

NATIONAL PBR

- Darzi Review – Commitment to make mental health currencies available by 2010/11
- Aim. To introduce a consistent methodology for the contracting and payments of mental health services and fail date benchmarking and comparison.

Mental Health PbR – The Need

- Consulted on the Future of PbR in Spring 2007. Asked for priorities in expanding the scope of PbR.
- Mental Health emerged as the no.1 priority for an expansion to the scope of PbR.

“urgent need for a funding solution for Mental Health/Learning Disability Services to avoid random disinvestment”

Consultation Respondee

- Concern from providers that without a more transparent funding solution for mental health, there will be disinvestment in mental health versus services within PbR

Longer Timescales

- 2010/11 – Currencies available for use. Likely to be used in shadow form
- Beyond this commitment, our timescales are subject to review, but our assumptions are:
 - 2011/12 – All health economies should be using the currencies in some form and be establishing local prices
 - 2013/2014 – The earliest possible date for a national tariff for mental health (if evidence from the use of a national currency presents a compelling case for a national price)

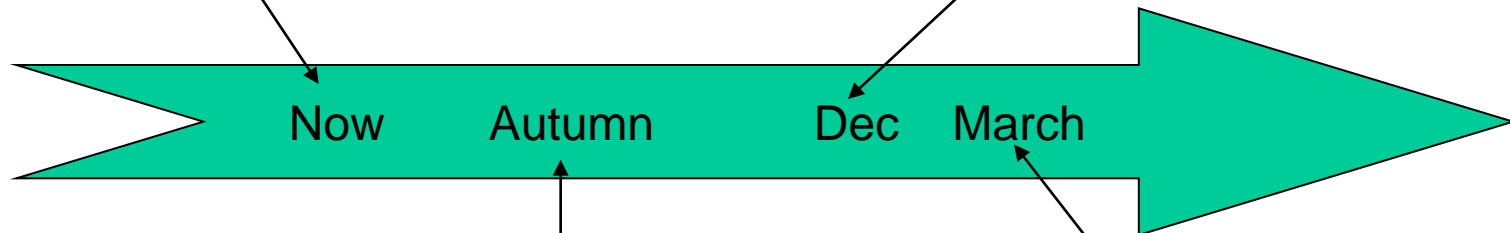
National position

- Letter from Bob Alexander covering governance, highlighting timescales and flagging up the publication of the following two documents:
- Practical Guide to Preparing for Mental Health PbR
- Clustering Booklet – HoNOS PbR (assessment tool) mapped against the 21 Clusters (currencies)

2009/10 Financial Year

Series of conferences and events to continue to raise profile of mental health PbR. Links made with related policies, eg dementia strategy

Publication of revised cluster booklet with agreed assessment tool, latest version of the clusters and cluster time duration.



Evaluation of HoNOS PbR and SARN assessment tools looking at their ability to allocate to clusters, useability and inter-rater reliability

Data Set Change Notice issued to bring required additional data items into Mental Health Minimum Data set

National Project

- Project built on the work carried out in the Care Packages and Pathways Project which involved six mental health provider Trusts testing a model developed by South West Yorkshire Mental Health Trust

DEVELOPMENTAL SITES (6)

- Care Packages & Pathway Project
- West Midlands SHA
- Pennine Care and its five PCTs
- Leicestershire Partnership Trust (focus on better costing)
- Plymouth PCT (Community Services including Community Mental Health)
- North East SHA Project on liaison Mental Health Services

PbR MUST SUPPORT PERSONALISED CARE

Care plans agreed following assessment must:

- Be created with the individual
- Consider the needs of Carers
- Identify the expected outcomes
- Take into account Best Practice Guidance where relevant
- For detained patients there will be an element of compulsion to their care plans

Care Pathways & Packages Approach

- Users assessed with a standard assessment tool derived from HoNOS
- Allocated to empirically derived care clusters/groups (1)
- These clusters are expected to be the currency unit so that you would commission for 10 people in cluster 1, 20 people in cluster 2 etc

