Monitor
Making the health sector work for patients

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2015/16 Mental Health TED Workshop

Broadway House, Victoria, London, 14 August 2014

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What's in this record

Read the slide titles to ***get an overview in five minutes***

Executive summary

- A series of presentations and structured activities enabled the Monitor / NHS England (NHSE) team to understand the mental health sector's views on the tariff setting process, including in the areas of compliance and efficiency factor
- Delegates listened to presentations from those working to set the tariff as well as from those in the service with innovative ideas on payments mechanisms
- A separate Word document contains key themes emerging from all strands of work during the day, aggregated with equivalent work from a previous mental health tariff workshop
- Links and resources signposted during the day included:
  - Video on liaison psychiatry: http://www.cnwl.nhs.uk/services/mental-health-services/psychological-medicine/liaison-psychiatry/
  - Twitter hashtag for the process is #MHpayment1516
  - Health and Social Care Information Centre's (HSCIC) data set and tool: https://public.tableausoftware.com/profile/community.and.mental.health.team#!/vizhome/MentalheathCurrencyandPaymentreports-April2014/Dashboard1

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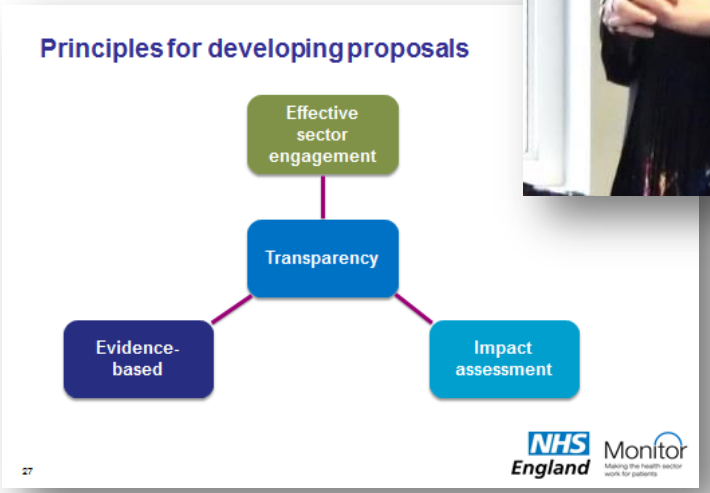
PROCESS

Phil and Catherine welcomed delegates and set the scene for the workshop

Catherine covered process and objectives, timelines for consultation and tariff setting, scope of the national tariff and how national and local variations were dealt with, and how Monitor and NHSE work together.

She spoke briefly about the principles underpinning the tariff setting process, including transparency, engagement and impact assessment. She also showed the proposed changes that would apply not just to mental health, but across the tariff, including new payment designs (using good practice from elsewhere when appropriate), and improving data and other 'building blocks' of the tariff.

"Transparency is at the heart of our principles; we are working very hard to open the 'black box'"



Catherine's presentation is in the Annex (slides 36-44)

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Process

Phil introduced a brief table discussion on the key question, and Sarah and Sue presented the TED proposals

- Headline feedback from the table discussion included:
  - concern about moving away from block contracts
  - how do we bridge from what we've done so far to a personalised recovery based approach?
  - parity of esteem
- Sarah presented the results of the March stocktake event, and the work that remains to be done; Sue presented the mental health implications of the current national tariff proposals
- Fewer than half of delegates knew about the MMHDS for collection of data and currency development, and only 3-4 people were using them
- Delegates' confidence that the proposals were going in the right direction was not very high at this stage

Photos of the completed posters are on slides 16-18; Sarah and Sue's presentations are on slides 45-58

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Phil introduced presentations on experiences from the sector, and led a panel discussion…

- **Steve Reid** showed a video about liaison psychiatry and spoke about the NW London experience of setting up services
- **Phil Moore** presented on how the payments system supports the service to help real patients
- **Stuart Bell** spoke about how a partnership was being created in Oxford to deliver adult metal health services, and the way the payments system needed to change to support this approach

"You can save money with well-designed liaison psychiatry services. We are moving from pilot to mainstream service"

"How well does my commissioning support a person's citizenship?"

"The payments system is perverse … and we need it to help us "

Presentations and notes are in the Annex (slides 59-92)

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… where presenters answered questions from delegates

- Q (to Steve): Why did you say you would not apply for winter pressure money to get your service up and running?
- A: It's nice to have the money, but the timescale implications are large, eg on recruitment of staff.
- Q: How do you get the benefit to follow the investment? For instance, for liaison psychiatry, focusing on the mental health (MH) tariff isn't as helpful as focusing on the acute tariff.
- A (Stuart): Our service is a hybrid: the acute hospital provides an in-hospital service to minimise the length of stay. It was developed that way entirely so that the benefit went to the acute provider. You do need to ask "who is benefiting from the incentives?" You should design the problem carefully, and then let people solve them, rather than defining the solution and imposing it (that will get people's backs up).
- Q: I have a concern that introducing a new liaison psychiatry service itself creates a barrier to integrated care; it's another service to pass people on to.
- A (Steve): Yes, it is a challenge for liaison psychiatry which can be seen as a specialist service called in by others. There's a need to change the culture.

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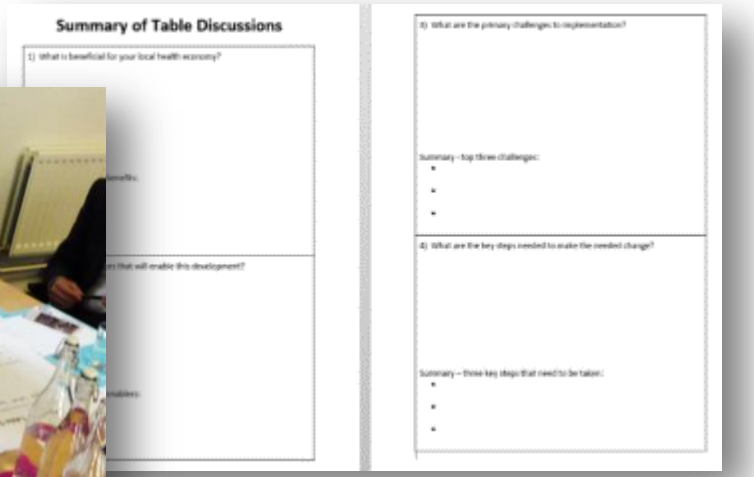
Carl demoed the Monthly Mental Health Minimum Dataset then tables worked on a set of questions using posters



- https://public.tableausoftware.com/profile/community.and.mental.health.team#!/vizhome/MentalheathCurrencyandPaymentreports-April2014/Dashboard1

Photographs of the posters (and notes from feedback) are on slides 19-25

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Phil asked for any burning comments to be noted before lunch

We are not much further on than we were a few years ago. Clustering is here to stay, and we are making better use of this information, but guidance is still as tentative as it was last year. We are not making huge leaps are we?

How many service users are in the room who are helping us in this work?

It is filtering down to users that we are getting to a tipping point of beneficial change.

On clustering: patients are not so keen – I don't use "cluster", there are other ways.

Do users talk about financial systems? People are aware about the need for value, but frustrated when things that seem "obvious" haven't happened – it makes it sound like voices aren't being heard. For instance, having a triage of nurses for liaison psychiatry in A&E, or having a MH person in every GP surgery. And where is the user-led MH service improvement project (like the physical ones)?

Interesting that the conversation is about data. My view is that the data has improved significantly over the last few years, and supports the kicking off of conversations between commissioners and providers. There must be a strong message pushed out that getting data into the system is necessary

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After lunch Michael asked a question about compliance

This is the first year that there's been a statutory basis for compliance with the national tariff. What does this mean? Less to do with enforcement but more to do with understanding why there is non-compliance, and what are the issues and pressures that are preventing it.

There are 3 parts to Monitor's approach to compliance:

- *A short-term pragmatic improvement in transparency*
- *A step change in use and quality of data – within organisations and between commissioners and providers*
- *A longer-term redesign of the payments system to address unintended consequence of national / local pricing issues*

To reiterate, we really want to understand why people don't follow the tariff rules, and where these rules don't work properly, so that things can be improved for the immediate and longer-term future.

Please consider how Monitor might improve the system to improve compliance and the quality of care at a local level.

Responses to this questions from verbal and paper feedback are summarised on slide 26

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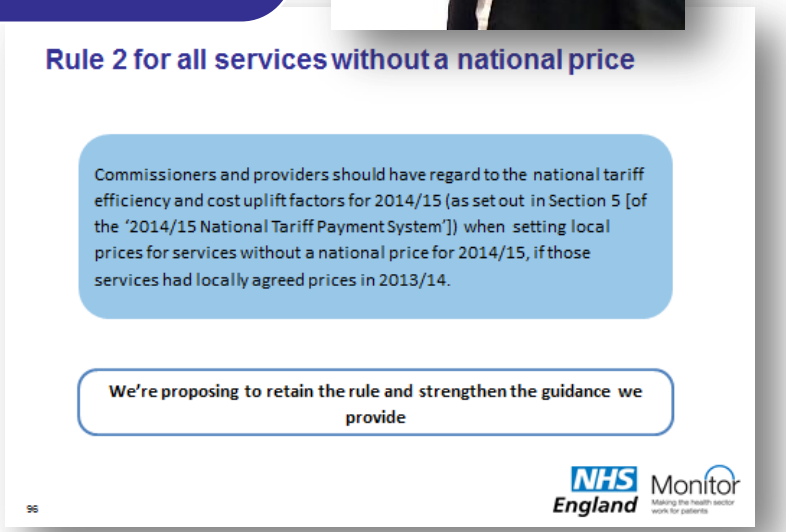
Ben presented on the “efficiency factor”

- Ben explained Rule 2 and outlined the challenge in implementing it in practice to avoid perverse incentives
- He said Rule 2 allows for flexibility; the intention is to encourage a conversation about local cost structures (though he acknowledged that there have been difficulties with how the rule has been interpreted)
- He ran through cost uplift and efficiency factors; the proposal for 2015-16 for cost uplift is not to change the structure, but to work hard to get the numbers right (especially for service development) through consultation
- For the efficiency factor the evidence base will be significantly improved and processes will be more transparent; there has been consultation on the methodology and expert help to set the efficiency factor value (expected to be 3-5% for 2015-16 compared with 2-4% the previous year)

The core challenge is arriving at a mechanism that takes into account a real distribution of efficiencies, perhaps within the reference cost (which also takes into account many other variable factors)



Q&A notes are on slides 27-28; Ben's presentation is on slides 95-98

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Groups then worked on specific topics from the morning … and fed back their work …

The topics worked on were:

- **Table 1 – How to get buy-in**
- **Table 2 – Creating a collaborative community**
- **Table 3 – Data and analysis**
- **Table 4 – Using clusters within payment**
- **Table 5 – Using outcomes within payment**
- **Table 6 – What should be nationally mandated**

Posters and notes from this work are on slides xx-xx

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Sue and Katy summed up and thanked delegates for their input

- “Everyone has come today because they are interested but we are scratching at the surface of potential engagement so please tell us what more we can do.”
- Phil handed out review forms
- Katy and Sue thanked people for their work during the day, pointing out the highlights of understanding what is trying to be achieved, and the commitment to driving things forward
- Katy said that examples of how positive change was being, or could be, implemented would be created (with help of people in the room) as there was a clear demand for this
- She said there was a mix of practice and use of data out there, and that Monitor / NHSE would consider this in future work
- Sue said that she had picked up on the importance of relationships and collaboration, as well as risk and messaging during the day, especially when it comes to service re-scoping and ownership of outcomes

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OUTPUTS

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Key objectives for the day (from tables) [1]

What is your key objective for today?

- TO INFLUENCE PROPOSALS SO THAT THEY REWARD DOING THE RIGHT THING + PROMOTE PARITY OF ESTEEM.

What are your other important objectives for today?

- HOW DO WE DELIVER QUALITY OUTCOMES
- DEFINING 'RIGHT THING' + OUTCOMES
- REPORTING LIFE-TIME COST SAVINGS AS OPPOSED TO 'IN-YEAR' COST SAVING.

What is your key objective for today?

- ROADMAP TOWARDS CONSISTENCY
- KNOW WHAT COMISSIONERS THINK
- UNDERSTANDING LINKS B/W TARIFF / OUTCOMES
- UNDERSTANDING WHAT COMISSIONERS ARE GETTING FOR TARIFF
- MANAGING RISK FOR BOTH PROVIDERS & COMISSIONERS AROUND SWITCH TO PBR.

What are your other important objectives for today?

- HOW COBICS WORKS IN MH
- CURRENCY.

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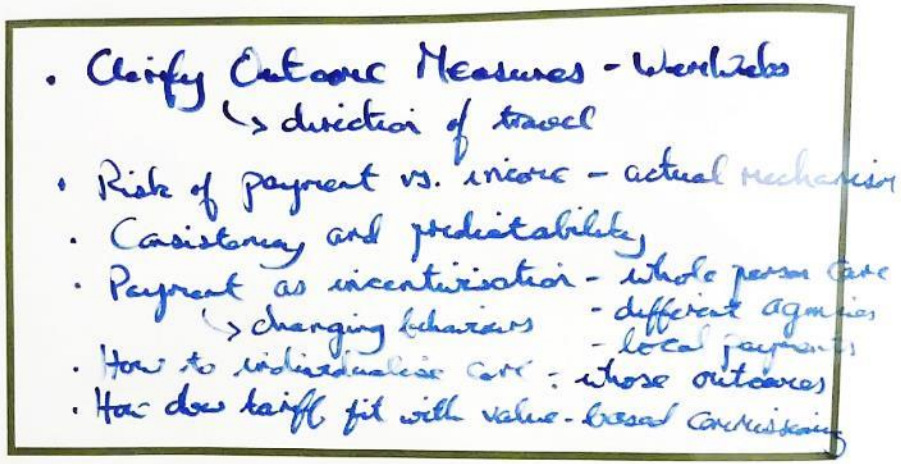
Key objectives for the day (from tables) [2]

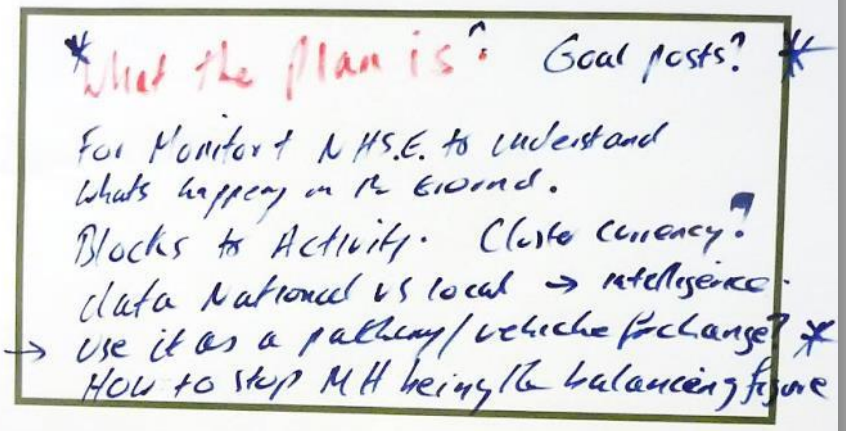
What is your key objective for today?



What are your other important objectives for today?

- Clarify details detail around tariff
- How will it all work ?
- What will happen after next year?

What is your key objective for today?



What are your other important objectives for today?

