Introduction and aims of the day

CAMHS Payment System Project engagement events,
December 2014

Welcome and housekeeping

Acknowledgements

Operational team

Miranda Wolpert

Panos Vostanis

Isobel Fleming

Peter Martin

Andy Whale

Benjamin Ritchie

Charlotte Payne

Former members:

Andy Fugard

Davide de Francesco

Katy Hopkins

Melanie Jones

Rebecca Kyrke-Smith

Ruth Sweeting

MegaNexus (secure data storage)

Lee Murray

NHS England

Martin Campbell

Sue Nowak

Barbara Fittall

Steering Group and Project Group

Simon Young

Bruce Clark

Rob Senior

Pat Howley

Project Group

Ann York

Lynne Howey

Mary Ann Doyle

Roger Davies

Tony Martin

Service user consultation

Kate Martin

Aims of the day

- Share the information and learning that has informed our data analysis and potential currency models for CAMHS

- Gather your views on potential currencies

  - Advantages and disadvantages of different currency options (whether to have sub-groups to add granularity)
    - E.g. with regard to clinical meaning & feasibility, relationship to resource use, and engagement with service users
    - Ranking of options

  - Are there factors that aren't currently included which should be considered (including the relevance or otherwise of complexity factors)

What we are not going to cover today

- Pricing
- Total level of funding for children's and adolescent's mental health services
- Consultation, teaching and training that is not directly related to an individual child, young person or family

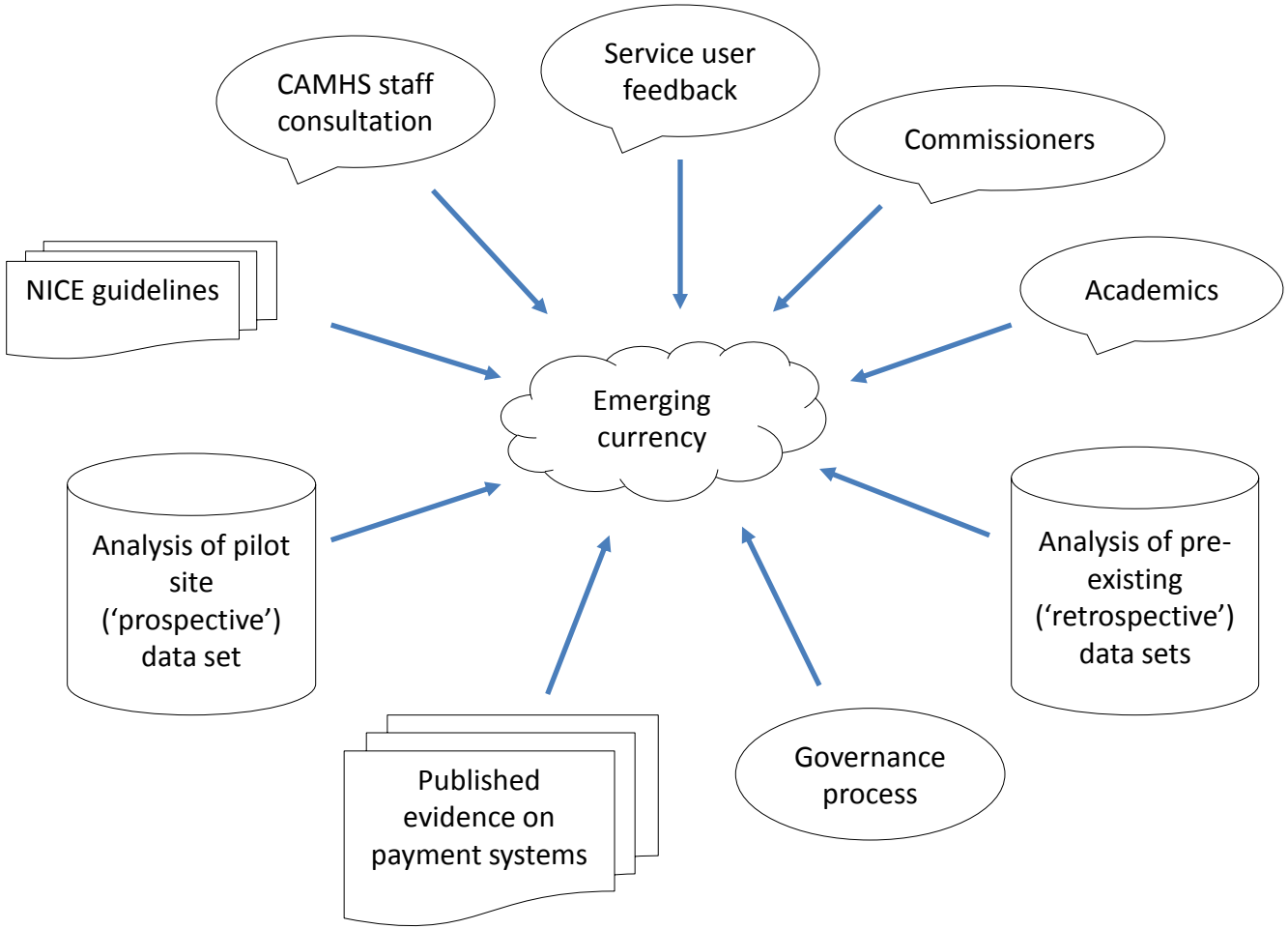
A new payment system for CAMHS – separate slide set

