Care Pathways and Packages Project

Developing currencies for mental health

The legacy

March 2015

Foreword from the Chair and Project Director

The Care Pathways and Packages Project (CPPP) has been a major success and an excellent example of various parts of the health service working together to inform policy and also make it a reality.

A great deal has been achieved during the eight years of the projects existence and we are proud to have directed the group that has led the way in the development and implementation of the Mental Health Payment and Pricing model.

From the beginning of this journey the Consortium's motivation was to see a currency model develop that would ensure the right incentives were an integral component and that service user needs, experience and outcomes were central to it. This has resulted in the delivery of a workable model that has utility and value to the stakeholders we set out to serve: service users, clinicians, providers and commissioners.

In addition the project has been instrumental in encouraging huge improvements in data completeness and quality that has provided the opportunity to increase confidence and understanding in the use of this data, as well as greater transparency and opportunities for joint work between commissioners and providers.

The CPPP has led the delivery of a range of quality and outcome metrics that are now being produced by the Health and Social Care Information Centre (HSCIC) and made available for use at a local, regional and national level. This is a major achievement and provides opportunities for benchmarking and choice that will also provide a sound basis upon which to build national and local additions to.

Work in other areas of mental health payment and pricing was steered by the CPPP. The project has hosted the secure and forensic currency project which has established a model linked with the generic cluster model that will be made available as a Local Payment Example as part of the 2015/16 payment and pricing guidance.

The initial development work for Learning Disability currency models will produce a report in 2015 to inform the future direction and was organised by the CPPP. The project has also influenced and supported the IAPT currency development resulting in the clusters being integrated within the IAPT model.

These are only some of the headline achievements, there are many more.

With so much of the development work complete the board concluded that the project had reached a natural conclusion, and the CPPP should end on 31 March 2015. This does not mean that the work for commissioners and providers is complete – there remain significant challenges ahead, but these need to be addressed locally and within the newly developing national governance arrangements.

We hope that the joint working and networks established by the CPPP will continue to flourish, to influence on-going policy development and to provide further opportunities to work smart, reduce duplication and burden, and realise all of the potential benefits new payment and pricing models can offer.

Steven Michael, OBE, CPPP Chair and Carole Green, Project Director, CPPP

Background

Following a request by the Department of Health (DH) for service engagement in supporting the development of a currency model for Mental Health (MH) services, formerly known as Payment by Results (PbR) the CPPP Consortium was established in 2007. Mental Health Providers in Yorkshire & Humber and the North East initially came together with a common aim to influence the currency development, ensuring that the resulting model encouraged the correct incentives to continue to change and modernise MH services and to deliver the key outcomes required, whilst learning the lessons from payment and pricing in the acute sector.

The Consortium undertook an initial piece of work that demonstrated the potential of the cluster model and following the DH consultation on the future of payment and pricing in 2008, this resulted in it being taken forward for further development and testing as the underpinning classification system for MH currencies and payment.

As the Consortium grew the Strategic Health Authorities (SHA's) for Yorkshire & Humber and the North East, the Primary Care Trusts (PCT's) and MH providers in the two SHA patches were included. It continued developing the tools and products required for payment and pricing, testing and refining these in the CPPP sites, supporting members into the implementation phase and then extending the scope of currency and payment development into other areas of Mental Health and Learning Disability services.

Many products and mini-projects were successfully delivered by the Consortium showing an excellent example of how providers and commissioners can work together to successfully inform and shape national policy and direction.

Key Achievements

The CPPP has made a major contribution to the development of MH payment and pricing for generic MH services and continues to do so in the work to extend the current scope. The following are some of the key achievements:

Secured stakeholder support and engagement in the cluster model.	Established the CPPP and wider networks to support joint work and national influence.
Provided evidence to allow the Mental Health Clustering Tool (MHCT) and 21 Clusters to be mandated for national use from 2011/12.	Produced and delivered training in the use of the MHCT and clusters within the CPPP and nationally.
Established the clusters as the underpinning classification system for national use.	Led the development of additional clinical guidance documents to improve cluster accuracy in particular situations.
Contributed to the content of the currency and tariff guidance every year from 2010 to 2015.	Developed and established the CPPP brand as playing a leading role in the development of MH Payment and Pricing.
Developed the costing methodology that is nationally agreed and recommended as part of the currency guidance and informed the updating of the national reference cost guidance.	Supported the collaboration between the NHS and the pharmaceutical industry to establish the IMHSeC website – providing guidance on care package content associated with each of the 21 clusters.
Led the Quality & Outcomes work within the CPPP and nationally that has resulted in: • A transparent set of key quality indicators that enable benchmarking across providers and commissioners. • Publication of a 4 Factor Model of HoNOS that enables providers and commissioners to benchmark the impact of their interventions. • Initial pilot testing of a Patient Rated Outcome Measure (PROM) - the Short version of the Warwick & Edinburgh Mental Well Being Scale (SWEMWBS). • The Care Quality Commission (CQC) patient survey including cluster, potentially linking patient experience results into the payment and pricing model.	Steered and supported the extension of the scope of clusters for payment and pricing, including: • Led the development of a potential payment and pricing model for Learning Disability services. • Hosted the national project work to develop a payment and pricing model for secure and forensic MH & LD services – ensuring alignment between the MH, Secure and Forensic and LD models. • Completed IAPT alignment work to ensure Cluster model is integrated within the IAPT model. • Supported the work to develop a currency model for Liaison MH.
Established a series of cluster-based service specifications that have been widely adopted across the CPPP patch.	Developed and made nationally available an electronic algorithm to support clinical allocation to cluster on initial assessment.
Developed an ELearning module that is free to use for all the CPPP sites.	