- Contract round.
- Business Rules

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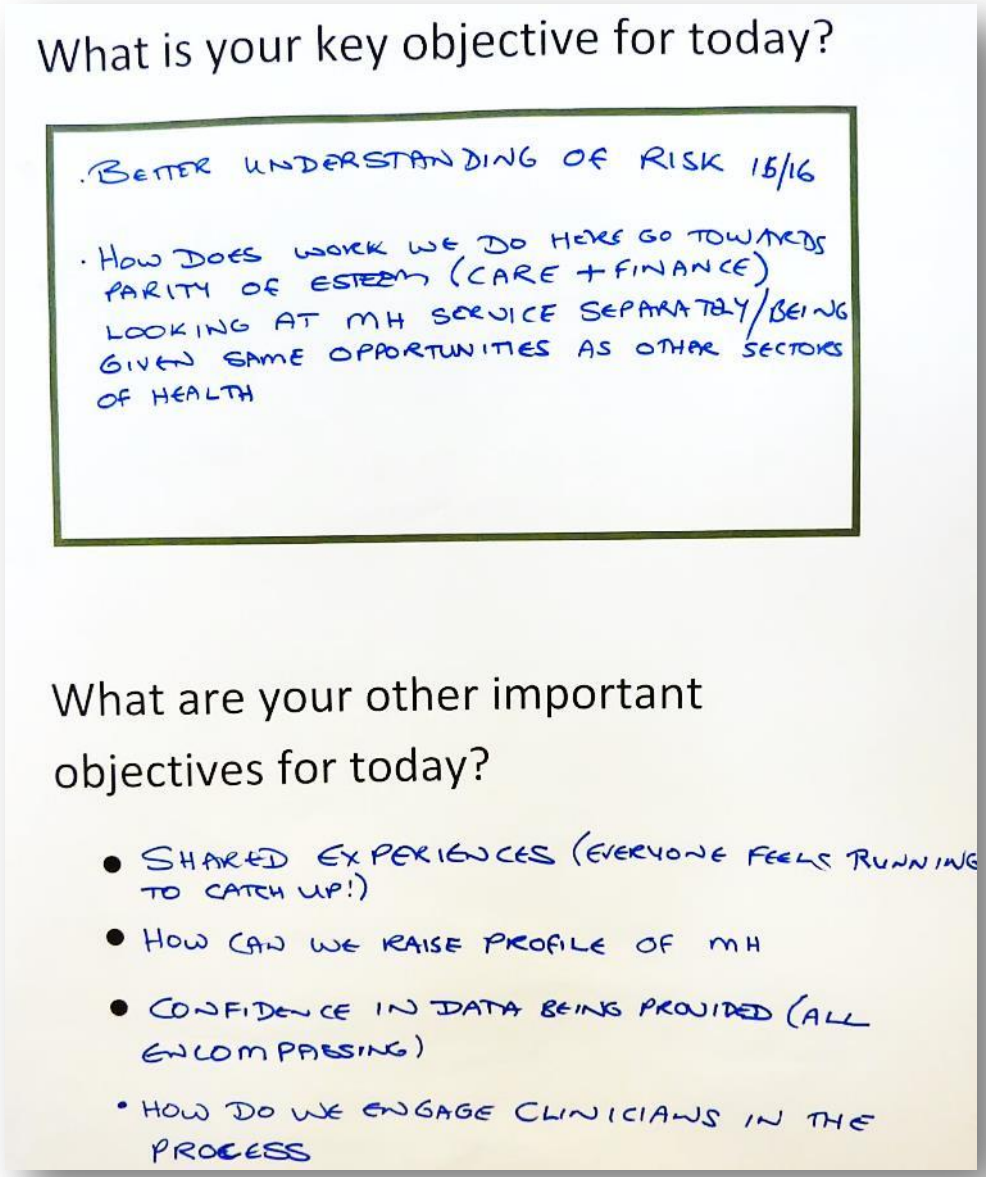
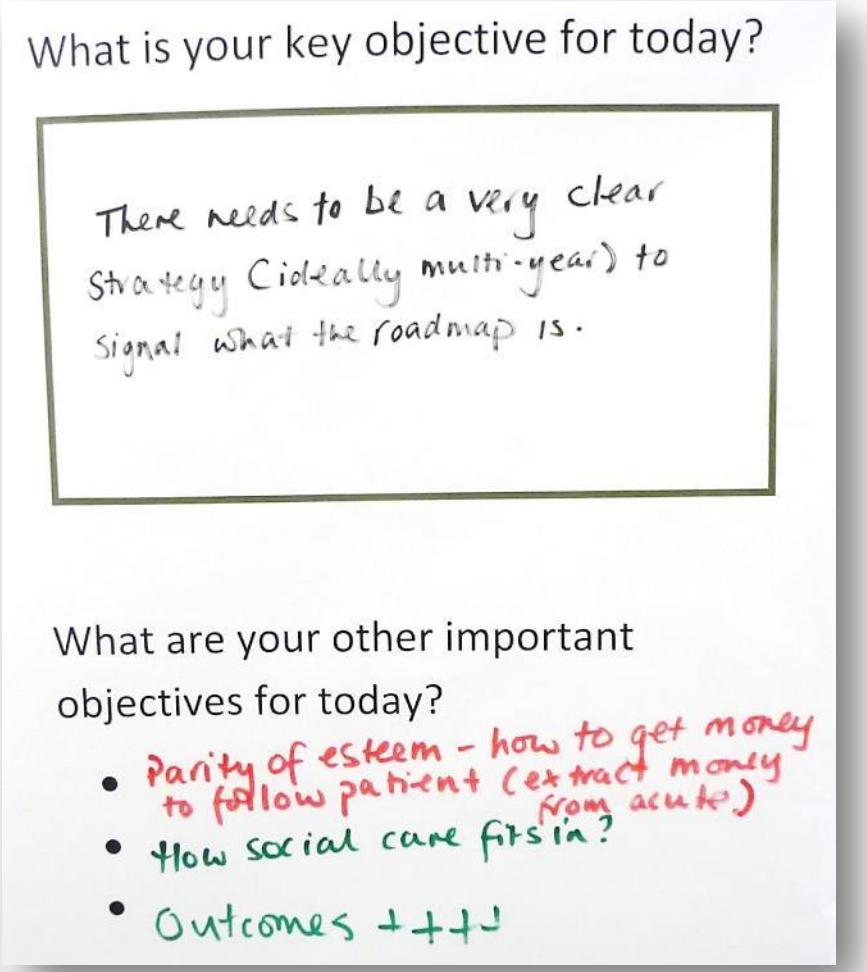
Key objectives for the day (from tables) [3]





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Morning poster work A

Summary of Table Discussions

1) What is beneficial for your local health economy?

- Look at data - know what's going on.
- Costs info helpful. - supports "Party" discussion.
- Mandated move to cost collect.
- encourages en innovation approaches

Summary - top three benefits:

- Information getting better
- Stimulation of conversation.
- Helping transformation? Internally yes outside maybe.
- Outcomes.

2) What are key factors that will enable this development?

- data improve - eir incentive.
- enforcement / accountability in system.
- measuring the outcomes

Summary - top three enablers:

- Build upon data sets on patient access/outcomes
- National data set investment.
- Ø Relationship support/Guidance

3) What are the primary challenges to implementation?

Local price. ie 3 different prices 3 CCGs 1 provider
Split/single.
Clarity on what is being accounted for/enhanced.
Genuine transparent local shared in common.
Timescale + capacity.
Make CQUIN meaningful

Summary - top three challenges:

- Mandate + enforcement + incentive
- Clinical information. + effectiveness.
- Sharing the benefits + Risks.

4) What are the key steps needed to make the needed change?

Clear direction:
examples for High volume + cost series. ie CMHT.
Clear series examples

Summary – three key steps that need to be taken:

- clear guidance on benefit + risk sharing
- Cross Commissioning principles. ie Two foundation trusts.
- Clarity on who owns this. avoid fragmentation ie provider + commissioner.

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Morning poster work B

Summary of Table Discussions

1) What is beneficial for your local health economy?

Synthesis between Phil's articulation of prob + Stuart's work to try + address it.
Freeing
Idea of sector partnership for benefit of individual patient.

Summary - top three benefits:

-
-
-

2) What are key factors that will enable this development?

Want to know how can make delivery happen
understanding the needs of your population
move away from admission discharge concept to understand patient care needs over period of time - patient flows
building good relationships - across orgns - social care
wellbeing of work force.
creating communities

3) What are the primary challenges to implementation?

Defining outcomes which partners want
Incentivising capture of clinical feedback.
What is the balance = clinical and other outcomes - do we know what makes sense
Be brave about 'always events'
too much variation from dist + CCGs in area
need to work together more

Summary - top three challenges: funding continuum of care over lifetime of needs

-
-
-

4) What are the key steps needed to make the needed change?

Orpg capable patient - self management + peer support
building a
Shared sense of vision across health economy
Setting out the problem thoughtfully asking the right questions
understanding patient journey + interaction across the system (martin knapp tool?)
Sharing experiences - + case studies

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Morning poster work C

Summary of Table Discussions

1) What is beneficial for your local health economy?

Many for patients
Value for money - ↑ quality for less outlay
Low cost - high value.
↑ productivity

Summary - top three benefits:

- Better pt experience - what pt wants
- Better use of resources.
- Shared/integrated goals.

2) What are key factors that will enable this development?

- Not standard contract - better contracting tools
- Organisational stability + better collaboration
- 'Open Book' - transparency
- Need a 'space', 'vagueness' - don't overdefine
- Memorandum of understanding
- Greater flexibility
- Need a 'road-map' for next few years
- Need clarity of vision - with CCGs over.

Summary - top three enablers:

- Do something different for 5 people per day.
- Shared intelligence/data
  Inspirational leadership
- Partnership working
  → risk-taking
- Patients at heart:
  - co-production

3) What are the primary challenges to implementation?

Provider lead - 'not there yet'
Much of this is aspirational
Need to change focus
What are next steps to take?
Vision not clear
Feels unstable currently
Cost base
Need incentives in right direction

Summary - top three challenges:

-
-
-

4) What are the key steps needed to make the needed change?

Need time to think
Longer term 5-7 yr plan?

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Morning poster work D

Summary of Table Discussions

1) What is beneficial for your local health economy?

- All agree Liaison beneficial - for PATIENTS.
- Benefits of scale – e.g. NWL / Oxford eg. opportunity for CSUs.
- Consistency – PBR for Acutes ∴ PBR for MH.
- ~~if not~~ BPT for Liason Psych.
- incentives to work with primary care. - work better.

Summary - top three benefits:

2) What are key factors that will enable this development?

- incentives to work with primary care.
- IPBs - → lower cost. [but need the right support to access.]
- Close ~~&~~ interagency working + information systems + sharing tech.

Summary - top three enablers:

- Culture.
- Incentives w' Primary care.

- Culture change

3) What are the primary challenges to implementation?

- who pays for "liason" - identifying who realises the benefit (financial) → also social care. eg.
- Annual round of contracting / annual + in-m.
- w' IPBS can remove budget. Risk to provider
- how do we incentivise the right behaviours.

Summary - top three challenges:

- Outcomes are tougher to measure than in Acutes / physical.
- All parties realising benefit.

4) What are the key steps needed to make the needed change?

- Longer term contracts / +ariffs.
- improve data quality (incentivise)
- understand what is being paid for - outcomes not just volume
- Direction from centre → outcomes measurement. progress options.

Summary – three key steps that need to be taken:

- → ROADMAP → better contracting.

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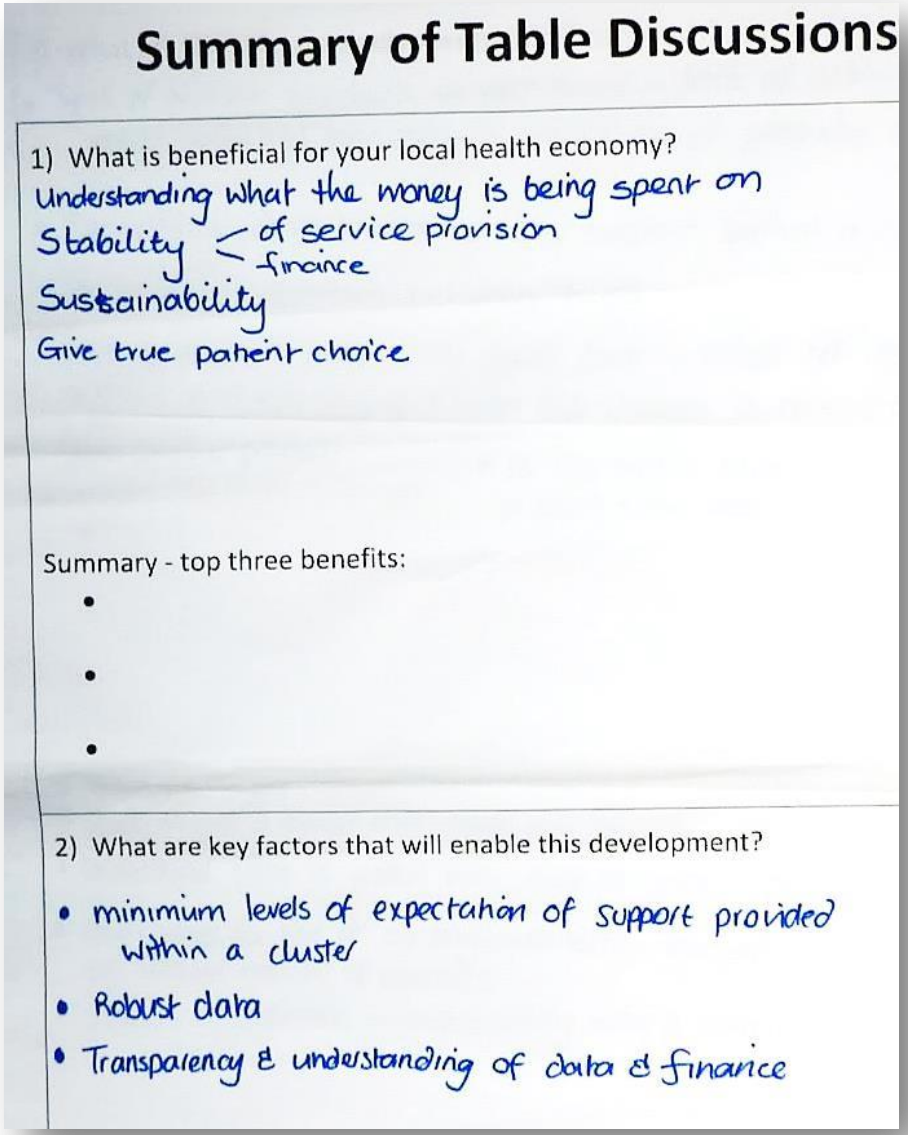
Morning poster work E



Summary of Table Discussions

1) What is beneficial for your local health economy?

Understanding what the money is being spent on
Stability < of service provision
< finance
Sustainability
Give true patient choice

Summary - top three benefits:

•
•
•

2) What are key factors that will enable this development?

• minimum levels of expectation of support provided within a cluster
• Robust data
• Transparency & understanding of data & finance

• Disconnect between clinicians and the process

3) What are the primary challenges to implementation?

• Robust Data
• Types of provider available in our area – lack of alternative giving potential monopoly – variation of provider model
• Describing what makes up the support within a cluster
↳ potential variation between trusts
• Everyone needs to move at the same time – those not on tariff may end up double paying if/when a pt chooses to receive care from another provider
• is too much expected within a short time scale

Summary - top three challenges:

•
•
•

4) What are the key steps needed to make the needed change?

