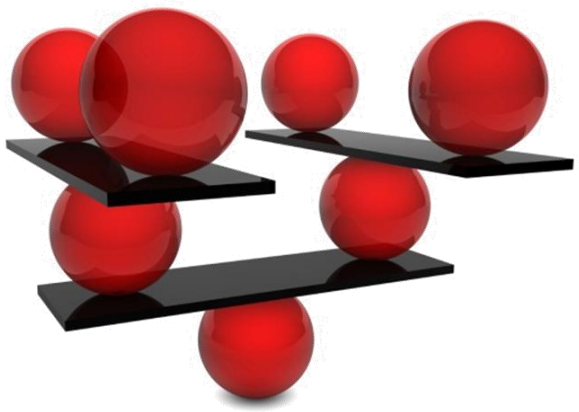
Primary Care Mental Health Models of Care

Economic Evaluation: Comparative report of PCMHS sites



Version 1.2

16th July 2018

NHS London Clinical Networks

Healthy London Partnership

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Content

Executive Summary 1: Purpose and Method

- Healthy London Partnership commissioned an economic evaluation of primary care mental health models in five different London Boroughs. The evaluation team was tasked to answer two questions:
  - How do the Primary care Mental Health Models contribute to financial efficiencies?
  - How do the Primary Care Mental Health models contribute value to the health system?

- The Evaluation Team deployed techniques from decision science to address these questions. Specifically the team used multi-criteria decision analysis to co-produce a characterisation of "value to the system" which comprised 29 components of value. This characterisation formed the basis of a maturity matrix which was then used to shape the lines of enquiry with each of the five sites. Decision Science techniques of swing weighting were used to mould the 29 components of value into a combined view of system value. To establish the impact on financial efficiencies, the team considered how PCMH models focus on prevention, early intervention, step-down and recovery affects the flow of activity through the health system and what that change in flow means for financial efficiencies.

- These five sites chose for this evaluation were: Islington, City and Hackney, Bexley, Hounslow and Richmond. The sites were chosen to reflect a range of approaches to PCMH. Following the evaluation they each have received and commented on individual reports providing a narrative (using the maturity matrix) on how they add value and where they might focus to add more value.

- This capping paper provides a comparison of value across four of the five sites. Four of the sites were able to provide data for the evaluation within the project timeframes. One site (Richmond) was not able to provide all the required data within the timeframe and it was agreed with Healthy London Partnership to not include Richmond findings in this capping paper.

- The overall purpose of this paper is to provide insights for commissioners, providers and policy makers to improve the way PCMHS are designed, commissioned and performance managed.

Executive Summary 2: Variety of Service Models

- The four sites contrasted in this capping paper represent a variety of service models

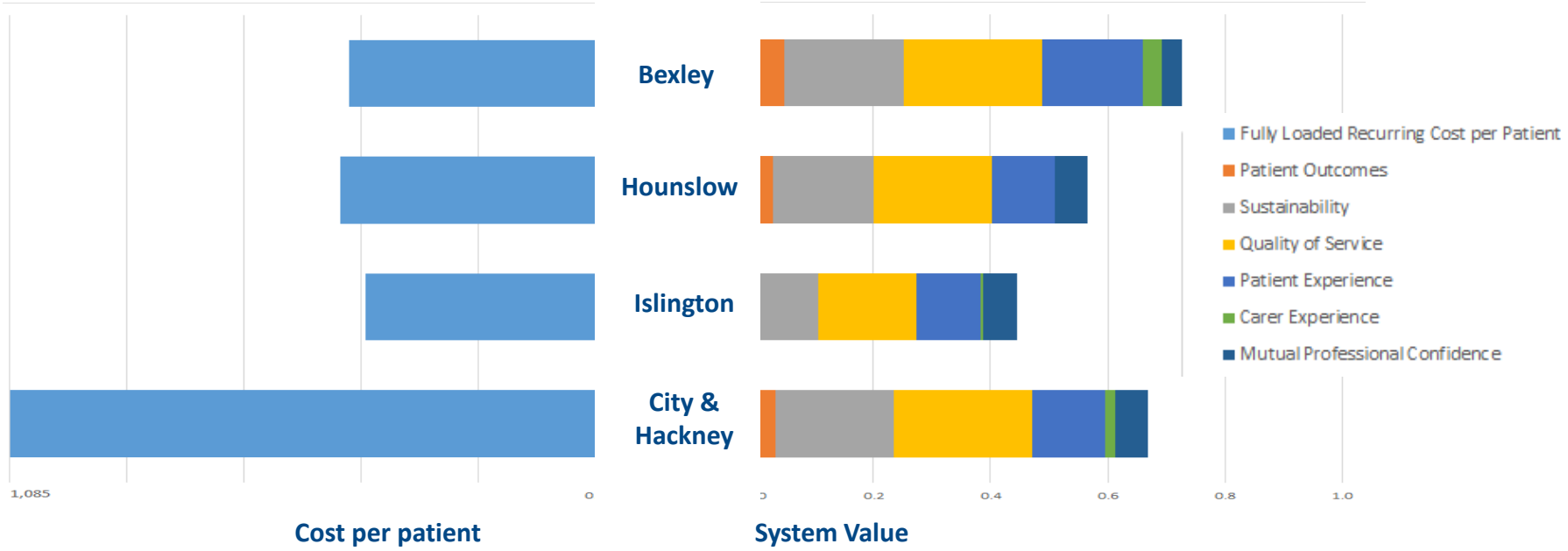
	Islington	City and Hackney	Hounslow	Bexley
Service Model	Islington is implementing a Practice Based Mental Health (PBMH) Service. The model is still embedding and this must be appreciated when comparing with other boroughs. The model is an in-reach primary care-based mental health liaison service.	The service comprises: Primary Care Psychotherapy Consultation Service Primary Care Liaison Service, Enhanced Primary Care Service, Family Action. The Primary Care Mental Health Alliance involves the GP Confederation, East London Foundation Trust, the Clinical Effectiveness Group and Family Action.	Hounslow operates a Consultation-Liaison model of care based in the primary care setting. It provides a mix of assessment, treatment, GP support and signposting	The Bexley Primary Care Mental Health Service is centred round a Recovery College which provides peer-led education and training programmes within mental health services: education as a route to recovery, not as a form of therapy. The model also include the IAPT service, the Employment Advice Hub, Welfare and Housing Advice and the Carer Service.
Case mix	PBMH acts as the access team for whole of Islington mental health pathway (except crisis) – they manage referrals and all of the information traffic from all sources including police/housing/social services.	Service caseload includes complex patients, frequent attenders and patients with medically unexplained symptoms, people with stable psychosis, anxiety, depression and personality disorders; people who have experienced high levels of trauma and many have complex needs	Service users include mix of psychotic and non-psychotic disorders	The service is for people experiencing severe and enduring mental health diagnosis (both psychotic and non-psychotic) and may include people who also experience learning difficulties and autistic spectrum disorder diagnosis.
Caseload volumes	c. 4,300 - 6000 cases per year	PCPCS - c.780; EPC - c.650, Family action - c.550 per year	c. 1,100 - 1,600 patients per year.	c. 1878 cases per year
Cost of service	c.£1,875,000	c.£2,150,000	c.£757,000	c.£860,000

Executive Summary 3: Cost and Value

- The tornado graph below illustrates the comparative cost-value impact of each of the four PCMHS evaluated. The blue bar on the left hand side shows the crude cost per patient. The multi-coloured bar on the right hand side shows the combined system value of the service in terms of patient outcomes, sustainability, quality, patient experience, carer experience and mutual professional confidence. These were the top level categories co-produced using the decision science approach. Beneath these six top level categories there are 29 elements of value which together are combined to produce an overall rating of value.

- The sites are ordered by "system value to cost ratio". City & Hackney has the highest crude cost per patient, whereas Islington has the lowest crude cost per patient. Bexley has the highest ratio of value to cost

- The major factors affecting cost per patient in each model are the number of staff, the type of staff (therapists vs clinical staff vs volunteers/support staff) and the size of the caseload. The complexity of the case-mix may also be a factor driving cost: the boundary between enhanced primary care and secondary care is not tightly defined.



Executive Summary 4: Lessons Identified

- **Medical vs non-medical model.** Bearing in mind the many factors which combine to influence poor mental health, it is vital to strike an appropriate balance between the social model of care and the medical model. This is more than multi-disciplinary working: it is responding to individual need in the most appropriate way. It is important to focus on enhancing the confidence and self-management skills of users – as a critical overall objective of the service (research indicates this is vital to manage costs and make long term care sustainable).

- **Person Centred – Recovery Centred.** Focus on enhancing the confidence and self-management skills of users – as a critical overall objective of the service. One helpful distinction between primary and secondary care is that primary care operates with a case list and people have easy access whenever they feel they need it, whereas secondary care operates with a case load of people who meet a threshold for admission after a referral and who remain on the caseload until discharged. An Enhanced Primary Care Service should seek to operate with this "fluidity" principle of primary care working.

- **Legitimate Variation.** There is legitimate variation in the model of service in the following areas as defined by key queries around the service value and model:
  - How does the service make a difference to the generic GP's way of working?
  - Is it primarily about "Assess and Refer"?
  - To what extent is therapy a role within enhanced primary care?
  - To what extent do you "signpost" and to what extent do you "walk alongside the patient" too?
  - All services take referrals from secondary care and GPs. What should the balance be?
  - To what extent is primary care also about receiving non-crisis referrals from other agencies such as police, local authority and other referral sources?

- **Local Leadership.** Strong local leadership is required to "champion" an enhanced primary care mental health model. For the GP community it is best if that local champion is a GP. Colocation of the primary care mental health team in a primary care setting is good for patients and good for GPs, however there appears to be marked variability in the willingness of practices to provide space for an enhanced primary care practitioner. This can be resolved through strong local GP leadership. Leadership is also needed to overcome barriers to the sharing of data in the interests of patients and patient care.

Executive summary 5: Lessons Identified

- **Accountability.** Accountability (for both Commissioners and Service) requires good performance information and active performance management. There is a general lack of good quality data. Performance information must be shaped around sympathetic performance indicators. Ideally these should be tailored around: Patient outcomes – PROMS and longitudinal measures; Patient flow (including waiting times, points of onward care or discharge; Workforce; Quality of service (PREMs); Impact on wider system (including recourse to crisis, A&E, secondary care caseload).

- **Accountability.** Commissioners need to 'think performance' – when service level agreements are being designed, they must consider how the performance of that contract is going to be meaningfully managed. This is not just a data issue, it is one of culture: commissioners must constructively challenge providers in how well they are doing, and how to change if there are problems. . Performance management is not about setting targets. It is about measuring and monitoring to identify areas for management intervention. Where commissioning works well, providers welcome that creative challenge and respond positively.

- **Service agility.** Service which responds to need is vital. This is both individual need and strategic need of the service to develop. Every organisation strives to be responsive but it is hard for an organisation to be agile if it is risk averse or if it is subject to bureaucratic constraints or if it has "no skin in the game" (that is, there is no organisational risk involved in achieving the goal of the service). Smaller organisations tend to be more agile and closer to the service user. This means they can be more responsive to people's individual needs and they can respond more quickly to identified strategic need.

- **Cost and Value.** Understanding the unit cost per patient is important, but it is not something that is currently adequately understood. It should be a priority for both commissioners and provides to understand the unit cost per case and the variation in unit cost per case. Once that cost variation is described, the action should be to understand the reasons why there is variation. The variation in unit cost should be explored in the context of the value added to the health system. Is the additional cost adding additional value?

Acknowledgement

- We are very grateful to all who have contributed to this evaluation – service users, PCMH team members, GPs, commissioners and others.

- It has been a fascinating privilege to observe the different approaches. Although discerning "right" or "wrong" ways of doing things can be difficult in this context, the project identified some elements that work well (and why) and some elements which could, with some mostly small changes, make a greater difference. Where there is a greater challenge, is in the area of demonstrating outcomes and linking interventions to outcomes. This is a topic that is often regarded as too difficult or too controversial – in some small way, we hope that this work makes a small step in resolving that controversy.

Context

- New models of enhanced primary care in mental health have emerged internationally, nationally and in London in response to a shift in emphasis from specialist hospital based care and treatment to community settings. These models aim to improve people's lives by enhancing capacity and capability to deliver mental healthcare in primary care and community settings in an efficient and effective way.

- The new models of enhanced primary care in mental health developed in London vary significantly between areas in investment, interventions, outcome focus and scale. In 2017-18 a Healthy London Partnership project developed three documents to support commissioners and providers implement or improve their primary care mental health service: scoping document (models in London), literature review (publications covering PCMH models) and a commissioning guidance document.

- Healthy London Partnership has now commissioned an economic evaluation of five primary care mental health models. These five sites were: Islington, City and Hackney, Bexley, Hounslow and Richmond. The sites were chosen to reflect a range of approaches to PCMH. There is one site from each STP area within London. Four of the sites engaged positively with the evaluation. The Richmond team was not as engaged with the evaluation and as a consequence the evaluation team reluctantly agreed with Healthy London Partnership not to include the Richmond findings in this final capping paper.

The questions driving the evaluation are these:

- To what extent do the new PCMH models contribute to financial efficiencies?
- To what extent do the new PCMH models add value to the health system?

- The scope of this work is about enhanced primary care. This is specifically about extending the cohort of people with mental health conditions whose care is managed within a primary care context. It is less about mental health conditions requiring GP care only.

- The intent is to learn lessons: this is a formative evaluation, although it is vital that services and commissioners respond to lessons so ultimately there can be a positive summative outcome.

Purpose of this document

This document provides a comparison of the economic evaluations of four primary care mental health models, one in each of the London boroughs of Islington, City and Hackney, Hounslow and Bexley.

It briefly describes the method chosen for this economic evaluation and then it compares and contrasts the four models under consideration. It discusses areas where and why each of those models is contributing value to the system and it provides a crude value for cost comparison. It then goes on to explore the financial efficiencies offered by each of those models.

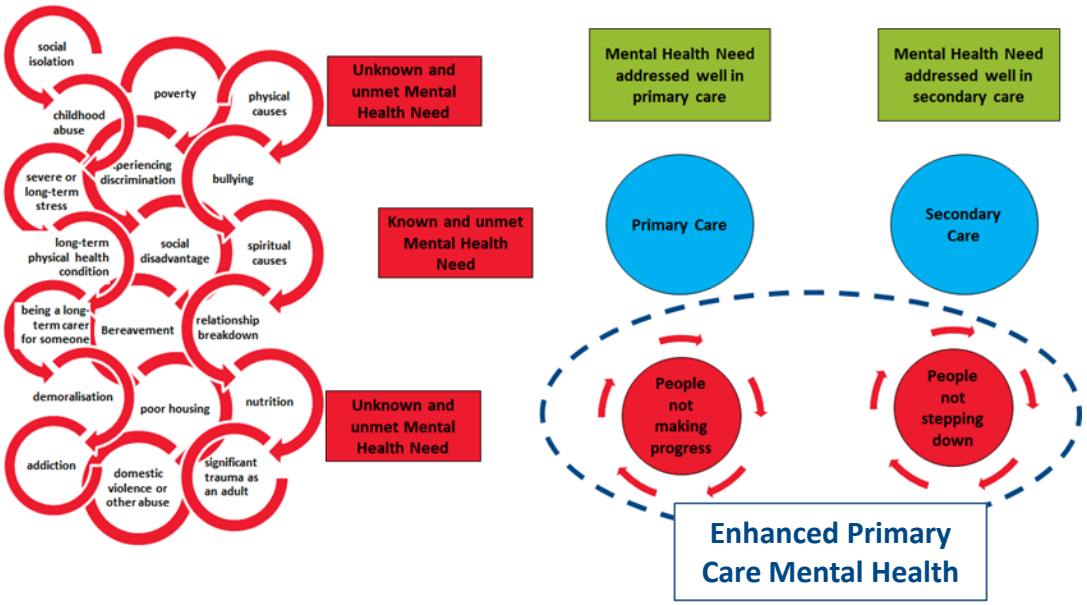
The objective is to learn lessons and share good practice.

The document finishes with seven conclusions.

The appendix has a more detailed description of the method.

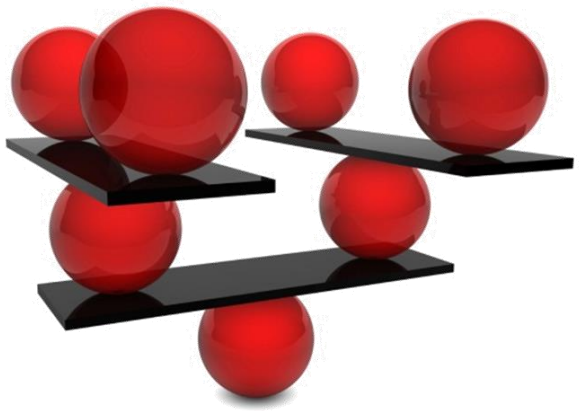
The PCMH models reviewed in their context

- The boroughs of Islington, Hounslow, City and Hackney, and Bexley are each distinct in terms of their demographic and the structures of each local health system have evolved in response to that local demographic. But they all face a similar challenge in terms of primary care mental health:
  - How to encourage "step-down" from secondary care services for people who no longer require that level of intervention and support them in primary care led services
  - How to support people whose mental health challenges are beyond the expertise of primary care (in that they are not progressing) but who are not unwell enough to require secondary care support.



