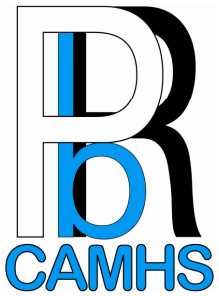


Consultation Document

CAMHS Payment by Results (PbR) Project

February 16th 2012

Contents

Introduction

Payment by Results (PbR) is the method that the Government uses to pay for healthcare in the acute sector. From 2012/13 it will be introduced for Mental Health services for Working age adults and older people and ministers have stated that they want the approach extended to cover CAMHS by 2014. In October 2011, a consortium, led by Tavistock and Portman NHS Trust and South London and Maudsley NHS Trust, and including providers, commissioners, and academics was appointed by the DH to take forward the development of currencies for CAMHS. They have set up a project group details of which can be found at Appendix 1. The consortium is supported by an Expert Advisory Group made up of stakeholders from around the country, and other government departments (membership can be found in Appendix 2).

Purpose of this Document

This document aims to share progress on the development of Payment by Results (PbR) in CAMHS and invite comments on specific questions.

It has been produced by the Project Group, agreed by the Department of Health CAMHS PbR Programme Board and amended in response to consultation with the Expert Advisory Group (see Appendix 2 for detailed reporting structures).

The Project Group is currently seeking input from a wide range of expert stakeholders, including clinical representatives and user groups.

The Project Group was asked in the first instance to address three particular questions by March 2012:

1. Should children be placed into clusters characterised by requiring the same level of resource allocation; on the basis of sharing a common diagnosis; based on problem/need formulation; or on care package?
2. How should we take account of the fact that CAMHS provision often involves input from agencies outside health, in particular social care and education?
3. What might be the next steps for the project?

It has been acknowledged by all involved that there is no easy, right or wrong approach to these questions but the group aims to agree a way forward in relation to each of these questions, to avoid circular debate that could undermine the project moving forwards.

.

How does Payment by Results Work?

Payment by results works by paying providers a set amount of money for healthcare interventions. In the case of acute care, these interventions are grouped into Health Resource Groups (HRGs). All procedures that might be undertaken as part of that HRG relate to a similar part of the body or system, and consume a similar amount of resources. In Mental Health, the equivalent to HRGs are needs related clusters and service users are allocated by clinicians to the most appropriate cluster for their current need.

Payment by Results is being introduced from 1 April 2012 in mental health services for working age adults and older people. Details of the clusters and the tools that are used to allocate service users to clusters can be found on the DH website at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132656.pdf

Department of Health's Code of Conduct for Payment by Results

The objectives of PbR, as set out in the Department of Health's Code of Conduct for Payment by Results, are to:

- Improve efficiency and value for money through enhanced service quality, as both commissioners and providers can retain and invest surpluses and savings to improve services
- Facilitate choice, by enabling funds to go to the services and providers chosen by patients
- Facilitate plurality and increase contestability, enabling funds to go to any provider (NHS or independent sector)
- Enable service innovation and improve quality, by rewarding providers whose services attract patients
- Drive the introduction of new models of care
- Help reduce waiting times by rewarding providers for the volume of work done
- Make the system fairer and more transparent, using consistent fixed price payments to providers based on volume and complexity of activity
- Get the price 'right' for services, by paying a price that ensures value for money for the taxpayer and incentivises the provision of innovative, high quality patient care.

Your comments are invited

Stakeholders are asked to comment in particular on the following two questions:

A) If you have experience of CAMH services, please comment from your perspective on

- In your experience could children, young people and families accessing CAMHS, be allocated to the provisional clusters outlined in the document.
- If there are particular examples of children you feel would not fit the clusters, or for whom it would be difficult to choose which cluster, please describe these cases.

B) If you are someone with experience of CAMH provision from outside NHS funded care, such as social care, education, the voluntary or independent sector (including user perspectives), please comment on how you best consider that this group can model and link with provision in these areas.

Our online survey http://www.surveymonkey.com/s/PbRComments provides an opportunity to respond to these specific questions and to offer general feedback on the project.

Please respond by Thursday 8th March so that we can take account of your contributions in our report to the Department of Health due to be submitted by the end of March.