To cover: What is a currency?

How did we get to the draft currencies?

CAMHS Payment System Project engagement events, December 2014

Who have we asked and what have we looked at?



What have we learned from reviewing National Institute for Health & Care Excellence (NICE) guidelines?

- Included majority of child mental health problems
- Predominantly diagnostic-driven
- Largely not contextualised (i.e. in relation to service implementation, complexity, costings)
- No indirect activities
- Evidence complemented by expert consensus

Summary of learning from consultation with the CAMHS community

- Needs- rather than diagnostic-led
- Should not drive clinical decisions
- Consider complexity
- Measure indirect activities
- Link with outcomes and resource use

- Source: Questionnaire survey (n=180) and participatory workshops (n=91) in 2012

Commissioning perspective – Summary of themes

- The payment system should include reward for outcomes, and not just be payment by activity
- Challenge of how CAMHS currencies would fit with multi agency nature of support for children
- Very complex case such as LAC/CP/LD all have multi agency input and so challenge about measuring CAMHS impact
- Move towards earliest possible interventions leads to model of outreach, advice, consultation, training, for CAMHS. This is harder to identify/measure CAMHS input and by implication harder to allocate to currencies
- How to avoid gaming – providers deliberately put children in higher currency grouping to optimise their income
- Need to engage with CCG/GPs to ensure understanding and buy-in to CAMHS payment system

What feedback did we receive from service users?

- Overarching message: Language used in policy and programmes becomes part of the language of clinicians and services

- Young people expressed strongly a need to avoid using language that links currencies to severity

"If you weren't put in the severe group, but you were feeling really bad it would make you feel worthless, inferior. It would make you think what do you need to do to get that help?"

"You could just say the support they need? So, rather than saying you're more severe so you need more support […] You just say it's about levels of support rather than levels of severity."

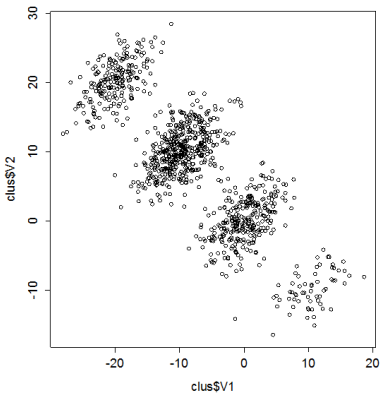
- Source: Consultation with young people in Leeds in April 2013

Summary of learning from reviewing the international literature

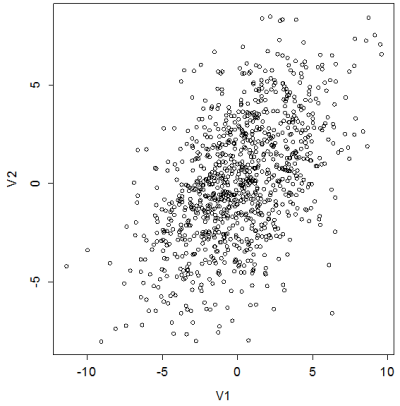
- Moving from a payment system based on block contracts or individual appointments to one based on periods of care provides different incentives, including the ability to focus on delivering outcomes
- Needs-based payment systems for periods of mental health care (that include all settings) are in development or are being rolled out (e.g. for working age adults and older people's mental health services in England), and there are no full evaluations yet
  - Recurring constraint: How little the information collected on service user characteristics at the start of a period of care can predict resource use
- Empirical studies aimed at examining the effect of period of care-based payment have concentrated on the acute hospital sector
  - Impact is hard to isolate from other policies and trends, and is dependent on context (e.g. prior funding arrangements)

What have we learned from data analysis?