• Understand & accept that there will be risk
• Understand what is within each block contract – provision & finance
• outcomes for the pt so payment isn't focussed on LOS or number of contacts
• Clinical engagement – understanding why & usefulness of clustering

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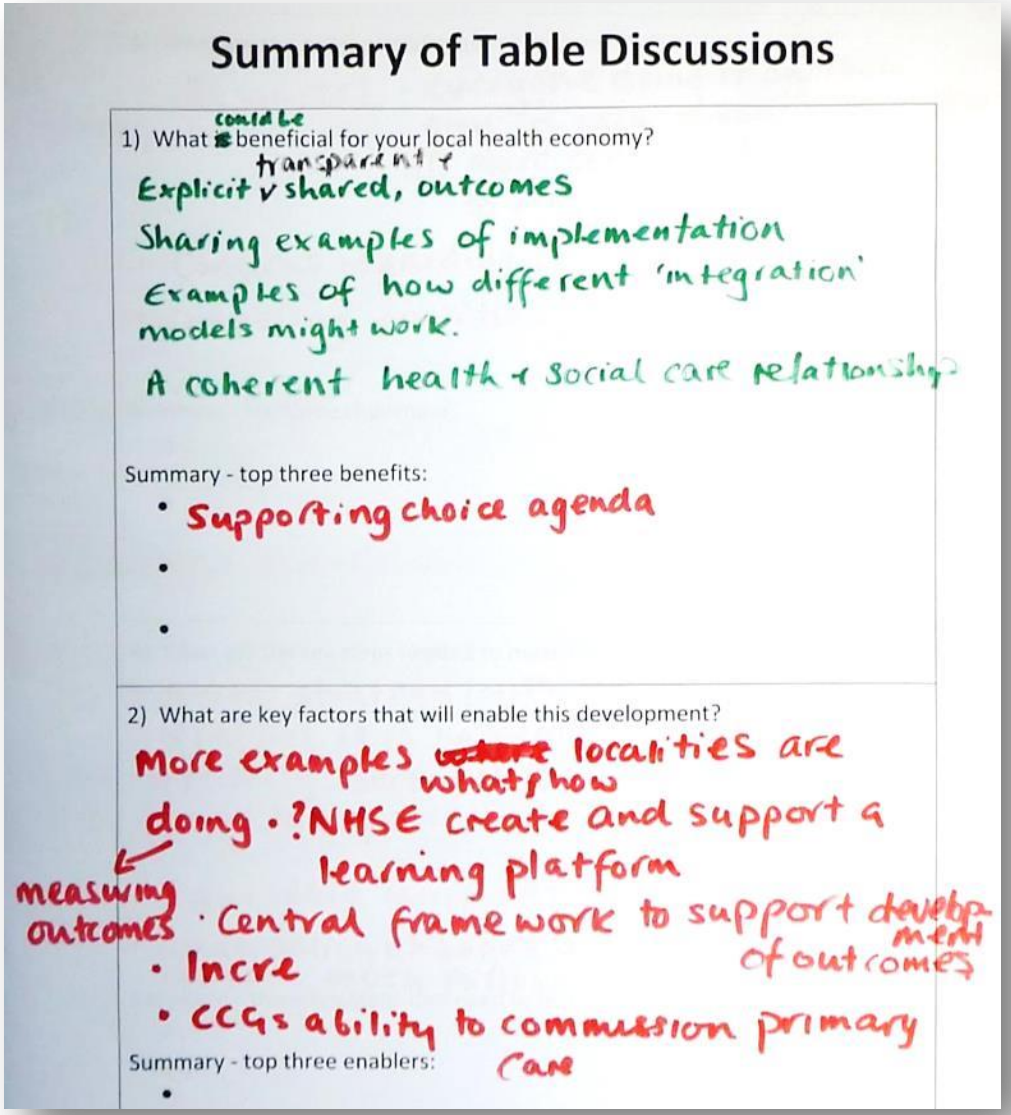
Morning poster work F



Summary of Table Discussions

1) What could be beneficial for your local health economy?

Explicit transparent & shared, outcomes

Sharing examples of implementation

Examples of how different 'integration' models might work.

A coherent health & social care relationship

Summary - top three benefits:

- Supporting choice agenda
-
-

2) What are key factors that will enable this development?

More examples ~~of~~ localities are what/how doing. ?NHSE create and support a learning platform

measuring outcomes · Central framework to support development of outcomes

- Incre
- CCGs ability to commission primary care

Summary - top three enablers:

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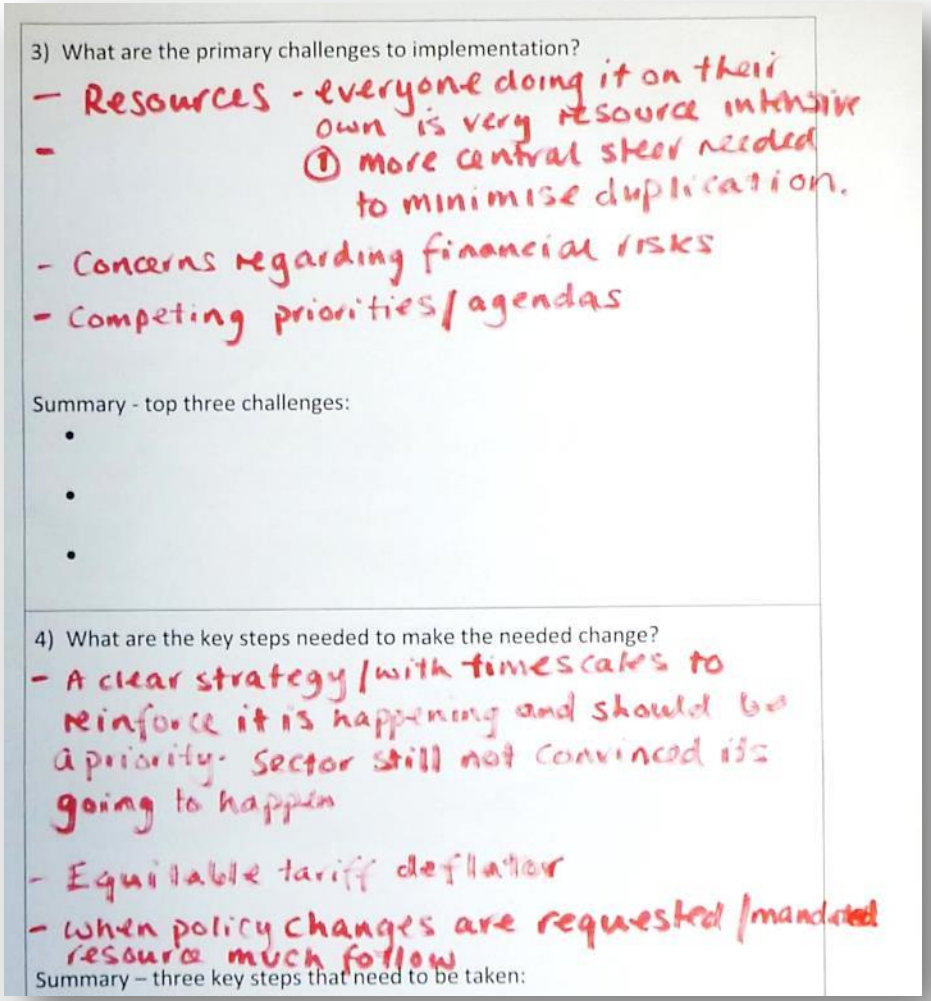

3) What are the primary challenges to implementation?

- Resources - everyone doing it on their own is very resource intensive
- ① more central steer needed to minimise duplication.
- Concerns regarding financial risks
- Competing priorities/agendas

Summary - top three challenges:

-
-
-

4) What are the key steps needed to make the needed change?

- A clear strategy/with timescales to reinforce it is happening and should be a priority. Sector still not convinced it's going to happen
- Equitable tariff deflator
- when policy changes are requested/mandated resource much follow

Summary – three key steps that need to be taken:

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Highlights fed back from morning poster session

- Concept of recognising the capable person / patient / client; their journey is at the heart
- Recognise continuing care (pathway without beginning and end) and use case studies and individuals to look at element / touch points and evaluate where this happens
- How real is this process and where is it heading? People have been working on a “shadow” process
- There is cynicism about the process and this needs recognising (not fast, far enough etc) and there is also tension between local decision making within a central framework
- Interest in some form of platform (like cases) examples where localities are doing things that make it happen
- Examples: surprised to see these were low-cost, low-volume and not clustered; they wouldn’t help the commissioners to innovate
- Need to get to the heart of the problem; much discussion about good local management information shared between commissioners and providers but this is dependent on local relationships
- Cross-commissioning principles: not just risk and cost sharing but also sharing benefits more widely; guidance would be useful
- Data needs to be robust: commissioners and providers need to be honest with each other and accept that there will be risks but we need to have productive discussions rather than hiding behind existing positions
- Trying out outcomes-based contracts and making these meaningful
- Annual round of contracting is difficult; would like longer rounds and longer contracts
- Conversation about culture: talking about contracts and finance isn’t as natural as it is in other parts of the service
- Partnership working between different organisations rather than current silos; we wondered if this was a consulting or partnership relationship? Can we keep some of the tariff for those consortiums or partnerships? This way of working should be promoted

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Verbal and paper feedback from Michael's question on compliance

- There might be local examples (several) where neither commissioner nor trust pays more than lip service (eg ticking "yes, it's cluster-based"); this is "surface compliance"
- We would find it useful to have a very clear indication of timescale – people are parking the issue because it doesn't seem to be this year's problem
  - *"I can't give you a date because we're on a journey and people aren't clear on the incentives or penalties yet." "It's not appropriate for us to be heavy handed; we want to understand what's not working, and to get more organisations complying, and to understand modes of compliance." "Next year we will feed this information back to the sector." "We are not yet ready to provide examples of good practice to the sector."*
- Link to a clear roadmap
- Give clear and strong messaging about what is required in the first place
- Support the sector by following through on what is proposed
- There is a lack of information and engagement on rules eg for CCGs, new organisations are not used to regulations
- Where are the consequences of not complying? For instance:
  - vague guidance and rules
  - fragmentation post-2012 act
  - last year disconnect between NHSE / Monitor
- Strong leadership, more engagement with commissioners
- Training and understanding needed
- "Implementation fatigue"
- Data usage: understanding the data you have got

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Discussion following Ben's presentation [1]

- **It's a flawed assumption that because things are getting financially tight, higher efficiency will necessarily follow.**
- Response: We do have a legal requirement to do an impact assessment on setting the efficiency factor. We have done some work on this, but more remains to be done. Also, it's all well and good for us to do the complicated maths in our office, but we really need input from the knowledge in this room to help us do that maths in the best way for the patient.
- **MH trusts have delivered 4% efficiency year-on-year for several years and MH is not the same as the acute sector.**
- Response: We can't pretend that there aren't data limitations. We are doing the best we can and trying to avoid errors. Longer term we need to understand cost pressures better for different services; we will put out a document later in the year that will ask for input into how we can gather better data to make better decisions on the efficiency factor.
- **We are at the point of making structural changes to the service locally. Local economies have changed; demand pressures are going up and local authority funding has fallen through the floor. There will be system changes (case mixes, cheaper staff, call centres) and some of these are in the opposite direction to "integration".**

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Discussion following Ben's presentation [2]

- Response: We need to try to get to the best outcome and allocation within the bigger picture on financing (which we can't solve).
- **Efficiency factor may not solve things but it can impede innovation and integration and partnership working; it shifts the focus on risk and it doesn't fit with the parity of esteem.**
- Response: It's a really important point, so the question is how we should interpret the efficiency drive? How do we innovate to make it work? A lot of what I have heard from other workshops has been about "how can we do the same at a lower cost?" and this isn't the right question. There isn't a fundamental issue about the belief that there should be improved efficiency over time.
- **Isn't MH a special case? The impact assessment of applying a single efficiency factor will be important. MH has always had a disproportionately high requirement to increase efficiency; it's never been standard with national services (eg acute) before.**
- Response: I'm not sure that's strictly true, because different regimes have applied in the past and I reiterate that there is an opportunity for local price setting.

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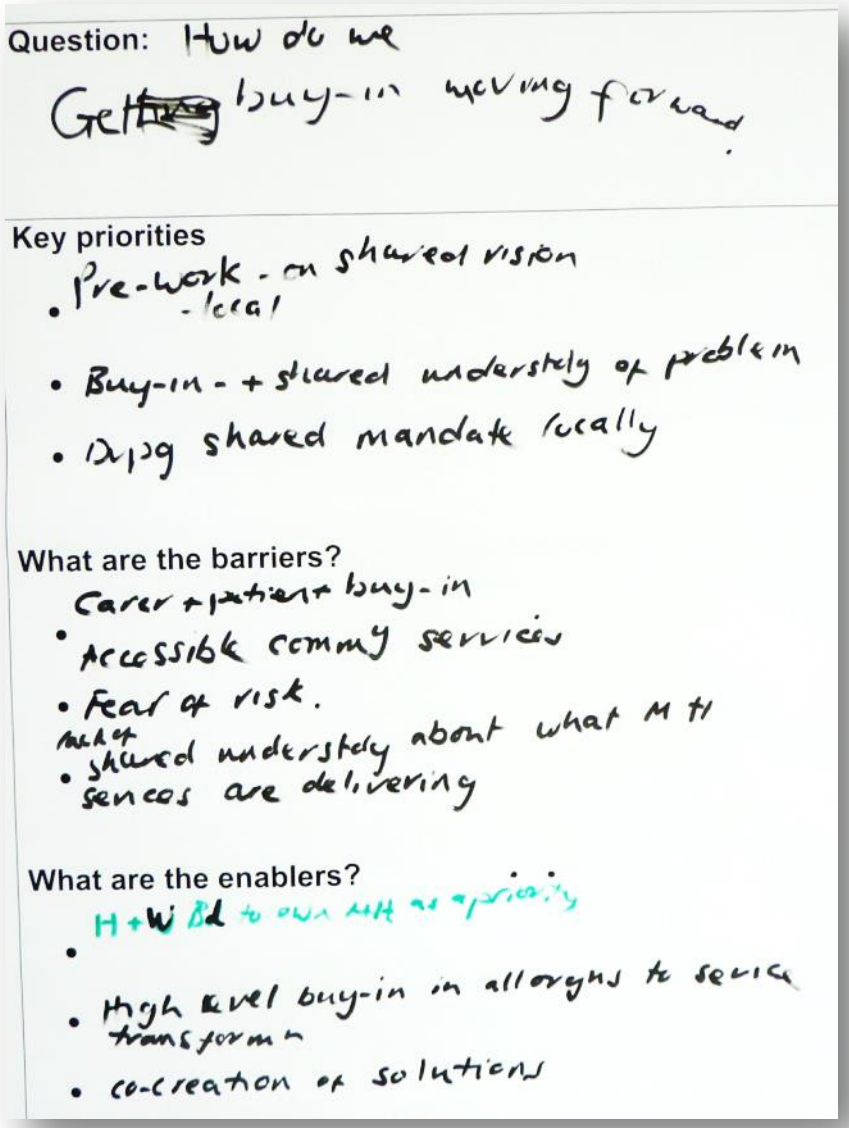
Group 1 poster and summary fed back



How to get buy in

- "Buy-in to what?"; piecemeal or earthquake? It has to be major and transformational
- Need for definition of what MH services will look like – wellbeing and care; what is the problem? Need to have a shared definition
- Barriers include fear of risk of big transformational change etc and will we get patient and carer buy-in?
- Need to re-establish "community"
- A good "health and wellbeing board" is a huge enabler; if it doesn't exist or isn't working then it needs a local champion
- Need to co-create