Stakeholders Benefits

Benefits to Service Users

The implementation of the Care Pathways and Packages has and will continue to deliver a number of benefits to service users. The model enables consistency across providers and because it is transparent, it will enable informed choice for service users based visible outcomes. The result should drive improvements in service user care.

Benefits to service users of the model include:

- Services are based on user needs, including self-defined needs and goals
- Needs are identified about the whole person and care plans are integrated
- Greater transparency about the whole system is provided for service users
- Supports innovation which improves quality and outcomes
- Avoids perverse incentives affecting care delivered
- Approach ensures a focus on outcomes

Benefits to Providers

In moving to a system where the needs of people accessing services are rated and described in a consistent evidence based way, it is possible to gain a better understanding of local needs as well as the costs involved in meeting these needs. When combined with an understanding of the quality and outcomes being achieved it is also possible to understand the cost-effectiveness of different services. This is important as providers and commissioners need to know how best to spend increasingly scarce resources to get the biggest benefits for people using them. If this can be shared with service users this may also have an impact on how resources are used.

Improving an organisations reputation, particularly if they can demonstrate good quality and outcome performance. This in turn can assist organisations in the longer term to give them the edge when tendering for new services or seeking new investment from commissioners.

Understanding the number of individuals with different types of needs requiring treatment, and the evidence-based treatments that should be offered, it is possible to understand the types and amounts of particular skills that are needed to deliver these interventions. This allows training to be provided and services to be configured around the people using the service rather than fitting people into services.

As well as benefits there are also challenges, a key one being the issue of winning hearts and minds of the clinical workforce because of their pivotal role in the core elements of the methodology such as clustering, outcome measurement and delivery of packages of care. If this is in place then the following benefits are realised. In order for this to happen, providers need to proactively “manage and lead” the approach to winning hearts and minds. This can be achieved via extensive training and on-going support on the practicalities of clustering and outcome measurement and needs to be at the grass roots level where people apply this work on a daily basis.

The table below summarises key benefits and challenges to providers:

Provider Benefits	Provider Challenges
Clarity of service user needs, and ability to quantify it.	Winning hearts and minds to enable the organisation to gain maximum benefits from the opportunities.
A common language across services and between providers and commissioners.	Improving the accuracy of the identification of need and therefore partially inappropriate deployment of resources. This will also have a negative impact on the ability to demonstrate outcomes.
Information that supports clinicians and organisations make sound clinical and business decisions.	The opportunity to improve the accuracy of costing/pricing shared between providers and commissioners.
Support providers in giving assurance to service users and commissioners regarding care provided.	Improving the completeness and quality of data or information being supplied and used to support payment and pricing.
Effective deployment of clinical resources and increased understanding of clinical productivity.	Using improved data to inform clinical and business decision making
A better understanding of where costs are being allocated, where investment is required and where to target efficiency schemes.	Flawed data can result in poor clinical and business decisions potentially being made
Greater understanding of clinical delivery and what outcomes are delivered.	

Benefits for Commissioners

Implementing a payment and pricing model presents significant benefits for commissioners, not least in understanding in the greater detail, the needs of service users accessing services within their locality.

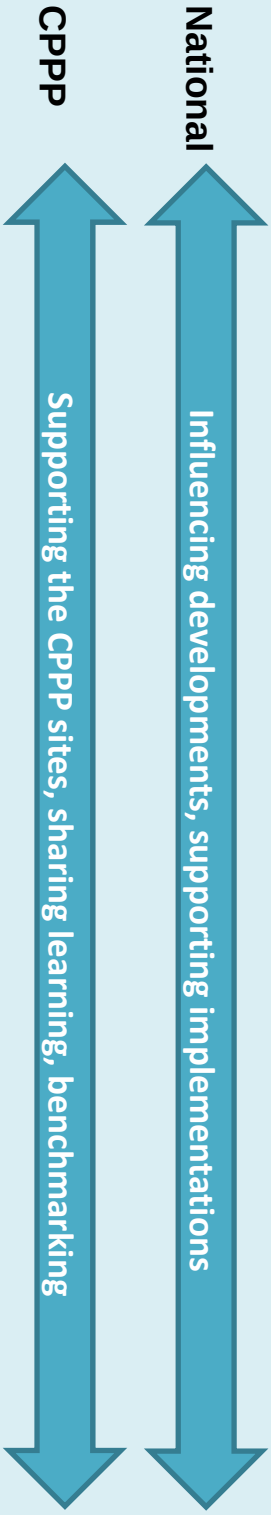
Joining this with greater understanding of quality and outcomes being achieved and benchmarking with other providers.

Implementation can give greater understanding and confidence in the prices paid for mental health services, enabling them to evaluate value for money for both packages of care and the entire service user pathway.

Whilst there are significant benefits there are also several challenges including raising the profile of mental health currencies so that the benefits can be demonstrated and that it is seen as a priority.

Commissioner Benefits	Commissioner Challenges
Able to join payment and pricing and public health data to establish a more comprehensive picture of commissioning needs.	Leadership in mental health currency will be a key challenge for CCG's in order for them to understand and use the currency model to its full potential.
Better understanding of Q&O metrics will enable constructive dialogue between commissioners, services users and providers about specific parts of the services.	Working collaboratively with other commissioners and agencies.
Greater pricing transparency giving greater confidence.	Resources - using reference cost and price data to promote positive change.
Measures what makes a difference to service users via patient rated outcome and experience measures.	Using the payment and pricing model to support positive working with social care and responding to key national priorities.
Enables commissioners to set improvement trajectories aligned with best practice.	Using information appropriately and develop more confidence in national data to reduce the local burden.
Aligned payment system across all local providers, but with room for local variation.	
Use of a common currency unit for comparison and benchmarking.	
Incentivises improvement to maximise desired outcomes.	
Payment system to maximise innovation for improvement.	