The data do not look like this…



…but rather more like this…



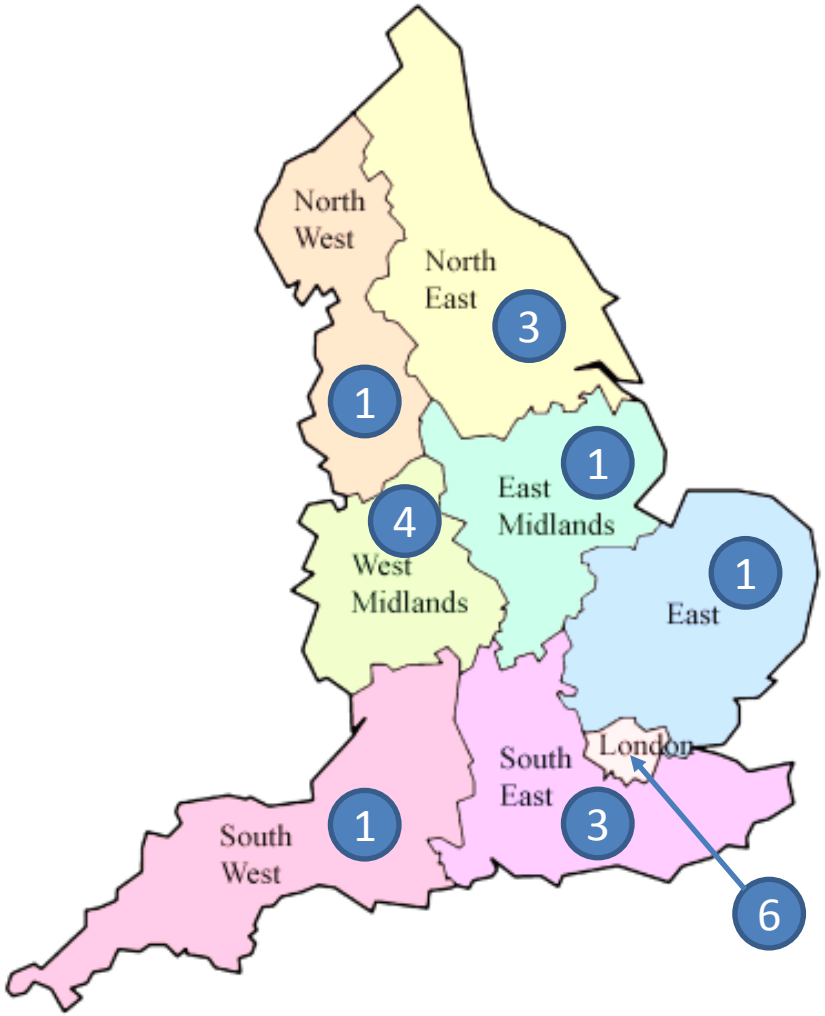
Details to follow in a subsequent presentation

NB. The second graph is not drawn using CAMHS data but serves as an illustrative depiction.

The prospective data collection pilot – 20 services participated

- Training late 2012 – early 2013
- Data collection until mid 2014 with focussed work on data quality
- Examples of services provided:
  - Outreach & intensive community treatment
  - Looked after children
  - Neurodevelopmental disorders
  - Learning disability
  - Paediatric liaison
  - Forensic
  - Tier 2
  - Tier 3
  - Eating disorders
  - Inpatient

- No. of sites in each region:



What data were pilot sites asked to collect?

- Consent (for personal data to be held by secure data storage company for non-identifiable analysis and reporting)
- Assessment information
  - Complete the Current View form after first contact
  - Update the form as necessary
- Activity information
  - Record all direct and indirect activity and liaison work
- Outcome information
  - Collect the patient and clinician rated outcome measures usually used within the service (e.g. SDQ, RCADS)
- Reason for end of contact
  - Complete the case closure form

We would like to express our immense gratitude to services for their participation

Data collection tool – the Current View

- One page form for clinicians to capture information hypothesised to impact on resource use and outcomes

- Divided into 4 components:
  - 30 provisional problem descriptions
  - 14 complexity factors
  - 4 contextual problems
  - EET attendance/attainment difficulties

