goals at the macro level, due to the fundamental conflicts between healthcare services, especially mental health services, and ordinary merchandise,

which in turn facilitated the formulation of research questions. The analysis also served to inform key objectives, such as the standardisation of tariff calculation, the standardisation of services, professionals' value systems and information asymmetry.

8.7.2 Research design and methodology

This study employed mixed methods, mainly relying upon qualitative approaches to triangulate the driving factors for the delay in policy implementation in an indirect way. The three-step analysis consisted of the theoretical evaluation of conceptual and constructional flaws of MH PbR, the semi-structured interviews exploring the participants' perspectives on the design of MH PbR and the relevant external factors from different angles, with the online surveys aiming to verify and complete interview findings. The top-down theoretical evaluation shed light upon the research direction and identified relevant key objectives for further exploration conducted by in-depth interviews. The adoption of the GTM principles in the interview data analysis enabled a flexible generation of concepts in a bottom-up order under a broad framework set by the prior theoretical evaluation. The online surveys were conducted to verify the findings from previous theoretical analysis and interview analysis.

8.7.3 Investigation of the research objectives

Serving as a bridge between the fundamental theories underpinning PbR and the practical problems occurring during its implementation, Chapter 5 contextualised PbR in mental health services and thus investigated the feasibility and impacts

of applying the standardisation principle in the clinical classification system and the tariff calculation system, respectively. This chapter developed two findings: it is feasible, though difficult, to manage mental health services in a standardised way; and MH PbR failed to serve its purpose due to the conceptual drawbacks of the classification system and consequently, the constructional drawbacks of case classification and cost calculation. The top-down evaluation indicated that the MH PbR policy was poorly formulated. This shed light upon the subsequent fieldwork that focused on investigating the implementation of MH PbR.

Chapters 6 and 7 presented early outcomes of the implementation of this policy derived from the semi-structured interviews and data derived from statistical analysis, respectively. The semi-structured interviews allowed participants from different interest groups to express their perspectives that facilitated furthering understanding from different angles. The questionnaire outcomes mainly served the purpose of verifying and completing the findings from the semi-structured interviews. In addition, Chapter 7 discussed the questionnaire outcomes by triangulated them with the corresponding findings derived from the previous qualitative approaches in order to increase the validity and reliability of the research findings. The empirical findings revealed the conflicting perspectives between the administrative-level participants and the frontline participants, which complies with Lipsky's (1980) "street-level bureaucracy" theory. It was noted that the administrative level participants held more optimistic perspectives on MH PbR given its utility as a governing instrument for collective case management, while the frontline participants were more concerned about its validity and utility