Work stream summaries



Working Age Adults/Older People Implementation

The **Q&O** work stream has developed and delivered a framework of indicators that can be implemented to form part of the MH currency and payment model.

It has delivered an appropriate range of Patient Rated Outcome Measures (PROM), Clinician Rated Outcome Measures (CROM) and Patient Rated Experience Measures (PREM).

The **Finance** work stream has advised and steered the development and implementation of Mental Health Currencies. It ensured that sound, shared and comprehensive methodologies and guidance have developed via a coordinated approach across the CPPP sites.

Information – The CPPP delivered a shared information warehouse across numerous sites. The information from this provided key data to support cluster booklet development, the algorithm, the 4 factor CROM model, quality indicators and local benchmarking. The Data Management group supported the HSCIC to deliver appropriate changes to support the transition to the use of MHLDDS version 1.

Algorithm / Transitions / MHCT work stream – The CPPP has led the development and annual update of the clustering booklet, including care transition protocols. The CPPP has also overseen the development of an algorithm to help support the clustering tool decision making at the point of

E-learning – Development of an e-learning package for the CPPP sites and wider use.

The **Commissioner Engagement** work stream has ensured that commissioners have been appropriately engaged in currency development and implementation, enabling them to influence the products being delivered and make best use of them. In particular, commissioners have led activity on development of quality indicators and cluster-based service specifications.

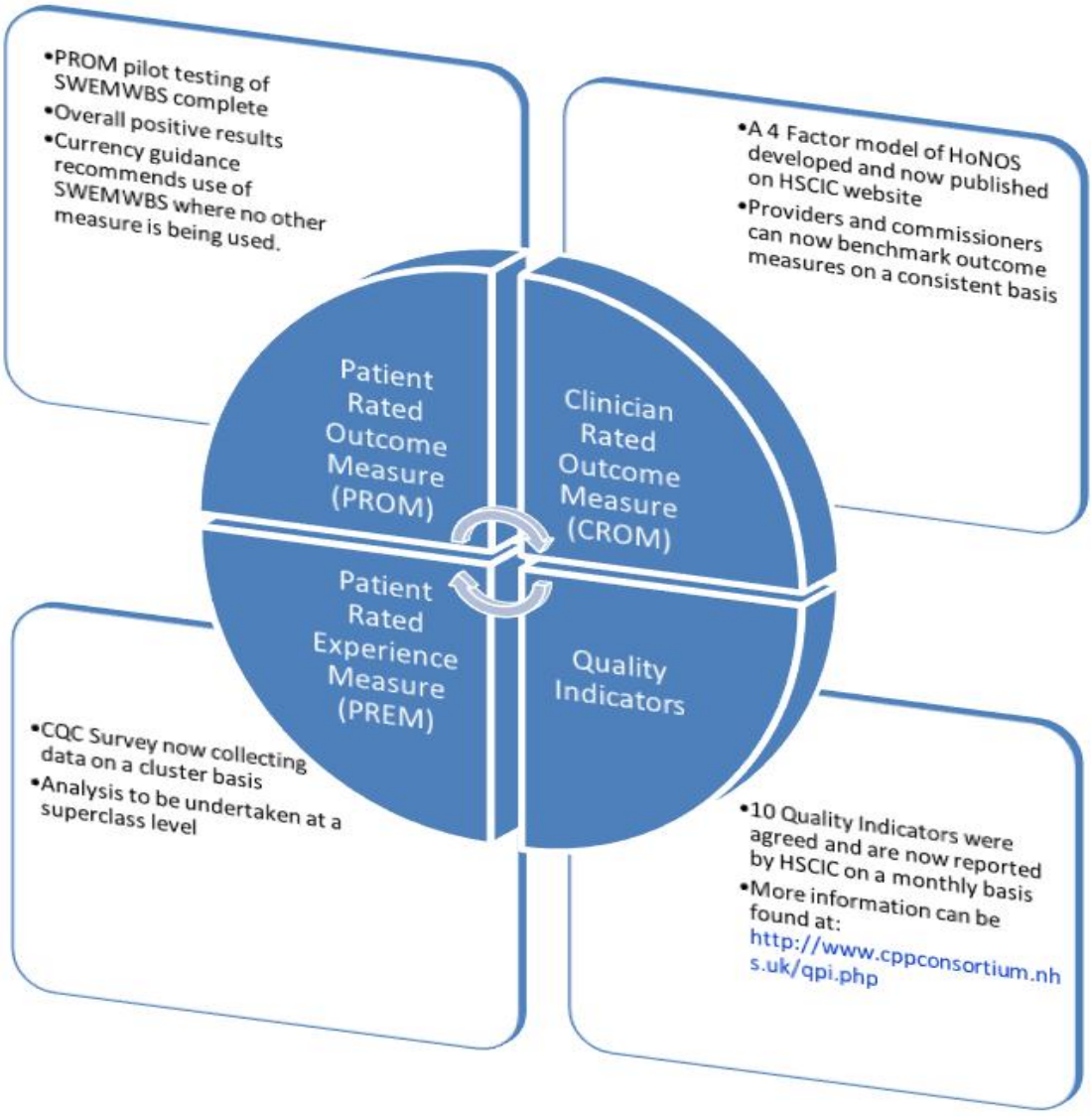
Extending the Scope

Learning Disabilities – The CPPP delivered a pilot project to define a series of statistically informed learning disabilities clusters and is going on to further validate the clusters, test them in practice, develop associated packages of care and implement an appropriate Quality and Outcomes framework.

Secure / Forensic – The CPPP has hosted the forensic currency and pricing project and supported the delivery of the cluster and 5 forensic pathway model.

