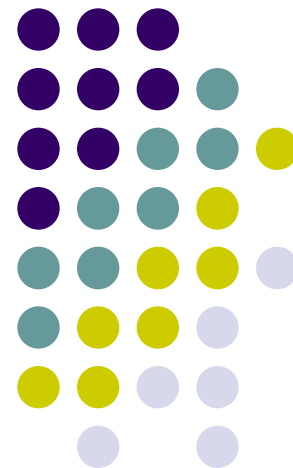
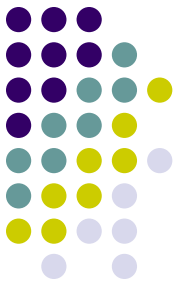

Introduction to Contracting using Care Clusters

Paddy Mc Kee - AWP



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.



White Paper: Equity and Excellence: Liberating the NHS

Putting patients and the public first (citizens) –

- choice
- information about care
- and about services

Improving healthcare outcomes –

- Outcomes not processes
- Quality standards developed by NICE (depression)
- Payment follows performance

Autonomy, accountability and democratic legitimacy –

- GP commissioning by consortia
- Joining up of local NHS services, social care and health improvement
- NHS Commissioning Board to allocate resources

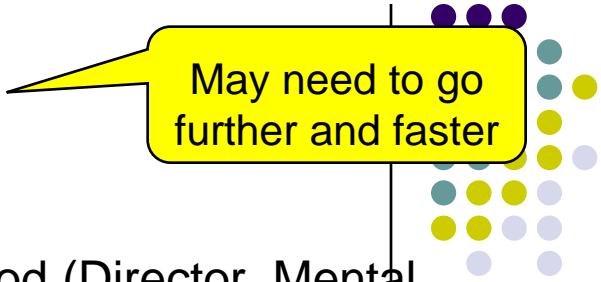


White Paper: Equity and Excellence: Liberating the NHS

Cutting bureaucracy and improving efficiency –

- £20 billion efficiency savings by 2014 reinvested to support quality and outcomes
- Reduce management costs by 45% over 4 years
- ‘We will radically delayer and simplify the number of NHS bodies...’

Timetable Clarified - 1 April



May need to go further and faster

- A Dear Colleague letter from Bruce Calderwood (Director, Mental Health Policy) and Bob Alexander (Director, NHS Finance) has clarified the timetable.
- **2010/11** – The clusters are available for use. Reference costs are returned on a cluster basis.
- **2011/12** –
 - All service users accessing mental health care (post GP or other referral) that have traditionally been labeled working age (including early intervention services from age 14) and older people's services, should be allocated to a cluster by 31 December 2011.
 - Local prices should be agreed for use in 2012/13 and this will require understanding of local costs per cluster
- **2012/13** – The clusters (with local prices) become mandatory for contracting and payment purposes.
- **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).

Currencies or Prices?



- When people talk about Payment by Results they often get currencies and prices/tariffs confused.
- Currencies = the unit for which payment is made e.g. Healthcare Resource Groups, Outpatient Attendances, Complexity-adjusted year of care for Cystic Fibrosis.
- Price/tariff = Set price for a given currency unit.



- Our focus is initially on developing a currency to be used across mental health services in England. This will allow benchmarking, comparability and transparency.

Variables required for a currency:



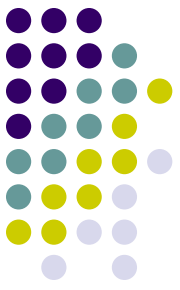
- The ability to categorise service users into groups
- A time period
- The ability to describe the interventions received by each group
- When care package changes – tariff needs to be reviewed known as “case transition point”

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

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.
- Different from acute (physical) PbR – paying for needs/characteristics over a period of time. Shares risk between commissioner and provider.
- Payment would be for all elements of care service user receives, both direct (e.g. therapies) and indirect (e.g. care co-ordination).

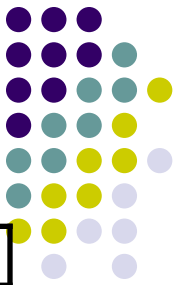
[1] Methodology set out in **Clinical Decision Support Tool: A rational needs-based approach to making clinical decisions**, *Journal of Mental Health*, February 2008, 33-48