CAMHS PbR Engagement Events

Two free events are planned, to which all interested are invited:

- CAMHS PbR Engagement Event – Friday 4th May at the Tavistock Centre, 120 Belsize Lane, London NW3 5BA
- CAMHS PbR Engagement Event – Tuesday 8th May in Leeds, venue TBC

Places will be allocated to allow maximum representation from across the country. To register go http://www.surveymonkey.com/s/PbRBookingForm

We will let you know if you have been allocated a place in April 2012.

Suggested Way Forward – For Consultation

Our provisional answers to the three questions are given below, we welcome your views:

1) **Should children be placed into clusters characterised by requiring the same level of resource allocation; on the basis of sharing a common diagnosis; based on problem/need formulation; or on care package?**

Clusters should be based on the needs of the referred child, i.e., they should be needs-led and should thus indicate the typical level of resources required. It has also been concluded that they need to be clinically meaningful.

Whilst there should not be a one-to-one relationship between clusters and diagnostic categories (e.g. ICD-10), within a cluster, diagnosis may inform a specific intervention.

Overarching Principles

- A needs-led approach
- Resource compatible
- Supports specific evidence-based treatment
- Outcomes focused

Participants in national CAMHS PbR meetings during 2011 (the conference in April and other meetings at the Department of Health) have suggested that clusters could be based on existing best practice and – where applicable – NICE guidance. Thus, a review of the existing NICE guidelines relating to child and adolescent mental health was carried out to ascertain:

a) What were the existing models of best practice to achieve the best possible outcomes?

b) What clusters and care packages were beginning to emerge for similar levels of need, irrespective of diagnosis?

c) What were the costs associated with these in order to consider how this information could inform the development of cluster in CAMHS?

Provisional Proposed Clusters

The tentative and provisional approach to clustering for CAMHS is outlined in Table 1 below. Seven clusters are proposed based on extent and severity of presenting problems. They include both the severity of difficulties and assessed risk to self or others.

1 = Limited need
2 = Moderate need
3 = Severe need
4 = Extensive need
5 = On-going need
6 = Specialised assessment need
7 = Uncertain need (this does not imply uncertain diagnosis)

Each of the seven clusters is sub-divided into two, according to the level of complexity (by which we mean factors outside the presenting mental health problems, which may have a significant effect on the amount of care needed).

It is proposed that initial assessments will include a process of allocating the patient to the appropriate cluster and a key next step will be to agree the process by which this will be achieved.

Preliminary thinking is that the resources required for cluster allocation and assessment more generally will be incorporated into each cluster. Specifics will be agreed once the clustering structure has been tested.

The group regard it as essential that each cluster will have predicted or target outcomes. The intention is that the next stage of data analysis, review and consultation will allow predicted and target outcomes for each cluster to be included in Table 1.

Examples of complexity factors are given below. Appendix3 provides some short examples of children who might be allocated to each cluster by complexity.

Examples of Contextual Factors Leading to Higher Complexity

- Young carer status
- Learning disability
- Serious physical illness (including chronic fatigue)
- Neurological issues, such as epilepsy,
- Current child protection plan
- Deemed “child in need” of social service input
- Refugee or asylum seeker
- Experience of war, torture or trafficking
- Social care placement breakdown at time of referral
- Contact with youth offending services
- Substance misuse/abuse
- Known parental mental health difficulties
- An interpreter required
- Family breakdown or discord