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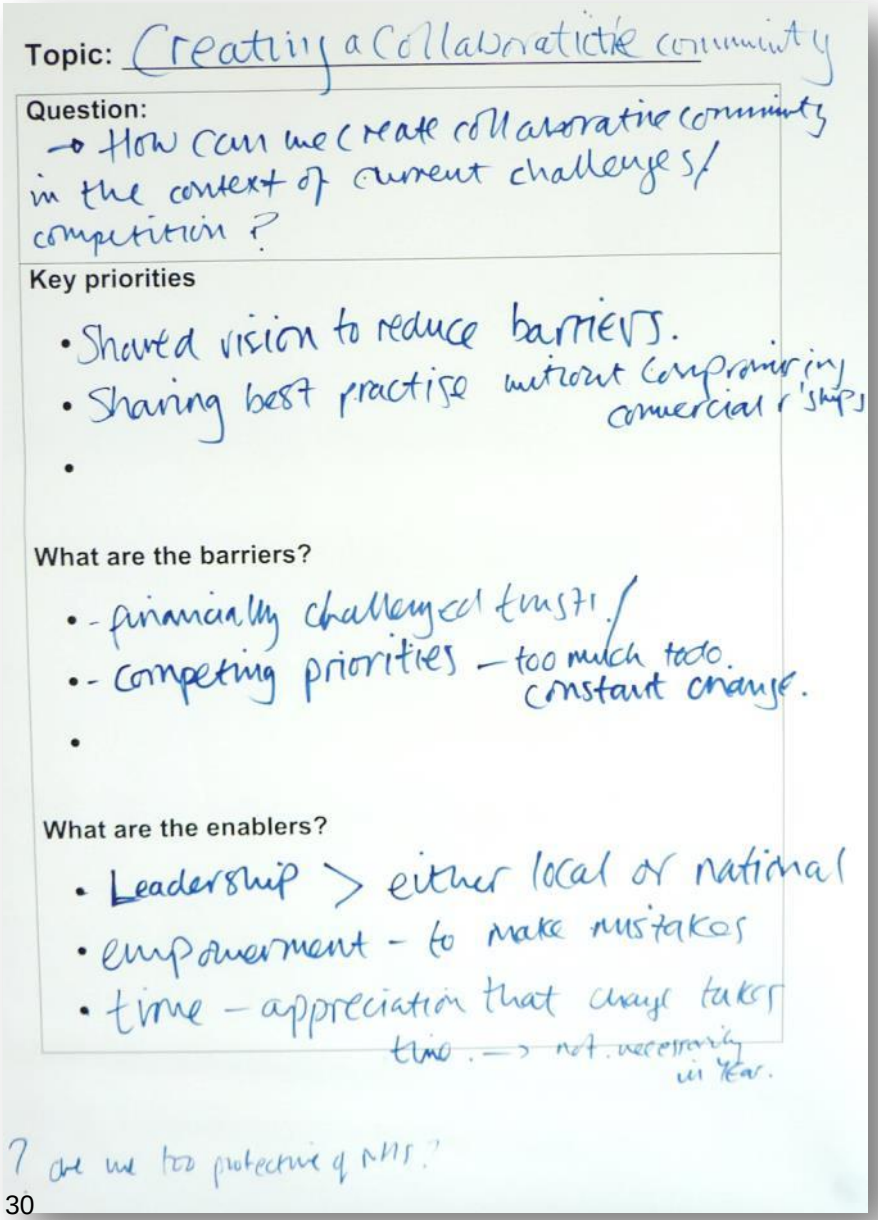
Group 2 poster and summary fed back

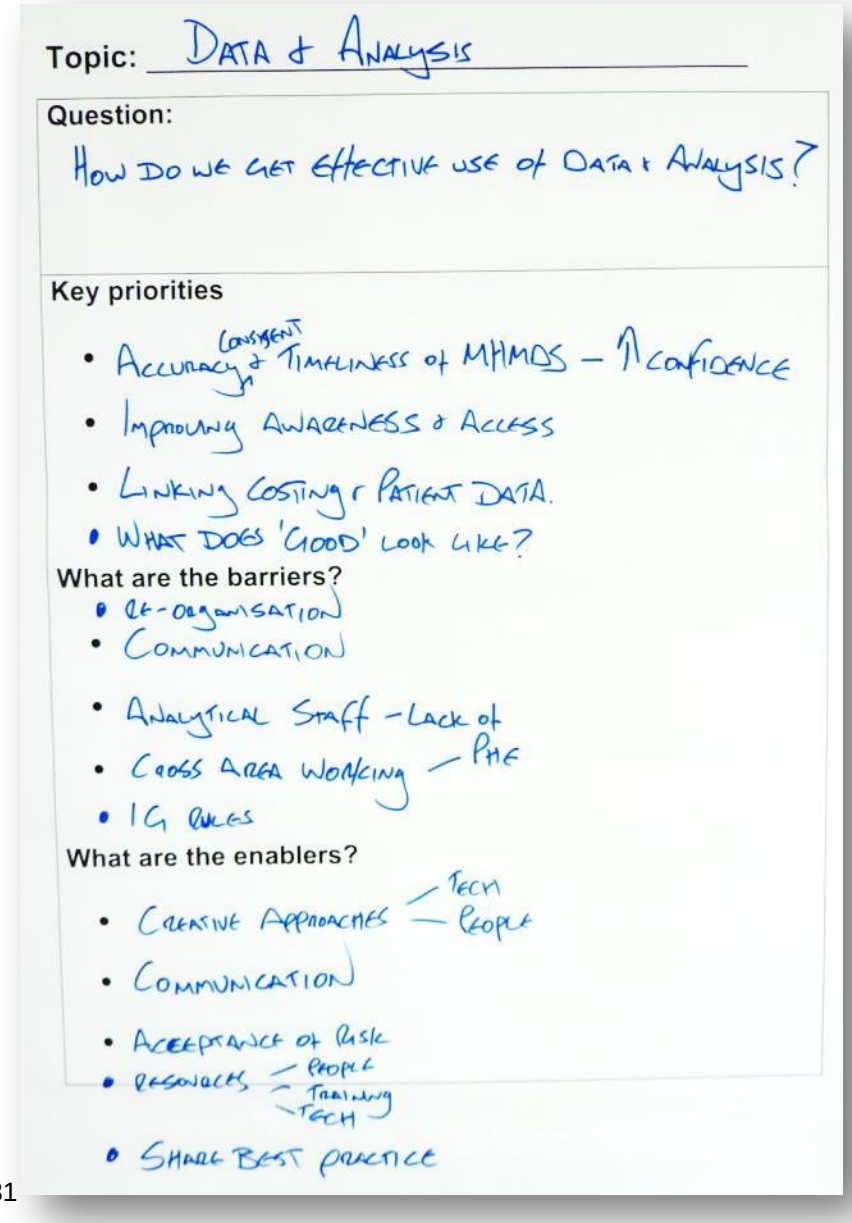


Creating a collaborative community

- We talked about building a shared vision; sharing best practice without damaging commercial confidences
- Financially distressed trusts; constant change and too much to do
- We spoke about leadership nationally and strong local leaderships (copy Sandhurst?); empowering local people to make mistakes; change takes time: are we too protective of the NHS? Are we stifling ourselves when trying to save it?

30

Group 3 poster and summary fed back



Topic: DATA & ANALYSIS

Question:

HOW DO WE GET EFFECTIVE USE OF DATA & ANALYSIS?

Key priorities

- ACCURACY (CONSISTENT) & TIMELINESS of MHMDS – ↑ CONFIDENCE
- IMPROVING AWARENESS & ACCESS
- LINKING COSTING & PATIENT DATA.
- WHAT DOES 'GOOD' LOOK LIKE?

What are the barriers?

- RE-ORGANISATION
- COMMUNICATION
- ANALYTICAL STAFF – LACK of
- CROSS AREA WORKING – PHE
- IG RULES

What are the enablers?

- CREATIVE APPROACHES – TECH – PEOPLE
- COMMUNICATION
- ACCEPTANCE of RISK
- RESOURCES – PEOPLE – TRAINING – TECH
- SHARE BEST PRACTICE

Data and analysis

- Accurate and timely data; awareness and access to analysis; what does 'good' look like?
- Communication is important: lack of MH specialists in CSUs?
- Be creative; accept risk; more resource and sharing of best practice

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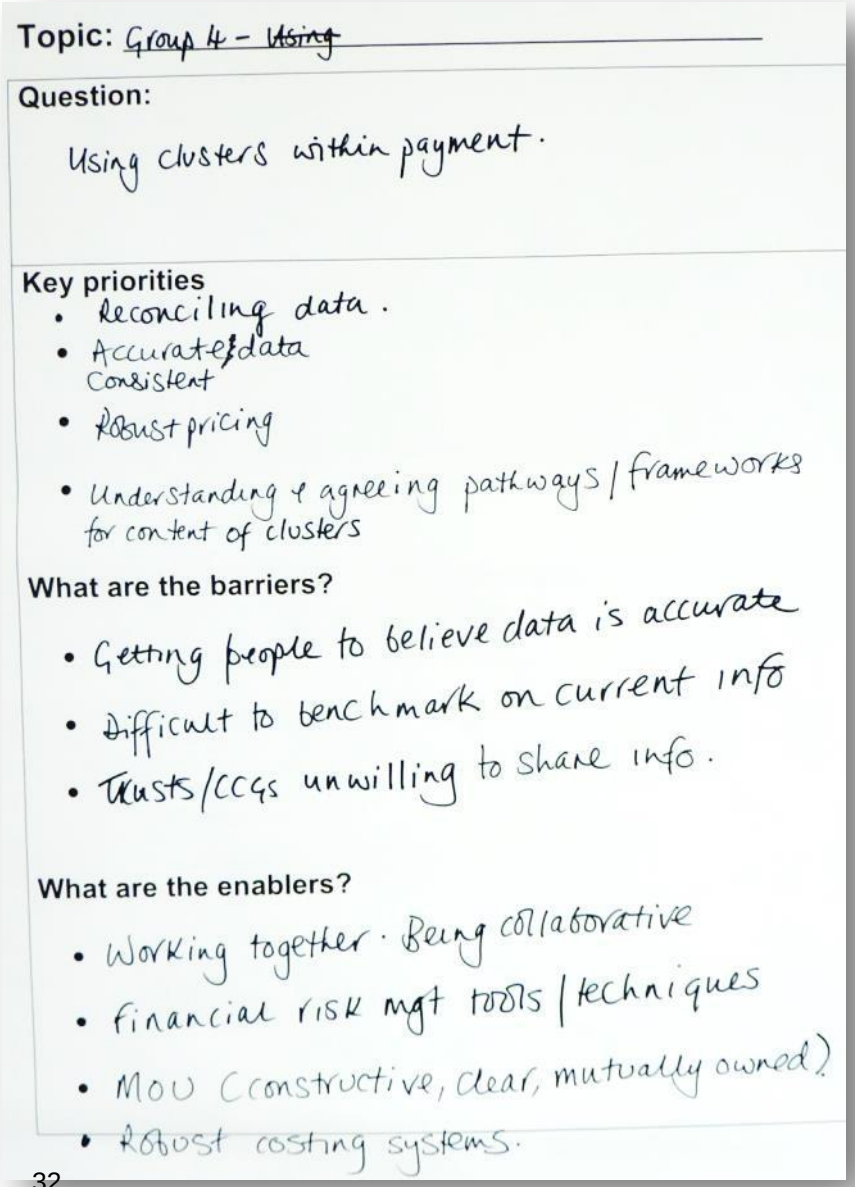
Group 4 poster and summary fed back



Topic: Group 4 – ~~Using~~

Question:

Using clusters within payment.

Key priorities

- Reconciling data.
- Accurate & data Consistent
- Robust pricing
- Understanding & agreeing pathways / frameworks for content of clusters

What are the barriers?

- Getting people to believe data is accurate
- Difficult to benchmark on current info
- Trusts/CCGs unwilling to share info.

What are the enablers?

- Working together. Being collaborative
- Financial risk mgt tools / techniques
- MOU (constructive, clear, mutually owned)
- Robust costing systems.

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Using clusters within payment

- Priorities: robust pricing system is required
- Barriers include CCGs' processes: they aren't willing to share, participate in benchmarking, or believe things presented to them
- The end point is 'better working together' with financial risk management tools being shared: constructive and owned by both parties

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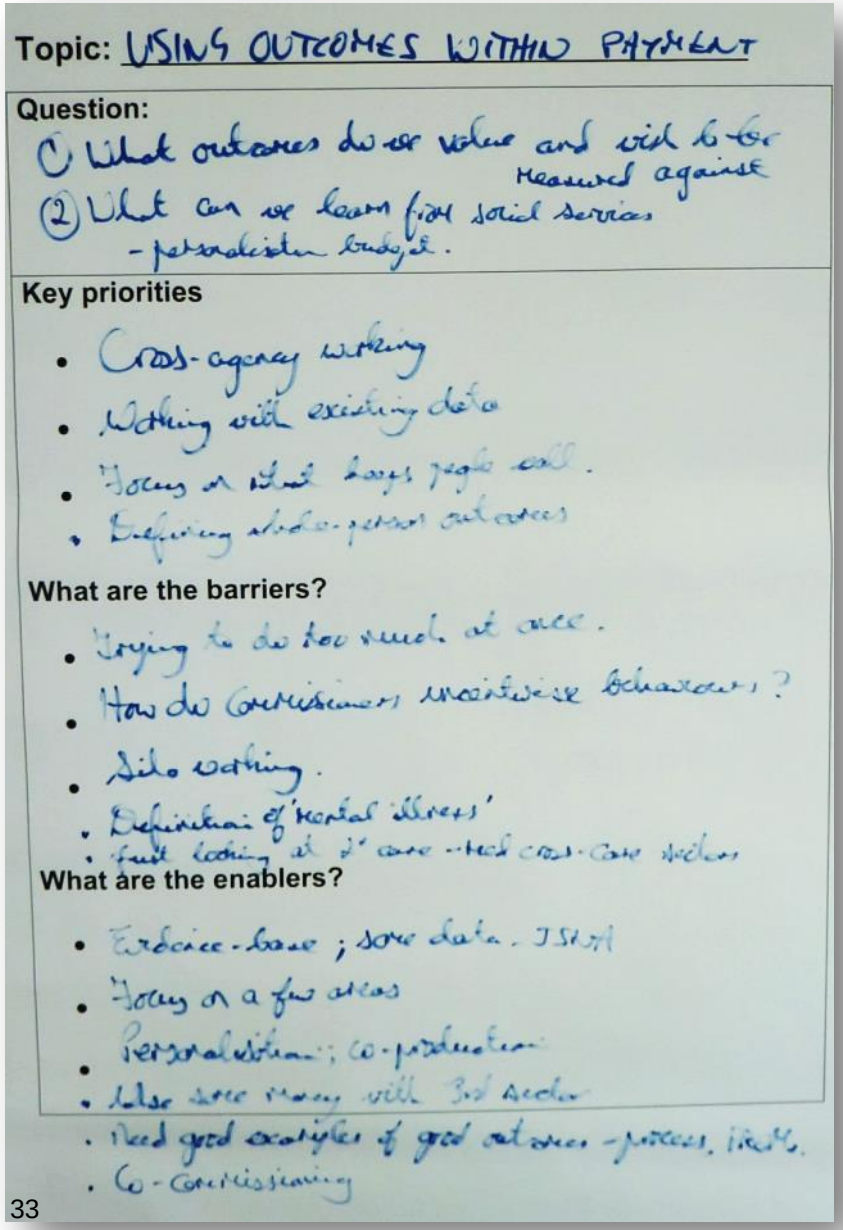
Group 5 poster and summary fed back


Topic: USING OUTCOMES WITHIN PAYMENT

Question:

(1) What outcomes do we value and wish to be measured against

(2) What can we learn from social services - personalisation budget.

Key priorities

- Cross-agency working
- Working with existing data
- Focus on what keeps people well.
- Exploring whole-person outcomes

What are the barriers?

- Trying to do too much at once.
- How do Commissioners incentivise behaviours?
- Silo working.
- Definition of 'Mental illness'
- Just looking at 2° care - need cross-care sectors

What are the enablers?