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

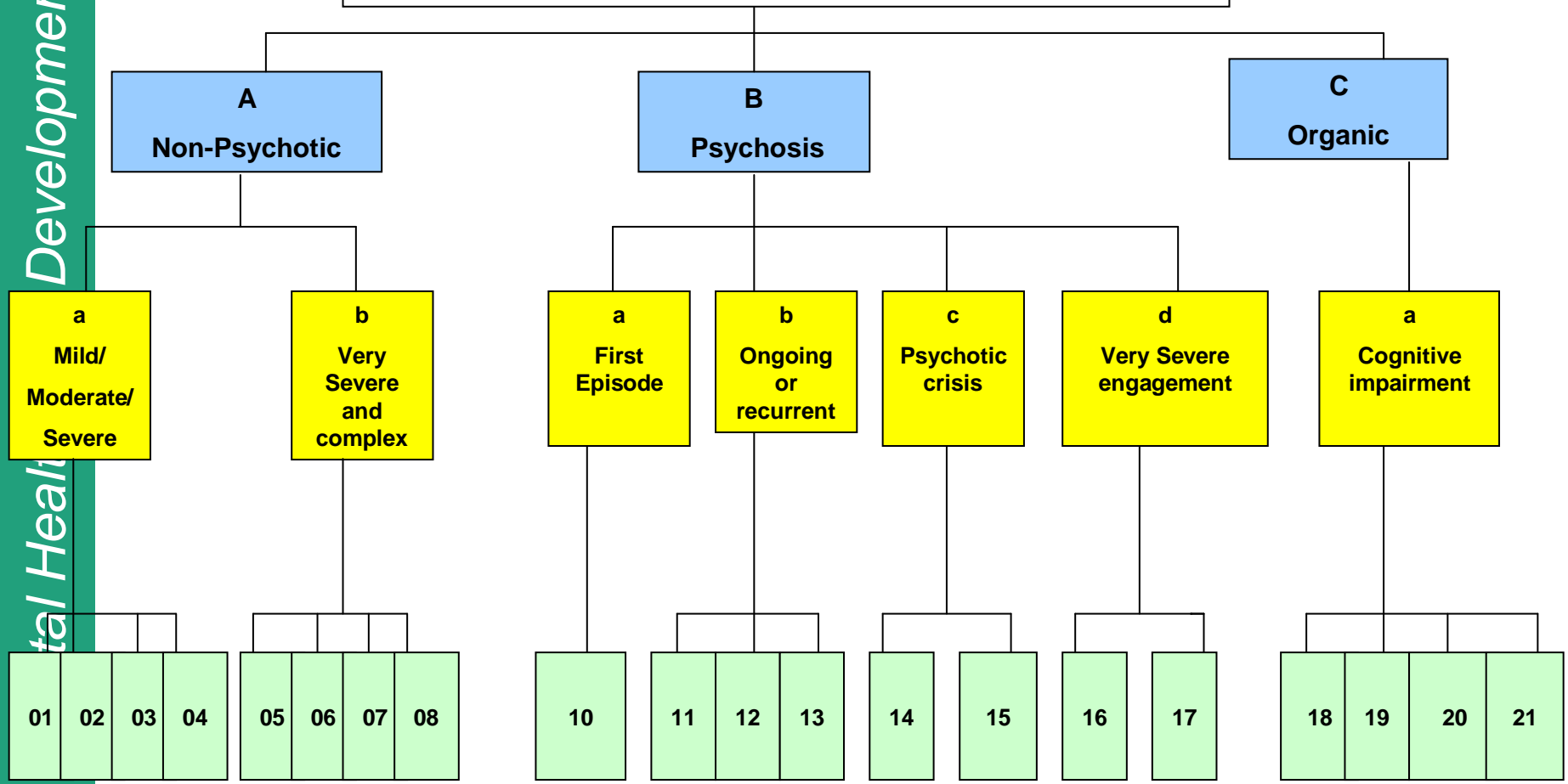


	HoNOS
1	OVERACTIVE, AGGRESSIVE, DISRUPTIVE OR AGITATED BEHAVIOUR*
2	NON ACCIDENTAL SELF-INJURY
3	PROBLEM DRINKING OR DRUG-TAKING
4	COGNITIVE PROBLEMS
5	PHYSICAL ILLNESS OR DISABILITY PROBLEMS
6	PROBLEMS ASSOCIATED WITH HALLUCINATIONS AND DELUSIONS
7	PROBLEMS WITH DEPRESSED MOOD
8	OTHER MENTAL HEALTH AND BEHAVIOURAL DISORDERS
9	PROBLEMS WITH RELATIONSHIPS
10	ACTIVITIES OF DAILY LIVING
11	LIVING CONDITIONS
12	PROBLEMS WITH OCCUPATION AND ACTIVITIES
	Summary Assessment of Characteristics (SAC)
13	STRONG UNREASONABLE BELIEFS
A	AGITATED BEHAVIOUR / EXPANSIVE MOOD (H)
B	REPEAT SELF HARM (H)
C	SAFEGUARDING CHILDREN & VULNERABLE ADULTS (H)
D	ENGAGEMENT (H)
E	VULNERABILITY (H)