Current View form – provisional problem descriptions

	Provisional Problem Description Rating need not imply a diagnosis	None	Mild	Moderate	Severe	Not known
1	Anxious away from caregivers (Separation anxiety)	☐	☐	☐	☐	☐
2	Anxious in social situations (Social anxiety/phobia)	☐	☐	☐	☐	☐
3	Anxious generally (Generalized anxiety)	☐	☐	☐	☐	☐
4	Compelled to do or think things (OCD)	☐	☐	☐	☐	☐
5	Panics (Panic disorder)	☐	☐	☐	☐	☐
6	Avoids going out (Agoraphobia)	☐	☐	☐	☐	☐
7	Avoids specific things (Specific phobia)	☐	☐	☐	☐	☐
8	Repetitive problematic behaviours (Habit problems)	☐	☐	☐	☐	☐
9	Depression/low mood (Depression)	☐	☐	☐	☐	☐
10	Self-Harm (Self injury or self-harm)	☐	☐	☐	☐	☐
11	Extremes of mood (Bipolar disorder)	☐	☐	☐	☐	☐
12	Delusional beliefs and hallucinations (Psychosis)	☐	☐	☐	☐	☐
13	Drug and alcohol difficulties (Substance abuse)	☐	☐	☐	☐	☐
14	Difficulties sitting still or concentrating (ADHD/Hyperactivity)	☐	☐	☐	☐	☐
15	Behavioural difficulties (CD or ODD)	☐	☐	☐	☐	☐
16	Poses risk to others	☐	☐	☐	☐	☐
17	Carer management of CYP behaviour (e.g., management of child)	☐	☐	☐	☐	☐
18	Doesn't get to toilet in time (Elimination problems)	☐	☐	☐	☐	☐
19	Disturbed by traumatic event (PTSD)	☐	☐	☐	☐	☐
20	Eating issues (Anorexia/Bulimia)	☐	☐	☐	☐	☐
21	Family relationship difficulties	☐	☐	☐	☐	☐
22	Problems in attachment to parent/carer (Attachment problems)	☐	☐	☐	☐	☐
23	Peer relationship difficulties	☐	☐	☐	☐	☐
24	Persistent difficulties managing relationships with others (includes emerging personality disorder)	☐	☐	☐	☐	☐
25	Does not speak (Selective mutism)	☐	☐	☐	☐	☐
26	Gender discomfort issues (Gender identity disorder)	☐	☐	☐	☐	☐
27	Unexplained physical symptoms	☐	☐	☐	☐	☐
28	Unexplained developmental difficulties	☐	☐	☐	☐	☐
29	Self-care Issues (includes medical care management, obesity)	☐	☐	☐	☐	☐
30	Adjustment to health issues	☐	☐	☐	☐	☐