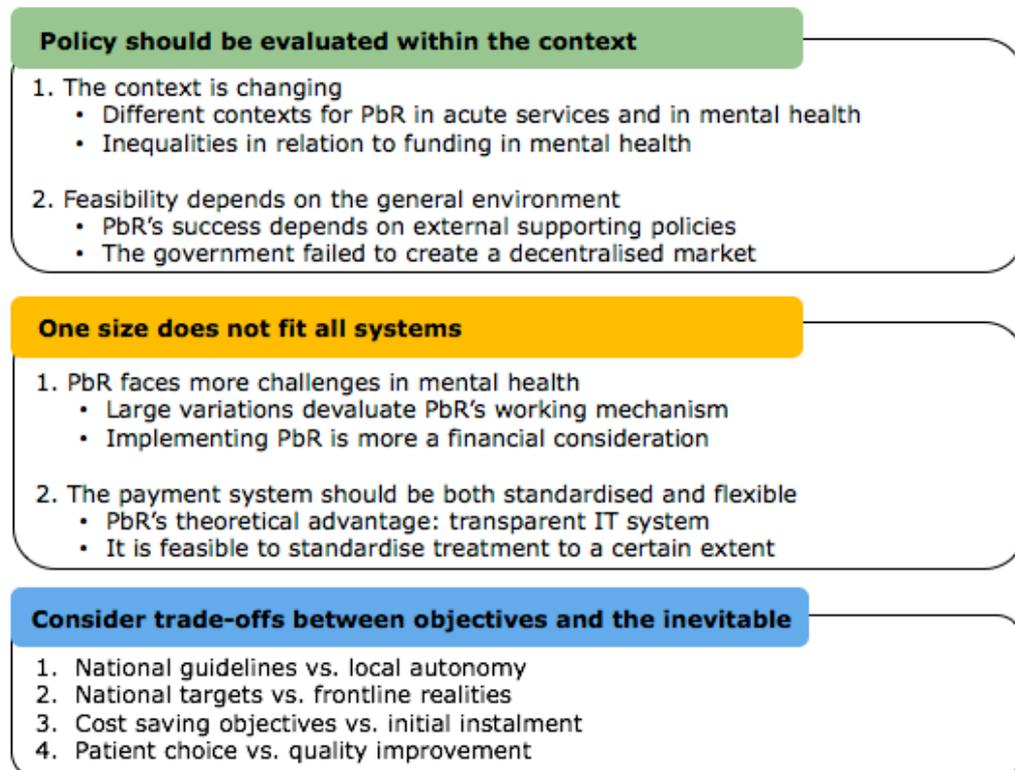
in everyday clinical practice. Regarding the research questions, the interview findings presented the current stage of the implementation of MH PbR by outlining how it affected the participants' daily work, while the questionnaire outcomes illustrated the extent of the impact of MH PbR. Subject to the research questions, the empirical findings outlined that the initial problems of the classification system, the complex nature of mental disorders, the intensively established policies, the frontline clinicians' involvement, the "gaming" behaviours, the delayed IT system and the negative attitude towards change emerged as factors responsible for the delayed implementation of MH PbR. The questionnaire outcomes revealed differences in the degree of importance and urgency of suggestions derived from the interview findings, indicating their descending order: "prioritising improving and applying care pathways", "improving clustering system", "publishing clear national direction and standards", "defining more effective quality measure instruments", "improving training" and "improving the integrity of care". In particular, the analysis demonstrated the reasons that caused frontline clinicians' reluctance to participate and the collateral obstacles which resulted from their reluctance. As an independent evaluation, these findings highlighted the necessity to address the conflicts between policies and frontline realities and reiterated the importance to prioritise frontline staff in policy-making.

8.7.4 Key findings and implications

In the current stage, this study considered the English government's attempt to implement a DRG system in mental health failed to achieve its intended goals. By combining the findings from the two-level theoretical analysis and the two-step

empirical research, this study developed three main implications in regard to the implementation of PbR in mental health, as Figure 8-4 displays.

Figure 8-4 Summary of the implications for the MH PbR policy



This study implied that policy should be evaluated within context by attributing the fundamental problem of implementing PbR in mental health to the changes in the financial and political environment. By comparing the financial contexts for the implementation of PbR in acute services and mental health services, this study pointed to the inappropriateness of predicting the implementation process merely according to its implementation in acute services. This simultaneously indicated that the current financial situation cannot afford such a radical reorganisation surrounding MH PbR. By comparing the NHS structure before and after the

Liberalisation of the NHS, this study revealed that the NHS becomes a more bureaucratic organisation rather than a market-oriented one, which leads to the government's failure to create a well-functioning Quasi-market for the development of MH PbR.

Regarding the second implication, this study argued that one size does not fit all systems by summarising the findings subject to the design of MH PbR in the formulation stage. The comparison was carried out between mental health services and acute settings in terms of the nature of services and the political context. The findings indicated that while PbR may fit acute services, it is potentially harmful to mental health, particularly in financial aspects at the current stage. Regarding mental health services, the study appreciated the feasibility of standardising treatments subject to patients' needs for care to a certain extent. By identifying the initial drawback of the Block Contract, the study illustrated that neither the Block Contract nor PbR is sufficient to achieve goals in both clinical and financial aspects. According to the current situation, the study suggested a combination of the two: on the one hand to employ MH PbR as a classification system that manages mental health services in a relatively standardised way, whilst on the other hand to keep the Block Contract as the payment method to avoid financial risks.

