



National Development Team **for inclusion**

Mental Health payment system and personalisation

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health



employment



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PART A: POLICY

1. Background

Payment by Results is a way of funding services based on the results they achieve.

In 2010/11, the Department of Health made its first steps to introducing what was then called Payment by Results (PbR) in mental health. This shift in payment method followed significant developments in PbR in other parts of the NHS from 2003/4, to the point where spend in health through PbR had reached over 60% of acute hospital income (around £29bn of services) and about one-third of what were then primary care trust (PCT) budgets. PbR also underpins reforms in many other areas of public services; the banner “PbR” covers a wide variety of funding models, for example in commissioning children’s centres, housing support, services for substance treatment, or services for troubled families.¹

The 2010 White Paper, *Equity and Excellence: Liberating the NHS*, reaffirmed the commitment to introduce PbR in mental health, and the year 2012/13 was a significant one for implementation of this requirement. During that year, the use of mental health currencies was mandated by the Department of Health, meaning that all people with mental health problems seen by secondary mental health services had to be allocated to one of 21 mental health clusters that reflected their needs. Tariffs – local prices associated with the support people get for their mental health problems – were also introduced.

By 2014/15, it was widely recognised across the mental health sector that the introduction of PbR in mental health had not progressed as quickly as intended.² This reflected findings across the broader health sector that there remained some difficulties with the PbR system.³

Responsibility for the design and oversight of the whole NHS payment system was formally transferred to NHS England and Monitor in 2014. With this change came a shift from a “Payment by Results system for mental health” to a “mental health payment system”.

¹ Payment by Results: Comparing PbR across public services and in housing related support, SITRA, May 2013: <http://www.sitra.org/policy-good-practice/payment-by-results/>

² Background to the 2015/16 proposals for the mental health payment system, NHS England, July 2014: <http://www.england.nhs.uk/wp-content/uploads/2014/07/dev-mental-health-pay-syst.pdf>

³ National Tariff Payment System 2014/15 guidance, NHS England and Monitor, December 2013: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300547/2014-15_National_Tariff_Payment_System_-_Revised_26_Feb_14.pdf

The current set of policy and guidance documents produced jointly by NHS England and Monitor that guide the entire health payment system now fall into two categories:

1. Information on the National Tariff Payment System in health and mental health in 2014/15. This incorporates an overarching document for the *2014/15 National Tariff Payment System*⁴ and associated *Guidance on mental health currencies and payment*⁵. The latter is based on the Department of Health's *Mental Health Payment by Results Guidance for 2013/14*, which represented the culmination of the thinking regarding PbR in mental health up to that point.
2. Significant consultation regarding the development of the *2015/16 National Tariff Payment System*⁶, including how it works in mental health.

It is clear that the change in responsibility to NHS England and Monitor has provided an opportunity to assess how the health payment system, including mental health, may develop in the future. Nevertheless, it is clear that both current guidance and future intentions regarding the payment system in health, including mental health, reaffirm a commitment to a payment system that uses currencies and tariffs.

⁴ *Ibid.*

⁵ Mental health currencies and payment: 2014/15 guidance, NHS England and Monitor, December 2013: <https://www.gov.uk/government/publications/mental-health-currencies-and-payment-guidance>

⁶ NHS National Tariff Payment System 2015/16: engagement, NHS England and Monitor, July 2014: <https://www.gov.uk/government/consultations/nhs-national-tariff-payment-system-201516-engagement-documents> and formal consultation: <https://www.gov.uk/government/consultations/national-tariff-payment-system-201516-a-consultation-notice>. The outcome of this work was recently published by Monitor and NHS England for 2015-2021: <https://www.gov.uk/government/consultations/improving-the-costing-of-nhs-services-proposals-for-2015-to-2021>



2. About this project

2.1 The mental health payment system and personalisation

Of the many facets that the mental health payment system covers, one area of particular interest has been how the mental health payment system supports the personalisation agenda.