N.B. not a diagnostic tool; does not replace a risk assessment

Current View form – complexity factors

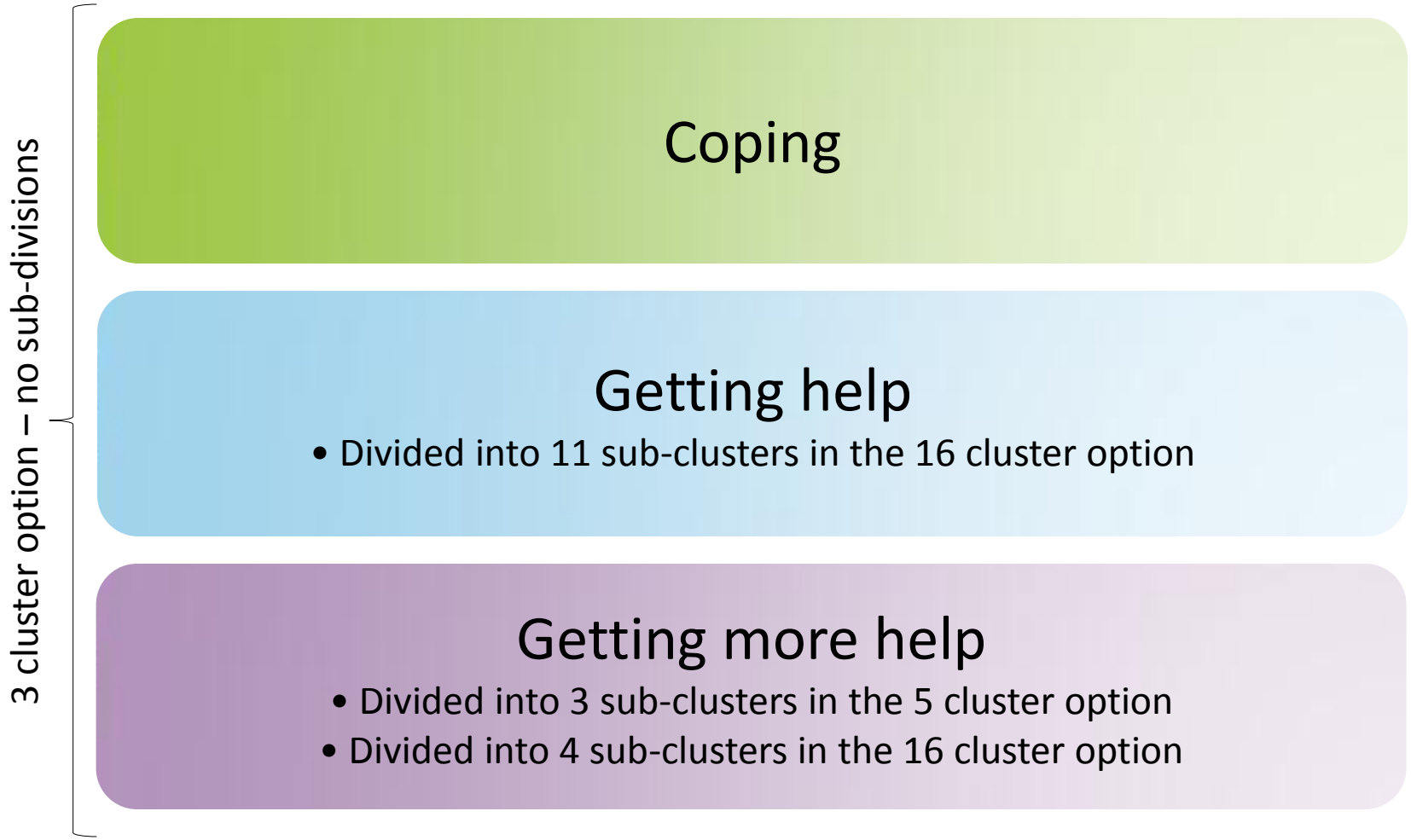
	SELECTED COMPLEXITY FACTORS	Yes	No	Not known
1	Looked after child			
2	Young carer status			
3	Learning disability			
4	Serious physical health issues (including chronic fatigue)			
5	Pervasive Developmental Disorders (Autism/Asperger's)			
6	Neurological issues (e.g. Tics or Tourette's)			
7	Current protection plan			
8	Deemed "child in need" of social service input			
9	Refugee or asylum seeker			
10	Experience of war, torture or trafficking			
11	Experience of abuse or neglect			
12	Parental health issues			
13	Contact with Youth Justice System			
14	Living in financial difficulty			

Learning from the data – separate slide set

Drawing together the information sources – the draft currency options

CAMHS Payment System Project engagement events,
December 2014

Draft currency options to be discussed and refined: 3 clusters, 5 clusters, 16 clusters



Hypothesis on the needs of service users

Children, young people and families who…

…are adjusting to life circumstances, with mild or temporary difficulties, where the best intervention is within the community with the possible addition of self-support

…would benefit from focused, evidence-based treatment, with clear aims, and criteria for assessing whether aims have been achieved

…would benefit from intensive (and potentially longer-term) treatment

Broad description of care packages offered

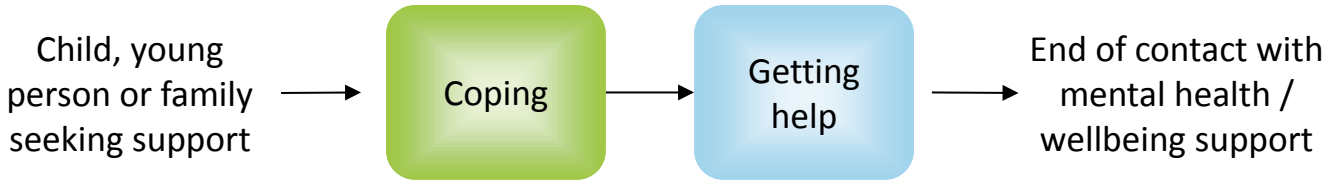
Signposting and self-management support

Assessment and treatment involving goals focussed, evidence informed and outcomes focussed intervention, or extended assessment

