

Central and North West London



NHS Foundation Trust

**Report to Harrow  
Scrutiny Committee  
7<sup>th</sup> October 2013**

**Payment by Results  
Programme  
Year 3 – 2013/14**

Sarah Khan  
PbR Programme Director



*Wellbeing for life*

## Contents

<b>Section</b>	<b>Page(s)</b>
<b>1. Introduction</b>	<b>3-7</b>
1.1 Programme purpose	3
1.2 Programme scope	3
1.3 What is PbR?	3-5
1.4 What implementation of PbR will mean in practice	5
1.5 DH implementation timetable	5-6
1.6 Trust achievements to date	6-7
<b>2. Priorities for 13/14</b>	<b>8</b>
<b>3. Programme Management &amp; Governance</b>	<b>9</b>
<b>4. September Position</b>	<b>10-11</b>
<b>Appendix 1 – Clustering Tree</b>	<b>12</b>

# 1. Introduction

## 1.1 Programme purpose

2013/14 marks the third year of CNWL's Payment by Results Programme. The programme's purpose is to ensure that appropriate and robust systems are in place to:

- Support the implementation of PbR currencies and tariffs in our contracts with commissioners;
- Support the delivery and evaluation of integrated, needs-driven, evidence-based care packages.

## 1.2 Programme Scope

Mental Health PbR currently encompasses all non-specialist adult services. All services within the following Trust Service Lines are therefore within the scope of implementation work:

- Acute
- Assessment & Brief Treatment (excluding Improving Access to Psychological Therapies)
- Community Recovery
- Rehabilitation
- Older People & Healthy Ageing

## 1.3 What is PbR?

Payment by results was originally established in acute care. It established a price against a procedure, or set of procedures, with the aim of incentivising competition and choice on the basis of quality rather than price. The 'currencies' within acute PbR are the procedures and these are structured according to diagnostic codes. The 'tariffs' are set nationally. Not all procedures or treatments are covered by PbR.

Initial work to design a model for Mental Health PbR focused on data already available through the Mental Health Minimum Data Set (MHMDS). Using this dataset, a significant piece of analysis was undertaken to try to identify whether diagnosis could predict resource use (the same approach taken to developing PbR within acute services). The key finding was that diagnosis alone was not a good predictor of resource use – other need / complexity factors must also be considered.

The alternative model put forward was the use of needs-based 'clusters' as the basis of MH PbR currencies. This approach was based upon a piece of work undertaken by a senior clinical psychologist and multidisciplinary colleagues at SW Yorkshire Mental Health Trust. This work had been driven not by the desire to develop a set of PbR currencies but rather by local concerns that the care service users received could vary according to locality / professional seen etc rather than according to service users' needs and preferences.

Dr Self and his colleagues worked together to agree a common summary needs assessment tool which comprised HoNOS (Health of the Nation Outcome Scales) plus some additional scales. This 'HoNOS+' tool was piloted with an adult community caseload sample and,

through an iterative process of statistical analysis and clinical validation, 13 needs assessment groupings or 'clusters' were identified and standard care packages (with variable elements) were developed for each of these groups.

## The SW Yorkshire work

- Summary needs assessment tool based on HONOS.
- Used to classify the needs of a community caseload sample

} Developing a 'shared vocabulary'

- Analysis of need 'clusters' based on "HONOS+" profiles resulted in identification of 21 empirically and clinically derived care groups with clear inclusion / exclusion criteria.
- Core and additional care package elements agreed for each of the groups.
- Common language agreed between clinicians to describe the aims and activities of care package interventions.

} Consensus-building 'participatory action research' approach.

- Tool used to support clinical decision making. DH adopted the approach as the basis for the development of MH PbR currencies

} Clear and consistent care pathways

Once the potential of this clustering approach as a means of identifying MH PbR currencies had been identified, Dr Self's work was expanded into a multi-trust pilot. Use of the clusters was extended to include acute and inpatient services and older adult services and the original 13 clusters were increased to 21, including 4 organic clusters (see Appendix 1). The findings of the pilot were that clinicians were able to allocate >90% of their caseload to one of the 21 clusters.