- The models selected for this economic evaluation were chosen to represent a variety of approaches to the same underlying challenge.

Method Described (Brief Version)



Short summary of method – Evaluation Method on a Page

- To what extent do the new PCMH models contribute to financial efficiencies?

Address this question using the Channel Shift method

Channel Shift
System Activity Shift
Resource shifting
Financial Flows shifting
Cost vs Price: routes to cash
Efficiency and Effectiveness

Use the Logic Model approach to establish the underpinning reasons for success, the opportunity for learning to build more success, and the potential for replicability elsewhere

Logic Model		
Components of Service	**Active Ingredients**	**Value Outcomes**
Staff mix	Leadership	Outcomes
Referral protocols	Patient empowerment	Quality of Service
IT	Compassion	Patient Experience
Infrastructure	Culture	Carer Experience
Pathways	Integrated working	Mutual Professional Confidence
	GP Engagement	Sustainability
	Communication	
Extrinsic factors		

- To what extent do the new PCMH models increase the value produced in the health system?

Address this question using the Catalyze/ Res Value approach based on Multi-Criteria Decision Analysis techniques

Catalyze / Res Focus
Define value
Assess and compare relative value

Economic-Financial Model – Channel Shift

We interpret the contribution to financial efficiencies as being primarily about recurrent costs incurred within the overall annual health budget. There are two major elements of the economic side of the evaluation.

- The cost and efficiency PCMH
  - What is the recurring cost per service user?
  - What variation might there be in terms of cost per service user?
  - What does the use of staff time (clinical utilisation) look like?
  - What variation might there be in clinical utilisation?

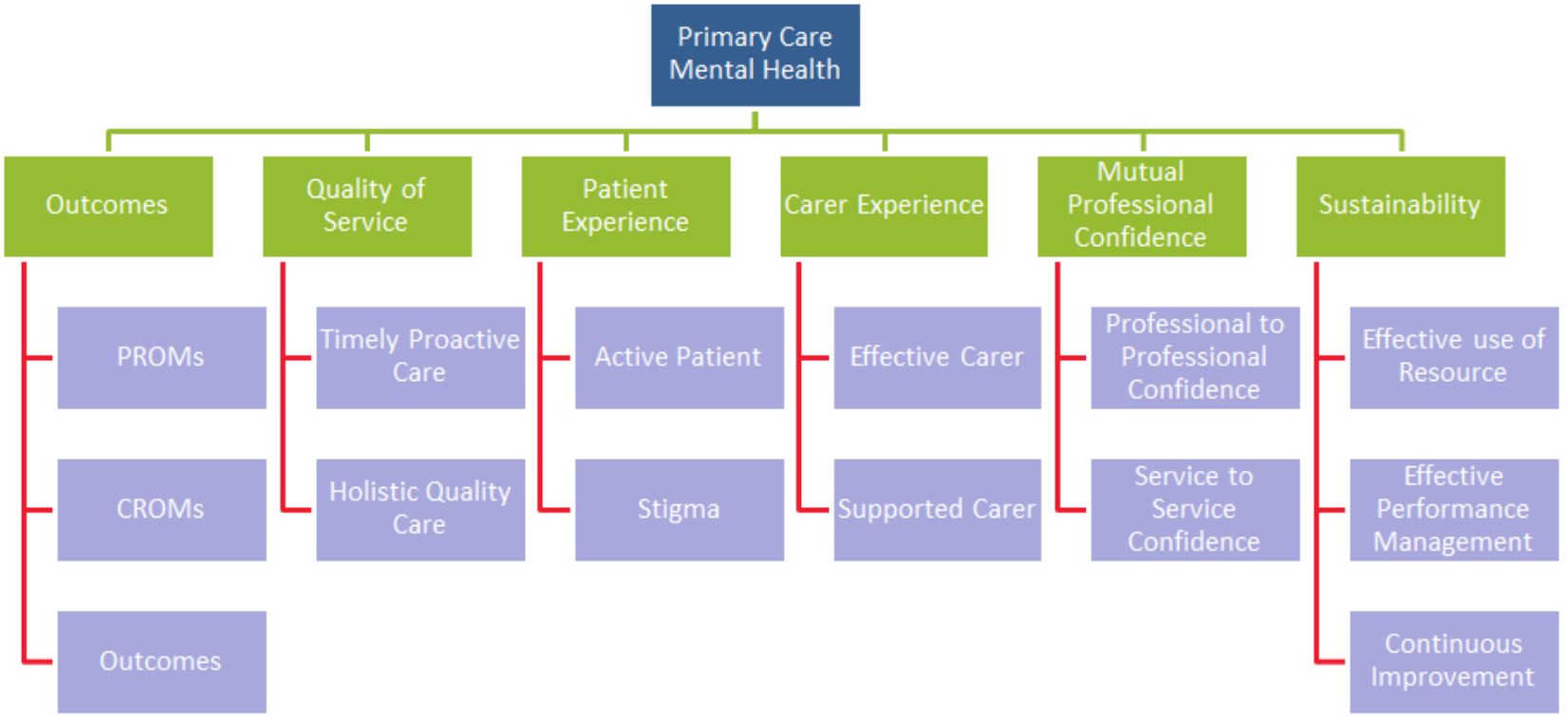
- The "routes to cash" as a result of PCMH: what evidence is there that cash savings have been realised and investment redistributed?
  - What is the displaced activity as a result of PCMH?
  - What is the capacity released elsewhere in the system as a result of PCMH?
  - What has happened to that released capacity? Has it been realised as a cash saving? Has it been redirected to other needs? Has it been re-invested elsewhere in the system?

  - What is the avoided activity as a result of PCMH?
    - Is this avoided inpatient bed days? Is this avoided drugs cost?
    - Other avoided activity, including recourse to crisis or use of A&E

Value Tree and Maturity Matrix

The project has developed a maturity model approach to capture the contribution of value made by the local Primary Care Mental Health Model. This maturity model has been co-produced with Healthy London Partnership and representatives from each of the boroughs participating in this evaluation, including team leaders, GP and consult leads and commissioners. There 29 components of value within the maturity matrix. These are grouped and the first two levels of the grouping are illustrated in the Value Tree below.

For each of the 29 components of value, the maturity matrix describes the spectrum between a "rudimentary service" and an "exemplary service" rated on a scale from 1 to 7. These descriptions are set out in the appendix.



Maturity Matrix

- The maturity matrix provides a structure that can be used to explore and describe the value produced in the health system.

- Each of the components of value agreed in the first co-production workshop has been further developed into a seven point rating scale to distinguish between a “rudimentary” service (where only the basic value is in place) and an “exemplary” service (where the best conceivable value is achieved). The detail in this description is provided in the appendix.

- Once the maturity matrix was agreed with Healthy London Partnership, evidence of value was sought from each of the boroughs in three main ways: through data and information, through documentation and through discussion with people who are engaged with the service.

- Each service is evaluated in contrast to its “counterfactual”. The counterfactual is the hypothetical parallel universe in which the service does not exist. The counterfactual helps us to determine what difference there is as a result of the PCMH Service. This is based on corporate memory of how things used to be, or based on longer term data (where it exists and is reliable.) Sometimes the counterfactual is easy to establish, but usually it is an informed judgement which is, of necessity, somewhat dependent on the expertise of the evaluating team.

Example Maturity Matrix (Unweighted Value)

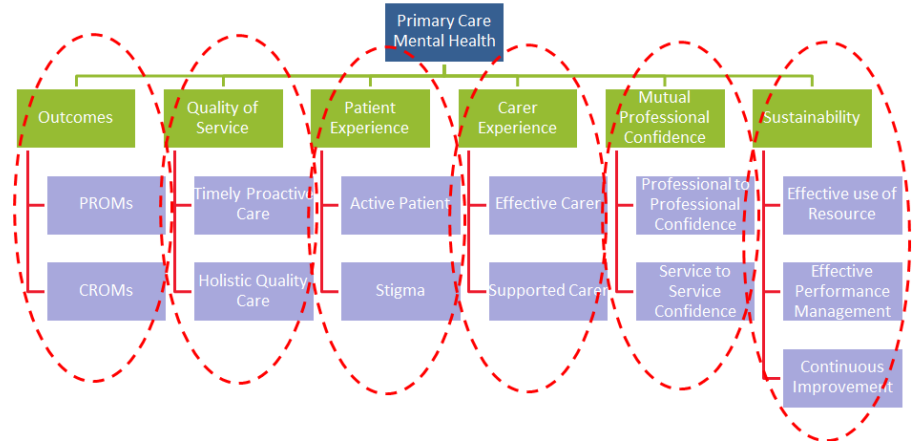
This chart illustrates how a PCMH model has been rated using the criteria within the maturity matrix. The appendix to this report provides descriptions for the facets of value within the maturity matrix and the interpretation of the scores. The colour coding is as below:

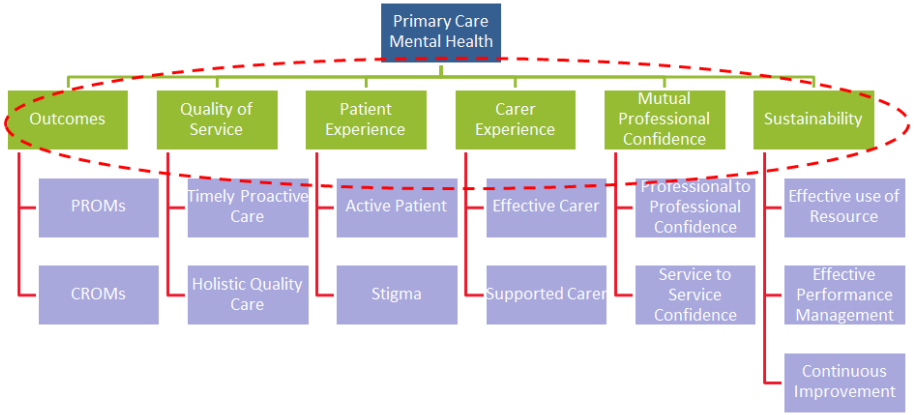
- **Orange squares** represent the counterfactual (ie. the estimated performance against a criteria if the PCMHS did not exist). No orange square indicates that we have not yet determined how to rate the counterfactual.
- **Dark blue squares** represent the actual performance of the PCMHS model. We have only scored areas where we have enough evidence to justify a score.
- **Light blue bars** indicate marked difference between the PCMH model and the counterfactual. NB: this does not mean that these areas are more important – the relative importance of the different facets of value will be determined later (following the second co-production workshop)
- **Orange bars** show where the new model is worse than the counterfactual
- **Grey bars** indicate that we have not yet determined how the service is rating against that value criteria.

Swing weighting to characterise value

- In a second co-production workshop we convened a cross-London group of stakeholders to finalise the evaluation model to be used to assess and compare the value delivered by the various Primary Care Mental Health Services.

- We systematically worked through each of the components of value using a "swing weighting" method. Swing weighting is a technique which presents the stakeholders with a set of stark choices:
  - Given a subset of the components of value, which improvement from rudimentary to exemplary offers the greatest value to the system and
  - How much greater is the additional value provided by improvement in one component compared with the improvement offered by another component.

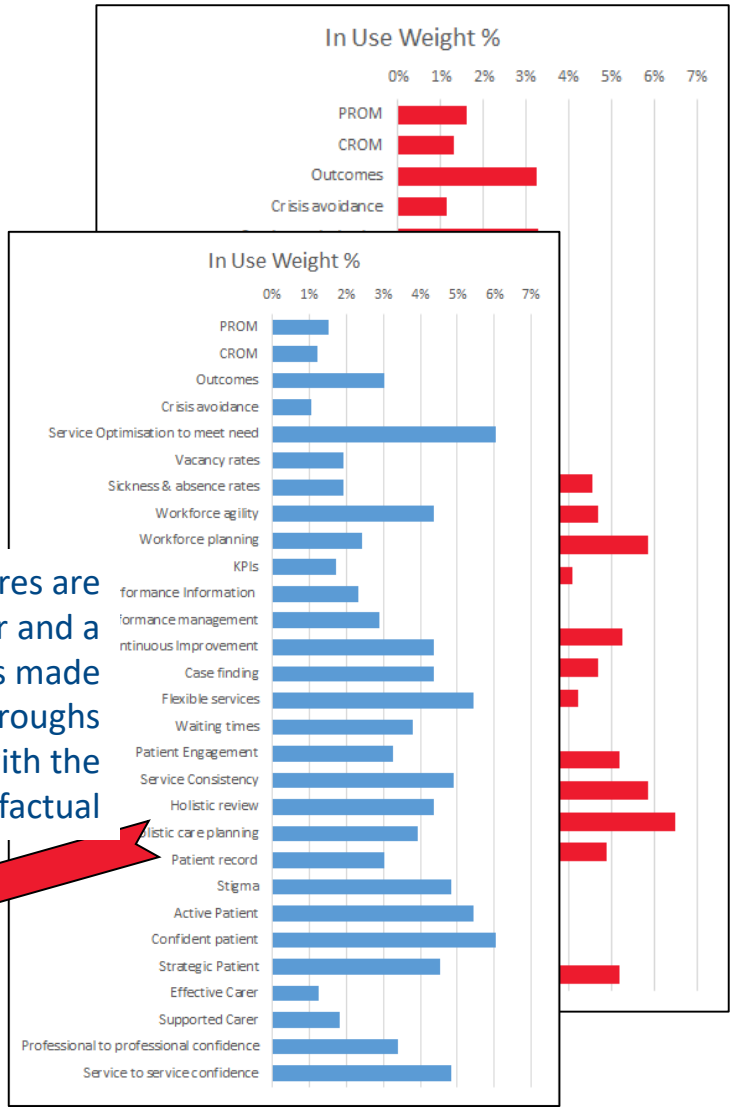




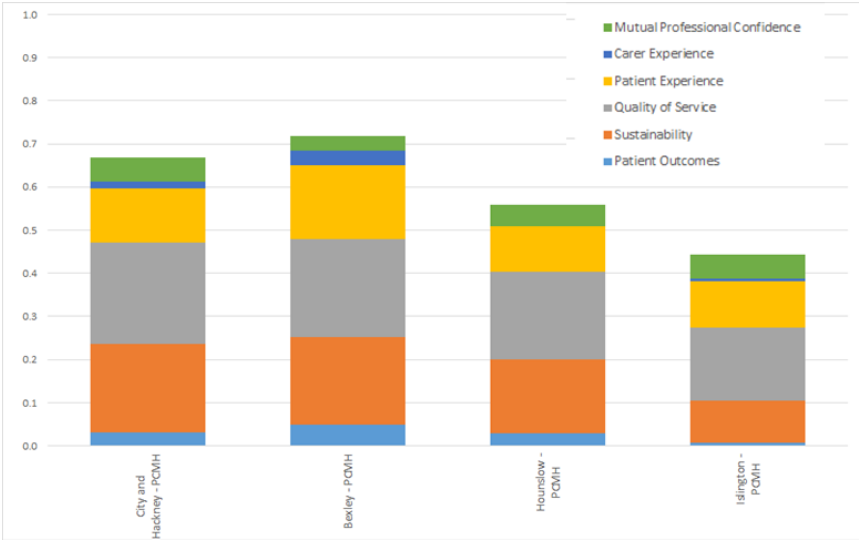
NB. It's important to note that we are not comparing the components, we are rather comparing the *improvement in a component from rudimentary to exemplary.* This is because the added value to the system is about the relative improvement achieved in a component and not about the component in isolation.

Example – Weighting Applied

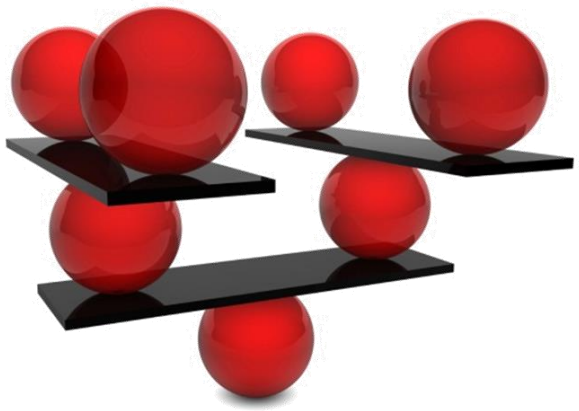
Unweighted scores have weights applied (with and without sensitivity)



Weighted scores are brought together and a comparison is made across the four boroughs and also with the counterfactual



Primary Care Mental Health Models Described



The PCMH models reviewed in their context

- The boroughs selected for this economic evaluation were chosen to represent a variety of approaches to the same underlying challenge. The table below describes the models for each of the sites.

