CAMHS Payment System Project engagement events December 2014
Frequently asked questions
Version 6

Question on the presentations

Are the slides from the events available?

Yes, copies of the slides can be downloaded from: http://pbrcamhs.org/resources/event-resources-3/december-2014-engagement-events/

Question on next steps

We were really pleased by the response to the engagement events, and the discussions at each event have helped us to refine our thinking. The latest iteration of the clusters will be available for comment in early February 2015.

General questions on CAMHS currencies

Will there be flexibility in deciding which cluster a child or young person should be assigned to?

Our view is that as long as the currencies are to remain needs-based, and routinely collected data cannot comprehensively capture 'need', the views of clinicians and service users need to be taken into account, along with the results of using a clustering tool, in deciding the appropriate cluster at a given point in time. Since the clustering process itself has not yet been piloted in CAMHS, the provisional results presented at the December 2014 engagement events show how the periods of contact in the data submitted by the pilot sites would have been clustered if a clustering tool algorithm alone was followed. This was for the purposes of illustration and discussion.

Will there be room for children and young people to move between clusters (e.g. if the clinical picture changes, during exam time)?

Yes, cluster allocation may change during the totality of an individual child's interaction with a CAMH service. The details of this are still being worked on and will require consideration of the start and end points of periods in a particular cluster. Advice on how frequently cluster assignment should be reviewed may be discussed as part of this.

Which tiers of CAMHS should the currencies apply to?

They will apply to all areas of CAMHS. The Project Group were originally asked to develop 'setting independent' currencies (i.e. to cover the whole range of CAMHS services). However, it is acknowledged that complexities have arisen from the separate commissioning arrangements for tier 4 CAMHS. Furthermore, due to the challenges of data collection, the data that were analysed and presented at the December 2014 engagement events relate to tiers 2 and 3 only.

How do the CAMHS currencies relate to transition to adult mental health?

The CAMHS currencies in development are different to the adult mental health currencies (care clusters and their associated review periods) because of the different needs of children, young people and families. It is currently proposed that service users will be 're-clustered' at the point of transition using the adult mental health currencies. The Project Group feel that transition to adult mental health services is best supported by clear transition policies and local protocols regardless of the payment system in use (either in CAMHS or adult mental health services).

Specific questions on the draft currency options

Can the names of the draft clusters be re-considered, particularly for the draft cluster called 'coping'?

Yes, we are suggesting changing the name of this grouping to 'getting advice'. The new names and clusters will be open for comment in early February 2015.

How do the draft cluster options deal with the high prevalence of co-occurring problems / co-morbidities in CAMHS?

We are very aware of the high level of co-occurring problems and co-morbidities in CAMHS. There are specific groupings for those with co-occurring problems/co-morbidities.

Where does self-harm fit into the draft currencies?

The current iteration of draft clusters enables cases involving self-harm to be categorised at different levels of need depending on factors such as the severity of the self-harm and the severity of co-occurring problems.

Where does crisis intervention fit?

We think that a proportion of cases in many of the clusters may benefit from crisis intervention. This will increase the cost of those particular clusters, but when the average cost of care for a large number of service users in a particular cluster is calculated, the amount of crisis intervention work for that cluster will be reflected in the average cost. Thus the cost of the care for an individual service user who receives crisis intervention care may be above the average cost for that cluster but, correspondingly, the cost of care for a service user who does not receive crisis intervention will be below the average cluster cost. It is important, therefore, to recognise that in currency-based payment systems, prices derived from average costs of care are not 'caps' or 'limits' on the care to be provided to an individual service user and that service providers should recover their costs when payments are summed over a large group of service users, containing those with both above and below average costs.

Questions on the data analysis to date

Why were appointments (face to face or telephone) the only aspect of resource use analysed?

The Project Group originally hoped to receive more comprehensive data on resource use than appointments. Due to the challenges of data collection, a high proportion of pilot sites were not able to submit more detailed data on resource use (e.g. indirect activity, types of professionals present at appointments). However, some data on the duration of appointments and the number and type of professionals present was submitted, and the project team plan to conduct further analyses on these data.

General questions on provider payment

What is the national direction of payment systems in the NHS?

Monitor and NHS England have recently published a paper describing the direction of payment system reform and how it supports the vision for the future of the NHS. The paper is available at: https://www.gov.uk/government/publications/reforming-the-payment-system-for-nhs-services-supporting-the-five-year-forward-view

How do personal health budgets fit in?

Mental health is an area of health care which is very amenable to personal health budgets, and it is expected that many more children who have on-going needs will be able to access these budgets in future. Experience from adult mental health services has shown that information on the costs of

delivering the care associated with currency units (care clusters and associated review periods) can be used to inform the value of personal health budgets. So having an agreed currency model for CAMH services which we can cost will help commissioners and providers to know how much money might form part of a personal health budget.

What about the risk of gaming?

There is a potential for 'gaming' in most if not all health care payment systems that employ categories of differing resource intensity. In its broadest sense, the term 'gaming' can be used to refer to a number of undesirable strategies that may be pursued to (i) increase revenue (e.g. manipulating the categorisation of service users into higher-priced currency groups) or (ii) reduce costs (e.g. 'cherry picking' people to accept for treatment within currency groups, discharging or transferring service users earlier than appropriate). Monitoring data trends over time and benchmarking helps to identify where this is happening. We will also be incorporating quality and outcomes metrics into the currency model and these may provide an additional incentive against inappropriate early discharge or transfer.