Assessment and treatment for
- psychosis and/or severe bipolar disorder
- eating disorders
- other problems and/or risk management

Cluster choice is not permanent

- We envisage the time spent in a cluster may form the whole, or a part, of a service user's journey while in contact with mental health/wellbeing support
- Examples:



Cluster assignment is not automated

- Due to the complex nature of need, we envisage that choice of one of the needs-based clusters will necessitate a combination of information (e.g. from the Current View form), clinical judgement and shared decision making
- Example:

Algorithm suggests 'getting help' cluster on the basis of rating of 'compelled to do or think things' item as 'severe' on the Current View form but young person chooses to live with symptoms (e.g. excessive hand washing) and collaboratively agreed between clinician and young person that consider bibliotherapy with one off follow up, and so 'coping' cluster is chosen

Incorporating monitoring of quality and outcomes

- The currency groupings may facilitate the identification of quality indicators with relevance to the needs of particular groups of children, young people and families

- Commissioners, providers and service user representatives could work together to identify and agree quality indicators for each of the currency groupings (illustrative examples on next slide)

Illustrative examples of areas in which to identify and agree PROCESS quality indicators

Coping
e.g. access to online support

Getting help
e.g. access to National Institute for Health and Care Excellence (NICE) recommended interventions

Getting more help
e.g. clear crisis management plans

Illustrative examples of areas in which to identify and agree OUTCOME quality indicators

Coping
e.g. satisfaction with service

Getting help
e.g achievement of goals (combined with change in symptoms where relevant area identified)

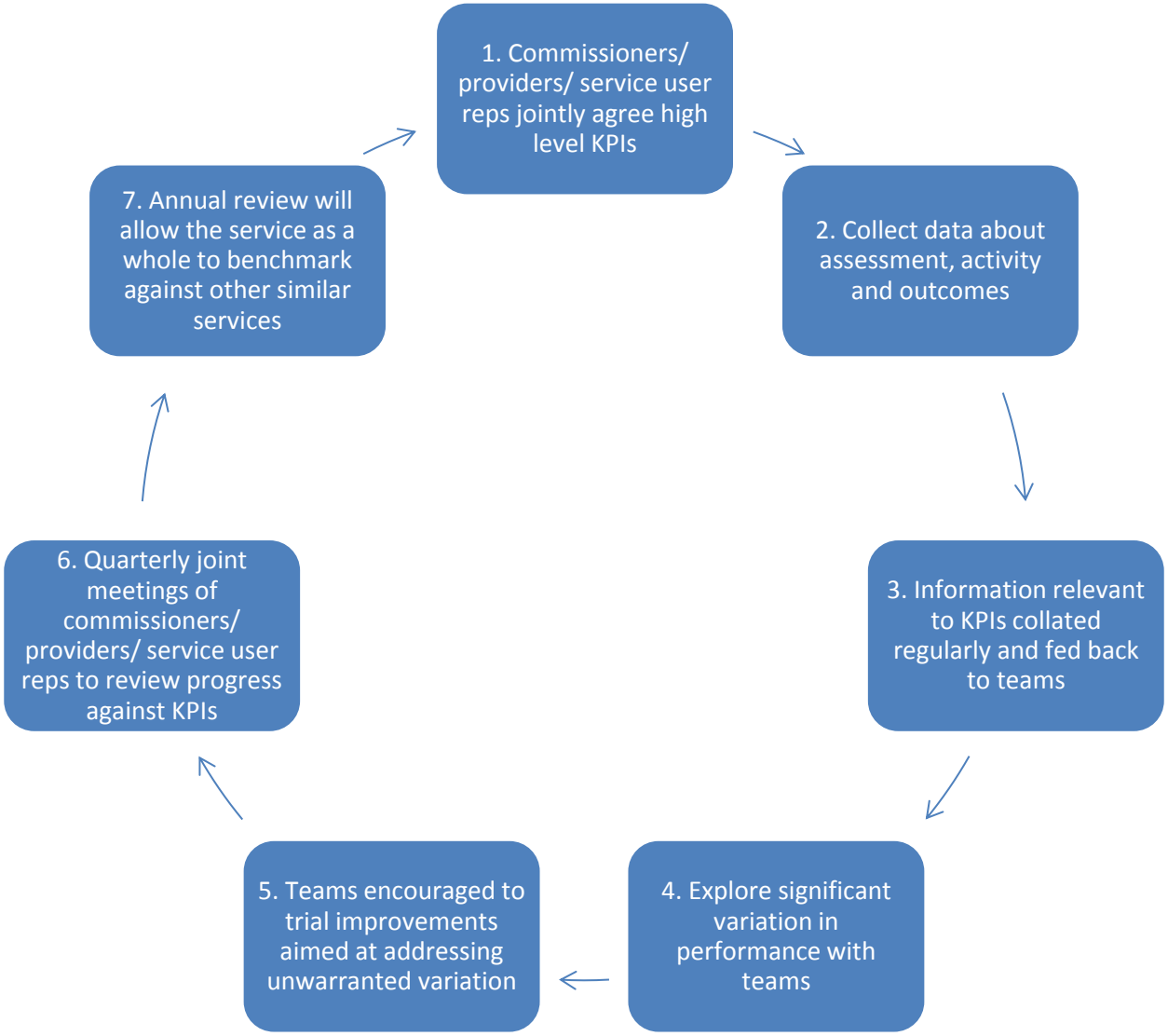
Getting more help
e.g. impact on life activities