Islington	City and Hackney	Hounslow	Bexley
Islington is implementing a Practice Based Mental Health (PBMH) Service. The model is still embedding and this must be appreciated when comparing with other boroughs. The model is an in-reach primary care-based mental health liaison service. PBMH acts as the access team for whole of Islington mental health pathway (except crisis) – they manage all of the information traffic from all sources including police/housing/social services. The service model consists of four locality based multi-disciplinary teams operating at practice level with the primary aim of developing a holistic approach to the management of the mental (and physical) health of patients outside of specialist care pathways.	The City and Hackney service comprises: Primary Care Psychotherapy Consultation Service, Primary Care Liaison Service providing linked psychiatry input into practices and the Primary Care Mental Health Alliance. This formal Alliance involves the GP Confederation, East London Foundation Trust (providing the Enhanced Primary Care Service), the Clinical Effectiveness Group and Family Action. Enhanced Primary Care and Family Action. Enhanced Primary Care Service (EPC) works across 100% of general practices in City and Hackney. The model is a 'Step-up/Step-down' approach.	Hounslow operates a Consultation-Liaison model of care based in the primary care setting. It's aim is the creation of a fully integrated mental health team within primary care, making the distinction between primary and secondary care much less evident. It provides a mix of assessment, treatment, GP support and signposting	The Bexley Primary Care Mental Health Service comprises an Adult Mental Health Recovery College, an IAPT service, Reinstate (the Employment Advice Hub), Welfare and Housing Advice, and the Carer Service. (IAPT not evaluated as part of this project)

PCMH Models – Organisation, Commissioning and Staffing

- Three CCGs have commissioned enhanced primary care services from NHS providers. Two CCGs have commissioned directly from third sector organisations. Bexley has commissioned IAPT and Enhanced Primary Care through MIND.

	Islington	City and Hackney	Hounslow	Bexley
Organisation	The Islington PBMH Service is provided by Camden and Islington Mental Health Trust.	PCPCS provided by Tavistock Clinic EPC Service provided by East London Foundation Trust Family Action is a third sector organisation	The Primary Care Mental Health Service is provided by West London Mental Health Trust	The Bexley Primary Care Mental Health Service is provided my MIND Bexley.
Commissioning arrangements	Commissioned by Islington CCG. The service has delegated social care responsibility from the Local Authority. It triages all non crisis referrals whatever the source.	EPC and Family Action commissioned by the CCG through an alliance agreement - The Primary Care Mental Health Alliance. It includes a psychotherapy service which increases the costs	Jointly commissioned by Hounslow CCG and the London Borough of Hounslow	Jointly commissioned by Bexley CCG and the London Borough of Bexley
Staff mix	This is a multi-disciplinary team of about 25 WTE. Led by a psychiatrist, the team includes psychologists, a pharmacist, nurses and social workers.	PCPCS is a psychology service with a predominantly psychological staff mix EPC is led by a clinical psychologist and the staff mix comprises 16 Whole Time Equivalent Staff	This is a multi-disciplinary team of 7.5 WTE led by a consultant psychiatrist with a team of six nurses and 0.5 psychologist.	Multi-disciplinary non-clinical team with c.21 FTE. This is made up of: Recovery College 10.5 WTE Reinstate (employment) support 5.5 FTE Resource (welfare/housing support) 4.4 FTE Carers 0.8 FTE

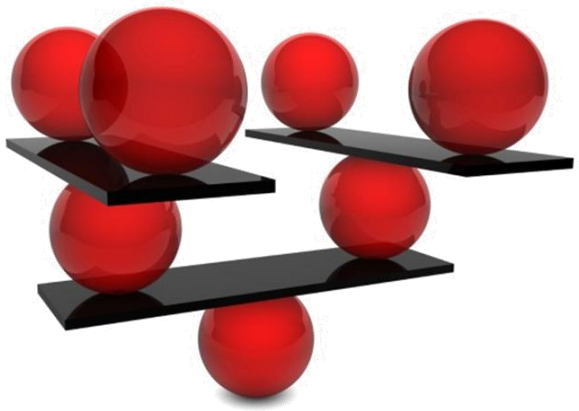
PCMH Models – Case Mix

- The case mix is very slightly different from borough to borough. As a core, each service addresses the needs of people who could benefit from step-down from secondary care or whose needs are somewhere between "standard" primary care and the thresholds required for secondary care service support.

- Islington takes a wider range of non-medical referrals. City and Hackney includes a specialist primary care psychotherapy service. Bexley specifically includes people who also experience learning difficulties or autism.

Islington	City and Hackney	Hounslow	Bexley
People with significant mental health problems that significantly affect their functioning. This would include working with people who are difficult for primary care teams to manage, but do not meet thresholds for or find it difficult to access, specialist mental health services and are not appropriate for IAPT services. People with drug and alcohol problems will not be excluded. PBMH acts as the access team for whole of Islington mental health pathway (except crisis) – they manage all of the information traffic from all sources including police/housing/social services.	Primary Care Psychotherapy Consultation Service caseload includes complex patients, frequent attenders and patients with medically unexplained symptoms. EPC Caseload includes people with stable psychosis, anxiety, depression and personality disorders. Family action caseload includes people who have experienced high levels of trauma and many have complex needs	Service users include mix of psychotic and non-psychotic disorders	Adults with severe and persistent mental health problems on a Care Programme Approach in mental health tariff clusters 4-21 associated with significant disability which may include schizophrenia and bipolar disorder, significant risk of self harm. The service is exclusive to people experiencing severe and enduring mental health diagnosis and may include people who also experience learning difficulties and autistic spectrum disorder diagnosis.

Comparison of Value



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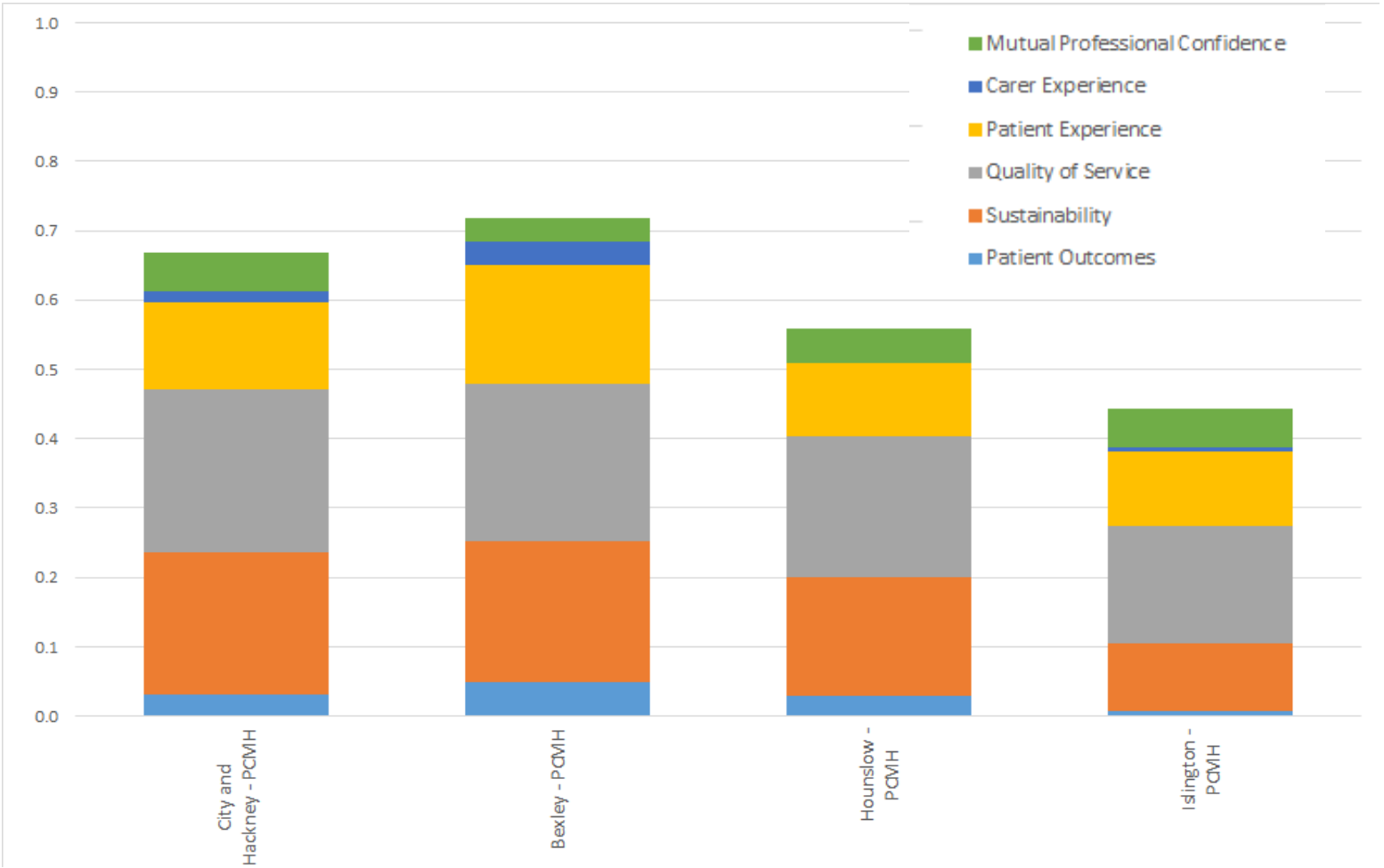
Summary of comparative weighted value to the system

This chart summarises the relative weighted value of the four models that completed this evaluation.

In overall terms, Bexley appears to offer greatest value. But this should not be taken as a definitive conclusion. Value is determined locally and the analysis for each area has the flexibility to adapt the weighting of value to reflect local priorities.

In the individual reports for each borough, the weighting analysis for each area was adapted to reflect local priorities



We will now consider each of the main value areas in turn

Value to the system – Patient Outcomes

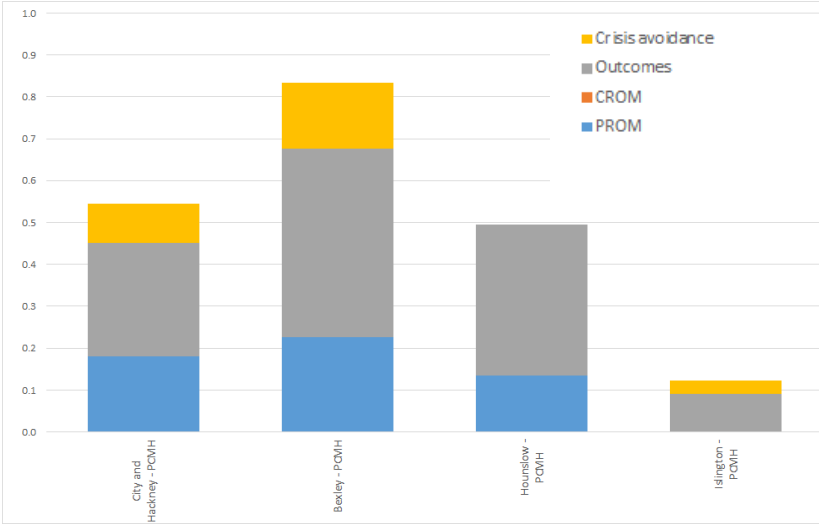
Patient Outcomes includes: Patient Recorded Outcomes , Clinician Recorded Outcomes, evidence that patients are progressing, evidence of impact on crisis.

Higher scoring boroughs were able to evidence (through Patient Recorded Outcome Measures or other measures) how people were making progress as a result of the interventions provided by the service.

The social prescribing service in Bexley uses WEMWBS routinely to assess how people have progressed: the WEMWBS tool is used at the beginning and at the end of a person's time in the service. This also fed into the evaluation of social prescribing. There are PROMS around recovery star. There are other outcome measures in terms of employment. These are indicating that the Bexley service is making a positive impact on the mental wellbeing of service users.

PCPCS in City and Hackney is also very strong in its use of PROMS to record the impact of the service.

Other services are less well developed in their use of PROMS. For Islington, the use of outcome measures is less relevant because the service is an "assess and refer" model and, although it does provide some therapeutic interventions, the service is set up to be a light touch service

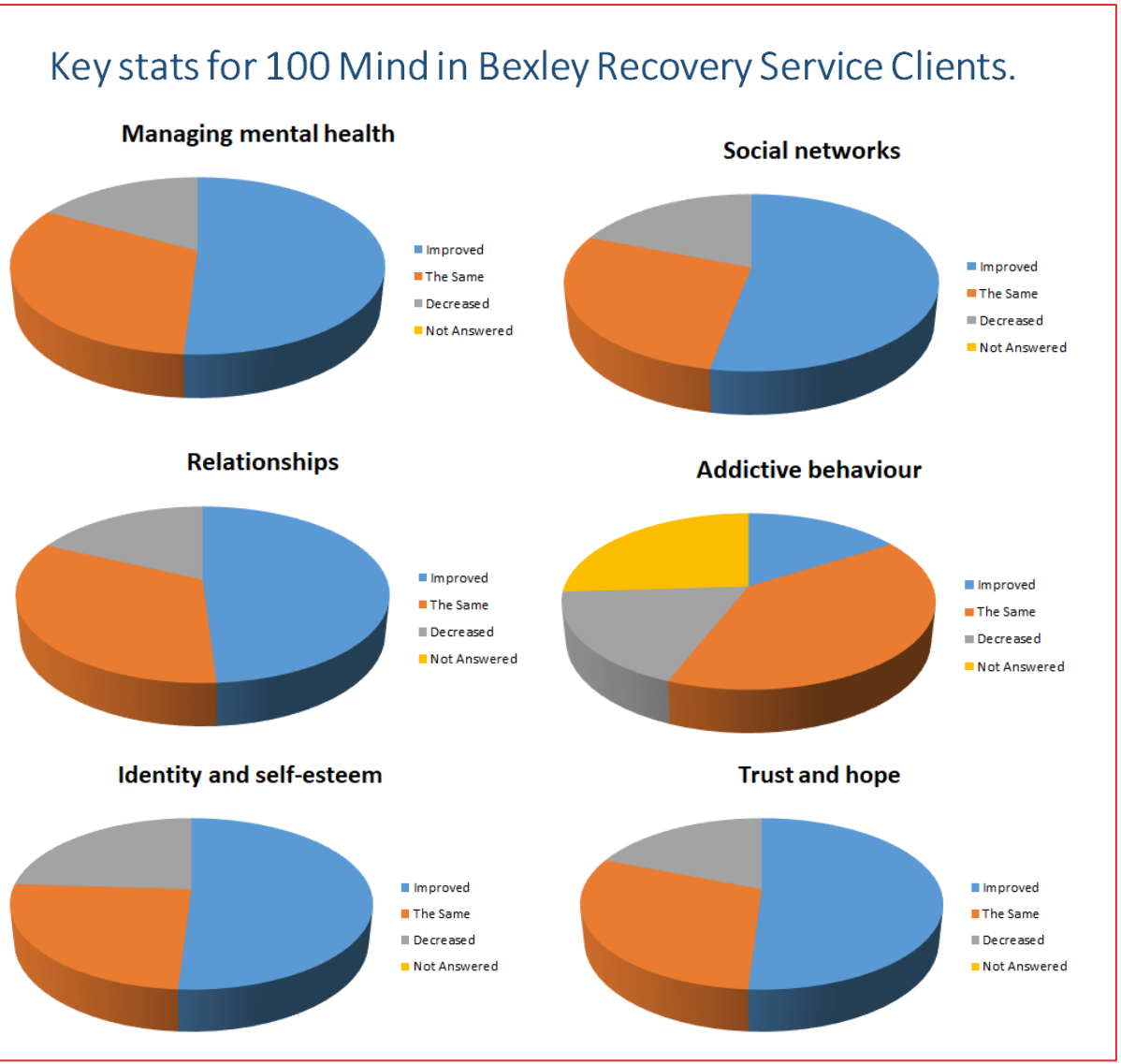


Why is Bexley comparatively good for outcomes?

Bexley has a focus on developing the "life plan" rather than a "care plan" with each service user and then working alongside the person to support and encourage the individual's confidence and self-management.

It addresses the psycho-social causes of mental ill health by taking time with people to address housing, debt, employment and whatever other non-medical factors are relevant.

Patient Outcomes – an example of good practice



During support through the Mind in Bexley Recovery Service, people are brought back to the Recovery Star at 12 to 15 weeks intervals. They look at the ladders again, assess the situation and plot a new Star Chart.

Over time this will help clients to build a picture of their own personal journey. People can see where they have come from and how things have changed. This can help clients to see things in a new way – to put the ups and downs of each week into a bigger picture. This can also be used as a measure of the service success: every quarter a sample of 100 recovery stars are chosen for analysis.