Regarding the third implication, this study outlined the side effects alongside the establishment of the MH PbR policy, according to which the study called for attention to the trade-offs between the objectives and the inevitable consequences. The comparison between national guidelines and local autonomy indicated the importance of balancing between top-

down and bottom-up managerial approaches. The mismatches between the national targets and the frontline realities revealed the drawbacks of the top-down management and thus called for further refinement of the targets. Based upon the argument of the changing context for the implementation of PbR in mental health, this study revealed the importance of sufficient financial investment to the success of the implementation and simultaneously pointed to the current austerity. By highlighting the conflicts between the two, this study reminded policymakers to make a cautious decision by considering additional costs brought alongside the implementation of PbR in mental health. By outlining the biases in patient opinion, this study suggested policymakers take account of both the objectives of devolving rights to patients and the inevitable consequences in light of the differences between patient-centred care and high quality/efficient services.

As an independent evaluation, this study used MH PbR as an epitome to understand the policy-making process and, therefore, offered implications for the future policy-making. This study found that the frequent change in structure and policy not only slowed down the development of healthcare services but also confused frontline clinicians, thus reducing their confidence in any future reforms. This study attempted to demonstrate that whether to adopt the hierarchy or the market-like bottom-up regulatory strategy depends upon the general environment. However, the only clear opinion is that the government should cease keeping reorganising the NHS, which would not only increase financial pressure, but also destabilise the system and undermine service quality. Besides the fact that policies tended to disappear before they had yielded any positive impact upon service delivery, some conflicted with the practical realities or

even harmed the quality of clinical services. This study thereby highlighted the importance of piloting policies and adjusting them according to clinical reality. In this regard, this study finally proposed two suggestions for the further development of policies: the policy-making process should be consistent rather than disjointed, and policies should be tested prior to formal implementation.

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Appendix 1: Interview structures

Commissioners:

1. Could you please describe your current role?
2. What is your general understanding of the implementation of PbR? Is it well designed or poorly designed?
3. Do you prefer the Block Contract or PbR? Why?
4. What is the current stage of commissioning PbR? Has there by any change in the interaction with providers? Would it be better or worse when PbR is fully implemented?
5. Has there been any change in the payment calculation mechanism? How do you negotiate with providers at the current stage?
6. How is service quality being measured? To what extent are these quality measurements related to the commissioning decisions?
7. How does PbR impact healthcare costs, volume and quality? How to define "quality"?
8. What is your perspective of the "Gaming" behaviours?
9. From your perspective, what are the driving factors for the delayed implementation of PbR?
10. How do you think these barriers might be overcome?
11. From your perspective, should PbR be implemented in mental health?

Hospital managers:

1. Could you please describe your current role?
2. Could you please describe your responsibilities in the collaboration with commissioners and frontline clinicians, respectively?
3. What is your broad understanding of PbR? Is it well designed or poorly designed?
4. Do you prefer the Block Contract or PbR? Why?
5. What is the current stage of implementing PbR? Has there by any change in the interaction with providers? Would it be better or worse when PbR is fully implemented?
6. Has there been any change in the way you collaborate with commissioners?
7. Has there been any change in the way you collaborate with frontline

clinicians?

8. Is there any other change brought by PbR in your daily work?
9. How is service quality being measured? To what extent are these quality measurements related to the commissioning decisions?
10. What is your perspective of the clustering system by comparing the MHCT to the ICD/DSM?
11. What is your perspective of the HoNOS and the collaboration between it and the MHCT?
12. How does PbR impact healthcare costs, volume and quality? How to define "quality"?
13. What is your perspective of the "gaming" behaviours?
14. From your perspective, what are the driving factors for the delayed implementation of PbR?
15. How do you think these barriers might be overcome?
16. From your perspective, should PbR be implemented in mental health?

Frontline clinicians:

1. Could you please describe your current role?
2. Please could you describe your responsibilities in the collaboration with your line managers?
3. What is your broad understanding of PbR? Is it well designed or poorly designed?
4. What is the current stage of the implementation of PbR in daily clinical practice?
5. To what extent do you feel PbR has changed the way you conduct clinical practice?
6. Has PbR changed the way you collaborate with managers and colleagues?
7. What is your perspective of the clustering system by comparing the MHCT to the ICD/DSM?
8. What is your perspective of the HoNOS and the collaboration between it and the MHCT?
9. From your perspective, to what extent do you think PbR is an effective way to improve health quality? How to define "quality"?
10. What is your perspective of the "gaming" behaviours?
11. From your perspective, what are the driving factors for the delayed

implementation of PbR?