- Evidence-base; some data. JSNA
- Focus on a few areas
- Personalisation; co-production
- Links some many with 3rd sector
- Need good examples of good outcomes - process, results.
- Co-Commissioning

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Using outcomes within payment

- Cross-agency working and co-commissioning are key
- Using available (quantitative) data was important; some felt that personal budgets would be valuable (as in social care); not trying to do too much too quickly
- We acknowledged that we are moving to outcomes-based pricing and this must be wider than the currencies that exist at the moment

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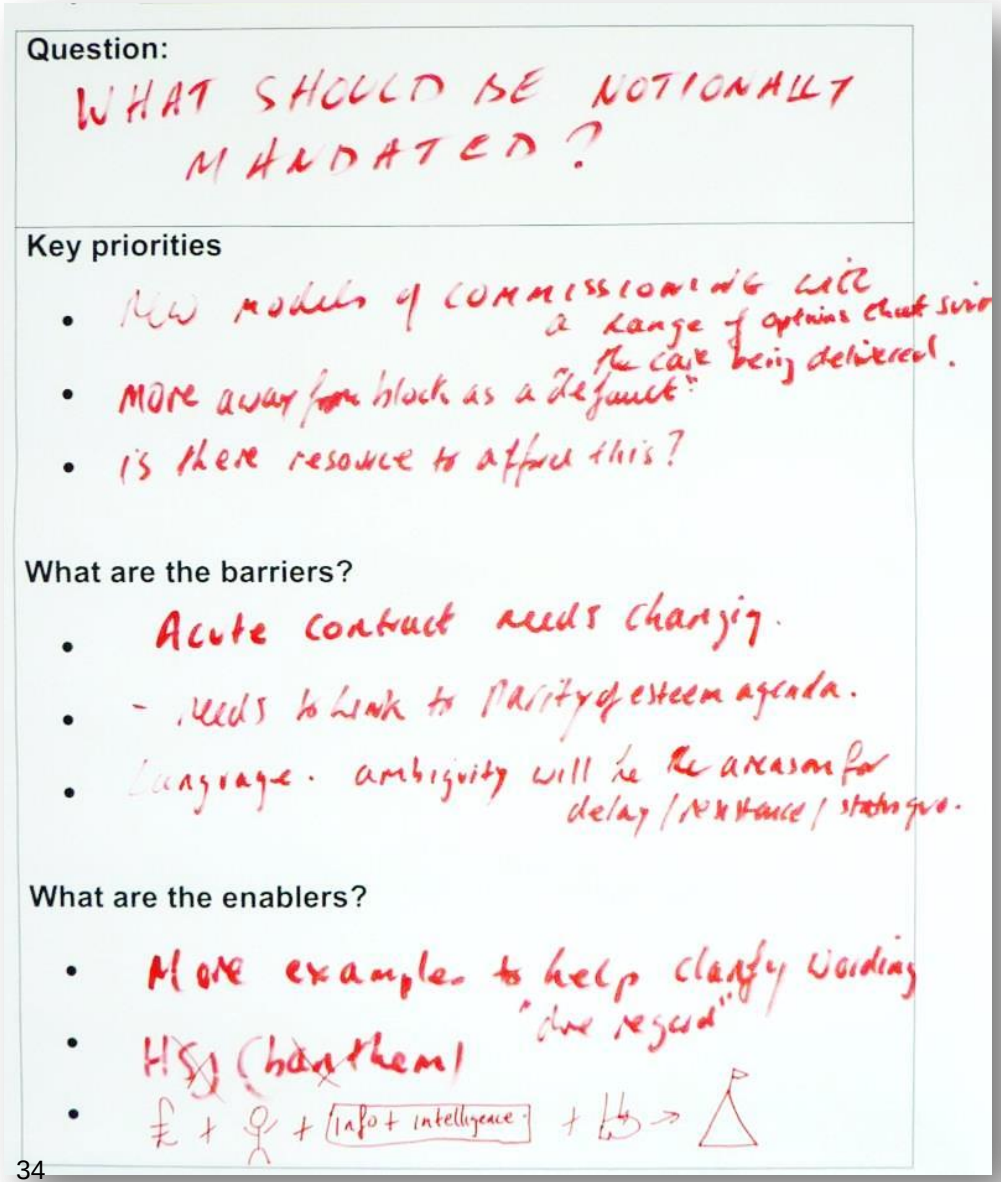
Group 6 poster and summary fed back



What should be mandated nationally?

- The end point is not about stopping block contracts, it is about clear activity-based contract for mental health
- Acute contracts have dominated and we need to get past this to the point where we are working together
- We can see that we are working backwards to where we want to be strategically; we will continue to play games so if we use phrases like ‘due regard’ then at least give us some examples about what this actually means so we are all nudged in the right direction

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ANNEX: PRESENTATIONS / TALKS GIVEN ON THE DAY

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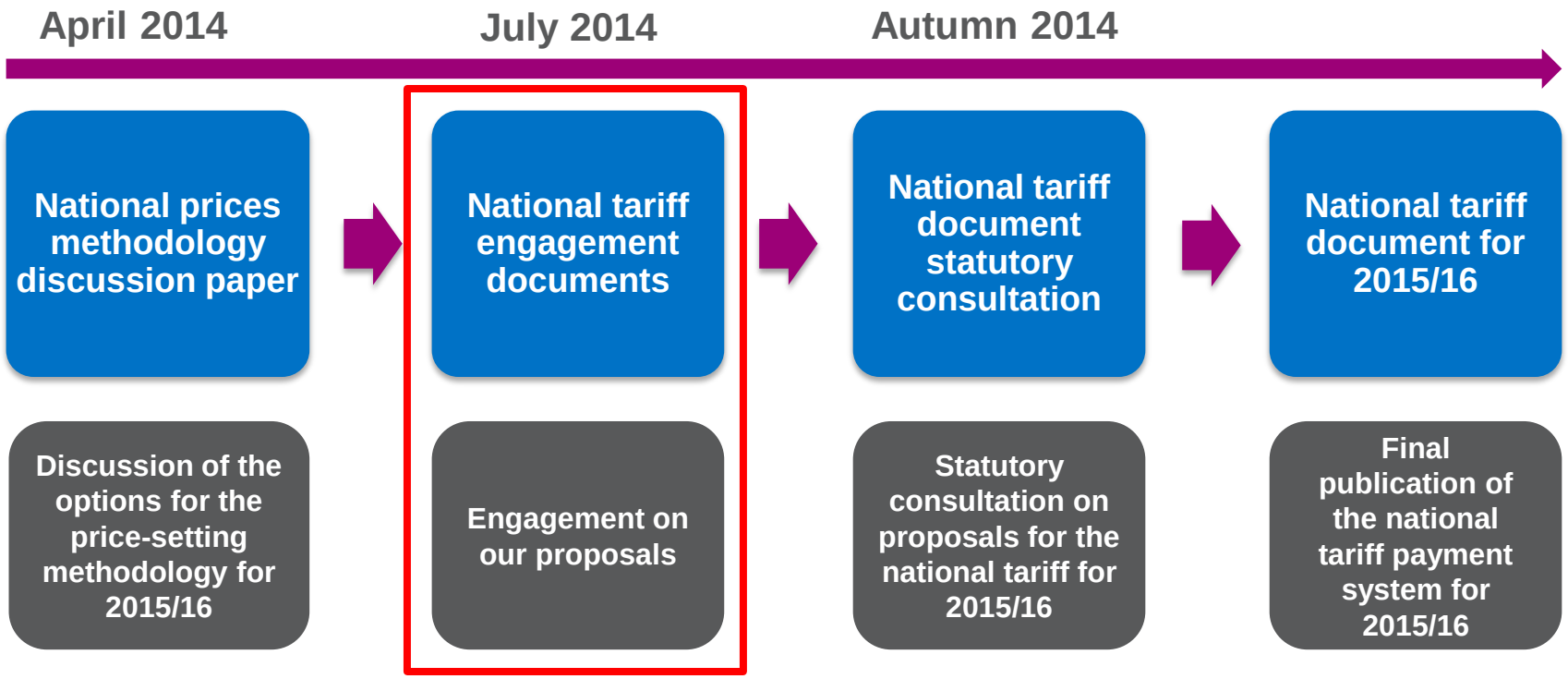
NHS England

Welcome!

Catherine Pollard

Development Director, Pricing

Overview of the process for 2015/16



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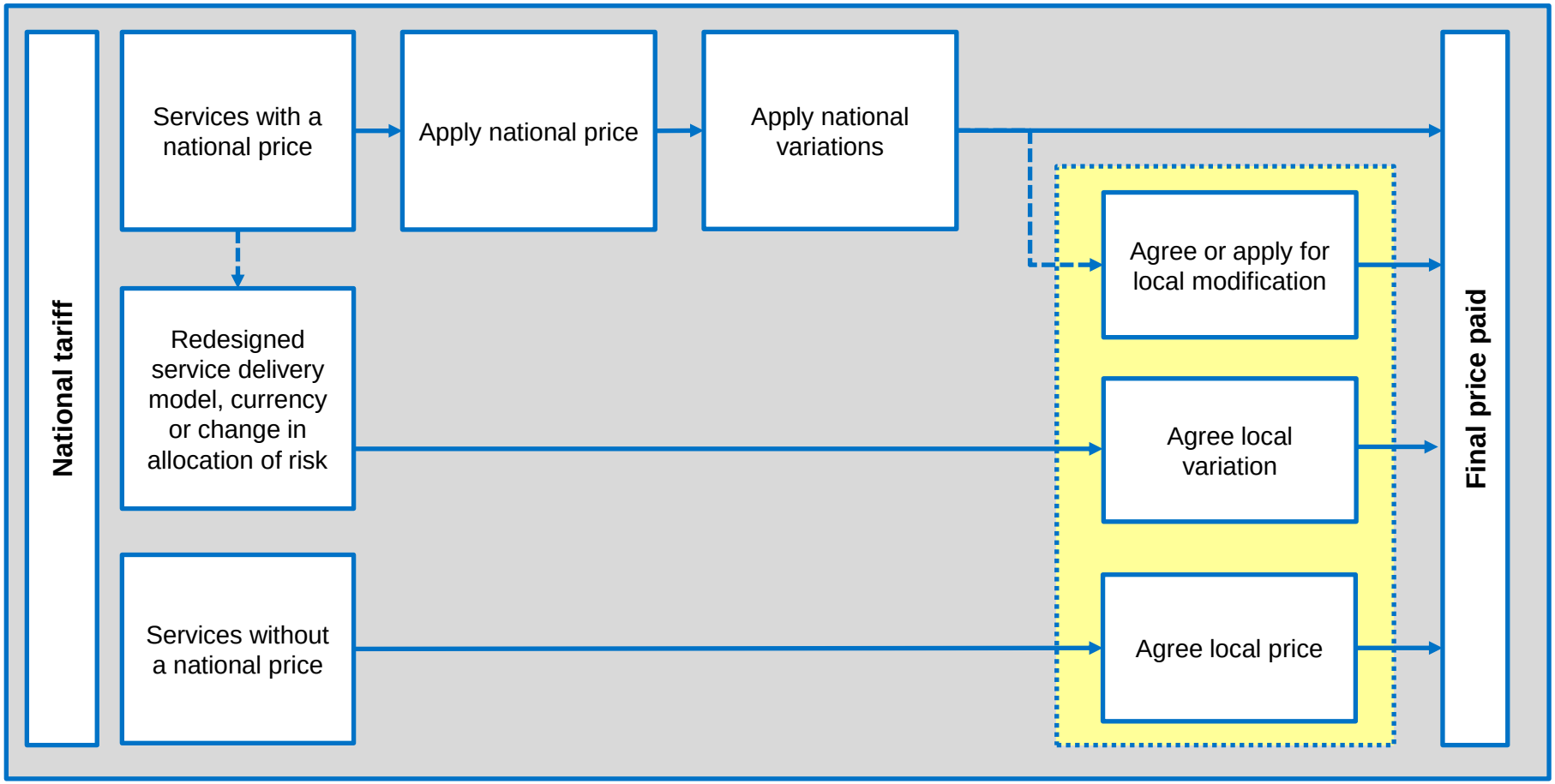
What does the national tariff cover?



NHS England and Monitor's tariff-setting roles

NHS England leads on:	Close working and agreement	Monitor leads on:
• scope and design of currencies • variation rules to national tariff currencies		• pricing methodology • regulated prices • local modifications • rules for local pricing and non-tariff pricing

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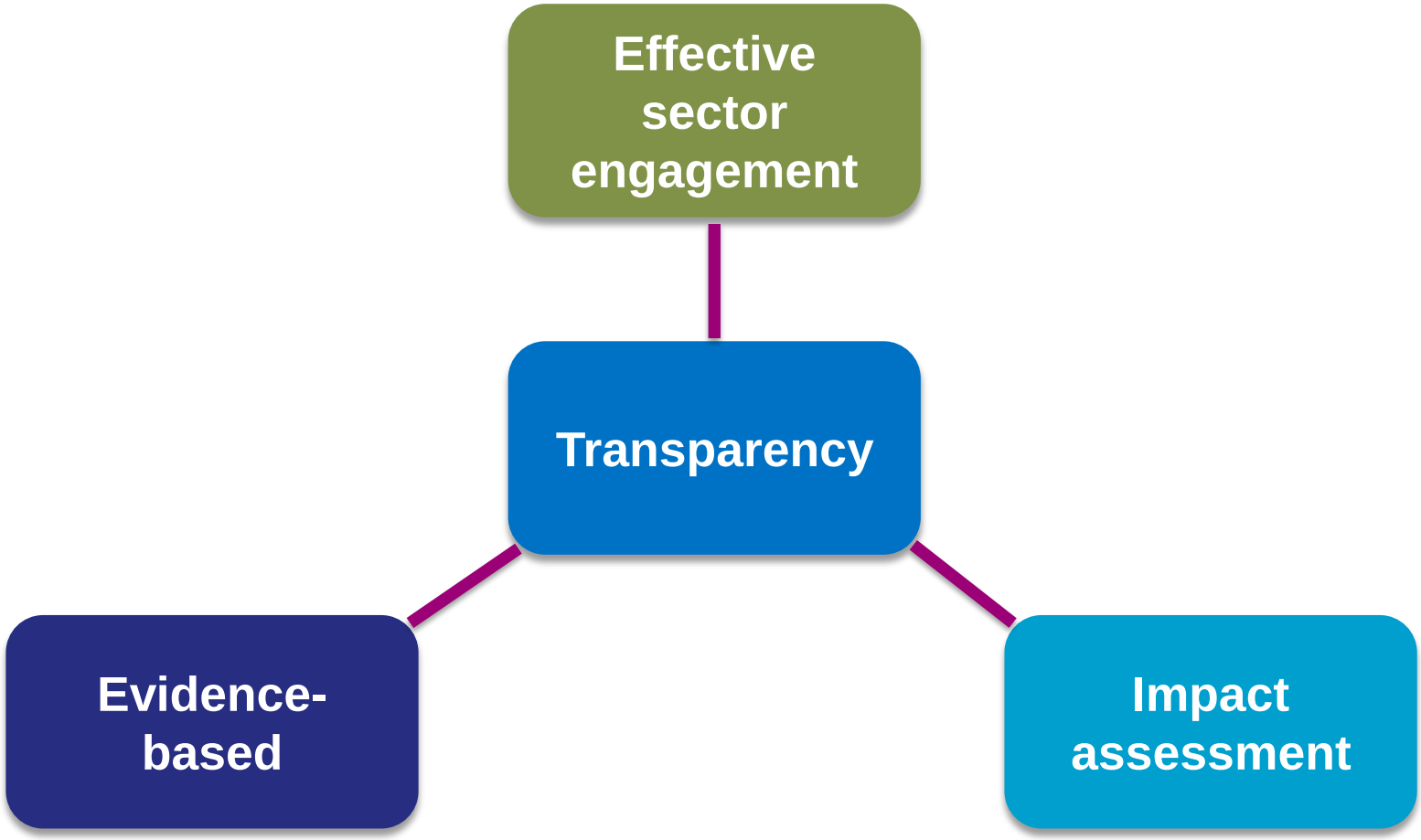
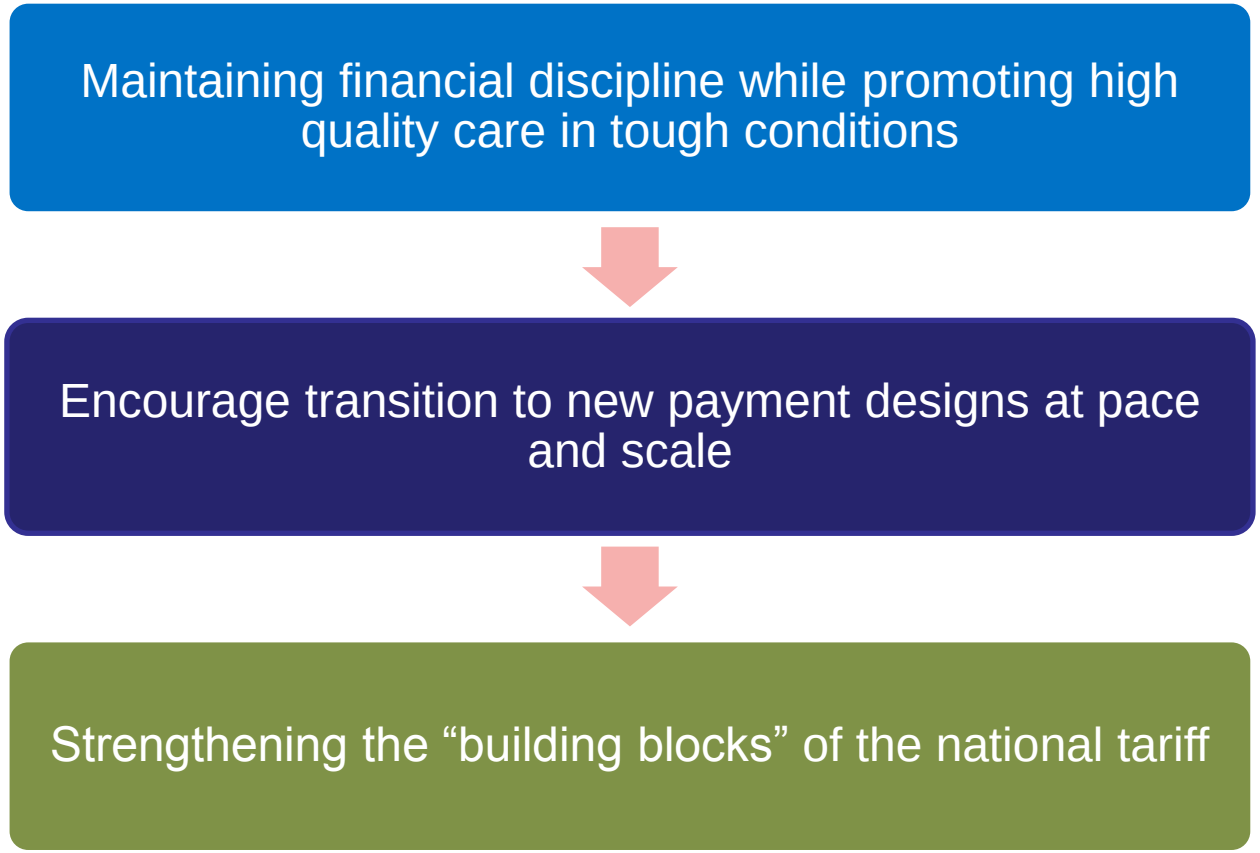
Principles for developing proposals