Value to the system – Sustainability

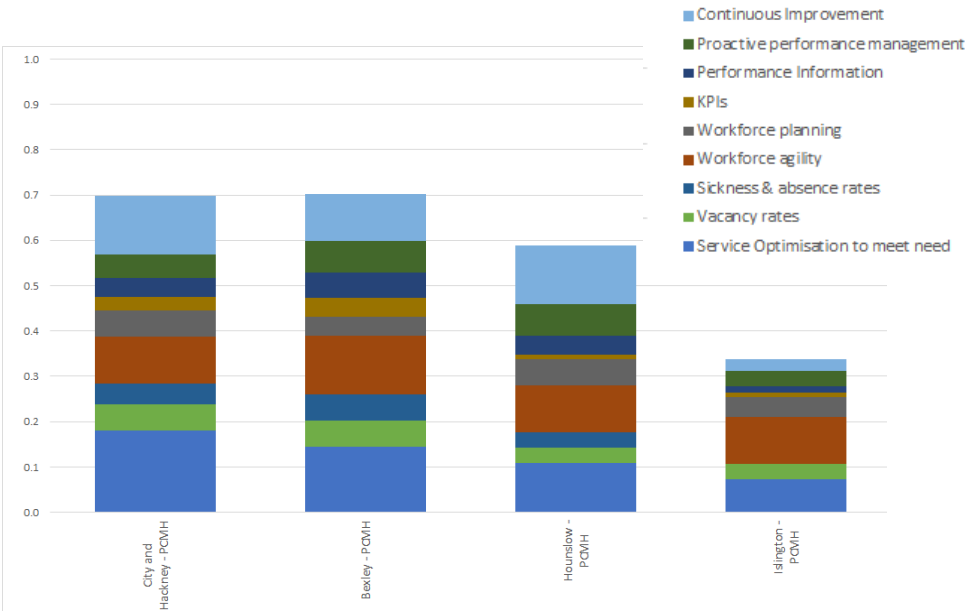
Sustainability includes: Optimising the service to meet need, Vacancy rates, Sickness & absence rates, Workforce agility, Workforce planning, KPIs, Performance Information, Proactive performance management, Continuous Improvement.

Higher scoring areas were able to demonstrate a clear shift of resources to match the need without duplicating services. The teams would be established with good development opportunities and good levels of morale as evidenced in (for example) staff turnover and sickness rates. Higher scoring areas also had sensible performance indicators in place and sympathetic yet robust management of performance. The more developed areas would also be continually developing the service to improve.

Both Islington and City & Hackney had made a conscious switch of resources from secondary care into the new primary care teams along with other investment. City & Hackney have evidence to demonstrate that the caseload for CMHTs has dropped.

Teams generally were well staffed and were well regarded. Bexley has 400 hours of volunteer support each month which is an indicator that people want to be part of the team.

City & Hackney provide their Primary Care Dashboard which is exemplary as an information source, but beyond that, there is a clear understanding by commissioners that performance management is not about target setting but is about identifying areas for management action.



Hounslow had deployed their Quality Improvement method to a number of areas within their primary care service.

It should be straightforward to create a set of performance indicators that consider: outcomes for patients, patient flow, quality of service, workforce morale and caseload, impact on the wider system (use of secondary care, crisis). No area has fully grasped this challenge. Such a set must not create an onerous burden in terms of data collection and generation of unreadable information.

This is important because without it, service managers and commissioners are unsighted on what is working and what is not.

Performance Measures – some good practice

	Psychological Treatment Clinical Dashboard - Reporting to Psychological Therapies Alliance and CCG	Proposed Frequency	Reason behind outcome measure
	Patient Flow		
1	Access rate: the number entering treatment	Monthly	Managing in flows across alliance providers and providing early warning of issues
2	% BAME access	Monthly	Ensuring equity of access for BAME. This is a quality premium target
	Activity		
3	% discharges, who have received a psychological intervention	Quarterly	Measures the extent to which patients have access to psychology within the team or ward
4	% discharges, who have received an individual psychological intervention	Quarterly	Measures the extent to which patients have access to psychology within the team or ward
5	% discharges, who have received a group psychological intervention	Quarterly	Measures the extent to which patients have access to psychology within the team or ward
6	% discharges from a BAME background who received a psychological intervention	Quarterly	Measures the extent to which patients have access to psychology within the team or ward
7	Average no. of psychological sessions completed on discharge per patient.	Quarterly	Measures the average amount of psychology received per patient
	Patient Engagement		
8	% DNA treatment	Quarterly	Improving efficiency and capacity
9	% Completing a treatment	Quarterly	Improving efficiency and capacity and recovery - high drop out tends to lower recovery
	Clinical Outcomes		
10	% of patients ending treatment over the reporting period assessed by PROMs	Quarterly	Demonstrating use of outcome measures
11	% of patients ending a treatment who achieving reliable improvement	Quarterly	Demonstrating reliable improvement
12	% of BAME patients ending a treatment who achieving reliable improvement	Quarterly	Demonstrating reliable improvement
13	% of patients ending a treatment over the reporting period that are assessed by a PREM satisfied with service based on PREM	Quarterly	Demonstrating patient satisfaction
14	% patients ending a treatment over the reporting period satisfied with the service	Quarterly	Demonstrating patient satisfaction

The table on the left (from City and Hackney) sets out a suite of measures that captures the flow of people through the service and the outcomes.

It has simplicity and clarity in the way it is set out. It does not include caseload, but it does provide a good example of measures which could be developed and used more widely.

The structure is helpful: Patient Flow – Activity – Patient Engagement – Clinical Outcomes.

For specific teams (for example teams with more emphasis on liaison) one would need to work through how best to capture these elements.

It is important to ensure that measures are easy to understand, comprehensive, centred on the patient but not forgetting the wider system, easy to collect.

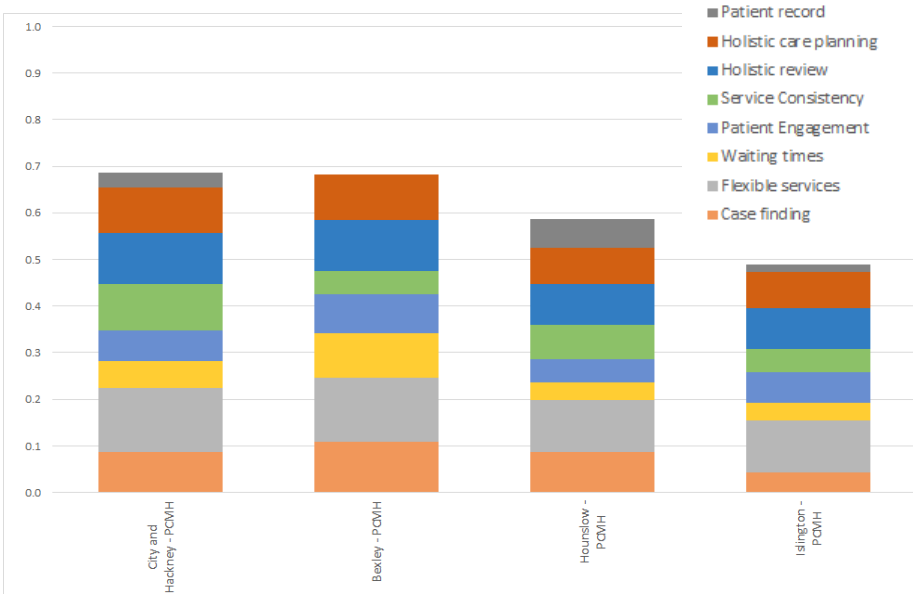
Value to the system – Quality of Service

Quality of Service includes: Case finding, Flexible services, Waiting times, Patient Engagement, Service Consistency, Holistic review, Holistic care planning, Patient record.

The higher scoring areas were able to demonstrate how they were active in drawing service users from other parts of the system into the primary care setting because it was more appropriate and therapeutically beneficial. High value services were flexible both to individual needs and also to the system pressures to manage demand. The waiting times would be low for both initial assessment and whatever follows and the DNA rates should be low. This is a primary care service, so can it be evidenced that there is a consistency from practice to practice. Is the approach fully holistic including psychosocial health, cultural health, social health, economic health, nutrition, mental health formulation and MH diagnosis.

Bexley was able to double its caseload from the originally anticipated volumes. As a one-stop-shop the handovers for people are very smooth. It has also developed new services very rapidly in response to identified system need – for example the new Crisis Café.

All areas struggle to some extent with consistency by practice. Where there is engaged senior GP leadership, this tends to be better.



All areas take a holistic approach

The Hounslow team has full access to SystmOne which allows for more integrated working with GPs. The PCMHS team worked with GPs to co-produce a template (now on SystmOne) for a holistic approach to review allowing better flow of information with other health professionals (e.g. practice nurses).

Islington, being a much newer service, has recently made a breakthrough with access to primary care information systems and this will enable greater transparency and improved performance management for the trust leadership and for commissioners. Bexley has no access to NHS records.

Weighted value to the system – Patient Experience

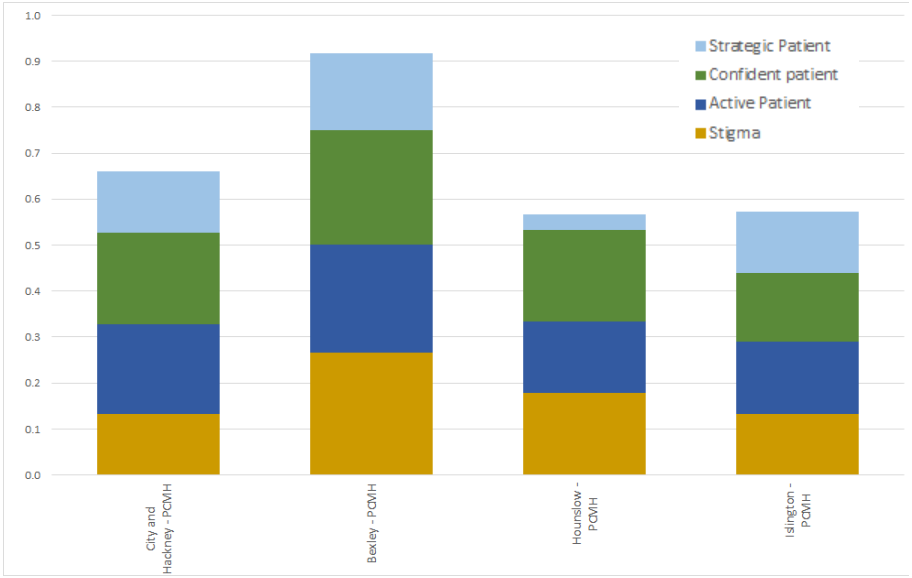
Patient Experience includes: Stigma, Active Patient, Confident Patient, Strategic Patient

High scoring areas were able to evidence a strong emphasis on eliminating stigma. Service users were evidently active in the development of plans and then confident to take ownership of those plans and put them into practice. Involving service users in the ongoing development of services also featured in the high scoring areas (strategic patient).

The Bexley Service works particularly hard to reduce stigma. That is the focus of the Revive Café (for example)

A strong feature of the Bexley Recovery College is that people are encouraged to develop a "life plan" rather than a "care plan". This small change of wording evokes perhaps something more profound in terms of approach.

Because Islington has more focus on assessment and refer, there is less opportunity to impact on the patient experience. But it is well positioned to impact on the stigma that people still encounter in primary care surgeries



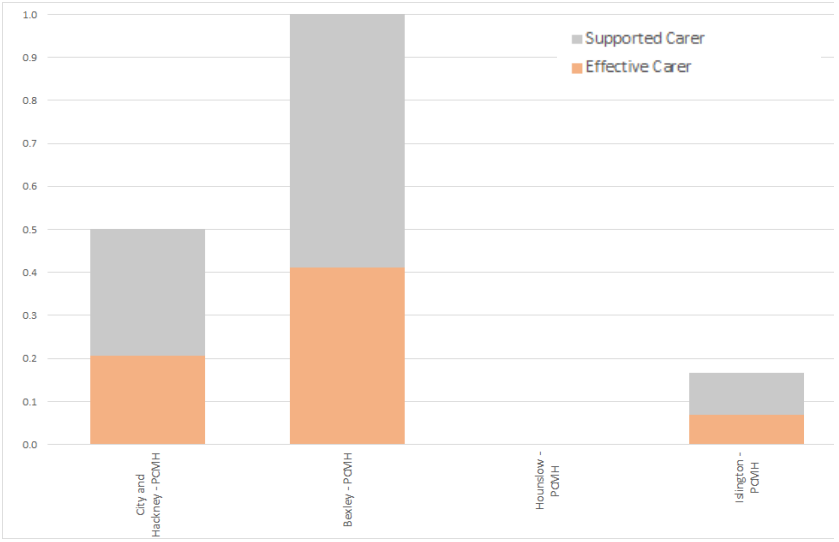
Weighted value to the system – Carer Experience

The Carer Experience includes: supported carer and effective carer.

High scoring areas were able to evidence the extent to which carers of people with MH needs have confidence in caring for their loved one and know where to go to get help (Effective Carer). Carers are supported in their caring role. They understand their own vulnerability and how to manage that risk. (Supported Carer)

Bexley funds a Carers Network as part of the Primary Care Model which is very active and effective in supporting the supporters.

Other areas are sympathetic to carers and there is often something similar in existence but, because it is not part of the primary care service, it becomes a matter of signposting.

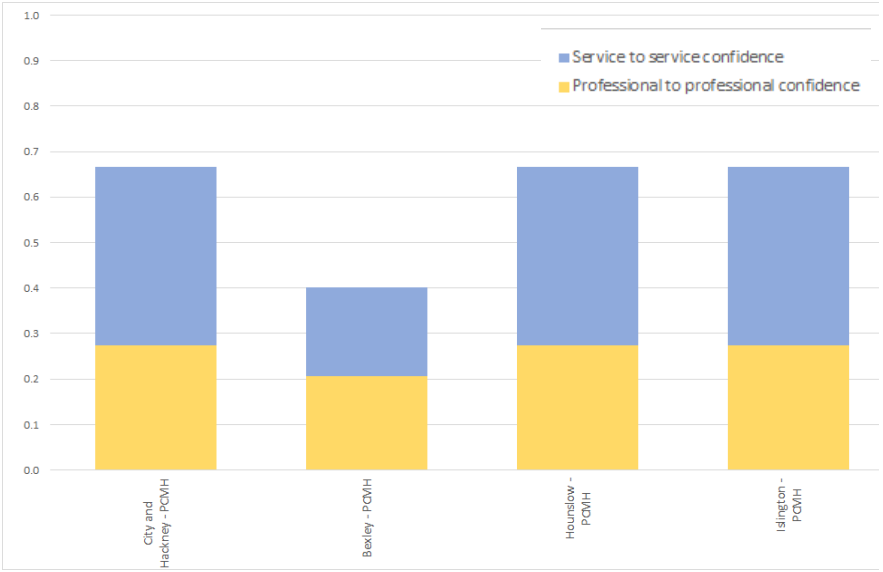


Weighted value to the system – mutual professional confidence

Mutual professional confidence includes: Professional to professional confidence and Service to service confidence

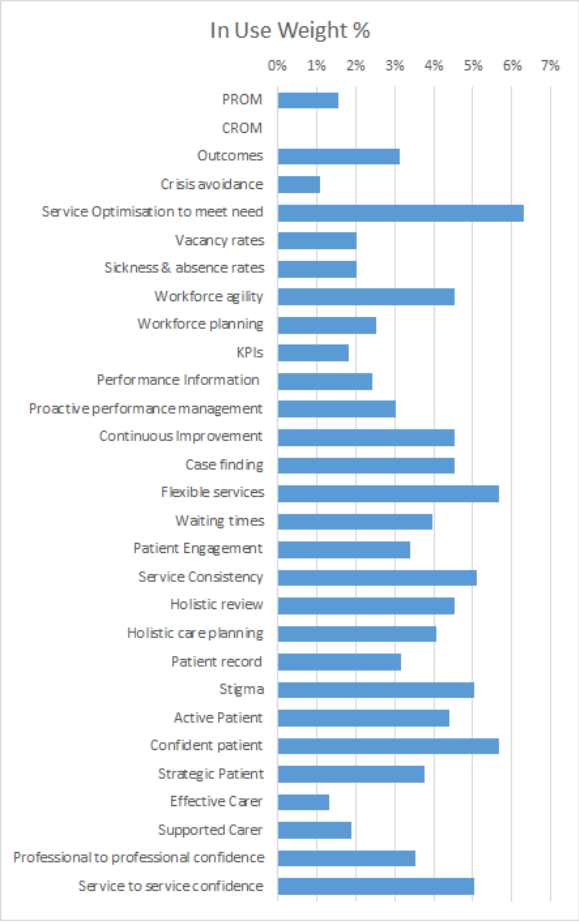
High scoring areas here were able to demonstrate how there is strong mutual respect and trust between individual clinicians across organisations. (Specifically GPs and secondary care clinicians). They can also evidence effective working relationships built on good communications between organisations: secondary care, PCMHS, community, adult social care, and third sector

The three areas with strong consultant psychiatrist leadership all score highly on developing mutual trust across organisations. Bexley has excellent relationships with Oxleas but lost its local GP champion and does not have the profile with GPs that other models enjoy (which itself is a reflection of a particular local challenge around GPs). Having MH nurses/ practitioners in the surgery is particularly important for building these relationships with the GPs.