12. How do you think these barriers might be overcome?
13. From your perspective, should PbR be implemented in mental health?

Appendix 2: Questionnaire structures

Commissioners:

Part 1: General questions:

1. How do you describe your current post?
 - A. Financing Officer
 - B. Contracting Officer
 - C. GP Commissioner
 - D. Head of Commissioning
 - E. Other (please specify)

2. Which option could best describe your major responsibilities in terms of collaborating with the providers:
 - 1) Collaboration type:
 - A. Payment negotiation
 - B. Clinical practice monitor
 - C. Multi-disciplinary coordination
 - D. No direct collaboration

 - 2) Meeting frequency:
 - A. ≥ 1 /week
 - B. 2-3/month
 - C. 1/month
 - D. < 1 /month
 - E. N/A

Part 2: Current stage of implementation

3. In order to describe the current stage of the implementation of PbR in the trust that you contract with, please tick the box of the following checklist:

	Yes	No	Not known
Currently under the Block Contract			
The deadline for Moving to PbR has been settled			
Financial incentives have been employed			
Care pathways have been implemented			

4. In order to describe the current progress of PbR implementation in the trust that you contract with, please tick the box of the following checklist:

	<50%	50%-75%	>75%	Not known
Patients have been clustered				
Cluster 1-3 & C11 patients discharged				
Training sessions provided to frontline staff				
Data collection completed				

5. In terms of your understanding of key elements in the PbR system, to what extent do you agree with the following statement? (1-5: strongly disagree - strongly agree)

	1	2	3	4	5	Not known
The Mental Health Clustering Tool (MHCT) is able to predict the standardised interventions and resource allocation.						
The MHCT care pathways provide proper guidance and enable the cost calculation.						
The HoNOS, The MHCT and the MHCT care pathways work smoothly as a whole system.						
Service quality SHOULD be properly measured.						
Service quality CAN be properly measured.						
The Patient-Rated Experience Measurement (PREM) is reliable.						
The HoNOS outcome measures can accurately represent patients' outcomes.						
The IT system is accurate and transparent.						
The commissioners and providers are in close collaboration.						
The current monitor mechanism can effectively prevent "gaming" behaviours from happening.						
Government policies are clear.						
Government policies are able to guide local commissioning activity.						

Part 3: Driving factors for the delay

6. How would you rate the following factors according to the impact on the delayed implementation of PbR in mental health? (1-5: not important at all – very important)

	1	2	3	4	5	Not known
Complex nature of mental disorders						
The ideology of clustering						
A finance-led, target-driven system						
Poor design of the MHCT						
Poor design of the HoNOS						
Credibility of the interaction between the HoNOS and the MHCT						
Incomplete care pathways						
Incomplete IT system						
Clinicians' lack of understanding						
Variations in clinical skills						
Training lack of effectiveness						
"Gaming" behaviours (up-coding)						
Government policies						
Experiences from acute services						

Other (please specify)

Part 4: General attitudes

7. Overall, do you think PbR should be implemented in mental health?

- A. Yes (skip to Q9)
- B. Hard to Say
- C. No

8. Which option can best describe the reason for your objection to the implementation of PbR?

- A. Finance and target-led system
- B. The ideology of clustering
- C. Complex nature of mental disorders
- D. Mix of all above
- E. Other (please specify)

9. Please rate the order in which the following actions should be carried out to improve the system. (1-5: should be implemented first – implemented last)

<input type="text"/>	Prioritising the improvement and application of the care pathways
<input type="text"/>	Improving the clustering system (unbundling the HoNOS from the MHCT/add more measures for clustering)
<input type="text"/>	Improving training
<input type="text"/>	Publishing clear national guidelines and standards
<input type="text"/>	Defining more effective quality measurement instruments

10. What do you think is the most obvious benefit brought by PbR?

- A. Standardised treatments
- B. Outcome and service measurements
- C. More efficient IT system
- D. The idea of cost-efficiency
- E. Quality promotion mechanism
- F. Other (please specify)

Managers:

Part 1: General questions:

1. How do you describe your current post?
 - A. Financial manager
 - B. Clinical manager
 - C. PbR trainer
 - D. Interim manager
 - E. Other (please specify)