The CPPP has delivered bespoke support and analysis for national **IAPT** currency project and the emerging **Liaison Psychiatry** project.

Quality and Outcomes



The Coalition Government have made it clear that judging care by outcomes is one of its top priorities for the NHS. The White Paper “Equity and Excellence: Liberating the NHS” sets this out and is supported by the Outcomes Framework, published in November 2010 and the mental health outcomes strategy “No Health without Mental Health”, published February 2011.

The introduction of a mental health payment and pricing system has been a major change for both providers and commissioners.

Therefore, a key component of the system is being able to measure and understand the quality and quantity of the services that are being delivered and whether service users achieve positive outcomes.

Against this backdrop of the outcomes policy environment, a decision was taken to coordinate Quality & Outcomes work at a national level, taking account of regional and specialist input.

The DH led National Quality and Outcomes Product Review Group (PRG) sub group was formed with the primary objective to identify indicators and outcome measures specifically linked to payment and pricing currency groups, and to recommend how these could be used as an integral part of the currencies.

Reporting to these groups, the CPPP has developed a comprehensive range of quality indicators and outcome measures as an integral part of the Mental Health Payment and pricing currency model to ensure the correct incentives are applied. This work has been undertaken with engagement from stakeholders and services users across the CPPP Consortium.

The quality and outcome focus of the mental health currency model has four main components each complementing the other. A range of quality indicators commensurate with national outcome frameworks for health, social care and public health have been chosen for benchmarking purposes to demonstrate a range of metrics felt to be important in terms of quality care. Outcome should be reported by clinicians and patients and the experience patients have whilst receiving care should be incentivised to improve quality.

Quality Indicators

The purpose of the Quality Indicators work stream was to recommend a suite of Quality Indicators that can be used within the payment and pricing model as a basis for payment according to quality. Indicators are linked to clusters and available by mental health service provider. Activity on the Quality Indicators focused only on data which is already collected on a national basis.

A range of Quality Indicators were considered from those metrics already collected nationally. Consideration was given to those that were consistently reported. A number of quality indicators relating specifically to clustering were developed (C1-3). 10 quality indicators were agreed and analysed. (http://www.cppconsortium.nhs.uk/qpi.php) was completed for benchmarking purposes. From July 2014 these 10 indicators are published monthly by HSCIC http://www.hscic.gov.uk/.

The MH Payment and Pricing guidance for 2014-15 stated that for each care cluster Quality Indicators must be agreed between providers and commissioners. Agreed Quality Indicators must be monitored on a quarterly basis by both providers and commissioners. C1-C3 are key cluster process indicators, and where the target rates are not being met providers and commissioners should agree the period of time over which this will be achieved. Contractual penalties for non-achievement of agreed improvement trajectories can be considered. Specific targets for quality indicators (R1-7) should be chosen dependent on local performance and compliance rates and be used as a driver to improve quality.

The Quality Indicators and analysis for benchmarking can be accessed via these links
R1 The Proportion of users in each cluster who are on CPA
R2 The proportion of users on CPA who have had a review within the last 12 months
R3 The completeness of ethnicity recording
R4 The accommodation status of all users
R5 The intensity of care
R6 The proportion of users with a crisis plan in place limited to those on CPA
R7 The proportion of users who have a valid ICD10 diagnosis recorded
C1 Proportion of in scope patients assigned to a cluster
C2 Proportion of initial cluster allocations adhering to red rules
C3 Proportion of patients within cluster review periods

More information, including initial targets can be found on the CPPP website

http://www.cppconsortium.nhs.uk/qpi.php

Case studies/worked examples have been developed which offer insight into how the Quality Indicators can be used locally to drive change within the mental health currency model. The case studies are available by clicking the links below:

Making use of Commissioner Information - The Cluster Pathway

http://www.cppconsortium.nhs.uk/qualityAndOutcomes.php

Clinician Rated Outcome Measures (CROMs)

From April 2011 the use of the Mental Health Clustering Tool (MHCT) has been implemented nationally. The Health of the Nation Outcome Scale (HoNOS) sits within the MHCT and is reported through MHMDS. The 2011 Quality and Outcomes Mental Health PbR report identified HoNOS/MHCT as the only CROM that is routinely used, collected and reported to the national data set.

Therefore, the scope of developing a CROM to support the currency model was limited to test and establish the use of MHCT/HoNOS ratings only, focussing on:

1. Exploring the utility of the MHCT/HoNOS as a generic CROM for evaluating outcomes within all the payment and pricing superclass's and care clusters for working age and older adult mental health services.

2. Exploring the factor structure of the MHCT/HoNOS to identify the most generalisable factor structure across the 21 clusters.

3. Evaluating the MHCT/HoNOS mean total scores and total factor scores from any emergent factor structure in terms of their sensitivity to change over time.

A 4 Factor Model of HoNOS was developed and tested on national data from MHMDS submissions during 2013. The model evaluated cluster specific outcomes and the results are reported by cluster for each organisation/service provider at both episode and spell level.

The first national publication of 4 Factor results was made available on the HSCIC website from November 2014 and results were published by provider and commissioning organisations. These reports are limited to episodes and spells that commenced after April 2013. Episode level reports show how effective interventions have been relating to a specific cluster. The initial scores on entering the cluster are compared to the final scores on leaving the cluster and outcome is reported as an effect size across the four factors. Spell level reports also report effect size but relate to the entire patient journey and are reported against the superclass which the patient was subject to at the point of discharge.