Table 1. Provisional Proposal for CAMHS PbR Clusters

Cluster for Resource Allocation Need based on extent & severity of presenting problems	**Examples**	**Complexity Level** Based on contextual factors requiring more service management	**Examples of the Intensity of Treatment (based on NICE guidance)**
1 = Limited need	e.g. Mild depression, mild anxiety, mild conduct problems	*Low*	Likely to be around 6 sessions with mental health professional, plus liaison & review meetings
		High	The higher the complexity, the more likely the need for consultation/inter-agency working/involvement of other professionals and possibly the longer the case-work. Plus liaison & review meetings e.g. up to 8 sessions
2 = Moderate need	e.g. Moderate depression, moderate anxiety, moderate conduct problems	*Low*	Likely to be around 12 sessions on average with mental health professional. Increased likelihood than lower clusters of medication as part of therapeutic package. Plus, liaison & review meetings
		High	The higher the complexity, the more likely the need for liaison, review meetings/consultation/ inter-agency working/ involvement of other professionals and possibly longer case work.
3 = Severe need	e.g. Severe depression, severe anxiety, severe conduct problems	*Low*	Likely to be around 12-24 sessions with mental health professional. Increased likelihood than lower clusters of medication as part of therapeutic package. Liaison & review meetings.
		High	The higher the complexity, the more likely the need for consultation/ inter-agency working/ involvement of other professionals and possibly longer case work
4 = Extensive need	e.g. Anorexia nervosa, emerging personality disorder, or psychotic episode	*Low*	Intensive outreach, day patient or inpatient care, timescale unspecified, for review at fixed intervals. Increased likelihood than lower clusters of medication as part of therapeutic package. Inpatient stay/intensive work. Liaison & review meetings
		High	The higher the complexity the more likely the need for liaison, review, consultation/interagency working/involvement of other professionals. Face to face meetings.
5 = On-going need	e.g. ADHD, on-going psychosis management	*Low*	Less frequent treatment offered over a longer period of time, reviewed at fixed intervals. Liaison & review meetings
		High	The higher the complexity, the more likely the need for consultation/ inter-agency working/ involvement of other professionals. Face to face meetings. Liaison & review meetings
6 = Specialised assessment need	e.g. Neuropsychological or developmental assessment	*Low*	Likely to be more than 4 face to face meetings for assessment with child and parents, school visit, plus liaison & review meetings.
		High	Likely to be more than 4 face to face meetings for assessment with child and parents, plus additional liaison with school and visit, adult mental health services and social care, interdisciplinary meetings &follow up review meetings
7 = Uncertain need (this does not imply uncertain diagnosis)	e.g. Initial presentation of mild depression/anxiety	*Low*	Watchful waiting up to 4 weeks, including consultation to other professionals, liaison & review meetings.
		High	Watchful waiting, includes increased amounts of consultation to other professionals, liaison & review meetings.

2) **How should we take account of the fact that CAMHS provision often involves input from agencies outside health, in particular social care and education?**

To address the issues of non-health provision of CAMHS, our suggestion is that we include all provision in our considerations currently, including those funded outside the health sector and look to link with colleagues in the Department of Education and Social Care to develop best ways to jointly address this area of provision in parallel with cluster development.

We are aware of the variation in funding streams for similar care packages, with or without Local Authority contributions, across different parts of the country as well as the fact that PbR tariffs constitute an NHS mechanism. Accordingly, our suggestion so far is to adopt a needs-led approach of determining clusters and care packages based on a child's mental health needs, including complexity and risk (which are prominent among children and families where several agencies are involved), rather than on the source of funding at this stage. This could inform a piece of work at a later stage.

Other suggested action points based on advice from the Expert Advisory Group:

- To link with The Children and Young People's Health Outcomes Forum, co-Chaired by RCPCH Fellow Professor Ian Lewis, maybe also helpful. The Forum is an independent body comprising experts from across the charitable, healthcare and local government sectors looking at recommendations for improved outcomes in child mental health.
- To map what PbR means for different services and providers, including schools.
- To consider the impact of PbR clustering on Non-NHS services as they too may decide it is a useful commissioning framework.

We welcome all views on this approach.

3) What might be the next steps for the project?

It is suggested that the provisional cluster structure outlined above be explored as follows:

- Consultation with practitioners and others, to determine to what extent the approach is compatible with clinical experience.

- Exploratory audit will be used with services to investigate how existing needs assessment tools and approaches can be used to allocate to clusters in meaningful ways and also to consider how outcome data may contribute to this analysis.

- Modelling data from existing datasets, including CYP IAPT data currently being collected, to see how far the actual data support the model above and to refine the model in the light of this analysis both in terms of cluster membership and thresholds between clusters and potential outcomes.

It will be vital to triangulate information from each of these sources as no single one of these approaches alone is likely to provide enough clear information to make final decisions. This may lead to developments in the model over time as increased granularity may be introduced.

This will also involve careful mapping of clusters onto relevant other models such as adult mental health care clusters. At this stage it will also be beneficial to consider the transition between child and adult mental health services.