2. Which option could best describe your major responsibilities in terms of collaborating with the commissioners:
 - 1) Collaboration type:
 - A. Payment negotiation
 - B. Clinical strategy design
 - C. Multi-disciplinary coordination
 - D. No direct collaboration

 - 2) Meeting frequency:
 - A. $\geq 1/\text{week}$
 - B. 2-3/month
 - C. 1/month
 - D. $< 1/\text{month}$
 - E. N/A

3. Which option could best describe your major responsibilities in the collaboration with the frontline clinicians:
 - 1) Collaboration type:
 - A. Direct daily clinical practice
 - B. Provide standardised training
 - C. Manage from a strategic level
 - D. No direct collaboration

 - 2) Meeting frequency:
 - A. $\geq 1/\text{week}$
 - B. 2-3/month
 - C. 1/month
 - D. $< 1/\text{month}$
 - E. N/A

Part 2: Current stage of implementation

4. In order to describe the current stage of PbR implementation in your organisation, please tick the box of the following checklist:

	Yes	No	Not known
Currently under the Block contract			
The deadline for Moving to PbR has been settled			
The MHCT care pathways have been implemented			
Quality measurements (other than the HoNOS outcome measurement) have been implemented			

5. In order to describe the current progress of PbR implementation in your organisation, please tick the box of the following checklist:

	<50%	50%-75%	>75%	Not known
Patients have been clustered				
Cluster 1-3 patients have been discharged				
Training sessions provided to frontline staff				
PbR related data collection is completed				

6. In terms of the effectiveness of key elements in PbR, to what extent do you agree with the following statements? (1-5: strongly disagree - strongly agree)

	1	2	3	4	5	Not known
The MHCT is more useful than the DSM system.						
Distinctions between neighbouring clusters are clear.						
The HoNOS is well designed and able to detect patients' needs.						
The HoNOS scores always lead to the correct clusters.						
The MHCT care pathways provide better guidance than the NICE guidelines.						
The HoNOS, the MHCT and the MHCT care pathways work smoothly as a whole system.						
Service quality SHOULD be properly measured.						
Service quality CAN be properly measured.						
Patient rated measures can accurately reflect service quality.						
The HoNOS outcome measures can accurately represent patients' outcomes.						
Government policies are clear.						
Government policies are able to guide local commissioning activity.						

Part 3: Driving factors for the delay

7. How would you rate the following factors according to the impact on the delayed implementation of PbR in mental health? (1-5: not important at all – very important)

	1	2	3	4	5	Not known
Complex nature of mental disorders						
The ideology of clustering						
A finance-led, target-driven system						
Design of the MHCT						
Design of the HoNOS						
Credibility of the interaction between the HoNOS and the MHCT						
Incomplete care pathways						
Incomplete IT system						
Frontline clinicians' lack of understanding						
Variations in clinical skills						
Training lack of effectiveness						
"Gaming" behaviours (up-coding)						
Government policies						
Experiences from acute services						

Other (please specify)

Part 4: General attitudes

8. Overall, do you think PbR should be implemented in mental health?

- A. Yes (skip to Q10)
- B. Hard to Say
- C. No

9. Which option can best describe the reason for your objection to the implementation of PbR?

- A. Finance and target-led system
- B. The ideology of clustering
- C. Complex nature of mental disorders
- D. Mix of all above
- E. Other (please specify)

10. Please rate the order in which the following actions should be carried out to improve the system. (1-5: should be implemented first – implemented last)

<input type="text"/>	Prioritising the improvement and application of the care pathways
<input type="text"/>	Improving the clustering system (unbundling the HoNOS from the MHCT/add more measures for clustering)
<input type="text"/>	Improving training
<input type="text"/>	Publishing clear national guidelines and standards
<input type="text"/>	Defining more effective quality measurement instruments

11. What do you think is the most obvious benefit brought by PbR?

- A. Standardised treatments
- B. Outcome and service measurements
- C. More efficient IT system
- D. The idea of cost-efficiency
- E. Quality promotion mechanism
- F. Other (please specify)

Frontline clinicians:

Part 1: General questions:

1. How do you describe your current post?
 - A. Psychiatrist
 - B. Psychologist
 - C. Occupational Therapist
 - D. Nurse
 - E. Social Worker
 - F. Other (please specify)