‘MINDFUL’ approach*

- **M**ultiple perspectives: child, parent, practitioner should all be considered separately.
- **I**nterpretation: at the most meaningful level e.g. team or care pathway where possible.
- **N**egative differences: where unit under consideration appears worse than others, this should be used as a starting point for discussions.
- **D**irected discussions: focus on what one would do if negative differences were real (75% discussion time) rather than examining reasons for why they might be not real (25% discussion time).
- **F**unnel plots: a good way to present data to reduce risk of over-interpretation, but still only a starting point.
- **U**ncertainty: important to remember all data are flawed and there is a need to triangulate data from a variety of sources.
- **L**earning collaborations: local learning collaborations of service users, commissioners and providers to meaningfully interpret data.

* Wolpert et al (2014). From ‘reckless’ to ‘mindful’ in the use of outcome data to inform service-level performance management: perspectives from child mental health. BMJ Qual Saf; 0:1-5.

7 steps to MINDFUL use of outcome data



Group discussions

CAMHS Payment System Project engagement events, December 2014

Group discussion 1

- In the first group discussion, we are going to ask you to consider the following:
  - Three draft options for the currency: 3 clusters, 5 clusters, 16 clusters
  - What are the advantages and disadvantages of each?
  - Consider clinical meaning & feasibility, relationship to resource use, and engagement with service users

- Facilitators will be asked to feed back 3 points from each group

- Please jot down any other questions on post-it notes

Draft options for the currency to discuss

3 cluster option	5 cluster option	16 cluster option
Coping	Coping	Coping
Getting help (including 10 NICE guideline categories and 'multiple moderate problems' category)	Getting help (including 10 NICE guideline categories and 'multiple moderate problems' category)	Getting help: Attention deficit hyperactivity disorder (ADHD)
Getting more help (including psychosis, eating disorders and other)	Getting more help: Psychosis and/or bipolar disorder (where 'extremes of mood' rated as 'severe' in the case of bipolar disorder)	Getting help: Autism
	Getting more help: Eating disorders	Getting help: Bipolar disorder (where 'extremes of mood' rated as 'moderate')
	Getting more help: Other (including self-harm rated as 'moderate' or 'severe', emerging BPD and 'multiple severe problems' category)	Getting help: Conduct disorders
		Getting help: Depression
		Getting help: Generalised anxiety disorder
		Getting help: Obsessive-compulsive disorder (OCD)
		Getting help: Panics
		Getting help: Post-traumatic stress disorder (PTSD)
		Getting help: Social anxiety disorder
		Getting help: Multiple moderate problems
		Getting more help: Psychosis and/or bipolar disorder (where 'extremes of mood' rated as 'severe' in the case of bipolar disorder)
		Getting more help: Eating disorders
		Getting more help: Self-harm
		Getting more help: Multiple severe problems (including emerging BPD and 'multiple severe problems' category)

Question applicable to all options: should moderate or severe self-harm be included under getting help, getting more help, or both (depending on a particular factor or factors)?

Group discussion 2

- In the second group discussion, focus on whether there are factors that aren't currently included which should be considered (including the relevance or otherwise of complexity factors)

- Please jot down any other questions on post-it notes