The key principles of this approach to MH PbR development may be summarised as follows:

MH PbR Principles	
1.	Identify and profile need
2.	Identify appropriate 'care responses' in relation to the profiles of need identified.
3.	Cost the care responses at patient level with a view to identifying meaningful average costs relating to each needs profile
4.	Identify target outcomes aligned to the care responses
5.	Identify indicators of quality aligned to the care responses
6.	Develop a dataset that captures elements (1) to (5) above.
7.	Reframe existing contracts / payment mechanisms such that: <ul style="list-style-type: none"> <li>● The needs-profiles become the currencies</li> </ul>

MH PbR Principles	
	<ul style="list-style-type: none"> <li>• The care-responses become the products purchased</li> <li>• The tariffs become the cost of the care responses</li> </ul>
8.	Shift the 'language' of commissioning so that: <ul style="list-style-type: none"> <li>• The dialogue is about planning, purchasing and evaluating care responses tailored to the profiled needs of the population served</li> <li>• QIPP discussions are focused around making care responses more efficient whilst maximising quality.</li> </ul>

## 1.4 What implementation of PbR will mean in practice

Full implementation of PbR will mean that:

- (i) All eligible service users are assigned to one of 21 needs-based clusters (including a variance cluster) following initial assessment
- (ii) Assignment to a particular cluster will trigger delivery of an associated package of care
- (iii) A service user's package of care is routinely reviewed – at prescribed intervals or if there is a significant change in need
- (iv) There is an expectation that specified quality standards are met and outcomes delivered in relation to each cluster-linked package of care
- (v) Our contracts shift from block to cost-and-volume; there are likely to be different cluster prices for different CCGs initially.
- (vi) There will eventually be a set of national cluster-linked prices so that providers will compete on the basis of quality and outcomes rather than price.

CNWL's focus for years one and two of the programme was on (i) to (iii) above. Our work in 13/14 has increasingly focused on (iv) and (v).

## 1.5 DH PbR implementation timetable

The Department of Health (DH) has taken a phased approach to PbR implementation with the following key milestones:

2011/12	All eligible service users to have been assigned to one of the 21 PbR clusters
2012/13	Clustering review intervals and care transition protocols to be implemented Care packages to have been developed for each cluster
2013/14	Contract to be rebased so that activity & finance schedule is framed in terms of cluster review periods and service specifications are linked to clusters and care packages Clustering data quality indicators to be routinely monitored Quality and outcome indicators to be identified for each cluster and monitored with a view to linking performance to a proportion of tariff in the

	future Local cluster prices to be refined through the course of the year
2014/15	Local prices to be implemented in a phased way, safeguarding stability within the health economy
2015/16	Earliest possible date for a set of national tariffs

## 1.6 Trust achievements to date

Through its PbR Programme, CNWL has ensured full compliance with all of the DH's PbR requirements. The Trust is also represented on all of the key regional (London) and national PbR forums and has successfully contributed to and influenced the development and shaping of PbR policy and implementation approaches. Whilst the scale of the challenges associated with PbR implementation should not be underestimated, the Trust began the third year of its PbR Programme having positioned itself well, having made sound progress and having learned valuable lessons along the way.