Changes we are proposing for 2015/16

Three key themes underpin changes proposed for 15/16



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Why do we need a national tariff?

- Reduce cost variability and incentivise efficient provision
- Transparency in payment , activity both locally and nationally
- Allows providers to compete on quality
- Allows commissioners to target needs of local population

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Goals for today

1) What are the proposals?

- Provide professionals in mental health sector:
  - background related to MH policy
  - an understanding of rules and expectations within the 2015/16 tariff proposals

2) How do they work?

- Enable the sector to consider how they can effectively implement 2015/16 tariff proposals and move toward the vision for MH services

3) What do you think?

- Gather feedback on 2015/16 tariff proposals and share “next steps” related to development of the 2015/16 national tariff

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Mental Health Payment System: 15/16 Proposals

14 August 2014

This presentation

1. Background to the 15/16 mental health payment system proposals: the March stocktake event

   Sarah Khan, NCD Adviser

   NHS England Medical Directorate

2. 15/16 proposals

   Sue Nowak, Head of Pricing Development

   Pricing Team, NHS England Finance Directorate

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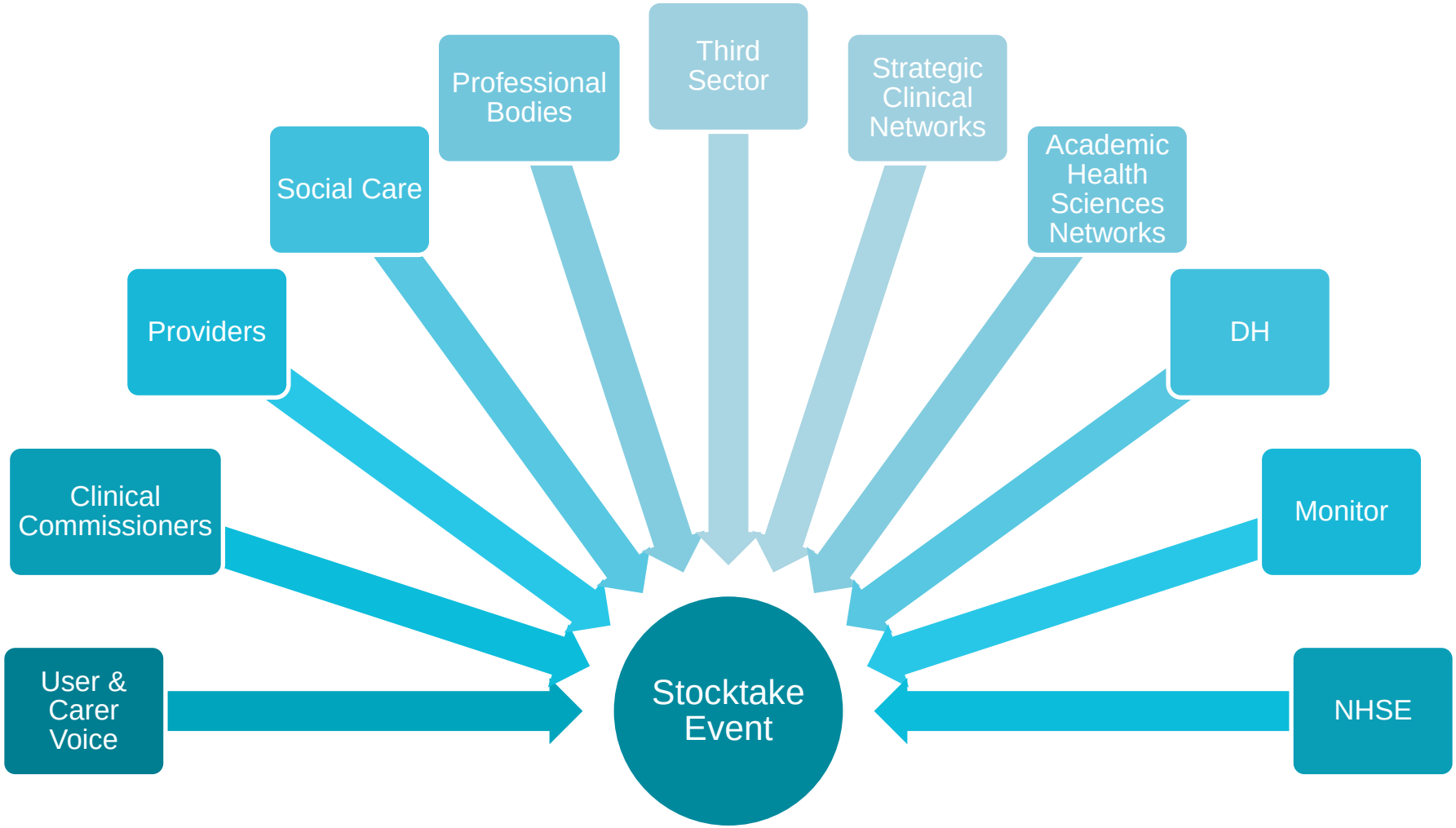
MH Payment System Stocktake Event – 19th March 2014

Aims:

1. To confirm the current and **future national policy direction** for mental health services and ensure that the national mental health payment system programme is fully aligned with this vision.
2. To update and consult with system leaders and partners on the options for **building on the work already undertaken** on mental health payment.
3. To consult and agree with system leaders and partners' shared objectives for **what the mental health payment system needs to deliver** and how to incentivise delivery over the next 2-3 years.
4. To **take stock of collective progress** towards these aims and objectives, both within and outside the current national MH payment system programme.
5. Identifying opportunities for continuing to develop the mental health payment system to inform **the future work programme**.

Excellent representation from across the system



The direction of travel for mental health services		
1.	**Empowered individuals**	• access to information and choice • recognition of individual and community assets • enhanced use of digital technology
2.	**Enhanced primary care services**	• development of local enhanced primary care schemes that support the prevention / early intervention / reablement agendas, and enable a supported and sustainable route out of secondary care
3.	**A modern model of integrated care**	• person-centred services with seamless integration across mental health, primary care, social care and housing • evidence-based mental health interventions integrated within physical health pathways and vice-versa
4.	**Highest quality urgent and emergency care**	• high quality crisis care with a combined focus on crisis prevention as well as its timely and effective management
5.	**A step change in productivity**	• rapid access to evidence-based interventions that deliver best outcomes making effective use of technology
6.	**Effective commissioning of specialist care**	• effective management of tier 4 demand; high quality specialist provision and a focus on least restrictive setting and integrated pathways out of specialist inpatient (often out of area) care

The services of the future: delivering outcomes and value

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My mental health, as well as my physical health, is assessed at GP registration and in annual health checks

My GP and practice nurse are trained to make an early diagnosis and help me in recovery

I can access treatment within weeks and not years (or never) as happens now

I receive NICE evidence-based psychological therapies as a routine (not just a 1:10 chance of getting it)

I am offered psychological therapies even if I come from a BAME community or I am older

I am prescribed medicines safely and helped to take them well

I have a care plan that includes effective interventions to recover and get employment

When I am in a mental health crisis I dial one number and get taken to a healthcare assessment centre

When I go to A&E I am assessed by staff trained in MH awareness & assessment in line with NICE

My family are well supported in caring for me

I am supported to self manage and continue to be part of my community and contribute to it

Every experience is a kind, compassionate, educating, skilled encounter

Other key messages from the system

Our overarching objective for the mental health pricing and payment system must be that **it enables and drives improved value for money**; it should be the best possible use of taxpayers' resources to achieve the best possible outcomes for service users and their families

We want to learn from the experiences of the acute sector; **we don't want a payment system based purely on episodes of secondary care activity**

Our focus must be on **integration wherever this delivers better experience and outcomes:** mental health and physical health, secondary care and primary care, health / social care / housing etc

We need to ensure the governance programme **engages all key stakeholders and reflects the new system leadership**

There is unlikely to be a one-size-fits-all solution and we may need to experiment and evaluate…

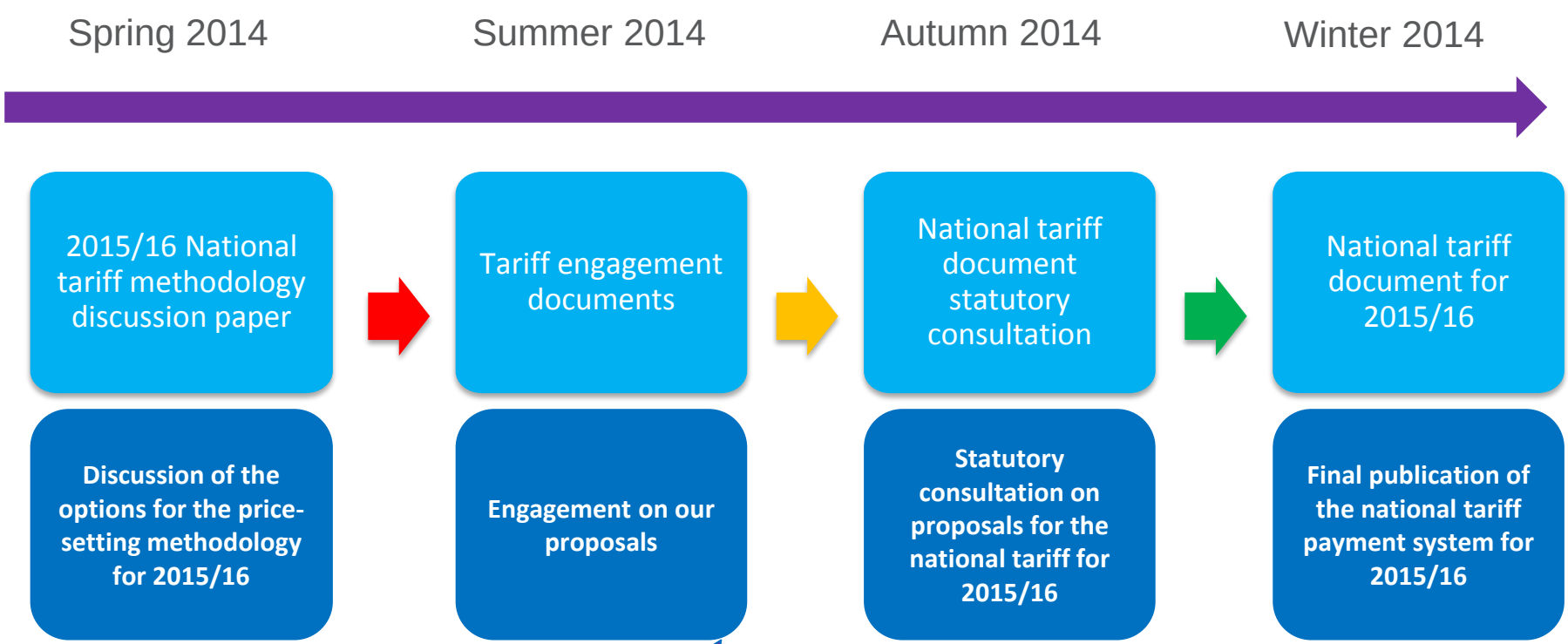
- Cluster-based currencies
- Pathway-based payment models
- Integrated MH / physical health payment models
- Outcome-based payment models
- Capitation-based funding
- Year of care models
- Alliance contracts
- Lead provider models
- Accountable care organisations

… and, crucially, learn from each other

And we can work together on the core building blocks that will be common to all

Evidence base: what works for whom?	• User voice • NICE / SCIE guidelines – mental health and physical health • High value service models
A focus on outcomes	• Defining the 'whole person' outcomes that matter • Measuring these routinely
Relevant, high quality data	• What are the effective interventions? What are the quality and outcome metrics? What needs to be in the MHMDS? • How can we drive up data quality and reduce administrative burden?
Stratification: where can the greatest gains can be made?	• The groups most at risk who should be targeted for early intervention • The most complex, vulnerable and high-cost groups who should be targeted for enhanced, integrated, care-coordinated approaches?

Timeline for the 2015/16 National Tariff Payment Document



National Tariff proposals 2015/16 mental health implications

- 2014/15 tariff rules restated and updated to take account of changes in name of MHMDS to mental health and learning disabilities dataset
  - mandatory submission of clusters to MHLDDS and reference cost collections
  - clusters currency for payment purposes unless alternative arrangements developed that benefit patients
  - transparent payment mechanisms
  - reporting requirements for local variations and prices
- Clear steer on the need to move away from unaccountable block contracts in 2015/16
- Local payment examples to help health economies move forward away from block contracts and in delivering longer-term objectives around integration and outcomes based commissioning
- How compliance with the rules will be promoted and action taken where required
- Consultation on the revised approach to setting the efficiency factor

Our approach is to support the sector to move forward

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Payment arrangements

In order to meet the needs of patients:

- ensure provision of care that is supported by a clear evidence base (e.g. NICE guidelines)
- ensure appropriate treatment at the right time and the right place, including appropriate coordination of care
- ensure the service is providing value for patients

You need constructive engagement between commissioners and providers leading to payment arrangements that are:

Transparent

- Clear about what payment is linked to and how it is calculated
- Know what services are / are not included

Accountable

- Reporting activity
- Ensuring outcomes
- Reporting agreed indicators of quality
- Ensuring relevant governance process is in place and followed

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What else are we doing?