Variables required for a currency:

- The ability to categorise service users into groups
- A time period
- The ability to describe the interventions received by each group
- When care package changes – tariff needs to be reviewed known as “case transition point”

Mental Health Care Clusters

Working-aged Adults and Older People with Mental Health Problems

A
Non-Psychotic

B
Psychosis

C
Organic

a
Mild/
Moderate/
Severe

b
Very
Severe
and
complex

a
First
Episode

b
Ongoing
or
recurrent

c
Psychotic
crisis

d
Very Severe
engagement

a
Cognitive
impairment

1

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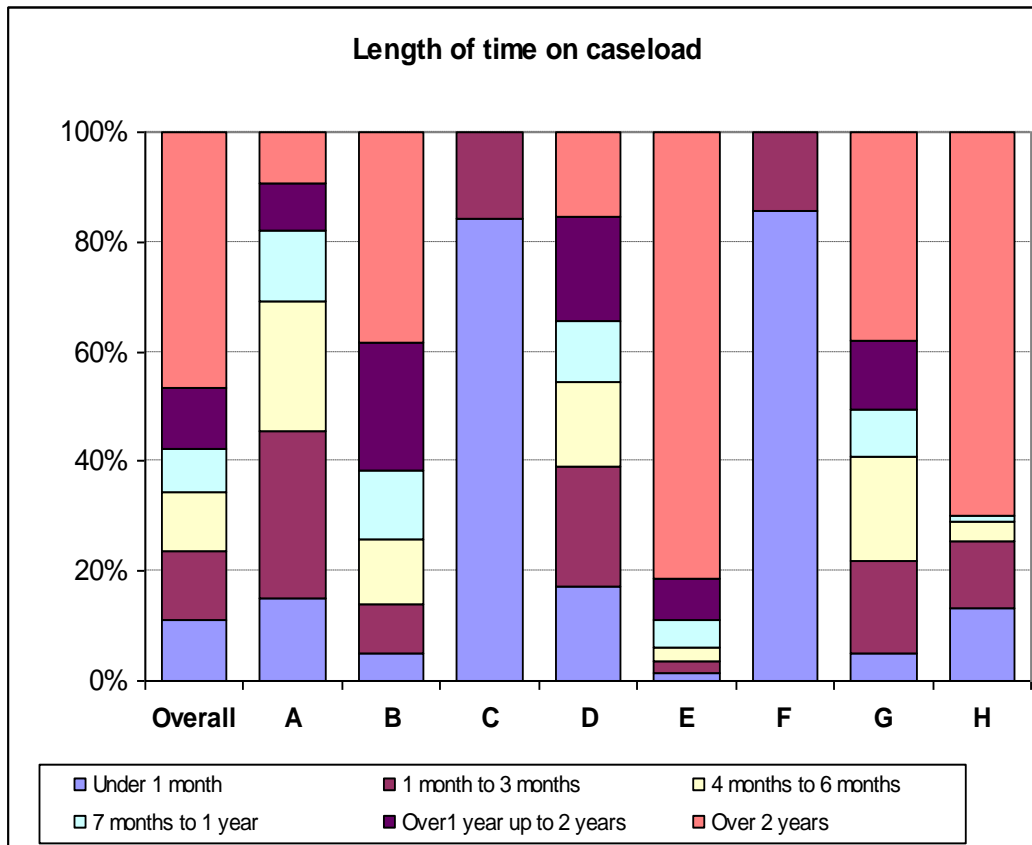
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Example