The 4 Factor Model is:

Personal Well-Being	**Emotional Well-Being**
Cognitive problems	Self harm
Physical illness or disability	Depression
Activities of daily living	Other symptoms
Problems with occupation and activities	
Social Well-Being	**Severe Disturbance**
Substance misuse	Overactive, aggressive, disruptive or agitated behaviour
Relationship problems	Problems associated with hallucinations and delusions
Problems with living conditions	
Problems with occupation/activities	

The HSCIC Mental Health Bulletin, Annual Report from MHMDS Returns - 2013/14 includes analysis of Clinician Reported Outcomes Measurements (CROMs) from MHMDS. The CROMs special topic may also be accessed via an on-line interactive visualisation tool that supports benchmarking.

http://www.hscic.gov.uk/catalogue/PUB15990

Interactive tool:

https://public.tableausoftware.com/profile/community.and.mental.health.team#!/vizhome/MentalHealthBulletin2014-CROMsSpecialTopic/Home

Guidance on the 4 Factor Model can be accessed by clicking on the following link:

http://www.cppconsortium.nhs.uk/crom.php

CROM Challenges:

Further work between providers and commissioners is required to ensure the MHCT data (from which HoNOS can be derived) submitted for each cluster is accurate, complete and of high quality. This will require providers to ensure all MHCT items are recorded accurately and completely at the required points in the service user journey, at initial referral assessment, routine review, significant change in presenting needs, and at discharge.

Patient Rated Outcome Measures (PROMs)

The National Q&O group set out the objective to test and establish the use of a PROM as an indicator of patient outcome on a cluster basis or superclass level.

A number of factors reduced the measures considered including cost, ease of use, time to complete (less than 20 minutes) and training requirements.

The CPPP then worked with service users to establish the most appropriate tool to be tested as the potential PROM and it was agreed that the short version of the Warwick and Edinburgh Mental Wellbeing Scale (sWEMWBS) should be tested further.

A pilot was undertaken during 2013-14 that examined whether sWEMWBS could be used as a generic PROM across all clusters. The objective of the pilot was to test whether it would be appropriate to use as part of the payment and pricing system, focusing specifically on:

- collectability on a cluster basis,
- sensitivity to change over time,
- correlation to MHCT/HoNOS.

The pilot was conducted on a national basis with seven providers participating. Key findings included:

- Collectability was similar or better than that reported for other PROMS including CORE-OM
- 49% of service users completed sWEMWBS independently
- There was insufficient data with which to evaluate sWEMWBS's sensitivity to detect change over time by cluster. However, when evaluated at the superclass level there is evidence to suggest SWEMWBS is sensitive to change for service users in non-psychotic and organic superclass's'.
- A clear relationship between scores on the emotional well-being factor of the CROM and sWEMWBS scores such that when the scores for the emotional well-being factor are high sWEMWBS scores will tend to be low and vice versa. This relationship was clear in all superclass's'; albeit slightly weaker in the organic superclass.

Patient Rated Experience Measure (PREMs)

As with PROMs, the national Q&O group were tasked with testing and establishing the use of PREMs that can be utilised at either a cluster or superclass level.

Good progress has been made in establishing service user preferences about patient experience, particularly from the CQC survey, establishing what patient experience questions are asked locally and how these could be integrated within the MH Payment and Pricing framework.

The CPPP undertook a series of consultations, including services users, and the following three questions, emerged as preferences:

1. Did you feel carefully listened to the last time you saw your NHS health care worker?
2. Do you have a telephone number to contact your mental health service out of hours?
3. Do you think your views were taken into account when deciding what was in your NHS care plan?

The national intention to roll out the use of the Friends and Family Test (FFT) in mental health then led to a CPPP pilot exploring its use to determine whether it could be used within the mental health currency model. The FFT was not felt appropriate for use within the model due to the inconsistent way in which the measure could be used dependant on local need.

The CPPP worked closely with the CQC to determine how the national Community Mental Health Survey could form part of the currency model. The 2014 survey results will be reported on a superclass basis and work is on-going to ensure future surveys can be reported in this way.

Finance/Costing

The finance work stream has advised and steered the development of costing and pricing for the Mental Health Currencies. The CPPP has been able to influence national developments through senior membership of national groups including the HFMA, Monitor and others associated with payment and pricing development. The costing group informed current thinking and supported development of currency guidance and the work stream has ensured that a sound, shared and comprehensive methodology and guidance has been implemented through a coordinated approach across the CPPP sites.

Key achievements include:

- Providing a major contribution to the content of the costing section that now sits in the Mental Health Payment and Pricing guidance.
- Informing the current thinking around Mental Health provider's utilisation of Patient Level Information Costing Systems (PLICS).
- Developing a methodology which enables care cluster activity to be weighted associated with underlying activities (Relative Value Unit approach).
- Defining a methodology for costing assessment and treatment days and produced a definition for assessment which has flowed into both the reference costs and pricing guidance.
- Defining a methodology for moving from historical block contracts to a care cluster price basis.
- Working collaboratively across providers and commissioners to benchmark and test thinking.
- Supported reference costs guidance – provided critique and advice - offered feedback on guidance/structured discussions at costing groups and feedback views.
- Encouraged and supported submission of cluster prices to NHSE/Monitor – benchmarked and compared results.
- Linked costing and pricing work streams to Q&O framework and enabled organisations to consider the implications on organisations associated with the Q&O metrics.
- Undertook detailed analysis inpatient, assessment and caseload to understand costs variations across organisations.

In the future, it is expected that the Costing group will continue to enable sites to benchmark their local information and share learning.

The CPPP Information work stream

The CPPP information work stream originally set up with the aim to manage the collection, validation, analysis and feedback of data that supports the development of the currency methodology and the on-going and consistent tracking of service users through care pathways.