PbR Programme: Key Achievements	
Year 1 – 11/12	
<p><u>Key target:</u> all eligible service users to have been clustered by December 2011 (achieved)</p> <p><u>Achievements:</u></p> <ul style="list-style-type: none"> <li>All relevant staff given RCPsych approved training in how to cluster</li> <li>Care packages drafted for all clusters, following significant consultation process</li> <li>Clinical activity types agreed to describe interventions provided by all community-based services</li> <li>Cluster review intervals came into operation and training provided on care transition protocols</li> </ul>	
Year 2 – 12/13	
<p><u>Overarching Objective:</u> To prepare internal and external stakeholders for the implementation of PbR as our 'BAU' (business as usual) way of working from April 2013.</p> <p><u>Priorities &amp; Achievements:</u></p> <ol style="list-style-type: none"> <li>1. To improve accuracy and timeliness of clustering across the five PbR-eligible service lines <ul style="list-style-type: none"> <li>Clear clustering processes developed with each service line to drive improvements in timeliness</li> <li>RAG cluster ratings developed for each service line to drive improvements in accuracy</li> <li>High quality clustering posters and booklets incorporating the above developed for each service line</li> <li>Tailored 'expert' clustering training packages developed for each service line</li> </ul> </li> <li>2. To improve the completeness, accuracy and consistency of front line JADE practice and influence the Trust's approach to clinical systems management and training going forward</li> </ol>	

'As-is' JADE processes mapped against service user pathways for every team / ward type across the 5 PbR Service Lines (> 60 detailed maps completed)

Variations in practice identified and impact-assessed and work underway to develop 'to be' JADE standard operating procedures for every team / ward type across the 5 PbR SLs.

3. To ensure that front line leaders (i.e. consultants, team managers and ward managers) understand what PbR will mean and will require in practice

PbR implementation launch workshops delivered for each of the 5 PbR SLs – included SMT, consultants and team / ward managers

Key messages reinforced via delivery of 'expert' clustering training programme and production of clustering posters, booklets etc.

Service Line PbR Steering Groups established for each of the 5 PbR SLs with multiprofessional membership. Members responsible for ensuring effective comms within the service line.

4. To engage with emerging commissioner organisations and agree a constructive way forward for PbR implementation

All draft care packages reviewed by group comprising CCG MH leads and CSU commissioner representatives. Recommended by the CCG MH PbR Lead to the Jan 13 meeting of the MH Programme Board.

PbR presentation delivered to the MH Programme Board (all 8 NWL CCG MH Leads in attendance), jointly with WLMHT, describing the Trust's PbR work; this was very well received.

5. To engage in and actively seek to influence national and regional PbR policy

The Trust is represented on almost all of the key regional (London) and national PbR forums and has successfully contributed to and influenced the development and shaping of PbR policy and implementation approaches throughout 12/13.

## 2. Priorities for 13/14

Each year, the PbR Programme's priorities have been driven by:

- (i) An analysis of DH requirements and an assessment of the position of the Trust against these
- (ii) Identification of the associated risks to the organisation
- (iii) Identification of the benefits that could be realised

As well as consideration of any lessons learned in previous years.