Mental Health Care Clusters

Working-aged Adults and Older People with Mental Health Problems

Developmental Health

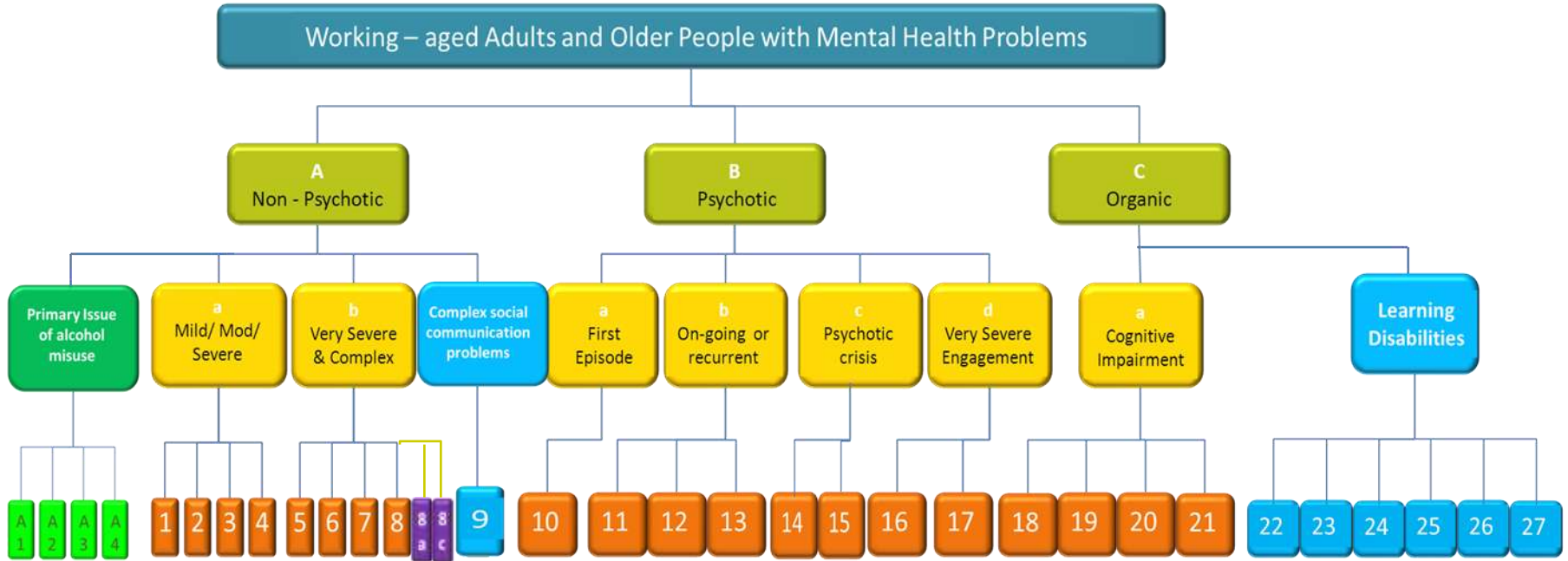


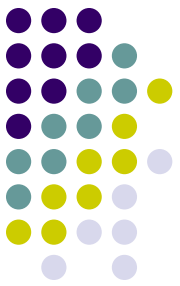
There are two additional codes if it is not possible to allocate to a Cluster or Super Class:

Z - Unable to assign patient to Mental Health Care Cluster Super Class

0 (Variance)

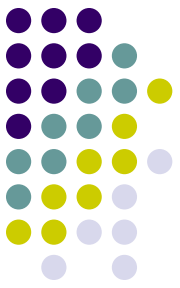
Relationship between mandated and proposed forensic, LD & alcohol misuse clusters





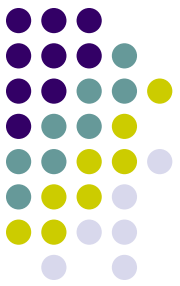
Cluster payment periods

- 1 Common mental health problems (low severity)-12 weeks
- 2 Common mental health problems-15 weeks
- 3 Non-psychotic (moderate severity)-6 months
- 4 Non-psychotic (severe)-6 months
- 5 Non-psychotic (very severe)-6 months
- 6 Non-psychotic disorders of overvalued Ideas-6 months
- 7 Enduring non-psychotic disorders (high disability)-Annual
- 8 Non-psychotic chaotic and challenging disorders-Annual
- 9 Blank cluster-Not applicable
- 10 First episode in psychosis-Annual
- 11 Ongoing recurrent psychosis (low symptoms)-Annual