- It delivered a shared data warehouse which numerous CPPP sites contributed data to with Data Sharing Agreements put in place.
- The data was used for local benchmarking and setting and monitoring progress towards meeting the targets.
- The information provided from the CPPP data warehouse was also critical in supporting:
    - MH Clustering Booklet development, including the setting of care transitions and review periods.
    - CROM development, in particular an extract that consisted of 23,641 patients and covered a time period of 16 months, from December 2009 to March 2011 and form the basis of the initial model.
    - The delivery of the MH Algorithm – with 14,288 clinician records from the data warehouse supporting the development of the algorithm.

Over time, the Information work stream evolved to support the effective transition of reporting and analysis from the locally managed Data Warehouse to the National Mental Health Minimum Dataset (MHMDS), encouraging high-levels of data quality and further consistent reporting and benchmarking across NHS provider trusts, broadly covering:

- MHMDS/MHLDDS development support activity
- On-going support for currency development (ie LD and SWEMWBS projects)
- Operational/Data Quality work

MHMDS/MHLDDS development support activity included:

- Supporting the implementation of MHLDDS version 1, reviewing fields in the system which led to refinements that ensured they were fit for currency purposes.
- Supporting review of intervention codes.
- Support MHLDDS version 2 development, including supporting information for consistent use of fields in the system.
- Assurance of Quality Indicator logic and testing Quality Indicator data.

On-going support for currency development including the data set delivery, data collection, and data quality reporting for the sWEMWBS, FFT and LD projects.

Operational/DQ:

- Establishment of Data Sharing Agreement with the HSCIC enabled the CPPP providers to receive spell level data in relation to indicators in development and align data locally.
- Identified reasons for local and MHMDS/MHLDDS data differing. The CPPP sites able to understand differences and resolve as appropriate.
- On-going benchmarking and shared learning.

Going forward, an Information Managers Group for the North of England Mental Health Providers already exists and local currency issues will be discussed and taken forward at that group in the future. This will also give a mechanism for information leads to support any future currency model development.

MHLDDS future developments will be taken forward via the HSCIC Technical User Group (TUG) meetings. Former CPPP members will ensure that they have at least one person attending each TUG meeting that can then feedback to the Information managers meetings.

All the CPPP members to use these existing and future networks to continue to influence on-going improvements in MH information:

http://www.hscic.gov.uk/mhmdsmonthly

http://www.cppconsortium.nhs.uk/index.php

Algorithm/Transitions/MHCT

The CPPP has led the development and refinement of the Mental Health Clustering Booklet and the supporting algorithm tool.

The Mental Health Clustering Booklet started life as a simple list of the clusters and their descriptions. It quickly developed into a single reference document containing a mixture of guidance and other information required to accurately allocate a patient to the most appropriate cluster.

At an early stage, it was recognised that, in addition to initial cluster allocations, guidance was also required when moving patients between clusters to ensure consistency. As a result a set of protocols were developed for each cluster, showing its relationship to the other clusters; the likelihood of transition to each cluster and the conditions/criteria that should lead to each transition.

These protocols were initially generated through clinical consensus however; as longitudinal data (regarding patients' movements between clusters) has become available it has been used to inform refinements to these criteria. This has resulted in an annual cycle of updates to the booklet.

The final development was in response to requests from clinicians for more active decision support regarding cluster allocations. As a result the CPPP facilitated the statistical analysis of regional and national data in order to produce a set of algorithms which indicate how likely a patient is to fit each cluster. These algorithms were published in order to allow organisations to integrate this decision support into their electronic patient record systems. They also made a web-based version available for organisations that were unable to secure this system development and finally a smartphone app for use by clinicians anywhere.

As part of the CPPPs legacy the analysis will be repeated on more contemporaneous national data to ensure the algorithms continue to reflect sound clinical allocations.

E-learning

From an early stage, the CPPP supported training across member sites and resourced training support to ensure that the clustering model was adopted in an appropriate and consistent way. The CPPP continued to facilitate shared learning via the Central Project team meetings and in 2013 set up a support network for people who deliver training on the use of the MHCT and clustering within their local provider organisations.

There are clear benefits to the provision of face-to-face training to ensure staff have the opportunity to raise questions and work with peers to develop a common understanding on the use of the scales and how to cluster. Training around service areas/teams was particularly successful as a mechanism for rolling out the required initial training and subsequent update training to the clinical workforce across whole Trusts.

However, this approach to training a clinical workforce is resource intensive and as a result, the trainers group proposed to develop e-learning modules to continue to support the on-going training and update training of clinical staff. It is intended that such a resource is not a substitute for face-to-face training, but will act as an additional resource to support trainers in rolling out training and updates to the workforce.

The e-learning packages that will support mental health Trusts to train their clinical workforce will be based around two modules:

- The first covers the use of the MHCT to summarise the clinical assessment of a patient.
- The second, how to use the MHCT score profile to allocate a patient to one of the 21 clusters and how to review a patient and effect a transition between clusters when clinically appropriate.

The CPPP also worked in partnership with the London MH Tariff Programme to deliver this and the package is now a jointly funded and agreed development. The hosting arrangement of the packages has yet to be finalised but it will facilitate member organisations having on-going access to training material for up to three years after the programme closes.

Commissioner Engagement

The Commissioner Engagement work stream commenced in May 2013 across the North East, Yorkshire and Humber; the programme continued in Yorkshire and the Humber in 2014, as commissioner engagement was seen as a priority at this point in time. With the introduction of the Health and Social Care Act this was an opportunity for Clinical Commissioning Groups (CCG's) to increase their knowledge and understanding of mental health currency and work jointly with providers across local health economies. A scoping exercise was undertaken identifying areas of development and a regional network of meetings were established in the North East and Yorkshire and Humber.

The key areas identified for this work stream included:

- The development and implementation of cluster based service specifications
- Understanding and using information
- Developing a greater understanding of payment and pricing costing information
- Enhancing opportunities for integration with other key strategic priorities.