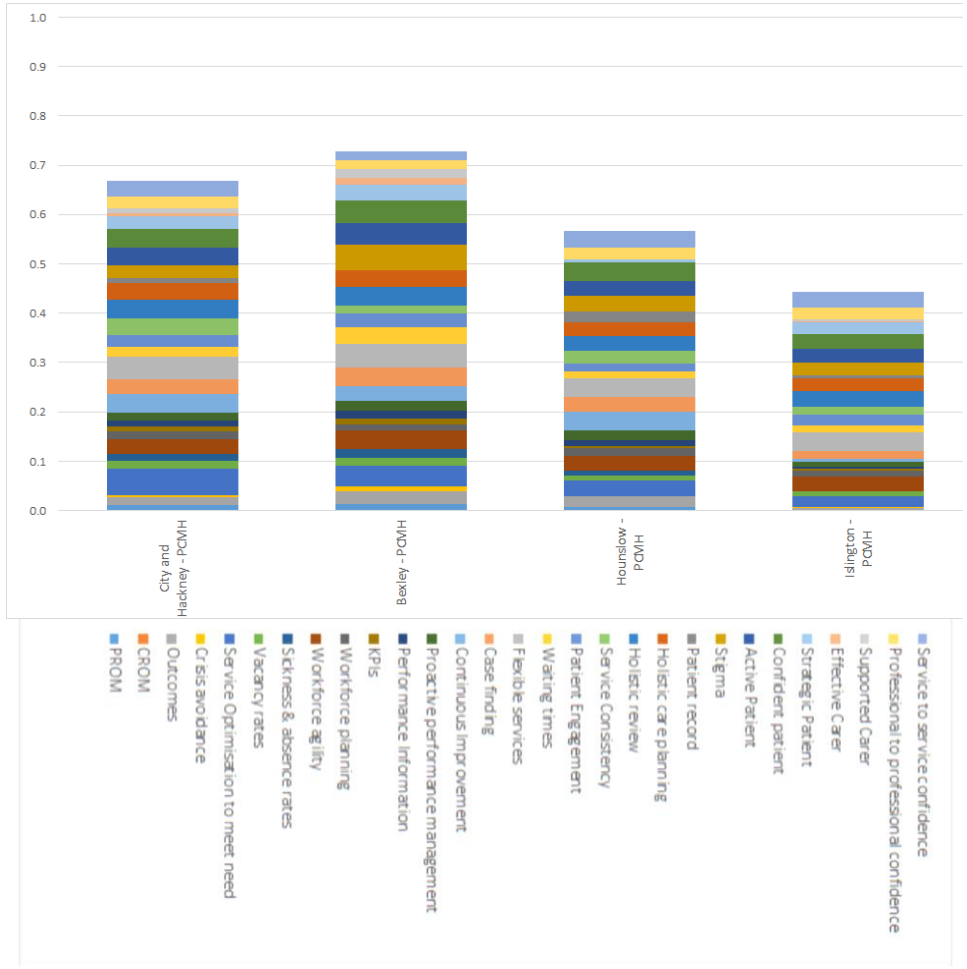


Combination of value

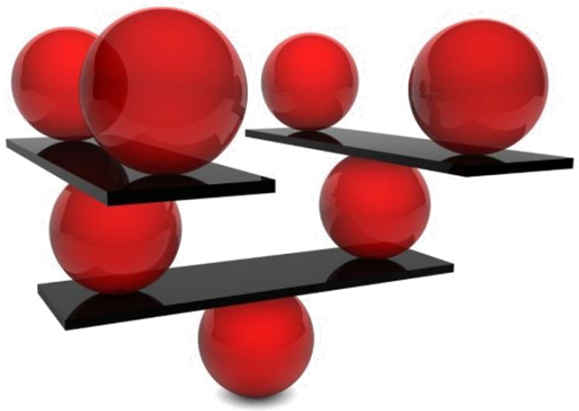
- The 29 components of value were weighted using the “swing weighting method”. This resulted in the following profile of weights to be assigned to each component.



- With this weighting profile, we arrive at the final combination of value profiles compared across the boroughs



Comparison of Activity Shift and Financial Efficiency



The Financial-Economic Model: Data challenges and how to overcome them

- In an economic evaluation it is possible to take a number of different perspectives on cost and financial efficiencies. We have deliberately not looked at wider societal cost impact or even cost impact within the greater public sector. We are looking specifically at the a service in a "steady state" to determine whether (once it is established) the service provides a more cost-effective and sustainable model of care than the counterfactual.

- This is related to activity shift within the health system. This includes displacing activity (the PCMH activity), displaced activity (activity no longer taking place elsewhere) and avoided activity (activity that simply ceases) and supply induced demand. This results in cost shift within the health system. This may be realised as a cashable saving or it may be cash released for reinvestment elsewhere or it may be resource released to meet previously unmet need.

- Activity shift is very difficult to prove from the data. This is partly because the data is not easily provided and the data which does exist is not sufficiently complete to allow for a sensible statistical analysis. However, previous evaluations have provided some bespoke analysis and we can build on that to provide estimates of activity shift as a result of PCMH models. These estimates necessarily include large margins of error.

- We have worked with the sites to populate the cost template. This considers the staff costs of the operational team, other variable costs, some set-up costs. Non-direct costs have been factored in at an additional 20%. Working with the local teams to establish annual caseload figures, this then enable us to calculate team utilisation and recurrent cost per case (again using other local data or assumptions agreed locally). This provides a guide on the efficiency of the service.

- The financial-economic model must be considered as part of the overall evaluation. Higher cost may result in greater value and, subject to affordability constraints, it is the ratio of cost to value that matters.

Indicative crude cost per case and clinical utilisation for EPC

The following cost template shows how the crude cost per case is estimated by using the staffing and the estimated annual caseload. This also allows an estimation of the utilisation of the team and a sense of its operating capacity.

Year 1 - Set up cost	

Staff parameters	
Weeks worked (after leave, sickness, training etc)	42.00
Hours per week	38

Example Staffing Resource	Band	WTE	Baseline Cost per WTE	Additional Resource Cost	Staff Hours per year for patient caseload
Consultant	Cons	1	£145,215	£145,215	0
Nurse Manager	8a	1	£61,937	£61,937	0
Liaison Practitioners	7	7	£51,455	£360,185	11,025
OT	6	0.5	£43,714	£21,857	0
Clinical Psychologist	8a	0.5	£61,937	£30,968	0
support workers	3	4	£26,666	£106,666	0
Admin	4	1	£30,315	£30,315	0
peer support	3	2	£26,666	£53,333	0
Totals		17		£810,476	11,025

Patient parameters	
Average EPC Band 7 Liaison staff hours input per patient	16.0
% utilisation of capacity of unit	90%
Average LOS in PCMH service (weeks)	52.00

Patients treated	
Annual team caseload (Hours available / hours per patient x utilisation)	620
Average caseload per clinician per annum	88.6
Average operating caseload per clinician	109.7

overhead @20%	£162,095
Total Cost	£972,570

Cost per patient	£1,568

PCMH Models – Commissioning, Volumes and Crude Costs

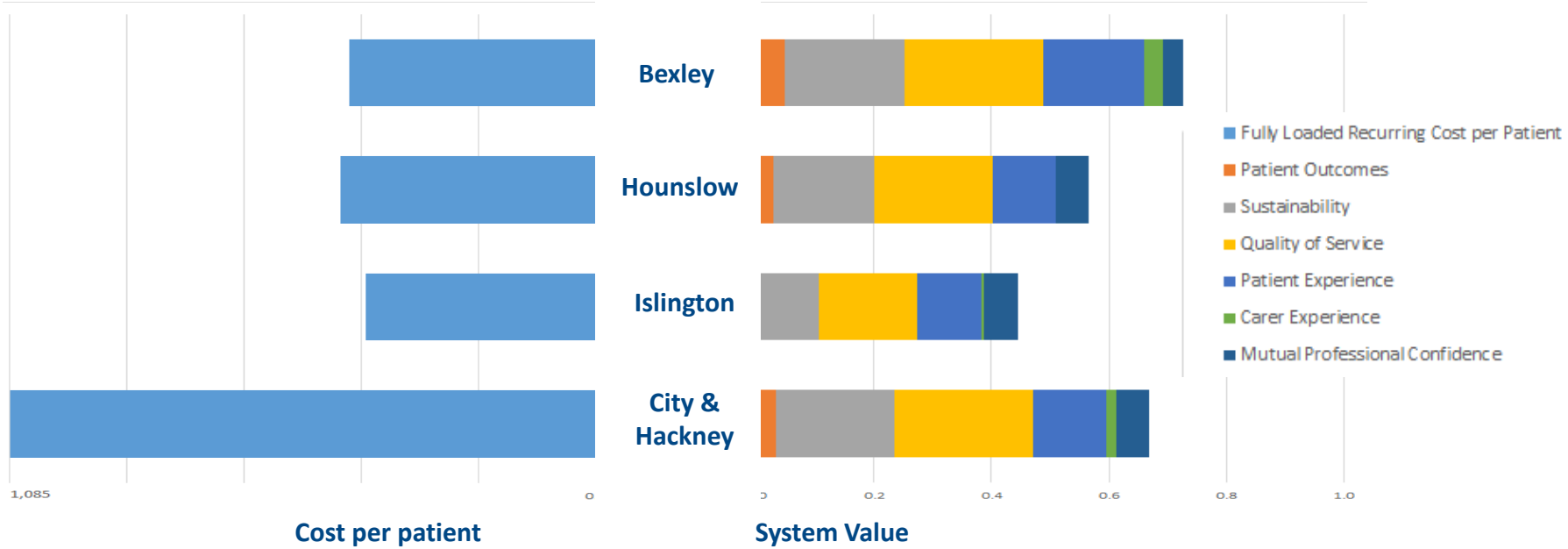
- The crude cost per case is calculated the same way for each service – it is necessarily a range estimate.

	Islington	City and Hackney	Hounslow	Bexley
Caseload volumes	c. 4,300 - 6000 cases per year	PCPCS - c.780; EPC - c.650, Family action - c.550	c. 1,100 - 1,600 patients per year.	c. 1878 cases per year
Cost of service	c.£1,875,000	c.£2,150,000	c.£757,000	c.£860,000
Cost per case	£425	£1,086	£473	£458
Cost per case (min)	£325	£1,085	£343	£413
Cost per case (max)	£488	£1,400	£515	£512

- City and Hackney has an innovative commissioning arrangement and includes therapeutic services with higher costs. The Islington caseload is high because it takes referrals from all non crisis pathways. The crude cost per case is calculated the same way for each service – it is necessarily a range estimate.

Cost to Value Comparison

- This final “Tornado Chart” shows the value to the system (on the right hand side) compared with the cost per case (on the left hand side). The areas are ranked in order of cost-to-value ratio.
- The major factors affecting cost in each model are the number of staff, the type of staff (therapists vs clinical staff vs volunteers/support staff) and the size of the caseload.
- It should be noted that this is a crude ranking – the value weightings that a local borough might prefer to be applied locally may affect the cost-to-value ratio ordering.



Activity Shift – Information Requirements

- The financial efficiencies from Primary Care Mental health arise as a result of avoided activity or "shifted" activity. This means fewer service users in secondary care, fewer GP consultations, a reduction in recourse to crisis including MH crisis teams, A&E and emergency admissions.

- Some services (Islington and City & Hackney) are explicit in the shift of resources to be achieved as a result of replacing secondary care teams with the new primary care teams. In this way they demonstrate a cost shift rather than any financial saving. Bexley is explicit in stating that the primary care model was not intended to save money, but a previous unsatisfactory service was decommissioned.

- The information requirement for a proper understanding of the impact of primary care mental health service on secondary care mental health services is presented below:

Monthly referral data for CCG patients into Enhance Primary Care Service. To include:
Source of referral (GP, police, secondary care, other)
Eventual place of care following referral (e.g. accepted into secondary care services [which cluster, which team], onward referral into primary care services, discharged, other)
Number of crisis interventions
Average waiting time by month for (mean, median, % exceeding 18 weeks)
Any additional data on patient diagnosis organised by cluster with disposal information linked to referral source
Any outcomes data linked to referral source

- However this information simply is not available and so we must develop alternative approaches.

Financial Efficiencies – An alternative approach

- There was an independent assessment of City and Hackney Family Action in 2014 by Dr Alison Longwill. This review concluded that "there is converging evidence, using validated outcome measures, that the WellFamily service achieves a clinically significant impact on clients' wellbeing in terms of anxiety and depressive symptoms and improved social adjustment and recovery in terms of mental health, financial status, self-care and physical health, social networks, work, education and training, relationships, independent living and addictive behaviour." Dr Longwill provided an estimate of the shift in activity as a result of Family Action. This is the mid estimate in the table below.

- Dr Longwill estimated the financial savings as a result of this s=avoided activity. Of the channels where Dr Longwill estimates that activity is reduced, it is possible that there might be cashable savings from either the CMHT caseload or the IAPT High Intensity Service. But there is no indication that any potential savings have actually been realised – it is more likely that the capacity released has met the previously unmet need.

Family Action Annual Caseload (estimated)	550			Unit	Annual reduction per client			Total annual reduction			Financial Efficiency Implication		
					Min	Mid	Max	Min	Mid	Max	Cashable saving?	Non-cashable efficiency saving (Doing more with less)	Meeting unmet need
			GP Consultation	10 minute consultation	0.5	1	4	275	550	2200	N	N	Y
			CMHT consultation (nurse)	CMHT caseload	0.1	0.2	0.3	55	110	165	P	N	P
			Consultant psychiatrist	Assessment	0.1	0.1	0.2	55	55	110	N	N	P
			A&E Attendance	Attendance	0.1	0.25	1	55	137.5	550	N	N	N
			Social worker assessment	1 hour consultation	0.1	0.1	0.2	55	55	110	N	N	P
			Referral to IAPT High Intensity Service	Course of treatment	0.1	0.2	0.3	55	110	165	P	N	P

- We have adapted Dr Longwill's method to provide estimates on the impact of Primary Care Mental Health on the impacted channels of activity: GP consultations, secondary care caseload, A&E attendance

Estimate of Activity Shift – alternative approach

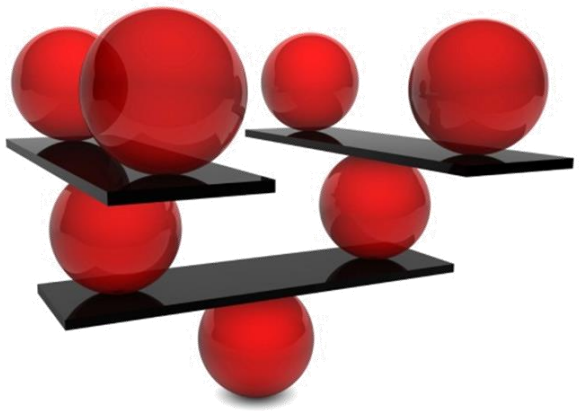
- The estimates in the table below give a wide range. Precise data is hard to establish, but in Bexley there was some analysis done to understand
  - GP appointments before and after the service
  - A&E Attendances before and after the service
  - Admissions and length of stay before and after the service

			Islington	City and Hackney	Hounslow	Bexley
Assumed PCMH Caseload			4400	1980	1600	1878
	unit					
Reduction in GP Consultation	GP appointments	Min	2200	1705	800	476
		Med	4400	4160	1600	664
		Max	8800	8840	3200	953
Reduction in secondary care caseload	Caseload	Min	880	380	320	302
		Med	1320	565	480	403
		Max	1540	653	640	604
Reduction in A&E	ED attend	Min	440	965	160	831
		Med	1100	2023	1100	1068
		Max	4400	3540	1600	1424
Reduction in psychiatrist assessment	Secondary care consultation	Min	440	120	160	0
		Med	1100	185	400	0
		Max	1540	273	464	0

- These estimated numbers for activity shift are too small to be cash releasing except possibly for the secondary care caseload.