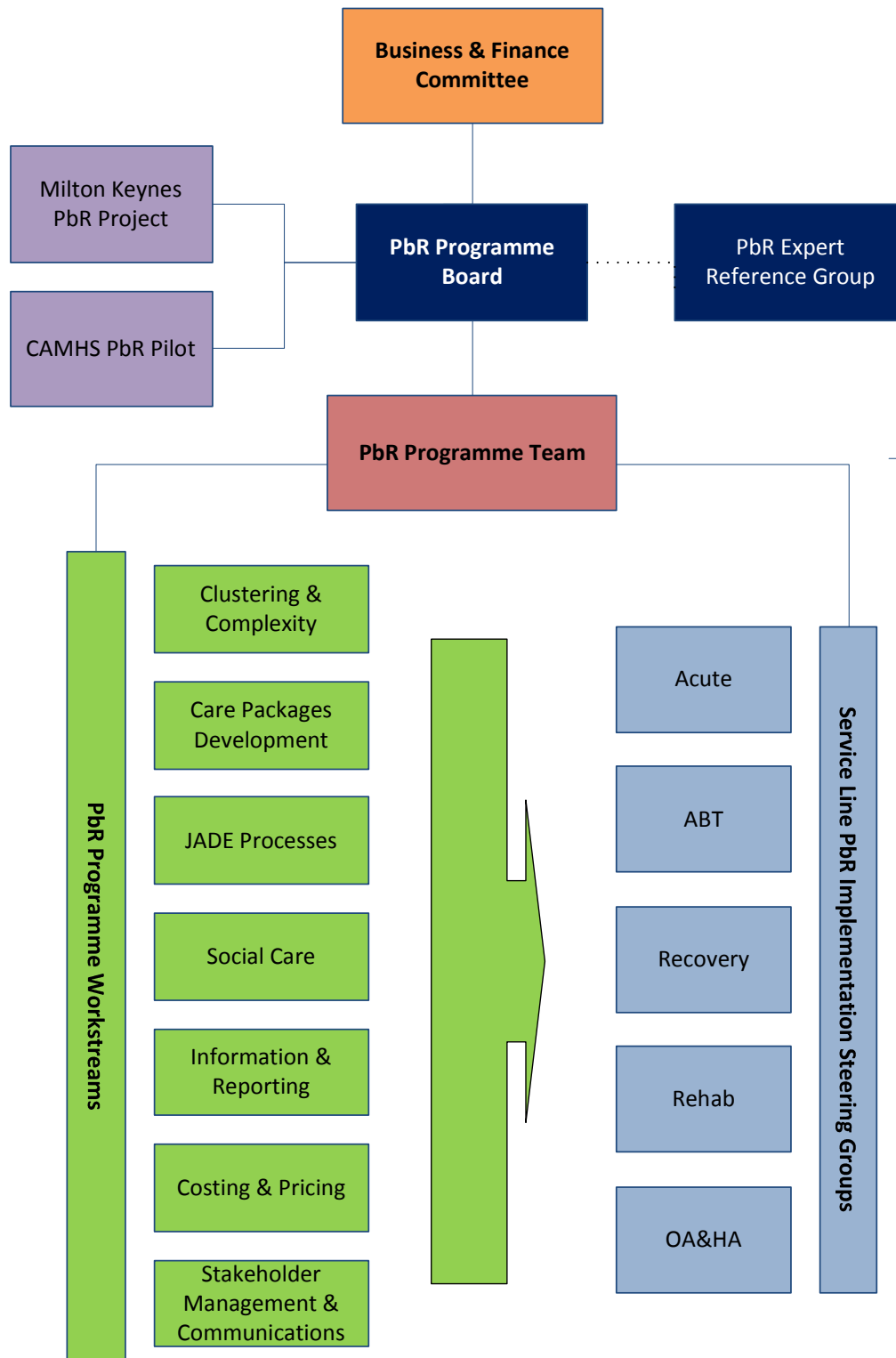
Following this analysis, seven priority workstreams were agreed for 2013/14:

Workstream	Purpose
1. <b>Clustering &amp; Complexity</b>	To ensure that clustering decisions are timely and accurate and that complexity factors are identified and analysed.
2. <b>Care Packages Development</b>	To lead the work required to align our care packages with NICE guidance / best practice and produce appropriate printed and web-based materials for internal and external stakeholders.
3. <b>JADE Processes</b>	To develop a set of JADE 'standard operating procedures' for each team / ward type, provide training to all staff in the 5 PbR SLs and provide follow-up support to try to realise sustainable data quality improvements.
4. <b>Social Care</b>	To lead the work required to ensure that our PbR implementation approach is fully aligned with personalisation requirements and bureaucracy / duplication minimised for both service users and staff.
5. <b>Information and Reporting</b>	To lead the work required to develop PbR reports for internal and external stakeholders.
6. <b>Costing and Pricing</b>	To lead the work required to price our PbR care packages and monitor the costs of delivery on an ongoing basis.
7. <b>Stakeholder Management &amp; Communication</b>	To ensure that all key stakeholders, internal and external, receive appropriate and timely communications regarding PbR implementation and the work of the PbR Programme.