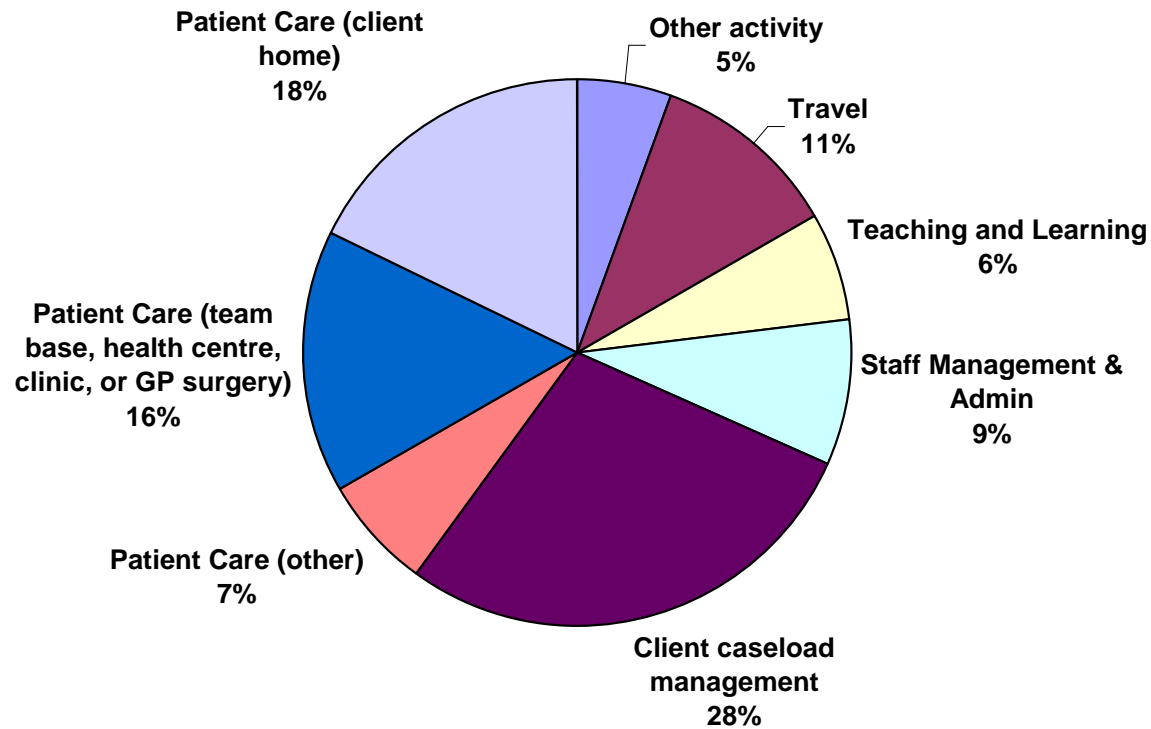
Cluster	Clinical (CPA) Review interval	Commissioning Period duration	Anticipated course of condition
1b	1 week	8 weeks	8 weeks
7	6 months	1 year	3 years

Cluster	Step up Criteria (<u>Any</u> of the following criterion is met)	Discharge Criteria (<u>All</u> of the following criterion are met)	Step Down Criteria (<u>All</u> of the following criterion are met)
1a	<ul style="list-style-type: none"> •Patient fits profile of any other cluster 	<ul style="list-style-type: none"> •Low mood scores 0 •Anxiety scores 0 •Suicidality scores 0 	N/A
13	<ul style="list-style-type: none"> •Patient fits profile for clusters 10 or 11 •Patient scores above 2 on substance misuse problems, and this results in excessive 	<ul style="list-style-type: none"> •Has received 2 years of specialist MH intervention •Requires no psychotropic medication or has been on a stable dose for the past year •Hallucinations/delusions score 0-1 •Is informal •Has required no inpatient/Intensive Home Treatment 	<ul style="list-style-type: none"> •Has fitted the profile for clusters 8a, 8b or 9 for past 12 months •Has required no inpatient/Intensive Home Treatment for the past year