- Exploring possibility of developing a local payment example on early intervention for 2015/16
- Publishing the secure and forensic currency model
- Working on IAPT reference tariffs
- Reaching conclusion on the collection of data and currency development of the CAMHS project
- Roll out of the HSCIC quality and outcomes reports

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Steve Reid

Clinical Director
Central and North West London NHS Foundation Trust

Video

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Liaison Psychiatry in in North West London:

Bridging the Gap

Steven Reid
CNWL NHS Foundation Trust

Overview

- Background
- Service development
- Evaluation(s)
- Next steps
- Funding models


Mental Health Network
NHS CONFEDERATION
briefing
November 2012 Issue 249
Liaison psychiatry – the way ahead
Key points
This Briefing sets out the findings of a report that details a study of liaison psychiatry services. It was commissioned by the NHS Confederation on behalf of the SHA mental health leads, and written
REPORT
Centre for Mental Health
Liaison psychiatry in the modern NHS


Joint Commissioning Panel for Mental Health
www.jcpmh.info
Guidance for commissioners of
liaison mental health services to acute hospitals
Volume Two:
Practical mental health commissioning

Key recommendations

- Every acute hospital should have a dedicated liaison psychiatry service
- Every service should be established on a sustainable basis
- A rapid response generic service should be the priority
- Liaison psychiatry should provide support on an all-ages, all-conditions basis
- Training and supervision of acute hospital staff should be a core function of liaison psychiatry

Hospitals in North West London

- **2** million people
- **8** Clinical Commissioning Groups (CCGs) & **8** Boroughs
- **10** acute & specialist trusts & **2** mental health trusts

Central and North West London NHS
NHS Foundation Trust

West London Mental Health NHS
NHS Trust

Potential savings

- Est. 15% of total expenditure in acute hospitals is due to co-morbid mental health problems
- For a 500 bed hospital, equates to £25 million p.a.
- Scope for savings:
  - reduction of health care costs per patient ~ 20%
  - £5million p.a. for a typical general hospital

- RAID evaluation:
  - incremental savings from RAID come to £3.5 million p.a. with an incremental cost of £0.8 million p.a.
  - benefit: cost ratio > 4:1

- Data from Centre for Mental Health and RAID evaluation

Savings across system - high scenario (£245 per bed day)

£ Savings	
1. Net Impact to Hospital	
Savings from all bed reductions (including excess bed-days)	15.9m
Less Income lost from excess bed days	2.8m
Less Income lost from reduced A&E tariff payments	0.4m
	12.7m
2. Net Impact to Commissioner	
Savings to Commissioner from reduced excess bed days	2.8m
Savings from reduced A&E tariff payments	0.4m
	3.2m
Total Savings (for Hospital & Commissioner)	**15.9m**

£ Costs	
1. Incremental cost of liaison team	8.6m
2. Other incremental costs	1.8m
Total Costs	**10.4m**
£ Net System Impact (Total Savings - Total Costs)	**5.5m**

We have agreed the "Optimal Standard" for psychiatric liaison for NWL hospitals

Summary of Optimal Standard Liaison Model for a NWL hospital of ~500 beds

What is it?

- The 'Optimal Standard' is a high quality liaison psychiatry service designed to operate in acute general hospitals in NWL, providing the following services:
  - Care for patients with significant mental health needs (outside specialist MH units)
  - Training for other hospital staff to enable them to support patients' mental health needs
  - Integration with other parts of the health system e.g., GPs, specialist mental health teams

Who delivers the service?

- 2 Consultant Psychiatrists
- 1 Team Manager
- 12 Team Nurses (Bands 6 and 7)
- 1 Alcohol Nurse
- 2 Specialist Registrars
- 1 Generic Therapist
- 1 Occupational Therapist
- 1 Social Worker
- 1 Administrative support
- 1 Research/Business Support Officer

What does the service look like?

- Highly **visible multi-disciplinary** mental health team fully **integrated** into the hospital
- **Single point of contact** for all patients (16+) in hospital with diagnosed or suspected mental health conditions of any severity
- **Rapid response** for patients requiring mental health support and 24/7 support in A&E and wards
- **Training experts** on mental health problems and related issues for non-mental health clinicians
- **Coordination with out-of-hospital** care providers and housing services
- **Integrated** with broader health and social care system
- **Single management** structure

SOURCE: North West London 2011/12 Q4 'Access Initiatives' Bid Proposal; Rapid Assessment Interface Discharge (RAID) report, Prof George Tadros(RAID Lead Clinician), Birmingham. Psychiatric liaison working group

Sept – Nov 2011	• NWL workshops developing business case
Dec 2011	• Application for access Initiative funds
Jan – Feb 2012	• Establish liaison psychiatry teams – three month pilot
May 2012	• End of pilot – services continue on rolling basis
Sept 2012	• Interim evaluation by NHS NWL • Funding to financial year-end secured
Dec 2012	• Further evaluation • Featured in *HSJ* as beacon of best practice

Evaluation 1. Pilot

- Response times
- ICD-10 coding of mental health conditions
- Medication reviews of patients 65+
- Reduction in mental health-related A&E breaches
- Patient/carer satisfaction surveys

Evaluation 2. LOS & costs

1. LOS with co-morbid LTC and MH diagnosis	7.2 vs. 5.9 days ↓ 1.5 days
2. LOS with primary mh, dementia or alcohol diagnosis	2.3 vs. 0.9 days ↓ 1.3 days
3. Avoidable admissions - A&E	11-15% ≅ 357 admissions

Comparison: Jan – Jun 11 vs Jan – Jun 12

Evaluation 3. Impact

- Patient tracking – diagnoses
- Care pathway evaluation – focus groups

  (AMU, alcohol, older adults)
- Referrer satisfaction
- Patient satisfaction

Evaluation

Themes from patient tracking and pathway reviews

- **Patients are complex**
  - Multiple diagnoses
  - High numbers of prescriptions
- **Treating ‘new’ patient population**
  - previously unidentified mental health needs
  - high utilisers of healthcare resource

Evaluation

Consistent referrer responses across sites

- Responsive and easily accessible services
- High quality assessment
- Impact on treatment outcomes and length of stay
- Changing attitudes and culture
- Integration of physical and mental health care

Two years on….

- Standardised model for NW London possible
- No longer pilots
- Evaluation fatigue
- Recruitment of substantive staff
- Focus on initiatives e.g. frequent attender CQUIN

Who pays?

- Who benefits: acute trust *vs* CCG?
- Acute HRGs

- Commissioning by acute trusts – Oxford
- Accountable lead provider models – integrated care

Phil Moore

GP Mental Health Lead
Kingston CCG

NHS England

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Kingston Clinical Commissioning Group

How could mental health payment systems support effective clinical commissioning?

…what does good looks like & why it is better for service users and carers?

Phil Moore

August 2014

phil@philmoore.org

To consider:

Good will depend on …

- What our populations want
- The commissioners' challenge
- Mental health's 'fit' in the system
- Where clinical commissioning is heading
- Direction of travel for payments system

What our populations want

I know where I can get help and support

I feel part of a community

I know who is in charge of co-ordinating my care

The care I receive is built around me

I am treated as a person and helped to stay well, and so is my carer

I am supported through difficult times

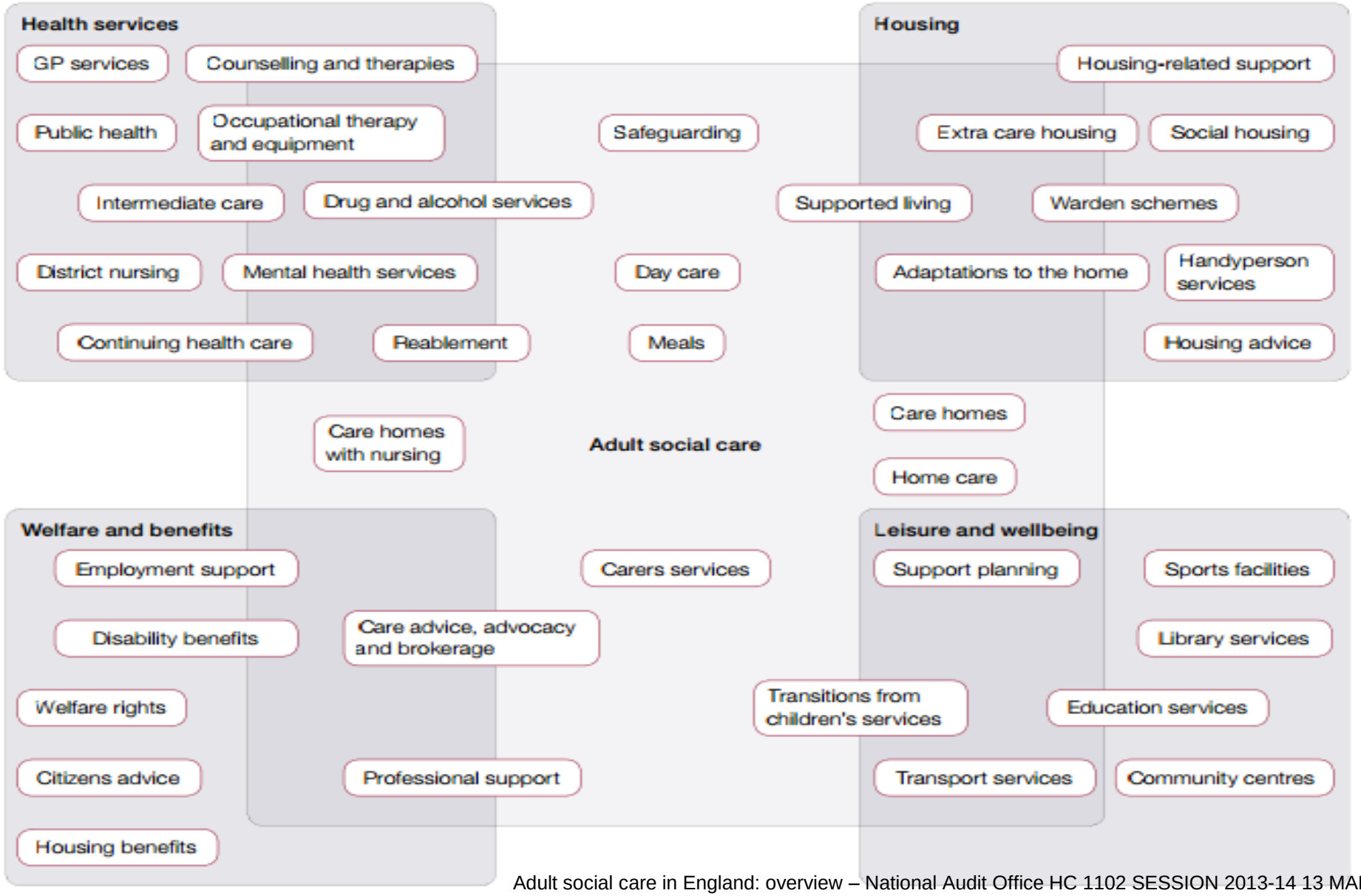
I live safely and well where I want to be

I manage my conditions myself and am in control of decisions about my care

My independence is respected

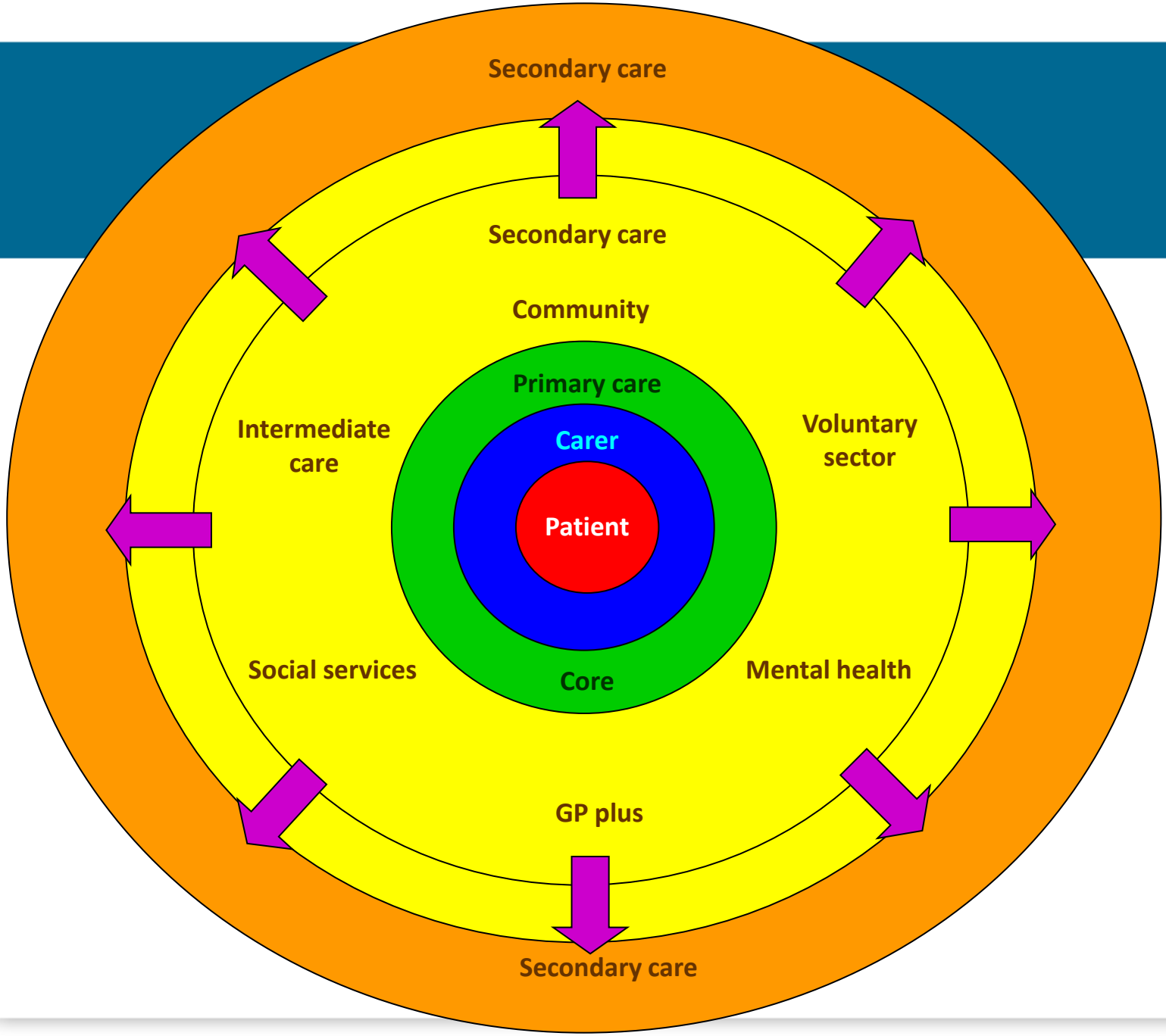
Figure 1
Adult care services and other services