- They do represent a significant impact in terms of GP time. That benefit is hard to establish directly, only a retrospective analysis with access to GP appointments linked to PCMHS caseload information can do that. This was not possible within the limitations of this evaluation

Conclusions and Ingredients for Success



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Conclusion 1 – Medical vs non-Medical Model

- Bearing in mind the many factors which combine to influence poor mental health, it is vital to strike an appropriate balance between the social model of care and the medical model. This is more than multi-disciplinary working: it is responding to individual need in the most appropriate way.
- This is done well in Bexley.
- GPs can do mental health - but GP responses may be limited to “tablets, talking and time”. GPs appreciate rapid access to advice (usually but not always from a consultant) and assessment when needed.
- Non-medical solutions may be more appropriate – where users have stable conditions (such as psychosis) or when the root causes of mental anguish are not medical, then recovery focussed models which deploy non-medical social care-orientated solutions may be more effective and less expensive (with less stigma)"

Conclusion 2 – Person Centred, Recovery Centred

- One helpful distinction between primary and secondary care is that primary care operates with a case list and people have easy access whenever they feel they need it, whereas secondary care operates with a case load of people who meet a threshold for admission after a referral and who remain on the caseload until discharged. An Enhanced Primary Care Service should seek to operate with this "fluidity" principle of primary care working.
- This is done well in Hounslow
- Focus on enhancing the confidence and self-management skills of users – as a critical overall objective of the service (research indicates this is vital to manage costs and make long term care sustainable).
- In what circumstances is a "life plan" better than a "care plan"?
- This is done well in Bexley

Conclusion 3 – Legitimate Variation

- Models of service can vary depending on the needs of the patient / service user group. Critical questions to ask to determine a better service model are:
  - How does the service make a difference to the generic GP's way of working?
  - Is the service primarily about "Assess and Refer"?
  - To what extent is therapy a role within primary care?
  - To what extent do you "signpost" and to what extent do you "walk alongside the patient" too?
  - All services take referrals from secondary care and GPs. To what extent is primary care also about receiving non-crisis referrals from other agencies such as police, local authority and other referral sources?
- The Bexley model leads with the social model and each client co-creates a "life plan" rather than a "care plan"
- The Islington PBMH acts as the access team for whole of Islington mental health pathway (except crisis). A difference from other models in that they manage all of the information traffic from all sources including police/housing/social services. It is forwarding information on to other teams, but it's also receiving a lot of information that is either out of date or for people who have had no contact with Trust/PBMH and are often intoxicated/behaviourally disturbed in public/having domestic disputes etc. All such reports are deemed to be 'mental health' related by police + Local Authority Access team and forwarded to PBMH. It takes significant time + resource to triage such reports and to decide whether there is in fact a mental health/illness component and whether to intervene or not.
- Is it cost effective to invest in therapeutic services for high frequency attenders?

Conclusion 4 – Local Leadership

- Strong local leadership is required to “champion” an enhanced primary care mental health model. For the GP community it is best if that local champion is a GP.
- Colocation of the primary care mental health team in a primary care setting is good for patients and good for GPs, however there appears to be marked variability in the willingness of practices to provide space for an enhanced primary care practitioner. This can be resolved through strong local GP leadership.
- Leadership is also needed to overcome barriers to the sharing of data in the interests of patients and patient care.
- There is strong GP leadership in Islington, City and Hackney and Hounslow

Conclusion 5 – Accountability

- Accountability for both service and commissioner requires good performance information and active performance management. There is a general lack of good quality data. Performance information must be shaped around sympathetic performance indicators. Ideally these should be tailored around
  - Patient outcomes – PROMS and longitudinal measures
  - Quality of service (PREMs)
  - Patient flow (including waiting times, ultimate disposition type)
  - Impact on wider system (including recourse to crisis, A&E, secondary care caseload)
  - Workforce
- There should also be regular feedback from stakeholders on their perception of the service and opportunities to improve. A culture of evaluation where is where there is a regular stocktake on how well things are going. Two of the sites have aa culture of evaluation. (Bexley and City and Hackney)
- There is no site that has fully developed its performance information. There are good examples in Bexley and in City and Hackney
- Get the basic data right – if nothing else ensure activity data, segmentation of users into diagnostic categories, feedback from users and carers, impact on admissions and use of resources, and some sense of outcomes.
- There are some good examples of measures, but no example of a fully comprehensive set of measures.
- Performance management is not about setting targets. It is not about finding fault and apportioning blame. It is about measuring and monitoring to identify areas for management intervention.
- Commissioners need to 'think performance' – when service level agreements are being designed, must consider how the performance of that contract is going to be meaningfully managed. This is not just a data issue, it is one of culture: commissioners must constructively challenge providers in how well they are doing, and how to change if there are problems.
- Where commissioning works well, providers welcome that creative challenge and respond positively.
- There is some wise use of performance information in City and Hackney but it remains a challenge to coax the NHS away from target driven behaviours.

Conclusion 6 – Service Agility

- Service development which responds to need is vital. Every organisation strives to be responsive but it is hard for an organisation to be agile if it is risk averse or subject to bureaucratic constraints or if it has “no skin in the game”. Smaller organisations tend to be more agile and closer to the service user.
- The agility of responsiveness is demonstrated well in Bexley
- Engage third sector early on – these agencies can provide different skill sets to compliment the health approach, plus taking some of the pressure off health budgets, especially if they can marshal volunteer support.
- Ensure active process of continuous improvement – through regular reviews and feedback from stakeholders.
- Hounslow has a good record in applying continuous improvement process

Conclusion 7 – Cost and Value

- Understanding the unit cost per patient is important, but it is not something that is currently adequately understood. One of the reasons for under-investment in mental health services is simply that it is unclear what is provided for the investment and what that investment achieves in terms of value.
- It should be a priority for both commissioners and provides to understand the unit cost per case and the variation in unit cost per case. Once that cost variation is described, the action should be to understand the reasons why there is variation.
- For three of the sites evaluated, the crude cost per patient is quite similar. One site appears to have significantly higher costs.
- The variation in unit cost should be explored in the context of the value added to the health system. Is additional cost adding enough additional value?
- Providers who cannot demonstrate performance in terms of activity, cost and value will not be able to present convincing business cases to commissioners. This project has made some progress in describing value to the system and in highlighting where the evidence base needs to be routinely strengthened in order to demonstrate the value that is (very probably) being delivered.

Lessons for Commissioners

- General
  - Be clear on the **actual needs** of the target patient / user service cohort
  - Drive the collection of **patient outcome measures**. Aspire to be a commissioner who commissions for outcomes
  - Take **accountability for system performance**. Make sure that **system metrics are in place** and that they are monitored and managed.
  - Focus on an **achievable definition of 'value of money'** within the PCMHS contract specification
  - Where possible build in **clear cash release opportunities** into the contract (e.g. achieving threshold level of step down from secondary care allowing real world savings)
  - Ensure there is a **minimum set of performance metrics** (including basic measures of activity, efficiency and outcomes) which are tested and delivered as part of ongoing reporting – proactively performance manage the PCMHS
  - Regularly **review stakeholder satisfaction** (patients, referrers, staff)
  - Regularly **review scope of service** to ensure aligns with original specification
  - The **third sector is not a cheaper alternative** – but it can **add to the richness of the service offer** which meets needs in a highly responsive way

- Specific
  - The need of service users may be mostly non-clinical, in which case a more **social care model** could be more appropriate
  - Ensuring **GPs well supported** in managing mental health will give them more confidence in dealing with issues themselves rather than referring on early (unless due to high risk or deterioration in clinical state)

Lessons for Providers

- General
  - Work hard to design and maintain a **minimum set of performance metrics** (including basic measures of activity, efficiency and outcomes) which can be provided to commissioners on a regular basis to demonstrate the positive value for money of the service
  - Foster a **culture of accountability** within the team in terms of data capture – remember that your duty is not just to the individual patient but also to the cohort of future potential patients. Information is vital for future service planning.
  - Regularly **review case mix against original business case** / service level agreement to ensure patient / user type is in line with expectations
  - Regularly **review stakeholder satisfaction** (patients, referrers, staff)
  - Consider how to enlist the third sector

- Specific
  - Ensure the care elements of the PCMHS are **targeted to the specific needs** of service users – for example, stable users may require more focus on non-clinical input such as social support & 'life plans'
  - Focus on PCMHS as **enabling primary care**, rather than extension of secondary care. This includes working with 'fluid' interfaces regarding access & discharge rather than rigid referral criteria

Lessons for Policy Makers

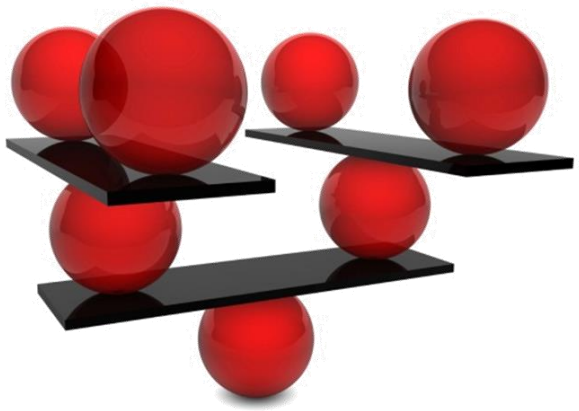
- General
  - Continue to **promote and review Parity of Esteem** to ensure equality of investment in services for people with mental health conditions – there is still comparative under investment
  - Focus on achieving **integrated data sharing** to allow a shared patient record for all services providing care in the mental health field
  - Provide a **positive policy environment for independent sector** organisations to grow and work collaboratively with statutory health and social care organisations. The third sector is not a cheaper alternative – but it can add to the richness of the service offer which meets needs in a highly responsive way

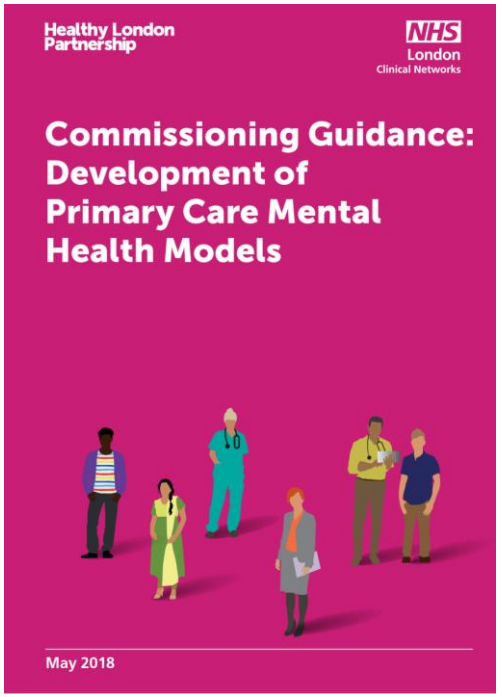
- Specific
  - As STPs configure into Integrated Care Systems, proactively work with stakeholders, including primary care, to **protect and develop effective mental health care pathways**, based around the early identification and early intervention PCMHS models
  - **Proactively protect mental health service budgets** in primary and secondary care and monitor and review contract spend around the country

*Features of a High Performance PCMHS

1. Service specification **reflects the specific social and medical needs** of service users, and allocates care components to meet these needs (e.g. social care predominates where clinical need low)
2. Aspiration to achieve '**confident patient**' status in all service users, to live independently and minimise demand on PCMHS
3. **Minimum indicator set** which includes basic activity, efficiency and outcomes (defined depending on service user types) including through put, change in condition from baseline to post-therapy or discharge
4. **Regular review** of stakeholder satisfaction with focus on service users, referrers and staff
5. **Annual self evaluation** in regard to alignment with original service level agreement / business case
6. **Focus on stakeholder needs** including:
    1. Rapid response to referrer requests
    2. Complete timely communication
    3. Routine but achievable risk review and management
    4. Regular education (for example of GPs and GP practices)
7. Regular and **routine internal performance review** (including not just data review, but plan for improvement, and follow up to ensure implementation
8. Focus on design of service as **not only patient-centric, but also GP Practice-centric**, ensuring that GPs and Practice Nurses are empowered to manage people with mental health conditions, while also knowing that rapid access to advice (in the first instance) and potential referral is available
9. **Positive, ongoing, challenging but constructive dialogue** between all parties including commissioners and providers to ensure the best models of service & working practices are in place
10. To ensure that the **value for money of the service** can continue to be demonstrated, based on the right metrics, the right service model, processes to ensure efficiency, and working towards the best patient outcomes

Commissioning Guidance



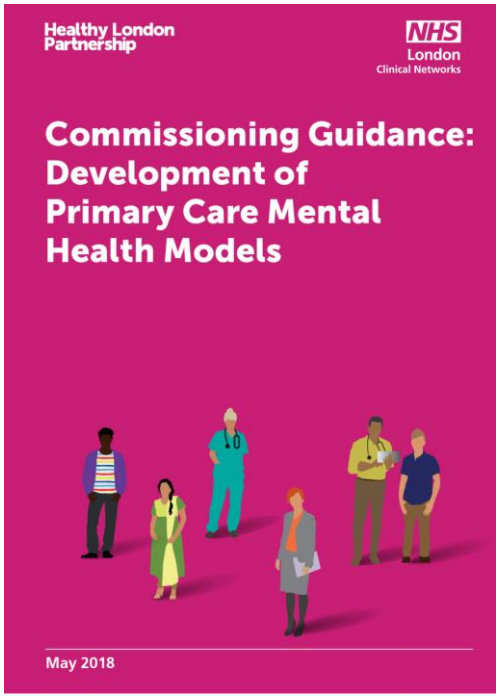


HLP Commissioning Guidance

- Healthy London Partnership has worked collaboratively across London to produce the London Primary Care Mental Health (PCMH) guidance. This has been written to support providers and commissioners in the development of PCMH services across London. It promotes more integrated and co-produced mental health services with individuals who have lived experience at the heart of new service development.

- The purpose of the guidance is to support the development of integrated health and care systems (ICSs). It is an aid for providers and commissioners in the planning and development of primary care mental health services; to help integrate treatment and support in a localised setting for Londoners. There is no consensus of a single service model of PCMH, and so the guidance does not propose one specific model of PCMH service. Instead, it identifies and promotes the service components that are essential to delivering effective PCMH services. The essential service components are described in this document as steps which commissioners and providers of mental health services can collaboratively take to produce integrated treatment and support for Londoners who are recovering from mental illness.

- The guidance describes eight components for a “Gold Standard Primary Care Service” and it also sets out a checklist for the development of a Primary Care Mental Health Service featuring 10 service domains.



HLP Commissioning Guidance: 8 factors to consider for "Gold Standard PCMH"

I. Providing systematic identification via disease registers for call, recall, physical health checks and screening for all long term mental health conditions. This includes; depression, anxiety, obsessive compulsive disorder, psychosis, personality disorder, bipolar and dementia. This facilitates patient reviews and analysis of data around prescribing, referrals on to therapies, social prescribing, substance misuse services and other help available. This approach starts to embed a consistent management approach to mental ill-health that, for some people, is a long term condition.

II. Primary care mental health requires a multidisciplinary team, available in primary care bases.

III. Understanding of the particular physical health care issues and providing appropriate care and services to address them. For example high rates of smoking and medication that affect cardiovascular risk in patients with severe and enduring mental illness, the side effects of medication and low uptake of health screening such as smear tests

IV. New models of recovery and returning patients to primary care, to ensure a flow of patients from secondary care. This allows for fast access for diagnostic assessments/crisis and relapse in an unclogged system. Understanding what community support is available is vital to ensuring that patients receive this help.

V. Mental health data collection; leading to emphasis on outcomes, dashboards and targets, as found in other long term condition management in primary care. Primary care thus becomes responsible for its population's health, and mental health is on a par with other medical conditions.

VI. Addressing other ways that patients present with emotional distress. For example looking at: (a.) Poorly controlled long term conditions and identifying possible mental health issues which may be affecting medication compliance and healthy lifestyle choices. (b.) Markers indicating medically unexplained symptoms, such as frequent referral and investigation. (c.) Engaging with sources of community support, through social prescribing, to enable a more holistic approach to recovery. This includes support for housing, debt management, employment, education and training.

VII. Any PCMH model is dependent on the competency, culture, capacity and confidence of the surrounding system.

VIII. The ease of flow between primary care staff and specialists, ensuring access to prompt advice from specialists that does not involve traditional referral and discharge processes but a shared care approach. Increasing the confidence of primary care staff to aid with the support and management of more complex mental health presentations is important.

HLP Commissioning Guidance: Checklist for development of PCMH Services

Service Domain	Key Questions
Service Maturity	Is there a planned/piloted or developed PCMH service in/associated with the practice? Is there co-location or named links of primary/specialist staff caring for individuals with MH needs or evidence of extensive MDT working across sites/provider tiers?
Scope	Is there a diagnostic range determined for patients under PCMH (e.g. age range, SMI, CMI, diagnostic codes)? Is there a clear distinction between individuals supported by PCMH versus specialist services?
Care Roles including Medicines Management	Is there a shared care plan? Are there clearly defined roles/responsibilities between different care providers, including medication prescribing/monitoring?
Access	Is there a clear referrals process in place? Is there good local awareness of PCMH service?
Communication	Is there a shared IT system? Is there clear, timely access to specialist advice for primary care staff? Is there evidence of liaison links between primary, specialist and community-based care services?
Co-produced Care	Are Service Users involved in service development?
Social Prescribing	Is there evidence of effective social prescribing?
System Flow & Capacity	Are individuals of all ages with stable MH conditions able to transition back to primary care services? How many service users are being enabled to transfer to primary care from secondary care mental health services? Is this process facilitated by liaison with secondary care?
Training	Is there dedicated training in mental health for all primary care staff (i.e. not just clinicians)? What level of support and supervision is available for primary care staff around mental health & wellbeing
Outcome Measures & Service Funding	How is the PCMH service funded? Is recurrent funding secured? Are there outcome measures in place to measure performance and inform service development?