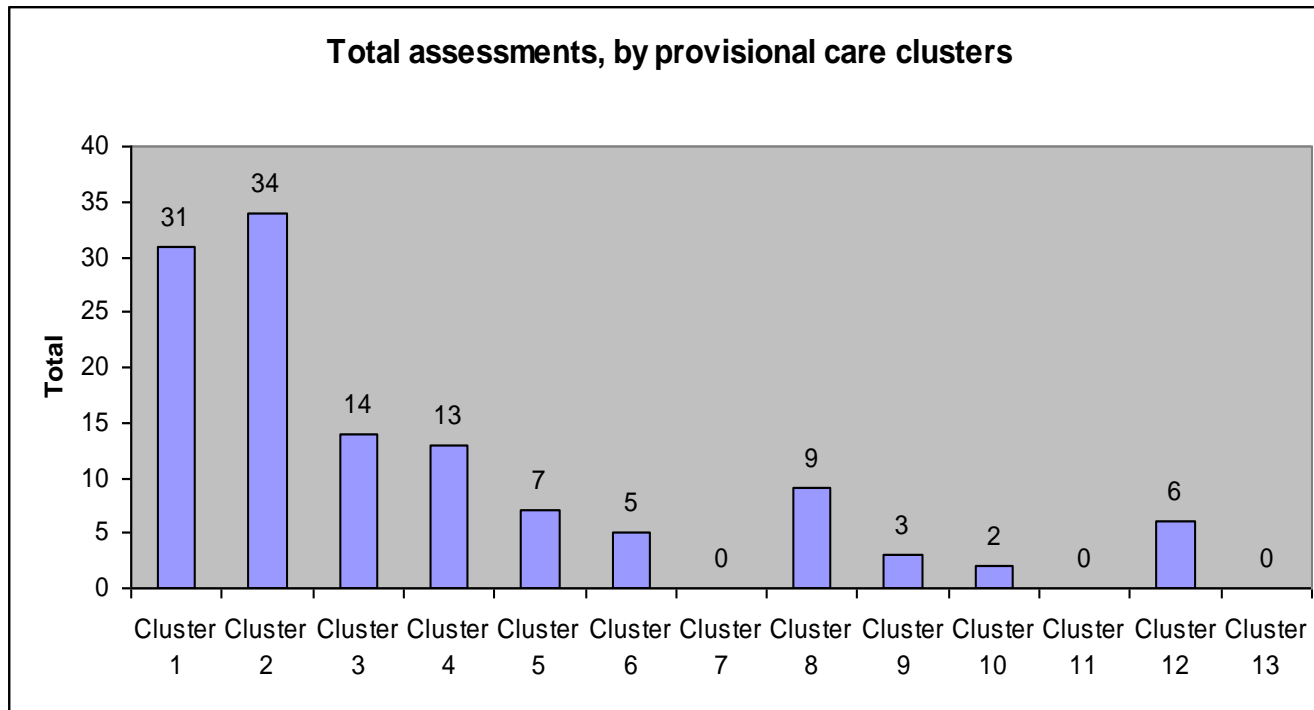
Analysis — time on caseload. Some very marked variations, in particular the contrast between team A and H



How did the staff spend their time?



Cluster results from service at assessment Dec 09



CARE CLUSTER 21: Cognitive Impairment or Dementia (High Physical or Engagement)

Description: People with cognitive impairment or dementia who are having significant problems in looking after themselves, and whose physical condition is

becoming increasingly frail. They may not be aware of their problems and there may be a significant risk of their care arrangements breaking down.

Diagnosis: Likely to include: F00 – Dementia in Alzheimer’s disease, F01 – Vascular dementia, F02 – Dementia in other diseases classified elsewhere, F03 –

Unspecified Dementia, F09 – unspecified organic or symptomatic mental disorder, Dementia with lewy bodies (DLB), Front temporal dementia (FTD)

Impairment: Likely to lack awareness of problems. Significant impairment of ADL function. Unable to fulfil self-care and social and family roles.

Major impairment of role functioning.

Risk: High risk of self-neglect. Risk of breakdown of care.