2. Which option could best describe your major responsibilities in terms of collaborating with your line managers:
 - 1) Collaboration type:
 - A. Quality check
 - B. Activity quantity check
 - C. Clinical strategy development
 - D. Quality and activity quantity check
 - E. Quality check and clinical development
 - F. Activity quantity check and clinical development
 - G. All of above

 - 2) Meeting frequency:
 - A. $\geq 1/\text{week}$
 - B. 2-3/month
 - C. 1/month
 - D. $< 1/\text{month}$
 - E. N/A

Part 2: Current stage of the implementation of PbR

3. In order to describe the current stage of PbR implementation in your organisation, please tick the box of the following checklist:

	Yes	No	Not known
Currently under the Block Contract			
The MHCT care pathways have been implemented			
Quality measurements (other than the HoNOS outcome measurement) have been implemented			

4. In order to describe your daily activity related to the implementation of PbR, please select the most suitable one in each option list:

1) How many contacts are you required to have in one day?

- A. ≤ 2 /day
- B. 3-4/day
- C. > 4 /day
- D. No specified requirement

2) How many PbR training sessions have you attended?

- A. 0
- B. 1-2
- C. 3-4
- D. 5-6
- E. > 6

5. How long do you normally spend on paperwork in one day?

- A. < 30 mins/day
- B. 30mins-1hour/day
- C. 1hour-2hours/day
- D. > 2 hours/day

6. To what extent are you confident that the Mental Health Clustering Tool (MHCT) reflects clinical activity?

- A. $< 50\%$
- B. 50%-75%
- C. $> 75\%$

D. Not known

7. In terms of the effectiveness of key elements in PbR, to what extent do you agree with the following statements? (1-5: strongly disagree - strongly agree)

	1	2	3	4	5	Not known
The MHCT is more useful than the DSM system.						
Distinctions between neighbouring clusters are clear.						
The HoNOS is well designed and able to identify patients' needs.						
The HoNOS scores always lead to the correct clusters.						
The MHCT care pathways provide better guidance than the NICE guidelines.						
The HoNOS, the MHCT and the MHCT care pathways work smoothly as a whole system.						
Service quality SHOULD be properly measured.						
Service quality CAN be properly measured.						
Patient rated measurements can accurately reflect service quality.						
The HoNOS outcome measures can accurately represent patients' outcomes.						
Government policies are clear.						
Government policies are able to guide local commissioning activity.						

Part 3: Driving factors for the delay

8. How would you rate the following factors according to the impact on the delayed implementation of PbR in mental health? (1-5: not important at all – very important)

	1	2	3	4	5	Not known
Complex nature of mental disorders						
The ideology of clustering						
A finance-led, target-driven system						
Design of the MHCT						
Design of the HoNOS						
Credibility of the interaction between the HoNOS and the MHCT						
Incomplete care pathways						
Incomplete information system						
Mixed messages regarding the implementation of PbR						
Variations in clinicians' abilities						
Training effectiveness						
"Gaming" behaviours (e.g. up-coding)						
Government policies						
Heavy workload						

Other (please specify)

Part 4: General attitudes

9. Overall, do you think PbR should be implemented in mental health?

- A. Yes (skip to Q11)
- B. Hard to Say
- C. No

10. Which option can best describe the reason for your objection to the implementation of PbR?

- A. Finance and target-led system
- B. The ideology of clustering
- C. Complex nature of mental disorders
- D. Mix of all above
- E. Other (please specify)

11. Please rate the order in which the following actions should be carried out to improve the system. (1-5: should be implemented first – implemented last)

<input type="text"/>	Prioritising the improvement and application of the care pathways
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<input type="text"/>	Improving training
<input type="text"/>	Publishing clear national guidelines and standards
<input type="text"/>	Defining more effective quality measurement instruments

12. What do you think is the most obvious benefit brought by PbR?

- A. Standardised treatments
- B. Outcome and service measurements
- C. More efficient IT system
- D. The idea of cost-efficiency
- E. Quality promotion mechanism
- F. Other (please specify)

Appendix 3: Publication

Wang, R., Shaw, I. and Middleton, H. (2015) "Delaying the implementation of Payment by Results in mental health: The application of standardisation", *Mental Health Review*, 20(3), pp. 156-165.