In January 2012 the National Development Team for Inclusion (NDTi) published a discussion paper that looked at how personalisation and what was then PbR were being understood and implemented together to achieve better outcomes for people using mental health services.⁷ This was followed up by an expert seminar run by the NDTi with Think Local Act Personal (TLAP) and the Social Care Institute for Excellence (SCIE). The audience included members of TLAP's National Co-production Advisory Group, representatives from three mental health foundation trusts, four local authorities, the Department of Health and the College of Social Work.

The event generated a focused discussion about the opportunities for and challenges of developing PbR and personalisation together. These debates highlighted a number of issues, including the absence of widely shared practice examples. As a result, the NHS Confederation's Mental Health Network⁸ commissioned NDTi to provide a snapshot of how aspects of PbR and personalisation were working together through highlighting and sharing learning from some of the emerging approaches across the country.

To do this, NDTi visited five different areas during 2013 to explore the progress they were making in implementing what was then PbR and personalisation. These areas were suggested by the then Strategic Health Authorities and included:

- Lambeth
- Northamptonshire
- Stockport
- Suffolk
- Worcestershire.

⁷ Getting it together for mental health care: Payment by Results, personalisation and whole system working, NDTi, 2012: http://www.ndti.org.uk/uploads/files/Pbr_and_pers_Final_v2.pdf

⁸ <http://www.nhsconfed.org/networks/mental-health-network>

In each area NDTi looked at:

- What had worked well
- The difficulties encountered on the way
- Critical success factors
- Pitfalls to avoid
- Plans for further development.

Drawing together the findings, a first version of this report was drafted in summer 2013. With the subsequent changes to the payment system in mental health the NHS Confederation Mental Health Network commissioned an update to the report in 2014. Despite the policy and guidance changes resulting in a shift from PbR to a mental health payment system much of the practical work done by areas to implement these changes remained similar. In Spring 2014 we therefore contacted each area to check on progress since the first visit, and these updates are reflected accordingly in this report.

2.2 Overview of the report

This report is structured as follows. Section 0 provides an introductory overview of both the mental health payment system and what good looks like in personalisation. Section 0 then explores the theory of how the mental health payment system could support personalisation for people with mental health problems, and how this is being done in practice in the good practice sites we visited. Annexes 1-5 provide full details of the work each site completed on the mental health payment system in relation to personalisation, as well as the main learning and success factors identified.



3. About the mental health payment system and personalisation

In this section we provide an introductory overview of:

- The mental health payment system
- Personalisation, recovery and what good looks like.

3.1 The mental health payment system

The mental health payment system is a funding system in which mental health commissioners pay service providers according to how well they achieve specified outcomes, according to a framework set jointly by NHS England and Monitor.

Such a payment system in mental health should aim generally to support the direction of travel for mental health services. These are broadly captured as being:

- Empowering people, including giving them choice and control about what care or treatment they have and who will provide it
- Enhancing primary care services that support prevention, early intervention and reablement, as well as to enable a supported and sustainable route for people out of secondary care
- Support a modern model of integrated care, including person-centred services that are integrated across all relevant sectors and which is based on the evidence base
- Provide high quality crisis support as well as a focus on crisis prevention
- A step change in productivity
- Effective commissioning.⁹

The practical aims of the mental health payment system are specifically to:

- Reduce cost variability and incentivise efficient provision

⁹ Background to the 2015/16 proposals for the mental health payment system, NHS England, July 2014: <http://www.england.nhs.uk/wp-content/uploads/2014/07/dev-mental-health-pay-syst.pdf>

- Provide transparency in payment and activity
- Allow providers to compete on quality
- Enable commissioners to target needs of the local population.¹⁰

The mental health payment system is based on units of service activity that are understood to be clinically effective and have a low level of variance in cost; these are known as “currencies”. A price is then arrived at locally to pay for each unit of service activity, known as “tariffs”. A local arrangement is then determined between commissioner(s) and provider(s), which covers currencies and tariffs, as well as care pathways, service models, volumes, outcome and performance measures.

Each of these components of the mental health payment system is discussed in more detail below.