Please let us know if you have a data set that we can use for these purposes: ebpu@annafreud.org

CAMHS PbR Engagement Events

Two free events are planned, to which all interested are invited subject to availability:

- CAMHS PbR Engagement Event - Friday 4th May at the Tavistock Centre, 120 Belsize Lane, London NW3 5BA
- CAMHS PbR Engagement Event - Tuesday 8th May in Leeds, venue TBC

Additional details about these events will be made available in April 2012.

Appendix 1

CAMHS PbR Project Group

Steering Group

Chair: Simon Young - Deputy Chief Executive & Director of Finance, Tavistock & Portman NHS Foundation Trust
Dr Gordana Milavic - Clinical Director, South London and Maudsley NHS Foundation Trust
Dr Rob Senior - Medical Director, Tavistock & Portman NHS Foundation Trust
Pat Howley - Children's Commissioning Manager, Commissioning Support Service, City & Hackney PCT

Project Directors

Dr Miranda Wolpert - Director, CAMHS Evidence Based Practice Unit (EBPU), Anna Freud Centre & University College London
Professor Panos Vostanis - Professor of Child Psychiatry, University of Leicester

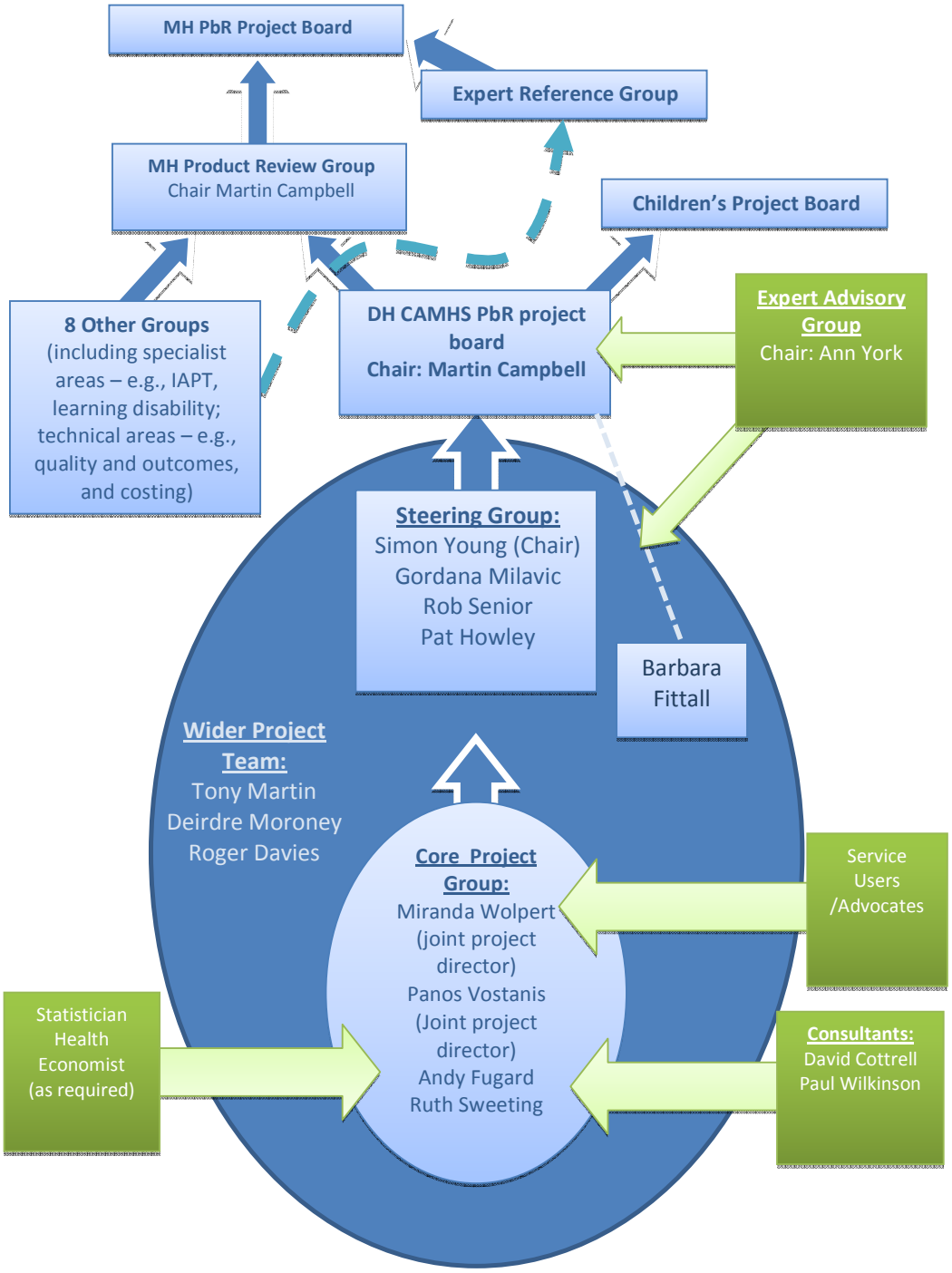
Core Project team

Dr Jessica Deighton - Deputy Director CAMHS EBPU, Anna Freud Centre & University College London
Dr Andy Fugard – Senior Data Analyst CAMHS EBPU
Dr Ruth Sweeting - Clinical Associate CAMHS EBPU

Wider Project Team

Deirdre Moroney – Business and Service Improvement Manager, Central & North West London Foundation Trust
Dr Roger Davies – Principal Clinical Psychologist, City & Hackney Child & Family Consultation Service, East London Foundation Trust
Tony Martin - Finance Lead, CAMHS PbR project & SLR Development Accountant,
South London and Maudsley NHS Foundation Trust

Appendix 2: Reporting Structures



CAMHS Expert Advisory Group
(Present at consultation *)

Chair: Dr Ann York, South West London and St Georges *

Healthcare Professional Organisations

Dr Duncan Law, *The British Psychological Society*

Dr Margaret Murphy, *The Royal College of Psychiatrists**

Andy Cotgrove, *The Royal College of Psychiatrists and Tier 4 **

Fiona Smith, *Royal College of Nursing*

Max Davie, *Royal College of Paediatrics and Child Health*

Tbc, *Royal College of General Practitioners*

Tbc, *Allied Health Professionals*

Commissioners/Providers

Roger Cook, *West Midlands Specialist Commissioners* *