The work stream delivered the following:

- A suite of cluster based service specifications that are now being used on a local and national basis.
- A specification for assessment.
- Influenced the development of the HSCIC indicator set.
- Held a series of workshops to inform commissioner about best use of MHLDDS information.
- Supported the Commissioning Support Units (CSU's) to focus on how they could tailor information analysis and interpretation for commissioners.
- Facilitated joint work between commissioning and costing work streams.
- Supported local reviews of the Better Care Fund arrangement's and the potential impact on mental health currency implementation.
- Facilitated a workshop with ADASS to identify potential joint work.
- Undertook scoping work around personal health budgets that have led to Action Learning Sets being organised for 2015.

Going forward, the Strategic Clinical Network (SCN), CSU and Mental Health Commissioners in CCGs will continue to take forward the work to support mental health currency progress in 2015/16.

Extending the Scope

The CPPP has been involved in additional work over the years, to establish currencies for other areas of MH and LD services in order to create a seamless set of needs-led clusters that are not restricted to organisational/commissioning boundaries. This has involved leading complete projects, undertaking specific pieces of work to support others, or supporting pilot site membership of other projects. The following describes the work we have been undertaken within these additional areas:

Learning Disabilities

The learning disabilities payment system development project has extended the current scope of the existing mental health model to describe the needs of patients requiring input from NHS funded specialist health services traditionally labelled as "adult learning disability services".

The first phase of data collection for the pilot project was completed with a final report presented to the NHSE Pricing Team. A large number of cases across 18 NHS Trusts were collected within this first phase of data collection. A cluster analysis was conducted using these cases to generate initial groupings. A series of multidisciplinary workshops were then held to review the results of this analysis and generate a comprehensive set of new and clinically meaningful learning disabilities related clusters. These new groups were then reviewed by clinicians who originally submitted data in order to check clinical utility. This led to the following:

- Nine proposed learning disabilities clusters which have good clinical and statistical validity in initial pilot testing.
- Integration of these clusters with the existing mental health payment system.
- Inclusion within these new clusters of increasing levels of risk posed to self and others together with varying levels of physical health need complicated by learning disability.
- Variation across these new clusters in levels of cognitive impairment, severity of needs, presence of autism spectrum characteristics and complexity of physical health need.

The first phase of data collection also highlighted that a significant proportion of cases were clinically allocated to the mental health clusters confirming that these existing groupings have value and use for a significant proportion of people currently accessing specialist learning disabilities health services.

The outcomes from the first phase of data collection were presented to the NHSE Learning Disabilities Programme Board and used to inform the next phase of NHSE Pricing's currency development for learning disabilities services. This has been alongside stakeholder scoping and engagement work that the CPPP has done in collaboration with NHSE Pricing.

A second phase of data collection has commenced with eight provider Trusts collecting data using the new model in practice with the follow aims:

Further validation of the current learning disabilities model:

- Evaluation of the learning disabilities model in practice;
- Understanding the costing of the learning disabilities model.

The outcomes of the second phase of data collection will be used to inform NHSE Pricing's decisions on a learning disabilities currency model. In addition, further work streams have been proposed including:

- How the model could be used to direct effective individualised interventions & care pathways,
- How the model can inform a quality and outcomes framework that supports more personalised care and join commissioning for people with learning disabilities.

NHSE Pricing is currently exploring funding opportunities to continue this work.

Liaison MH Services

The CPPP supported initial scoping work to establish a clearer picture of how Liaison MH services were provided and commissioned. This enabled further work to be undertaken to establish a potential currency model for Liaison services. It is expected that this will be produced as a Local Payment Example within the Payment & Pricing guidance for 2015/16.

Child & Adolescent Mental Health Services (CAMH's)

A national project has recently been completed, looking to develop currencies for CAMH's. The findings and recommendations from this work can be found on the relevant website: http://pbrcamhs.org/resources/event-resources-3/december-2014-engagement-events/

IAPT

The CPPP supported the national IAPT currency development work through membership of the national project group and specifically undertaking work to map the IAPT tiers with the MH Clusters. This work resulted in the clusters having value within the IAPT currency model and being mandated as part of the IAPT data set going forward.

This supports both a way of articulating increasing need within the IAPT model and also supporting seamless transition between IAPT and secondary MH care. http://www.iapt.nhs.uk/pbr/payments-by-results/

Secure & Forensic

The Secure & Forensic PRG Sub Group was established in 2010 with a remit to develop a currency model for High, Medium and Low secure Mental Health & Learning Disability Services. The group has been supported by key stakeholders and has been hosted by the CPPP.

Key Products/Objectives

- Develop a currency model for secure and forensic services that incentives high quality care and supports transition through the patient pathway.
- Establish a range of quality and outcome metrics that can be used as an integral part of the currency model to incentivise high quality care and demonstrable outcomes.
- Create a costing methodology that can be used to establish bench-markable prices.
- To produce a guidance to describe the content of care packages aligned to the currency groupings that are based on evidence and best practice.
- To establish a data set that can be collected and supports the implementation of the overall currency model.
- Test and develop the model for use in high secure services and high, medium and low secure Learning Disability services.

Current Status/Forward View

The model for medium and low secure MH services has been developed and described as a local payment example, due to be included in the 2015/16 Currency Guidance. The data set that supports the currency model has been included as a contractual requirement for all secure and forensic contracts in the current year and this will continue in 2015/16 contracts.

The development work has also been supported and informed by service users, specifically developing the quality and outcomes metrics.

Additional development work is required during 2015/16 to complete the development work for secure and forensic learning disability and high secure services.

Further work is also required to refine the costing methodology, improve methods of data collection and to develop and test further the quality and outcome metrics. This work will be taken forward within the new governance arrangements for MH payment and pricing.