3.1.1 Care clusters

The currency of the mental health payment system is the cluster. This is a way of grouping people with mental health problems according to their needs. It is based on descriptions of characteristics of people who are assumed to have similar mental health support needs, and the level of resource needed to meet these needs. There are 21 clusters under three main groupings (non-psychotic, psychotic and organic). For example, cluster 4 relates to people with severe non-psychotic conditions and cluster 10 relates to people with first episode psychosis.

A Mental Health Clustering Tool (MHCT) has been designed to assist clinicians in assigning people to a care cluster, and is required by guidance to be used by providers.¹¹ The MHCT incorporates items from the Health of the Nation Outcome Scales (HoNoS)¹², which measures health and social functioning outcomes in mental health, as well as other measures that consider historical information relating to the user.

3.1.2 Tariffs and payments

The *national* tariff is the primary way by which the total amount of money the government allocates to the NHS in England is translated into health care for individual patients every year. This national tariff consists of:

- National prices for a set of healthcare services

¹⁰ National Tariff Payment System 2014/15 guidance, NHS England and Monitor, December 2013:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300547/2014-15_National_Tariff_Payment_System_-_Revised_26_Feb_14.pdf

¹¹ Mental Health Clustering Booklet v4.0 (2015/16), NHS England:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/379574/S118_Annex_7C_NTCN1516.pdf

¹² Royal College of Psychiatrists Frequently Asked Questions about HoNoS:

<http://www.rcpsych.ac.uk/training/honos/generalinformation/faq.aspx>

- Principles for how these national prices can be varied to promote innovations in service and to reflect local conditions
- Rules and principles for agreeing locally how and how much to pay for healthcare services that do not have a national price.¹³

Mental health is one such area where there is no national price for services. As a result, a local tariff is associated with each mental health cluster. The local tariff is the local price to be agreed and paid by a commissioner to a provider for each unit of service activity.

Even though the national tariff doesn't apply to mental health *per se*, there are some principles of the national tariff that do apply to mental health. These include:

- Mandatory use of clusters for payment purposes
- The mandatory requirement to submit relevant data to NHS England and Monitor
- The need for transparent payment mechanisms
- A clear steer on the need to move away from unaccountable block contracts in 2015/16.

This national tariff also specifies principles that commissioners and providers must apply when setting local tariffs:

- That local tariffs must be in the best interests of patients
- That local tariffs must promote transparency to improve accountability and encourage the sharing of best practice
- That providers and commissioners must engage constructively with each other when trying to agree local tariffs.¹⁴

There are now understood to be a wide range of ways in which to set local tariffs, and a variety of different payment options for this local tariff. These options include:

- Cluster-based payments
- Pathway-based payments
- Integrated mental / physical health payments
- Outcomes-based payments
- Personal Health Budgets and/or Integrated Personal Commissioning approaches
- Capitation-based funding

¹³ Pricing healthcare, NHS England Better Care, Better Payment blog, October 2014:

<http://nhspaymentssystem.wordpress.com/2014/10/14/pricing-healthcare/>

¹⁴ 2015/16 National Tariff Payment System: engagement on local payment arrangements, NHS England and Monitor, July 2014,

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332131/NationalTariff2015-16_EngagementLocalPayment.pdf

- Year of care models
- Lead provider models
- Alliance contracting
- Accountable care organisations.¹⁵

3.1.3 Quality and outcomes

There are a variety of ways in which the quality of services and the outcomes they achieve could be linked to currencies and tariffs in the mental health payment system. Quality measures that can be used include:

- A set of ten quality indicators specifically related to the allocation of people with mental health problems to care clusters and associated processes¹⁶
- A Clinician Rated Outcome Measure (CROM), typically based on HoNOS¹⁷
- The development of a Patient Reported Outcome Measure (PROM)¹⁸, often using the Warwick-Edinburgh Mental Health Wellbeing Scale¹⁹
- Further development of Patient Rated Experience Measures (PREMs), perhaps linking to the emerging Friends & Family Test or the annual CQC service user survey.