Ian McPherson, *MH Providers Forum* *

John Hoar, *Independent Sector* *

Dr Susan Jennings, *Oxleas* *

Prof Susan Bailey (forensic*), President Royal College of Psychiatrists*

Experience of PbR currency development

Jon Painter, *Yorkshire* *

Jonathan Lovett, West Midlands

Damian Hart, Merseyside Youth Association

Data

Netta Hollings, Information Centre

Stakeholders and Officials

Sarah Brennan, Children and Young People's Mental Health Coalition *

Kathryn Pugh, Department of Health/CYP-IAPT

Tim Coulson, Association of Directors of Children's Services

Rob Willoughby (Wolverhampton), Association of Directors of Children's Services

Caroline Twitchett, Department of Health *

Bhupinder Bhoday, Department for Education *

Laura Cunningham, Department for Education

Howard Jasper, Youth Justice Board *

Raphael Kelvin, Department of Health professional adviser CAMHS *

Anne Spence, Department of Health/CAMHS *

David Daniel, Department of Health/Adult *

Appendix 3: Cluster Examples

Tentative examples of children or young people that might be allocated to a cluster by complexity level

1 = Limited Need

Low Complexity

- 4 year old child with sleep difficulties, no physical difficulties and parents willing to engage
- 4 year old with encopresis, no concerns about comorbid behavioural or emotional problems, or underlying causes
- 15 year old with three symptoms of depression lasting for 3mths, who is attending school with support from parents
- 6 year old not wanting to go to school with mild anxiety problems, but parents able to persuade occasionally

High Complexity

- 4 year old child with sleep difficulties whose parents are seeking refugee status, interpreter needed
- 4 year old with encopresis, current child protection plan
- 15 year old with four symptoms of depression lasting for 3mths, who has current contact with the youth offending services
- 6 year old child in looked after care not wanting to go to school with mild anxiety problems

2 = Moderate Need

Low Complexity

- 10 year old with marked inattention at school plus some behavioural problems at school and home, but with educational support plan and consistent parenting strategies
- Depressed adolescent who is not attending school some of the time7 year old with pervasive anxiety difficulties leading to vomiting. No physical concerns.