Economic Evaluation and Commissioning Guidance compared

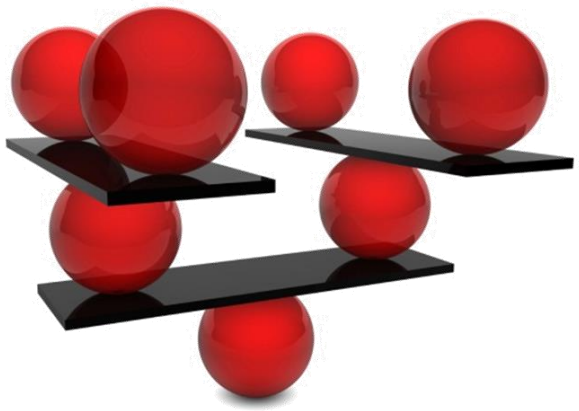
- The Commissioning Guidance sets out some advice for commissioners and provides a set of case studies to illustrate important points. The Economic Evaluation take the reverse view: it works through four (five) detailed case studies and then draws conclusions.

- This economic evaluation was tasked with two specific questions: the first relating to financial efficiencies and the second relating to system value. The starting point of the economic evaluation is different to that of the commissioning guidance as is its methodology and perspective. Nevertheless there is some clear mutual reinforcing of themes:
  - The need to develop and maintain a focus on outcomes for patients
  - The need to improve accountability through clarity of data and information
  - The need for an holistic approach responding to the wider causes of poor mental health.
  - The need for a multi-disciplinary approach
  - The need to improve flow, developing and maintaining a focus on recovery

- In terms of differences, it is more about emphasis and nuance rather than anything additional or contrary. This economic evaluation has developed:
  - A framework of system value
  - An initial estimate of the unit cost of care
  - A stronger challenge to consider the non-medical model as the lead model with medical model in a supporting role
  - A more expansive expression of the nature of accountability for both commissioners and providers
  - A need for commissioners to manage and monitor the system through wise performance management
  - A greater emphasis on the needs of carers
  - A greater emphasis on the notion of agility: a service able to be flexible both to the needs of individuals and also to the strategic need of service development

- Overall, there is a positive case for closer local dialogue and co-production to take the principles of the Commissioning guidance and ensure they are locally implemented

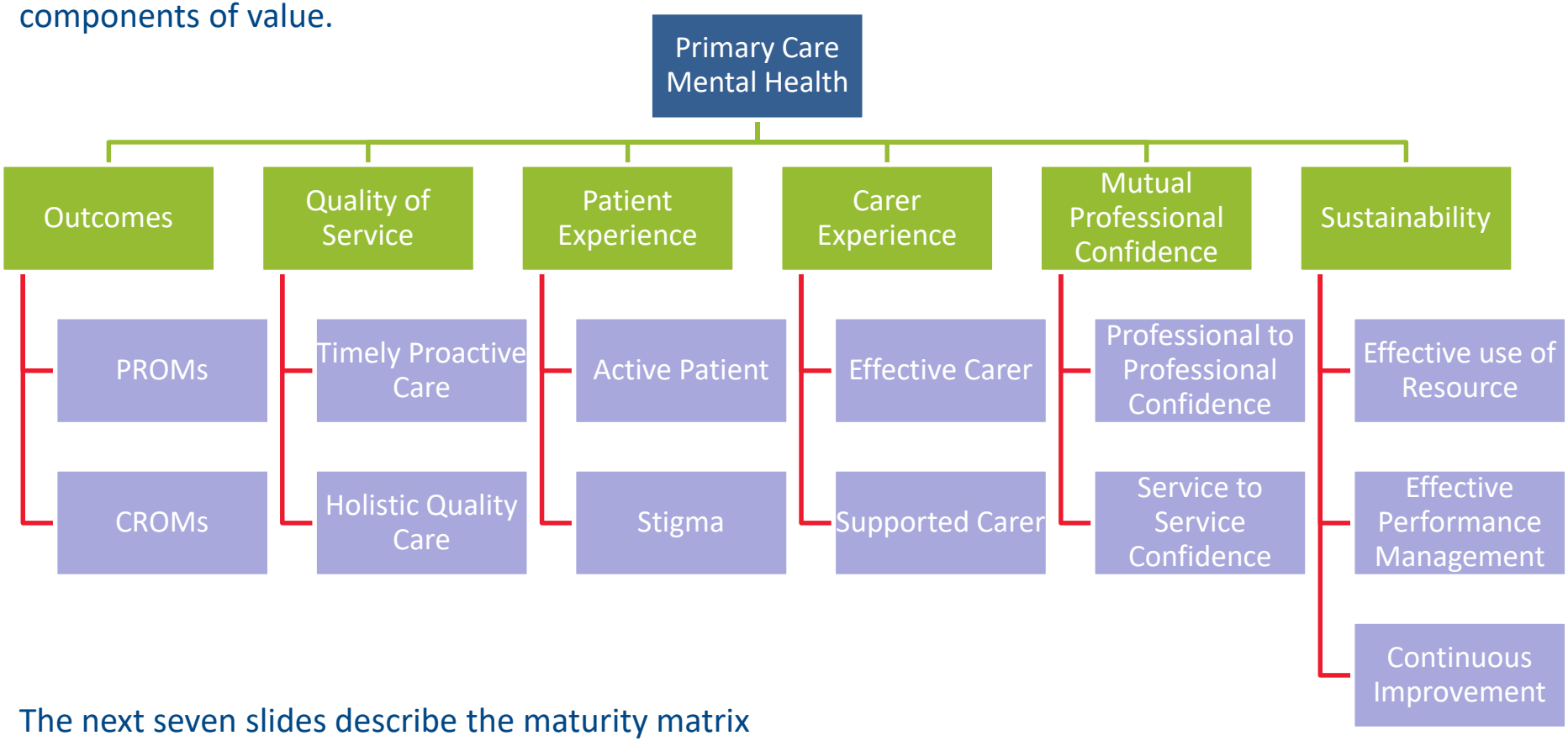
Appendix:
The Economic Evaluation Method – Maturity Matrix



Description of the Maturity Matrix

Value Tree

The first co-production workshop generated over 100 ideas on the meaning of "value". The Grouping and Sensemaking part of the workshop developed six principal areas of value. These areas are: outcomes, quality of service, patient experience, carer experience, mutual professional confidence, sustainability. In the final session of the workshop these areas were further broken down into the elements listed in the value tree. This was further developed by the project team to produce a maturity matrix with 29 components of value.



The next seven slides describe the maturity matrix

Maturity Matrix – 1st Level Value: Outcomes

ID	Second level value	Descriptor	Exemplary = 7	5	3	Rudimentary = 1
1	**PROM**	**PROM**	There are well defined PROMS in place for the service which measure how the service user cohort is improving	There are PROMs in place which are often completed but the service as a whole is not tracking them	There are PROMs in place but these are not consistently used with service users	There are no PROMs in place
2	**CROM**	**CROM**	There are well defined CROMS in place for the service which measure how the service user cohort is improving	There are CROMs in place which are often completed but the service as a whole is not tracking them	There are CROMs in place but these are not consistently used with service users	There are no CROMS in place
3	**Outcomes**	**Outcomes**	The majority of patients are getting better	A significant proportion of patients are getting better	Some patients are getting better but most patients are stable not deteriorating	Patients are stable but not routinely getting better
4	**Crisis avoidance**	**Crisis avoidance**	Service users are making less frequent use of A&E and this is demonstrably linked to PCMH There is a reduction recourse to crisis services and this is demonstrably linked to PCMH services	Service users are making less frequent use of A&E There is a reduction recourse to crisis services	There is no impact on A&E usage or recourse to crisis services	There is no means of determining if the PCMS service is having any impact on A&E or crisis services.

Maturity Matrix – 1st Level Value: Sustainability

ID	Second level value	Descriptor	Exemplary = 7	5	3	Rudimentary = 1
5	**Resources are deployed effectively**	**Service optimisation**	There is no duplication of service. The PCMS service commission included a clear and appropriate shift of resources from other parts of the system, or there is clear evidence that the original service is now able to address previously unmet need.	The PCMS commission involves a plan to decommission services elsewhere and this plan is on track, or there is some evidence that the original service is now able to address previously unmet need.	The PCMS commission involved the intent to decommission services but that has only been partially successful. The original service may be addressing unmet need, but the evidence for that is not strong.	The PCMH service is double running with other services
6	**Resources are deployed effectively**	**Vacancy rates**	PCMH workforce vacancy rates are below normal (using the NHS average)	PCMH workforce vacancy rates are consistently about normal (using the NHS average)	PCMH workforce vacancy rates are consistently higher than normal (using the NHS average) but this is not affecting service delivery	PCMS vacancy rates are consistently significantly higher than the NHS average
7	**Resources are deployed effectively**	**Sickness & absence rates**	PCMH sickness and absence rates are below normal (using the NHS average)	PCMH sickness and absence rates are consistently about normal (using the NHS average)	PCMH sickness and absence rates are consistently higher than normal (using the NHS average) but this is not affecting service delivery	PCMS sickness and absence are consistently significantly higher than the NHS average
8	**Resources are deployed effectively**	**Workforce agility**	Skill mix is agile to match case mix. The service can find the professional(s) with the set(s) of skills to meet the need of the service user.	The service has a comprehensive skill mix but sometimes the levels of flexibility to meet the needs of service users could be improved.	There is limited flexibility in the service to work across boundaries in the interest of the service users	There is a gap in the skill mix required to match the service user need.
9	**Resources are deployed effectively**	**Workforce planning**	Future workforce planning is in place with no major concerns	There is some workforce planning. It has identified some concerns	There is an awareness that future recruitment may be problematic	There is no workforce planning

Maturity Matrix – 1st Level Value: Sustainability

ID	Second level value	Descriptor	Exemplary = 7		5		3		Rudimentary = 1
10	**Performance Management**	**KPIs**	Key Performance Indicators are measuring the right things in the right way		There are good KPIs are in place but they are incomplete or onerous to collect		There are no KPIs. Or the KPIs are not being measured or monitored.		There are KPIs are in place but some of them are unhelpfully measuring the wrong things
11	**Performance Management**	**Performance Information**	Performance information is relevant and timely		Performance information is incomplete		Performance information exists but it is unreliable		There is no performance information
12	**Performance Management**	**Proactive performance management**	Strong evidence of intelligent proactive management action in response to performance reports (both positive and negative)		Evidence of management action in response to performance reports, but action tends to be reactive and/or corrective		Performance management is laissez-faire		There is little management interest in the service

ID	Second level value	Descriptor	Exemplary = 7		5		3		Rudimentary = 1
13	**Continuous Improvement**	**Continuous Improvement**	There is an active continuous improvement approach following a recognised method which is widely understood by people within the PCMH team		There is a continuous improvement method but it is not widely understood. There is some evidence of learning from experience		Continuous improvement is ad hoc. There is some evidence of learning from experience		There is no concept of continuous improvement

Maturity Matrix – 1st Level Value: Quality of Service

ID	Second level value	Descriptor	Exemplary = 7	5	3	Rudimentary = 1
14	**Timely Proactive Care**	**Case finding**	There is a high level of proactive case-finding to identify and invite people into the service. There is clear evidence of meeting unmet need	There is a some good examples of regular proactive case finding, but this proactive approach remains to be embedded. There is some evidence of meeting unmet need	There is limited proactive case finding. The service is mostly reactive.	The service is entirely reactive to referrals in. Unmet need remains unmet.
15	**Timely Proactive Care**	**Flexible services**	The service user experiences flexibility across all care providers (primary, secondary and third sector). There is step-up and step-down and easy access to (non MH) community based resources	The hand-overs between organisations are very occasionally a source of frustration for clinicians and service users.	The hand-overs between organisations are sometimes a source of frustration for clinicians and service users.	The hand-overs between organisations are often a source of frustration for clinicians and service users. There is limited access to (non MH) community based resource.
16	**Timely Proactive Care**	**Waiting times**	MH waiting times achieve parity with the best waiting for equivalent physical health services			MH waiting times are failing to meet required targets
17	**Timely Proactive Care**	**Patient Engagement**	Service users are fully engaged in their own recovery. The DNA rates are low	Service users are largely engaged in their own recovery	Service users are sometimes engaged in their own recovery	Service users are not routinely engaged in their own recovery. High DNA rates
18	**Timely Proactive Care**	**Service Consistency**	There is consistency of high quality care across all GP practices	There is mostly consistent high quality care across GP practices with a small number yet to fully engage	There is variation in the quality of care by GP practices but there is a plan to address that	There is wide variation in the quality of care across GP practices.

Maturity Matrix – 1st Level Value: Quality of Service

ID	Second level value	Descriptor	Exemplary = 7	5	3	Rudimentary = 1
19	**Holistic Quality Care**	**Holistic review**	Service users experience holistic review including: psychosocial health, cultural health, social health, economic health, nutrition, mental health, formulation and MH diagnosis	Service users experience most elements of holistic review including: psychosocial health, cultural health, social health, economic health, nutrition, mental health, formulation and MH diagnosis	Service users experience some elements of holistic review including: psychosocial health, cultural health, social health, economic health, nutrition, mental health, formulation and MH diagnosis	Service user reviews are focussed entirely on direct MH issues.
20	**Holistic Quality Care**	**Holistic care planning**	There is a holistic care plan including: psychosocial, cultural, social, economic, nutritional	There is a holistic care plan including most of the following elements: psychosocial, cultural, social, economic, nutritional	There is a holistic care plan including some of the following elements: psychosocial, cultural, social, economic, nutritional	Service user care plans are focussed entirely on direct MH issues.
21	**Holistic Quality Care**	**Patient record**	There is a consistent patient record accessible to all and communicated so that the story is not repeated unnecessarily.	There is a shared patient record but it is not accessible to all. Occasionally the service user is still required to repeat their story.	There is a shared patient record but it is not accessible to all. Often the service user is required to repeat their story.	There is no shared patient record accessible to all. The service user is almost always required to repeat their story

Maturity Matrix – 1st Level Value: Patient Experience

ID	Second level value	Descriptor	Exemplary = 7	5	3	Rudimentary = 1
22	**Stigma**	**Stigma**	Service users are not personally stigmatised in any way by service providers	There are proactive efforts to address stigma in the service	Although stigma still exists, the service makes efforts to address it whenever it is noticed	The service recognises that MH stigma exists and understands that stigma impacts upon the patient experience and outcomes negatively but there are few strategies to deal with stigma effectively within the service
23	**Active Patient**	**Active Patient**	Each service user is an active partner in defining their own care plan and outcomes, but not forgotten by professionals	Service users are routinely active in defining their own care plans and outcomes, sometimes without sufficient professional involvement	Service users are passive in the creation of care plans and outcomes.	There is no partnership in the developing of care plans
24	**Confident patient**	**Confident patient**	Service users are confident to manage their whole health and, if their health deteriorates, they know where to go and what to do	Service users have good knowledge of their condition but only partial information around range of services and sources of support	Service users have only basic knowledge of their condition and where to seek help	Service users are not confident to manage their whole health
25	**Strategic Patient**	**Strategic Patient**	Service users have a strong voice in shaping the development of the PCMH service			Service users have no effective voice in shaping the future of PCMH services

Maturity Matrix – 1st Level Value: Carer Experience

ID	Second level value	Descriptor	Exemplary = 7		5		3		Rudimentary = 1
26	**Effective Carer**	**Effective Carer**	Carers of people with MH needs have confidence in caring for their oved one and know where to go to get help		Carers have good knowledge of their loved ones condition but only partial information around range of services and sources of support		Carers have only basic knowledge of their loved ones condition and where to seek help		Carers of people with MH needs have limited confidence in caring for their oved one and do not always know where to go to get help
27	**Supported Carer**	**Supported Carer**	Carers are supported in their caring role. They understand their own vulnerability and how to manage that risk		Carers are supported in their caring role but have limited understanding of their own vulnerability & how to manage risks		Carers are have only basic support in their caring role and little or no understanding of their own vulnerability & how to manage risks		Carers are not routinely supported in their caring role. They are not fully aware of their own vulnerability and how to manage that risk

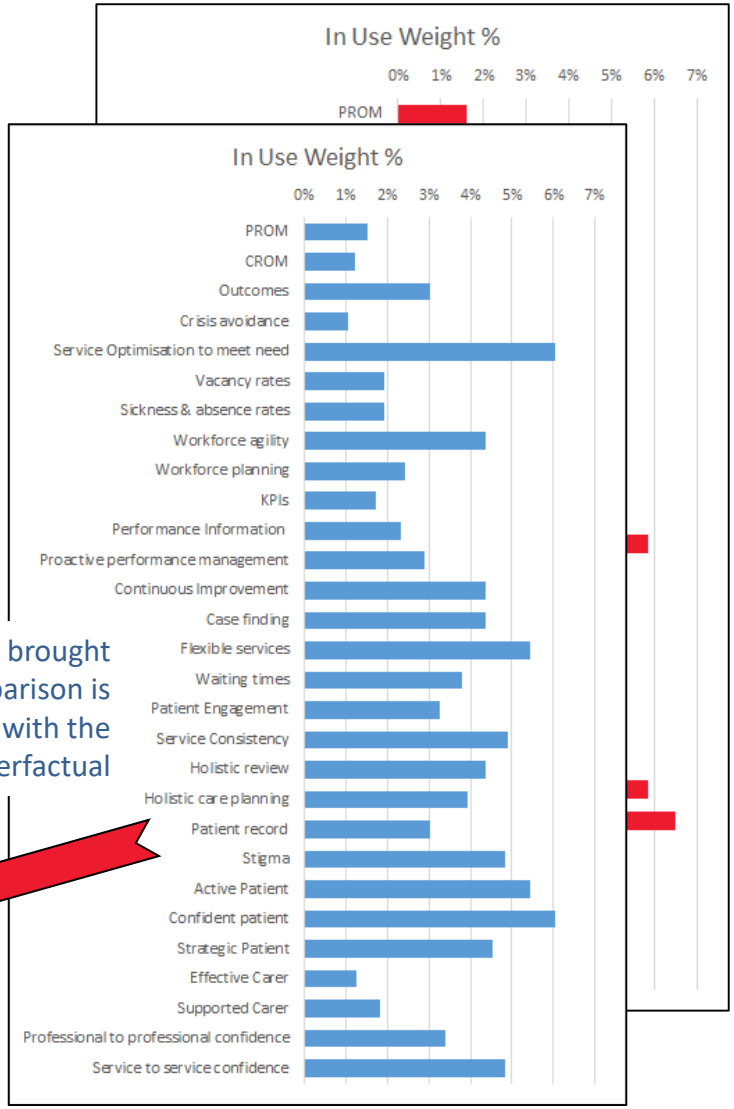
Maturity Matrix – 1st Level Value: Mutual Professional Confidence

The group saw mutual professional confidence as a first level value. This is about professional-to-professional confidence and also confidence between organisations.