3.1.4 Progress to date

Reflecting on progress over the last 2-3 years, there seem to be some benefits when the mental health payment system works well: it can deliver savings and bring in new resources, improve outcomes and encourage new ideas. The payment system can give commissioners and providers a greatly improved sense of who the people are who use their services, what they want and need, and can improve people's choice in how those needs are met.²⁰

¹⁵ For more information on these different payment models see 2015/16 National Tariff Payment System: engagement on local payment arrangements, NHS England and Monitor, July 2014, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332131/NationalTariff2015-16_EngagementLocalPayment.pdf

¹⁶ See Chapter 4 of Mental Health Currencies and Payment: 2014/15 guidance: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300864/Guidance_to_mental_health_currencies_and_payment.pdf

¹⁷ See <http://www.cppconsortium.nhs.uk/crom.php>

¹⁸ See, for example,

<http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/op/op78.aspx>

¹⁹ <http://www.healthscotland.com/scotlands-health/population/Measuring-positive-mental-health.aspx>

²⁰ Key steps for successful implementation of Mental Health Payment by Results, DH, February 2013:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214914/09-Key-steps-for-successful-implementation-of-mental-health-PbR.pdf

However, the payment system requires high levels of commissioning skill and there are risks in securing value for money. For example, the payment system could actually increase costs if tariffs are set too high or if they encourage increases in activity levels. Conversely, providers may be unable to maintain quality or sustainability as organisations if tariffs are set too low.

Other challenges being encountered in the evolution of the mental health payment system include:

- The development of robust care pathways because of a lack of consensus over optimal pathways and considerable local variation in mental health provision
- The development of robust local tariffs
- Consistency in the quality of clustering data and the validation of clustering decisions
- Developing good links with social care
- Making sure market and systems development keep pace with each other.

A recent survey by the Healthcare Financial Management Association (HFMA) shared the views of health finance managers on progress regarding the mental health payment system. Findings included:

- 84% reported commissioner understanding of the mental health payment system to be very poor, poor or fair
- 95% said they had open and regular dialogues with commissioners regarding the mental health payment system, but only 40% reported the same with service users
- 60% reported cluster-based activity as having “no” financial impact
- 70% reported that they still operated under a block contract with commissioners with a shadow tariff.

3.2 Personalisation, recovery and what good looks like

Personalisation and the recovery approach in mental health have been present in social care and health respectively for some time. *Getting Serious About Personalisation in the NHS*²¹, which complemented the launch of the Integrated Personal Commissioning (IPC) Programme – itself a driver for reform in payment in the health system²² – strongly reaffirms the NHS’s commitment to personalisation. Both these approaches are based on building on people’s strengths and preferences, self-management, the equality of relationships and social inclusion. The general focus of recovery and personalisation could be described as

²¹ Getting Serious About Personalisation in the NHS, TLAP, September 2014:
<http://www.england.nhs.uk/wp-content/uploads/2014/09/tlap-getting-serious.pdf>

²² Integrated Personal Commissioning Programme:
<http://www.england.nhs.uk/2014/09/04/ipc-prospectus/>

Recognising the goals that most people have for their lives – meaningful activity, meaningful relationships and a place to call home.²³

One of the key shifts that personalisation represents is giving people choice and control in arranging the care and support they need to achieve their goals and live their lives the way they choose to.

Because of this, the government's mental health strategy – *No Health Without Mental Health*²⁴ – also emphasizes the importance of personalisation:

Personalisation is about respecting a person's human rights, dignity and autonomy, and their right to shape and determine the way they lead their life. Personalised support and services are designed for the purposes of independence, wellbeing and dignity. Every person who receives support should have choice and control, regardless of the care setting.

One way of giving people more control over the support they may need is through an amount of money (a Personal Budget in social care, a Personal Health Budget in health) so that they can decide for themselves how it can best be used.

In the formal independent evaluations of both personal budgets in social care²⁵ and in the NHS²⁶ findings showed that having a personal budget was associated with better outcomes and higher perceived levels of control, and people having more positive aspirations for their lives. Specific benefits for people with mental health needs were reported: the evaluation of personal health budgets showed that those with personal health budgets reduced their use of other health services, including in-patient admissions, and that this approach was particularly cost-effective.