High Complexity

- 10 year old with marked inattention at school plus behaviour difficult to manage both at school and home. Child is a young carer at home for mother with a physical health condition.

- Adolescent with depression who is not attending school some of the time, current substance misuse.
- 7 year old with pervasive anxiety difficulties with anxiety leading to vomiting. No physical concerns. Parent with generalised anxiety disorder with somatisation.

3 = Severe Need

Low Complexity

- 15 year old experiencing the full range of depression symptoms, together with severe social impairment, self-harm ideation and severe agitation.
- 12 year old with severe conduct problems from early childhood. This includes physical cruelty to other children, truanting from school and running away from home.
- Adolescent with severe PSTD, no complexity factors

High Complexity

- 15 year old experiencing the full range of depression symptoms together with severe social impairment and severe agitation, active suicidal ideation and recurrent self-harm incidents. Has a moderate learning disability and difficulties communicating.
- 14 year old with severe conduct problems from early childhood. This includes physical cruelty to other children, truanting from school and running away from home. Involvement of Youth Offending and Social Services.
- Adolescent with severe PTSD, who requires an interpreter.

4 = Extensive Need

Low Complexity

- Late-teen experiencing early onset psychosis, supportive family network and good insight.
- 12 year old experiencing entrenched OCD, non-responsive to treatment, that is causing impairment to daily functioning. Supported to attend appointments by family, who are actively involved in treatment.
- 15 year old with entrenched behavioural difficulties. No comorbid disorders.
- Adolescent with a diagnosed eating disorder and persistent weight loss and supportive family.

High Complexity

- Late-teen experiencing early onset psychosis, with poor insight into their illness and living with extended family, because of parental discord.
- 12 year old experiencing entrenched OCD, unresponsive to treatment that is causing impairment to daily functioning. Parent with recurrent episodes of depression and hospital admissions.

- 15 year old with entrenched behavioural/attachment difficulties. Foster care placement breakdown at time of referral. Excluded from school. Substance abuse.
- Adolescent with a diagnosed eating disorder coupled with persistent weight loss,. Severe family discord.

5 = On-going Need

Low Complexity

- 17 year old with stabilised first episode of psychosis symptoms but treatment needs to be maintained. No complexity factors present.
- Young person with a recurrent depressive disorder taking medication that needs monitoring regularly and has engaged in psychological treatment for at least 3mths. No complexity factors present.
- 9 year old with a diagnosis of ADHD taking medication that needs monitoring regularly. Stable family environment and school support systems in place.

High Complexity

- 17 year old with a pervasive developmental disorder diagnosis, whose first episode of psychosis has stabilised but treatment needs to be maintained.
- Young person with a recurrent depressive disorder taking medication that needs monitoring regularly and has engaged in psychological treatment for at least 3mths. Family is currently seeking asylum.
- 9 year old with a diagnosis of ADHD taking medication that needs monitoring regularly. Learning disability and parenting difficulties.

6 = Specialised Assessment Need

Low Complexity

- 11 year old with behavioural difficulties at school requiring a specialised assessment to determine if attention or cognitive functioning is impacting on behaviour.
- 14 year old who becomes easily upset and tends to avoid other children, requiring an assessment to try to distinguish between depression and ASD.

High Complexity

- 11 year old with behavioural difficulties at school requiring a specialised assessment to determine if attention or cognitive functioning is impacting on behaviour. History of sexual abuse.
- 14 year old that becomes easily upset and tends to avoid other children requiring an assessment to try to distinguish between depression and ASD. Epilepsy.

7 = Uncertain Need (this does not imply uncertain diagnosis)

Low Complexity

- Adolescent experiencing intermittent difficulties with low mood difficulties over the past 2 months. No family problems.
- 4 year old with queried ASD, parents not sure they want to proceed with diagnostic assessment, but teacher has expressed concerns about functioning and social interaction with peers.

High Complexity

- Adolescent experiencing intermittent difficulties with low mood over the past 2 months. Diabetes.
- 4 year old with queried ASD, parents not sure they want to proceed with diagnostic assessment, but teacher has expressed concerns about functioning and social interaction with peers. Child protection concerns.