Going forward

The CPPP has completed and supported much of the work required to enable the new payment and pricing model to become a reality, but the work does not stop there. Further progress is required to refine and support the cluster model whilst completing the current development work for other areas of MH Payment & Pricing.

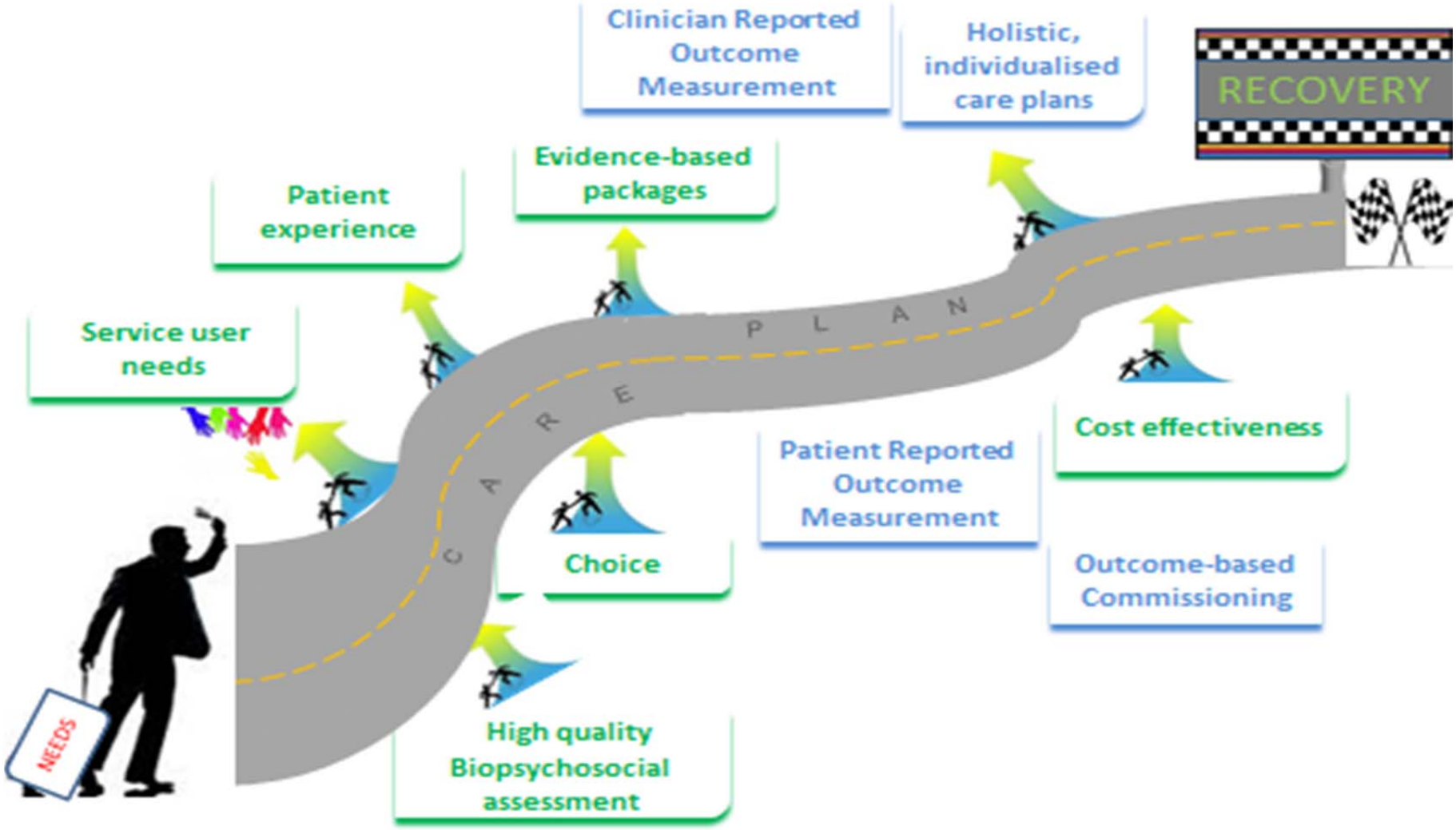
The newly emerging national governance arrangements will continue to draw on the knowledge, expertise and support of those organisations and individuals that have been part of the CPPP, and this will be the main route for on-going influence and the CPPP legacy.

The CPPP website will remain operational during 15/16 providing a range of useful information and signposting for those seeking guidance and help with mental health payment and pricing.

www.cppconsortium.nhs.uk

The next phase of implementation and further development will continue to focus on supporting the service user journey to achieve the maximum benefits and outcomes for all involved.

Vision for mental health payment and pricing system



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Care Pathways and Packages
Developing currencies for mental health

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Barnsley CCG	
Bradford City CCG	
Bradford Districts CCG	
Calderdale CCG	
Doncaster CCG	
East Riding of Yorkshire CCG	
Greater Huddersfield CCG	
Hambleton, Richmondshire & Whitby CCG	
Harrogate & Rural District CCG	**North East CCG's**
Hull CCG	Darlington CCG
Leeds North CCG	Durham Dales, Easington & Sedgefield CCG
Leeds South & East CCG	Gateshead CCG
Leeds West CCG	Hartlepool & Stockton-on-Tees CCG
NHS North Lincolnshire CCG	Newcastle North & East CCG
North East Lincolnshire CCG	Newcastle West CCG
North Kirklees CCG	North Durham CCG
Rotherham CCG	North Tyneside CCG
Scarborough & Ryedale CCG	Northumberland CCG
Sheffield CCG	South Tees CCG
Vale of York CCG	South Tyneside CCG
Wakefield CCG	Sunderland CCG

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