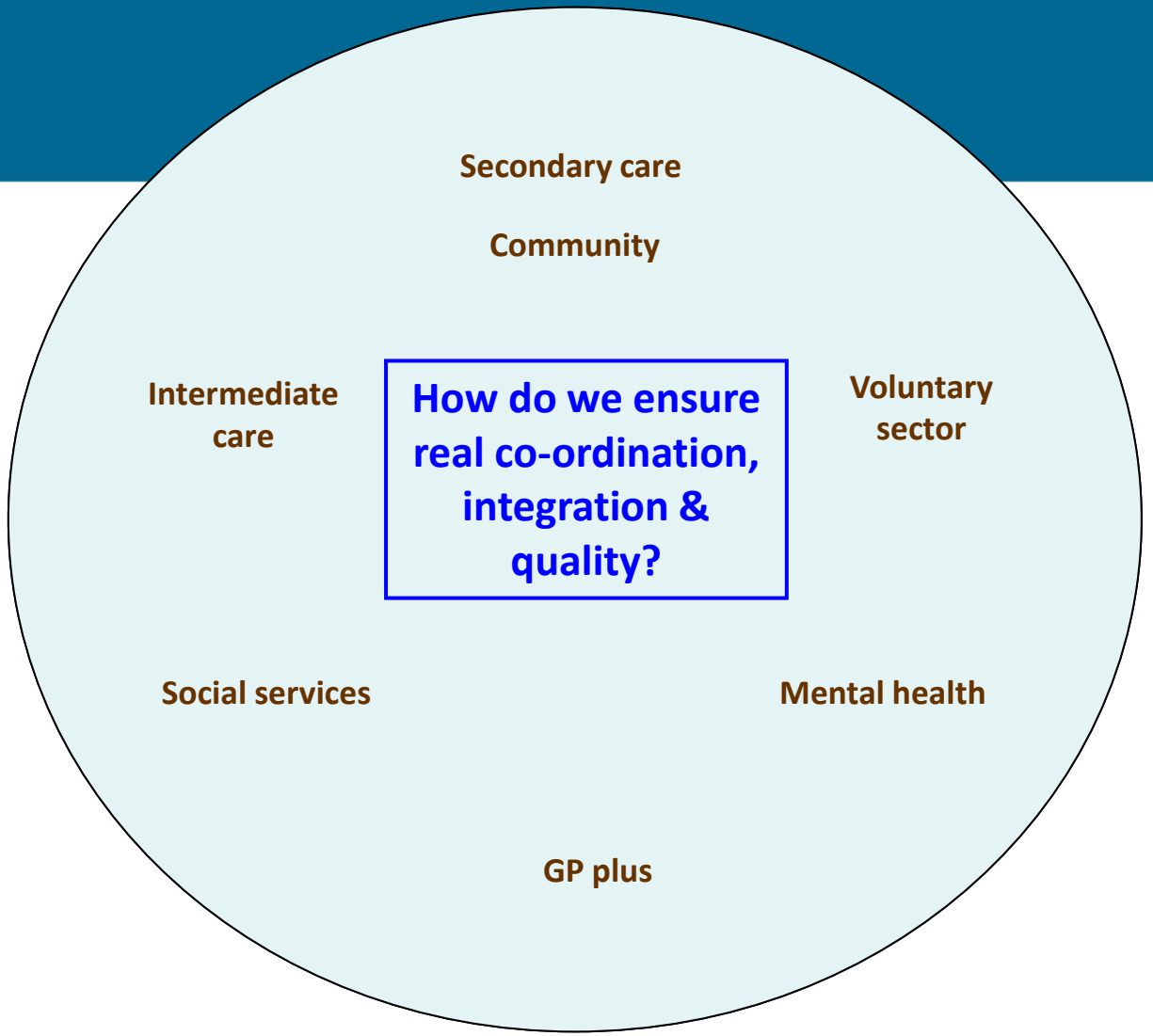
How well adults' needs are met depends on all parts interacting effectively



The commissioners' challenge

- **How well does my commissioning support the person's citizenship?**
  - **Includes:**
    - all commissioning – CCGs, NHSE, LA, PH, etc
    - voluntary sector
    - self-help and peer support
  - **Involves measuring outcomes:**
    - across more than health
    - well after active treatment has completed
    - taking into account the person's ongoing view


Secondary care
Secondary care
Community
Primary care
Carer
Patient
Core
Intermediate care
Voluntary sector
Social services
Mental health
GP plus
Secondary care



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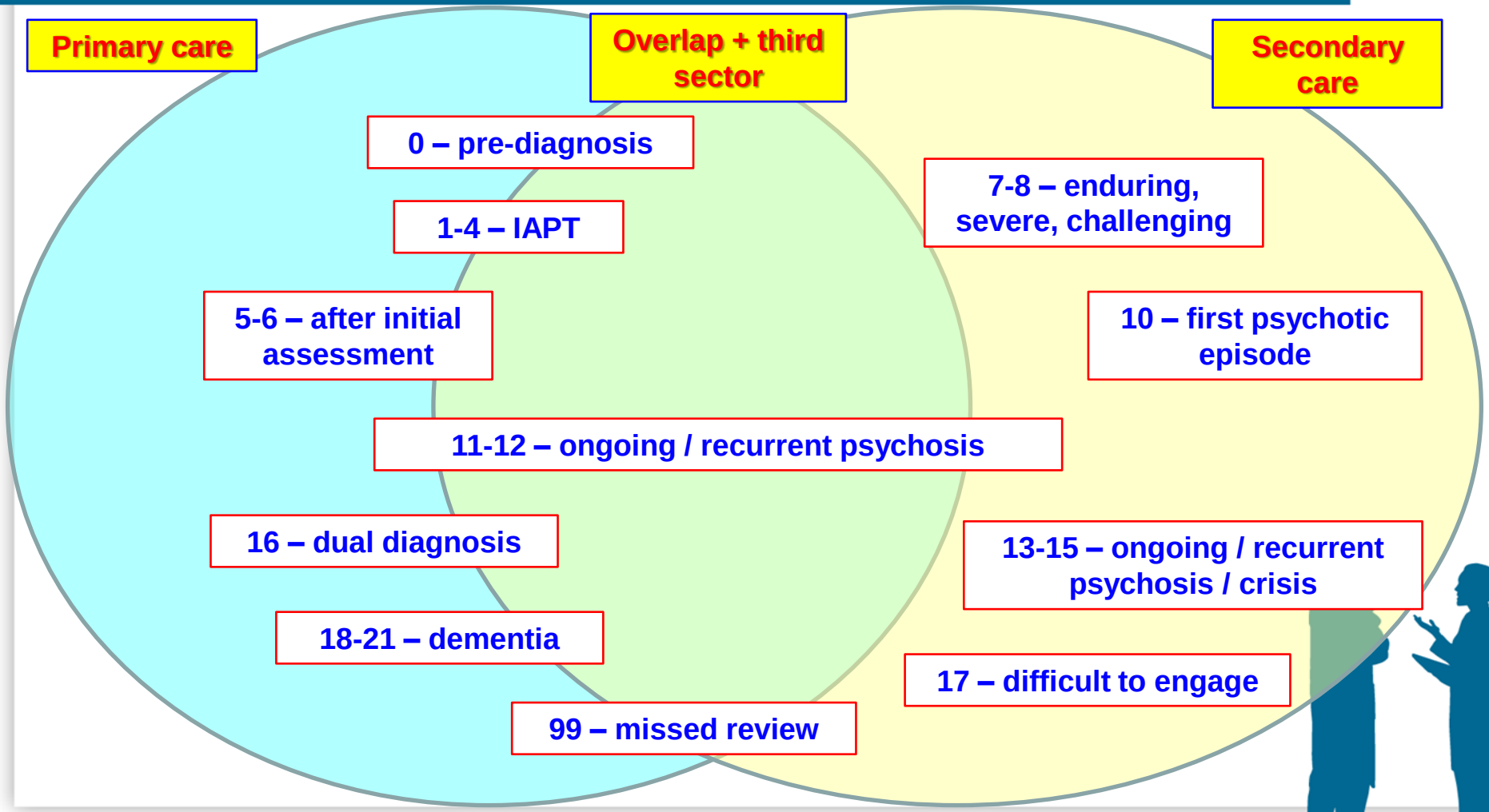
Where clinical commissioning is heading



‘A commissioner’s guide …

… **to primary care mental health - strengthening mental health commissioning in primary care: learning from experience**’

London MH SCN July 2014

- **108 case studies** in London, UK and internationally – some commissioner led; some provider led
- **summarised the learning and good practice** from the experience in the case studies
  - using the data available to inform transformation and being creative about use of payments system
  - clusters being used to enable shift to primary care
- **provided 10 key lessons** for commissioners to encourage and provoke changes in 15/16 commissioning intentions

A commissioner's guide to primary care mental health

Strengthening mental health commissioning in primary care: Learning from experience

www.Bit.ly/mhpricare

NHS England

London Strategic Clinical Networks

Direction of travel for payments system

The payments system must enable and encourage:

- **transformation** including primary care mental health
  - to produce a different and much more nuanced delivery that joins MH and primary care
  - to give greater flexibility to use the voluntary sector in commissioning (cluster-enabled)
- **outcomes designed around what people want** not just a medical model
  - to move away from standardised packages of care and pathways to quality outcomes
  - to be truly person-centred and to measure outcomes more widely and later
- **common outcomes across the system** that create aligned incentives
  - to make appropriate use of activity-based and emphasise outcomes-based payments
  - to prevent perverse incentives that work against integration
- **joined up commissioning**
  - CCG, NHSE, LA, PH
  - primary care, MH care in community and inpatient, specialised care
- **the use of intelligence** to inform commissioning

Thank you

Phil Moore

phil@philmoore.org

Stuart Bell

Chief Executive Officer
Oxford Health NHS Foundation Trust

NHS England

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Presentation notes

Notes from Stuart's talk [1]

- The fundamental problem is that the payments system is perverse – incentivising consumption of hospital services when we say we want to go the other way. This is not just an issue for primary care, but also for community health and mental health services
- This point has to be the basis for our discussion: how on earth do we get a comprehensive payments system that supports our stated priorities *[Stuart illustrated his point by showing the workshop's first slide containing a sign for "Main Hospital"]*
- We are trying to turn this situation around in Oxfordshire. I want the payment system to begin to address, and soon, the significant perversities that still exist
- The local example speaks to many points Phil has made. We were concerned to find a way to develop a model of service transformation for adult MH services in Oxfordshire that would be more outcome focused and speak to the things that people talk about; housing, occupation, employment, social connection etc. It had a bit of an abortive start because previous commissioners spoke to management consultants rather than the people that would have to do the job
- Now, though, we have developed the Oxfordshire MH Partnership involving Oxford Health NHS FT and five third sector organisations to deliver an outcome-based approach to adult MH. All six organisations have agreed we want to do this
- Oxford Health is the lead provider, and we are all happy with this. We are in the middle of the "capable provider" process with the CCG for a 5-7 year contract. We want the payment system to support us

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Notes from Stuart's talk [2]

- (We are also developing a similar model for long-term conditions with other hospitals – and we may end up with a similar system with primary care providers, looking at health and social care on a locality basis. It would be good to create partnerships that provide services in holistic ways)
- We are at an early stage. One critical thing is "how do you define what is in the service?" Sue's presentation is clear on this, eg IAP, personality services etc. Clusters are really helpful – you can use clusters and put numbers on it. It is effectively a capitation-based contract, not for a whole population, but a defined mix of numbers and need. This is the basis of how to measure the outcomes
- The way the contract should play out [on PBR] is something that should evolve during the length of the contract. We need to be careful not to get obsessed by metrics for outcomes because there's risk of inflexibility. We may find ourselves saying "you have to have the outcome as defined in the contract". Rather we must retain flexibility to respond to individuals' actual needs
- I can foresee that individual personal budgets might result from this evolution of outcome definition
- Note that you cannot copy the criminal justice outcomes-based contracts, because they relate to compulsion – we're not in this business
- There is scope to develop an increasingly outcomes-focused approach – and achieve integrated care. We already provide social care, but we can deliver more (this speaks to Phil's point about integrated commissioning). You can use the same mechanism to bring primary care into the provision of MH services. In 1948 we separated primary care and we still have this separation – now is the time we can change it

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Notes from Stuart's talk [3]

- There will come a point where one wants a more sophisticated way to bring mental and physical care together – it won't happen with our service, but would for other services. We will need clusters to define populations (e.g., how many people with COPD or heart failure are there within the cluster…)
- All this is positive. However, what this doesn't tackle is the fundamental problem with how the payment system works. We can stabilise and create positive incentives for better care but the tariff for acute care still needs to be tackled. We are considering bringing acute care from the John Radcliffe hospital into our service – this should help mitigate the perverse incentives
- Some observations: if you are a provider under the acute tariff you are paying at national tariff prices, so you benefit from your own efficiency (or vice versa). But if you are not funded on a national tariff, your efficiency benefits your commissioners and you have no incentive to increase your efficiency
- And it's worse because of generic nature of the annual cost improvement assumptions (4% pa). The more efficient you become, the relatively worse off you become. This is "disparity of esteem" in anyone's book, and it has to be tackled. And by the way, it is not the commissioners' fault
- To solve it, just take into account the reference cost input into the efficiency factors – and make them flexible. This will normalise the situation over time to create an even playing field of efficiency as has happened in the acute sector. This is essential to our work on the payments system or people will go bust for doing the right things!
- Will it give parity of esteem across all health sectors? It should.

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Presentation: case management

Michael Davies
Tariff Case Management Compliance Lead, Monitor

Group discussion

- Thinking about the proposals and ideas you've discussed today, how can we ensure that implementation at local level complies with the rules and principles in the national tariff?

- On a piece of A4 to hand into Danny

Presentation: Setting and adjusting local prices to reflect efficient costs

Ben Shafran
Monitor

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Rule 2 for all services without a national price

Commissioners and providers should have regard to the national tariff efficiency and cost uplift factors for 2014/15 (as set out in Section 5 [of the '2014/15 national tariff payment system']) when setting local prices for services without a national price for 2014/15, if those services had locally agreed prices in 2013/14.

We're proposing to retain the rule and strengthen the guidance we provide

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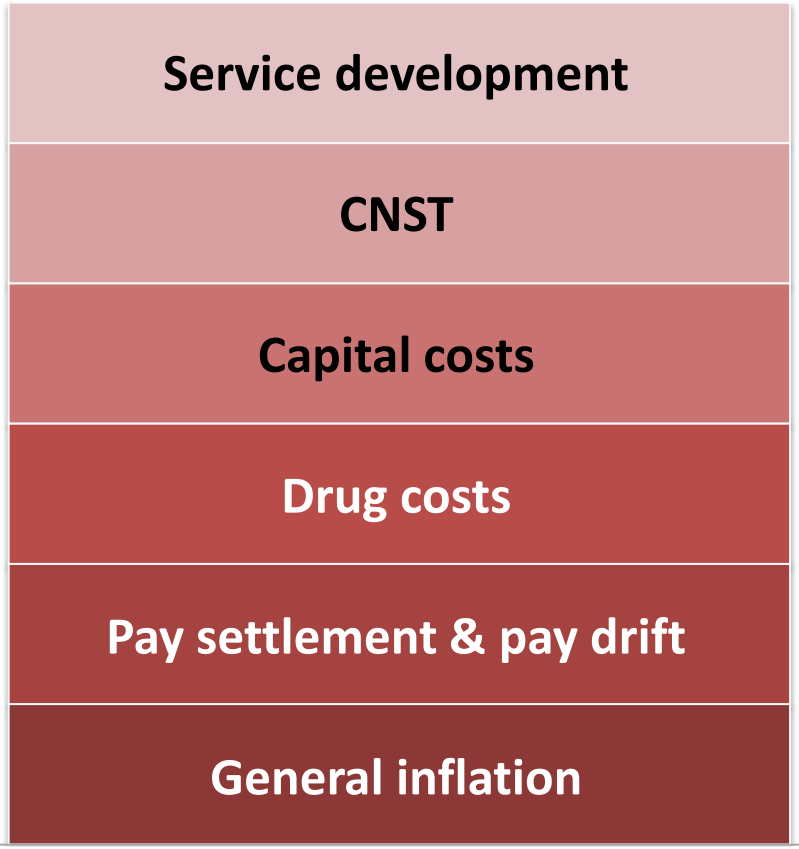
Cost uplift factors



Proposals for the efficiency factor

Single efficiency factor (as for 2014/15)

Estimated from data for acute services

Range of 3 – 5% based on historical evidence plus expectations for 2015/16

Want to improve guidance for application to local price-setting

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