Payment Periods Cont'd

- 12 Ongoing or recurrent psychosis (high disability)-Annual
- 13 Ongoing or recurrent psychosis (high symptom and disability)-Annual
- 14 Psychotic crisis-4 weeks
- 15 Severe psychotic depression-4 weeks
- 16 Dual diagnosis (substance abuse and mental illness)-6 months
- 17 Psychosis and affective disorder difficult to engage-6 months
- 18 Cognitive impairment (low need)-6 months
- 19 Cognitive impairment or dementia (moderate need)-6 months
- 20 Cognitive impairment or dementia (high need-6 months
- 21 Cognitive impairment or dementia (high physical or engagement)-6 months



DOH – 2012 - 0213 Draft Guidance

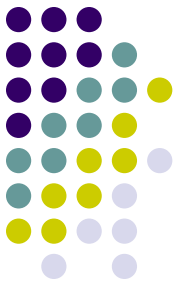
- ***NHS* commits mental health services to mandating the care clusters as the contract currency for 2012-13 with local prices.**
- **All service users accessing mental health care should have been allocated to a cluster by 31 December 2011.**
- **Providers to agree local prices with their commissioners, based on the clusters for use in 2012-13.**
- **During 2012-13 providers and commissioners will need to carefully monitor the initial cluster prices to build greater confidence in the approach.**

Readiness review



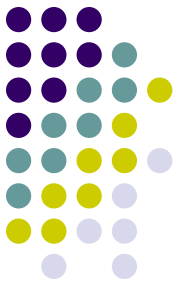
- Recommendations to be confirmed by the SHAs in November
- SHAs commissioned a readiness review
- High level messages around more and better guidance and more frequent communications
- Commissioner engagement a problem
- Draft DH mental health guidance now published
- Guidance tries to clarify how risks should be shared during introduction of PbR
- Guidance will be further refined in November following feedback from NHS

What do Commissioners want from the model?



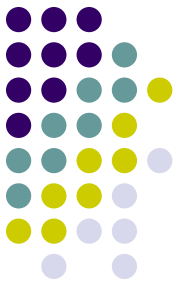
- Total numbers in each cluster (Needs)
- Diagnostic profile- particularly in some of the non-psychotic clusters
- Flow through clusters, where do people come from and where do they move on to?
- What is the agreed care pathway for the cluster and to what extent was this adhered to?

What do Commissioners want cont'd



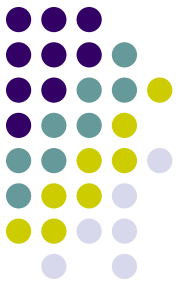
- Were the care pathway outcomes achieved?
- What other outcomes have been associated with the cluster – e.g. employment, stable accommodation, recovery and service user defined outcomes.
- What is the performance in each cluster in relation to quality standards or proxy measures such as CPA, delayed discharge, 7 day follow-up?

High level cluster themes that are beginning to inform Commissioning blocks



- Access and screening (pre cluster activity-eg assessed, not clustered- see next slide)
- Common mental health problems
- Severe and complex non psychotic
- Ongoing and recurring psychosis
- Organic and developmental mental health

Proposed PCL currency blocks based on recent DOH guidance on assessment



- **Assessed, not clustered**

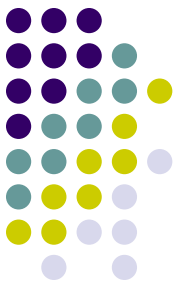
In this classification, an individual may be referred by their GP to a mental health provider for an initial assessment. The assessing mental health professional establishes that it is not appropriate for the individual to be allocated to a care cluster. The individual may be referred back to the GP by the mental health professional for other diagnosis or treatment, or signposted to other services. An example of this might be referral to non-mental health related substance misuse services.

- **Assessed, clustered**

As before, an individual may be referred by their GP to the mental health provider for an initial assessment. The assessment process establishes that the individual needs to be allocated to a care cluster. The individual then comes under the care of the mental health service provider, and a package of care is discussed and agreed with the service user.

- **PCL follow-up 'service'**

This classification differs from the previous two in that it aims to offer some form of primary care follow-up for an average of three sessions (up to a maximum of 6 sessions). (Previously referred to as short term interventions)



Information Systems update

- Developed CAST software support tool (Aug 2010)
- Updated CAST to incorporate MHMDS (July 2011)
- Developing Care plan knowledge centre (July- Nov 2011)
- Joint regional bid to develop integrated electronic care pathways across primary- secondary care services
- Linking CAST to RIO - data warehouse (Nov 2011-April 2012)

Payment by Result Framework