### **3. Programme management and governance**

A dedicated programme team is in place and a robust governance structure has been established to oversee programme delivery. The Programme Board meets on a bimonthly basis and reports to the Trust Board via the Business & Finance Committee.



#### 4. September Position

Workstream	Highlights	Status
------------	------------	--------

Workstream		Highlights	Status
1	Clustering & Complexity	<ul style="list-style-type: none"> <li>• Good progress is being made towards delivery of the 95% March 14 CQUIN targets for timeliness of clustering assessments and reviews and clustering accuracy.</li> <li>• Work to identify and analyse complexity factors (factors that will impact on the pattern of resource use / episode length within clusters) has commenced.</li> </ul>	Amber
2	Care Packages & NICE	<ul style="list-style-type: none"> <li>• The care packages have been agreed with the CCG leads and have been signed off by the service lines. A provider has been identified to present the care packages in an interactive way on Trustnet and awareness of the packages is being raised through the Jade Processes training</li> <li>• A senior expert resource has been identified to lead the NICE audit work. A bid for funding support for this work has been submitted to the NWL LETB.</li> </ul>	Green
3	JADE Care Processes	<ul style="list-style-type: none"> <li>• JADE standard operating procedures (SOPs) have been completed for all of the Service Lines together with user-friendly quick reference guides and care process maps. Team-based training is underway.</li> </ul>	Green
4	PbR & Self Directed Support	<p>Work is underway across the Trust to:</p> <ul style="list-style-type: none"> <li>• Review and develop a clear pathway for accessing self-directed support, exploring where choice in personal health budgets may fit</li> <li>• Further develop the process of assessment and initial support framework, this includes an assessment tool that allows for the assessment of both health and social care needs at the beginning of the service user pathway. The advent of PbR in mental health necessitates an assessment framework to cluster, the work will explore where these frameworks can be combined and where they should be separate.</li> <li>• Ensure that the packages of care under PbR enable seamless social care interventions and develop a better understanding of what those interventions are.</li> <li>• Understand and if necessary develop and promote the reablement pathway.</li> </ul>	Green
5	Information & Reporting	<ul style="list-style-type: none"> <li>• CQUIN reports enabling monitoring and analysis of performance by clinician / team / service line / CCG have been developed and rolled out. Training has been provided to service line leads.</li> </ul>	Green

Workstream	Highlights	Status
6	Costing & Pricing <ul style="list-style-type: none"> <li>• Reference costs were submitted in line with DH requirements.</li> <li>• Implementation of the Trust's new Patient Level Costing System (PLICS) is underway.</li> <li>• Improved data quality (clustering and activity data) are the key enablers for this workstream.</li> </ul>	Amber
7	Stakeholder Management & Communications <ul style="list-style-type: none"> <li>• PbR update / CQUIN launch presentations were delivered to each of the 5 PbR service lines during the first quarter of the year. Bimonthly slots booked at Service Line Senior Management Teams.</li> <li>• Link established with the new NWL MH Programme Board coordinator, Glen Monks, to establish a regular slot for PbR updates starting in October.</li> <li>• PbR Finance &amp; Information Sub-Group to be established by the CSU.</li> <li>• Additional CNWL representatives have joined the:               <ul style="list-style-type: none"> <li>Pan-London Mental Health Tariff Programme Board</li> <li>DH PbR Quality &amp; Outcomes Group</li> <li>DH Transitions &amp; Algorithms Group</li> <li>DH PbR Expert Reference Group</li> </ul> </li> <li>• CNWL is to host and lead a pan-London workshop on 27<sup>th</sup> September exploring the issues associated with implementing PbR within Rehab Services with a view to making a set of recommendations to the DH as to how PbR should most appropriately be implemented in this service area to ensure that incentives for the commissioning and delivery of high quality care, in least restrictive setting, close to home are effectively retained.</li> </ul>	Amber

Appendix 1 – Clustering Tree