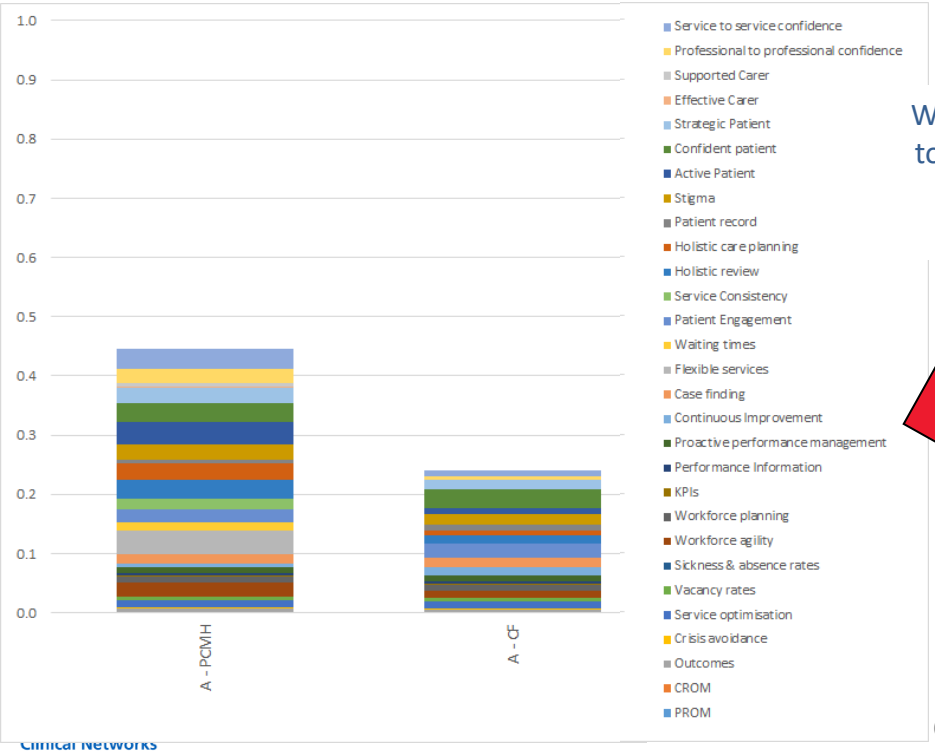
ID	Second level value	Second level value	Exemplary = 7		5		3		Rudimentary = 1
28	**Professional to Professional confidence**	**Professional to Professional confidence**	There is strong mutual respect and trust between individual clinicians across organisations. (Specifically GPs and secondary care clinicians)		Working relationships between clinicians are improving. There are many examples of mutual respect and trust but there remain pockets where individual professional relations are more strained.		Working relationships between clinicians are improving. There are examples of mutual respect and trust but this is not widespread		Working relationships between individual clinicians are problematic. The reasons for this have not been explored and/or addressed.
29	**Service to Service confidence**	**Service to Service confidence**	There are effective working relationships built on good communications between organisations: secondary care, PCMHS, community, adult social care, and third sector		There are many examples of effective working relationships between all types of organisations. Examples of poor communications leading to frustration are infrequent.		There are some examples of effective working relationships between organisations but elements of poor communications leading to frustration still exist.		There are regular instances of frustrated and frustrating organisational behaviours

Example – Weighting Applied

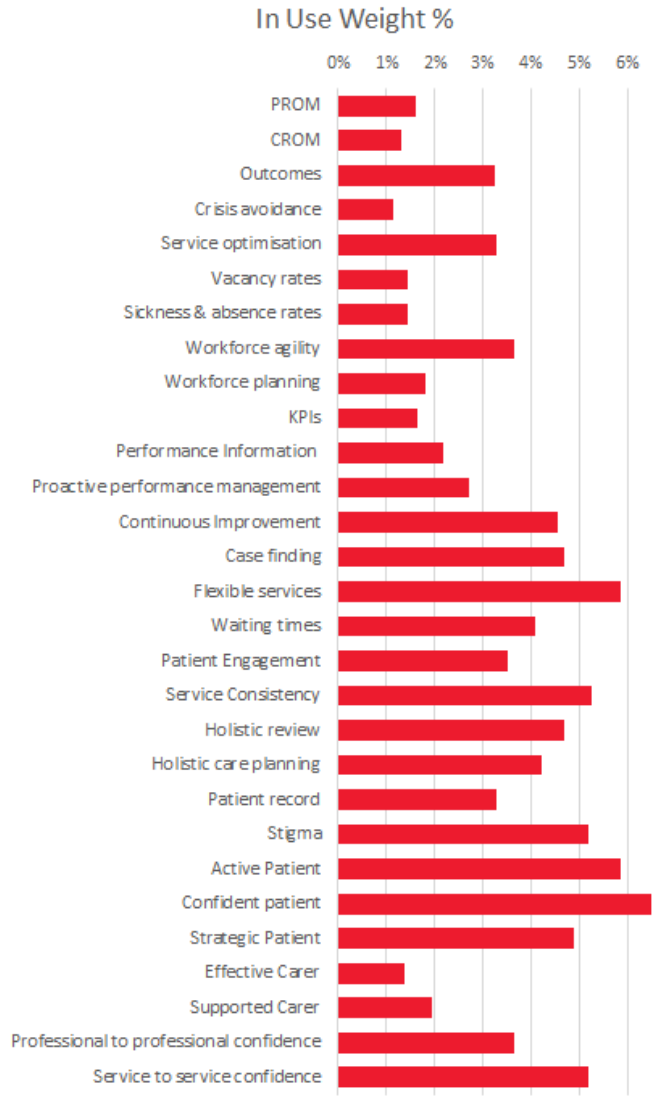
Unweighted scores have weights applied (with and without sensitivity)



Weighted scores are brought together and a comparison is made with the counterfactual



Swing Weighting – Output from co-production workshop

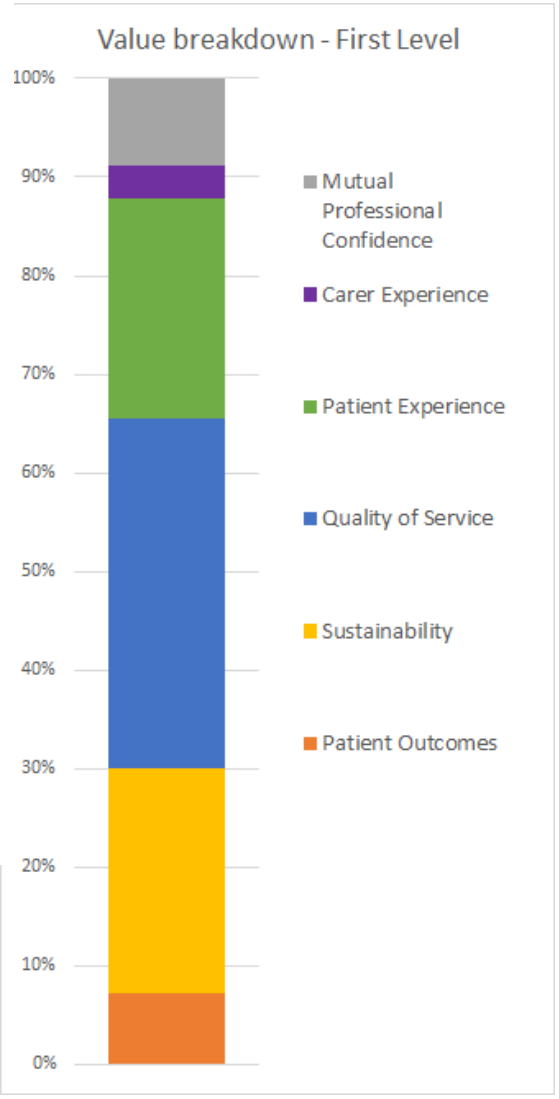


The chart on the left shows the relative weighting ascribed to each component of value.
Of all the components, those with the highest weighting are:

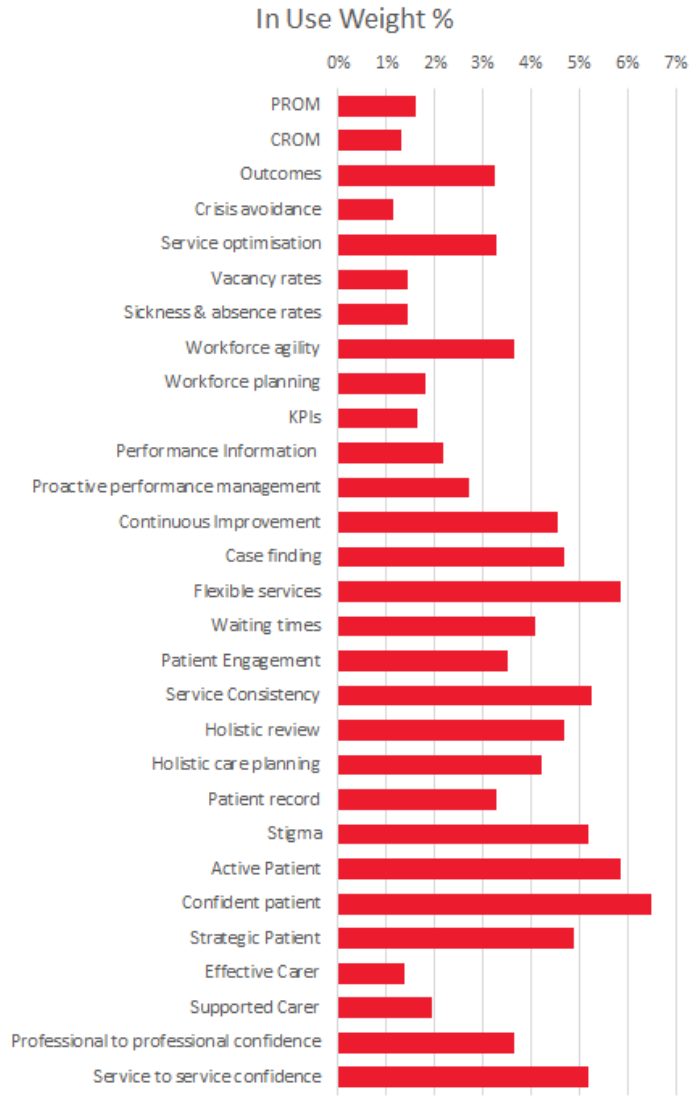
- Confident patient
- Active patient
- Flexible services
- Service to service confidence
- Stigma
- Service consistency

The chart on the right shows how the top level value groupings contribute to the overall weighting of value. The greatest contribution comes from Quality of Service followed by Patient Outcomes and Sustainability

Stakeholders in the workshop were able to review these charts at the end of all the swing weighting. The collective view was that this represented a view of value which was intuitively reasonable

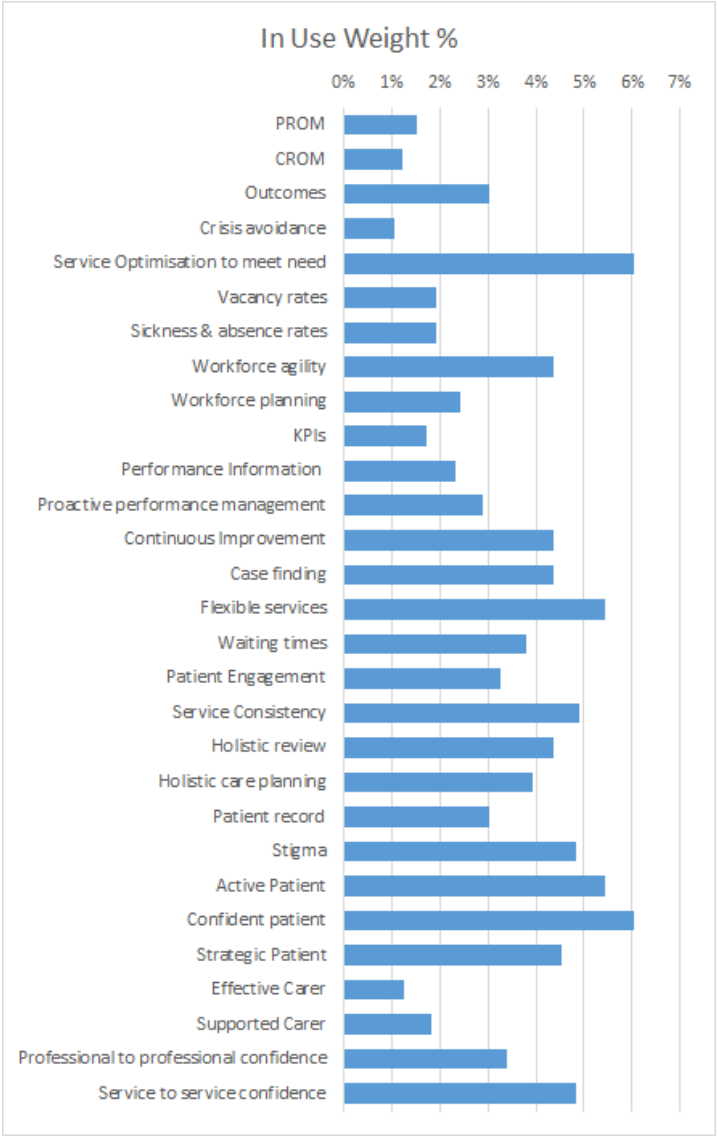


Sensitivity Analysis



On further reflection, the evaluation team formed the view that the maturity matrix did not sufficiently capture the concept of meeting the unmet need within the system. This was present within the definition of "service optimisation" but by renaming the component "service optimisation to meet need" and by increasing the weight on that component, the highest scores are assigned to the following:

- Confident patient
- Service optimisation to meet need
- Active patient
- Flexible services
- Service consistency
- Stigma



Mental Health Care Clusters (for reference)

Care Cluster	Title	Care Cluster	Title	Care Cluster	Title
0	Variance Cluster	7	Enduring Non Psychotic disorders (high disability)	15	Severe Psychotic Depression.
1	Common Mental Health Problems (Low severity)	8	Non-Psychotic chaotic and challenging disorders	16	Dual Diagnosis
2	Common Mental Health Problems (Low severity with greater need)	10	First Episode Psychosis	17	Psychosis and Affective Disorder Difficult to Engage
3	Non-Psychotic (moderate severity)	11	Ongoing Recurrent Psychosis (low symptoms)	18	Cognitive Impairment (low need)
4	Non-Psychotic (severe)	12	Ongoing Recurrent Psychosis (High Disability)	19	Cognitive Impairment or Dementia Complicated (Moderate Need)
5	Non-Psychotic (very severe)	13	Ongoing Recurrent Psychosis (low symptoms)	20	Cognitive Impairment or Dementia Complicated (High need)
6	Non-Psychotic Disorders of Over valued Ideas	14	Psychotic Crisis	21	Cognitive Impairment or Dementia Complicated (High Physical or engagement)

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