Course: Long Term

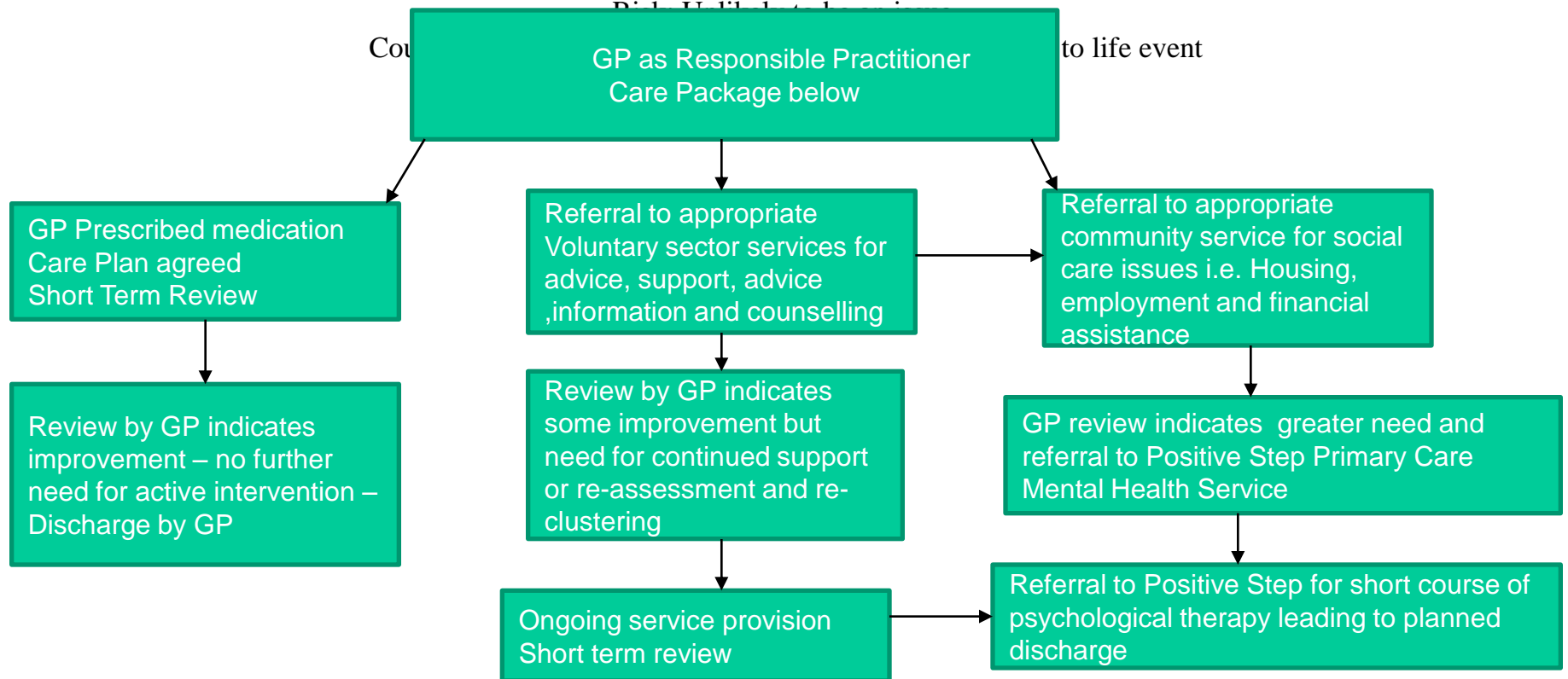
Colour Code	Service	lead care coordinator	Who Commissions?	What they do in the Cluster	Activity
	AGE Concern (Carer Component)		LA	Information, advice and advocacy	
	Alzheimer's (Carer Component)		LA	Support, education and information for carers	
	Aspects and Milestones (Somerset Hse)		PCT & LA	Delivering a mental healthcare package	
	Care Coordination		PCT	Monitor and care coordinate residential Placements	
	Crossroads Care Centre		PCT & LA	Carer support	
	Rethink's Awareness of Dementia (Carers)		LA	Carer support	
	Residential Placements		PCT	Delivering a mental health package	
	GPs	P	PCT	Ongoing health needs, End of life care	

CARE CLUSTER 2: Common Mental Health Problems (Low Severity with greater need)

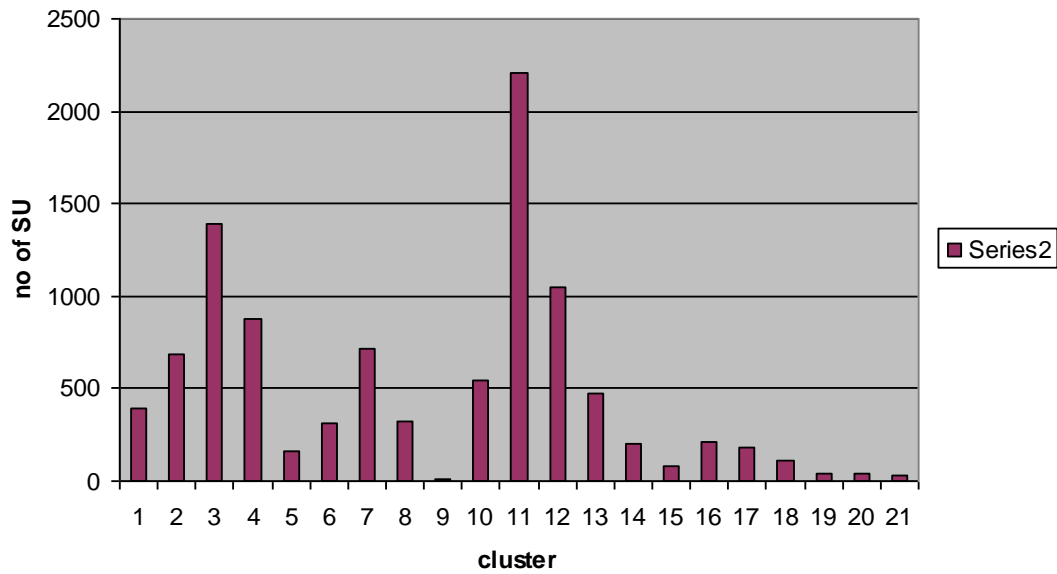
Decryption: This group has definite but minor problems of depressed mood, anxiety or other disorder but not with any distressing psychotic symptoms. They may have already received care associated with cluster 1 and require more specific intervention or previously been successfully treated at a higher level but are re-presenting with low level symptoms.

Diagnosis: Likely to include: F32 Depressive Episode, F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F50 Eating Disorder.

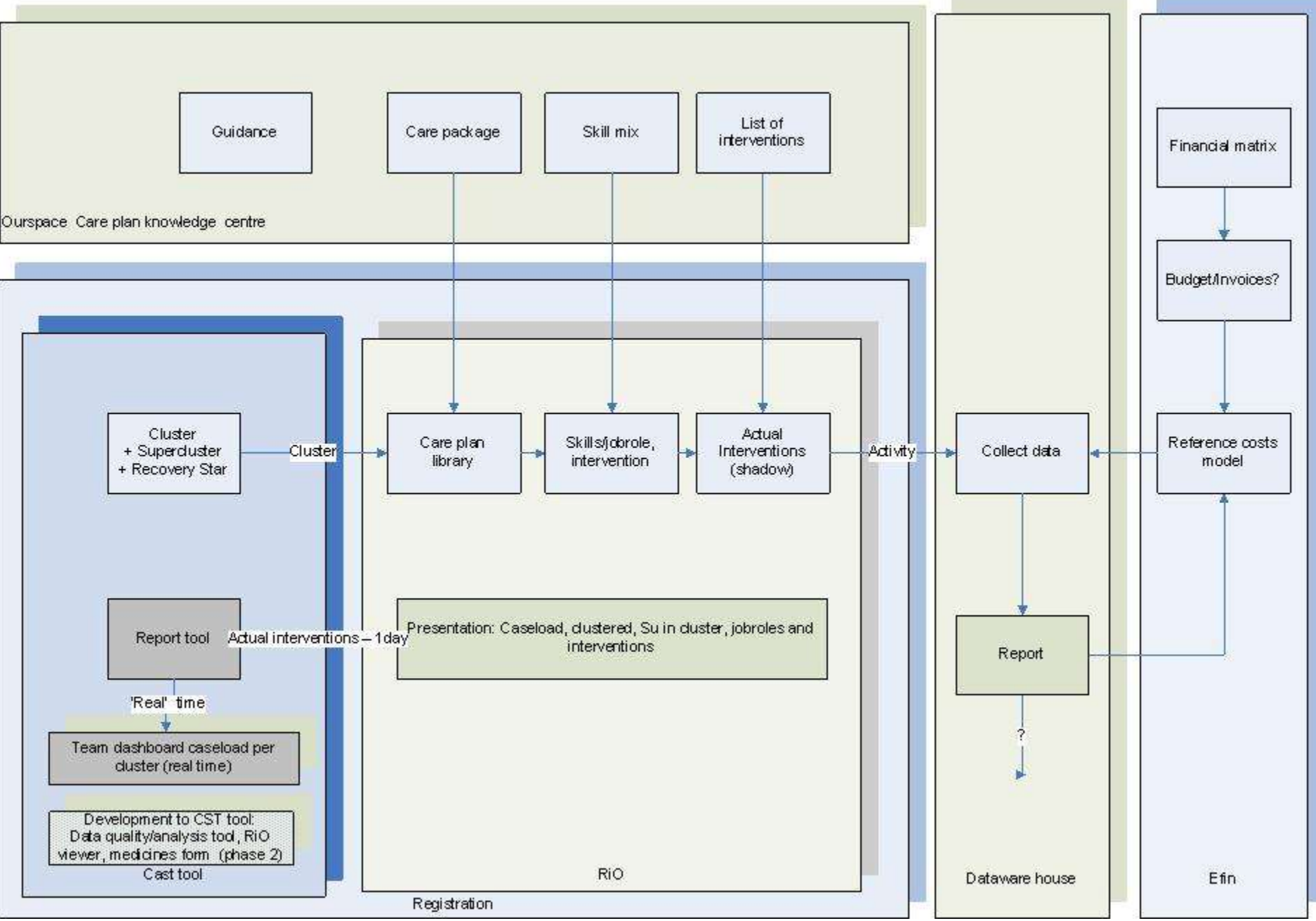
Impairment: Disorder unlikely to cause serious disruption to wider functioning but some people will experience minor problems.



adult clustering Sep 2010- Apr 2011



Payment by Result Framework



PBR – Current position

- Linked PBR to redesign via Trust Program Board
- Completed two annual PbR conferences
- Review CPA process based on emerging redesign model
- Complete 95% clustering target
- Develop data warehouse and care planning library
- Enhance CAST tool to collect care package bundles
- Review clinical data from cluster analysis
- Complete financial modelling of care packages

Lessons Learnt

- Essential to get early PCT/ Commissioner leadership
- Early involvement of Local Authority Partners
- Align to QIPP process if possible
- Involve all mental health commissioned providers at an early stage in developing a comprehensive care pathway
- Use a practice development approach to staff training
- Early engagement with service users and carers
- When planning new services consider PbR structures to advise on the developing models

Lessons Learnt — cont'd

- GP engagement from the start
- Establish comprehensive care pathways incorporating shared care protocols
- Consider new - (0 or 9) clusters for assessment , Liaison, referral management systems etc
- Develop care packages for specialist services .
- Maintain national networks
- Be innovative and challenge boundaries