However, the evaluation also highlighted major barriers to take up for people with mental health problems. More recent research²⁷ confirms these earlier findings and also shows that Direct Payments are least commonly provided for people with mental health needs^{28,29,30} and particularly for people with dementia.³¹

There are still challenges to be tackled to make further progress with personalisation and personal budgets. For example, progress still needs to be made in some areas in changing

²³ Lost Lives: The paucity of quality in human services, T Nerney, Michigan: Centre for Self-Determination, 2011: <http://www.centerforself-determination.com/docs/Paucity%20of%20Quality%20in%20Human%20Services%20April%202010.pdf>

²⁴ No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages, DH, 2011: <https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

²⁵ Evaluation of Individual Budgets Pilot Programme: Final Report (IBSEN), SPRU, 2008 <http://php.york.ac.uk/inst/spru/pubs/1119/>

²⁶ Evaluation of the personal health budget pilot programme, PSSRU/DH, 2012 <http://www.personalhealthbudgets.england.nhs.uk/Topics/latest/Resource/?cid=8603>

²⁷ Third National Personal Budget Survey, TLAP, 2014

<http://www.thinklocalactpersonal.org.uk/Latest/Resource/?cid=10343>

²⁸ Direct Payments: A national survey of direct payments policy and practice, PSSRU, 2007: <http://www.pssru.ac.uk/pdf/dprla.pdf>

²⁹ Getting Personal: Making direct payments work in local authorities, Rethink, 2011

³⁰ Direct Payments and mental health: New directions, JRF, 2005:

<http://www.jrf.org.uk/sites/files/jrf/1841961388.pdf>

³¹ Getting Personal: Making direct payments work for people with dementia, Alzheimer's Society, 2011: http://www.alzheimers.org.uk/site/scripts/news_article.php?newsID=1100

the culture in organisations, ensuring equality of access (particularly for people using mental health services), increasing the number of people with personal budgets, simplifying and streamlining systems, building community capacity, improving links between health and social care services, and developing and diversifying the market of mental health service providers.³²

People who use mental health services have defined themselves what they want from the mental health system. This is represented in three key frameworks:

- *Making It Real*: marking progress towards personalised, community-based support³³
- *Paths to Personalisation in Mental Health*³⁴
- *No Assumptions – A Narrative for Personalised, Coordinated Care and Support in Mental Health*³⁵

Together, they provide a clear view of what good, personalised mental health support looks like and what needs to be in place to achieve this. The key characteristics can be summarised as follows:

- Integrated and person-centred assessment and planning, and flexible care and support
- Enabling choice and control over support, including through creative commissioning, procurement and market development
- A whole-system approach, achieved through inclusive, integrated partnership working
Good information and advice
- System and culture change, achieved through good leadership, workforce development and risk enablement
- Good information, advice and guidance and fair access and equality throughout.

These characteristics form a framework against which we consider the theory of the mental health payment system and the good practice of the sites we visited.

³² Self-directed support and mental health: Practice paper 3, NDTi, 2014:
<http://www.gettingtheresds.com/wp-content/uploads/2014/02/SDS-and-mental-health-Background-Paper-3.pdf>

³³ Making it Real, TLAP, 2012:
<http://www.thinklocalactpersonal.org.uk/library/Resources/Personalisation/TLAP/MakingItReal.pdf>

³⁴ Paths to Personalisation in Mental Health, NDTi, 2013:
http://www.ndti.org.uk/uploads/files/New_Paths_to_Personalisation_%28NDTi,_April_2013%29.pdf

³⁵ No Assumptions: A Narrative for Personalised, Coordinated Care and Support in Mental Health:
<http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/noassumptionsfinal27august.pdf>



4. The mental health payment system and personalisation: theory and practice

In this section we explore the theory of how the mental health payment system could support personalisation for people with mental health problems, and how this is being achieved in the good practice sites we visited.

4.1 Theory

There is clearly a theoretical relationship between what the mental health payment system and personalisation seek to achieve. Any new mental health payment system could and should support personalisation.

The Department of Health in early policy statements on what was then Payment by Results said the payment system “supports personalisation and the introduction of personal health budgets”.³⁶ This has been echoed in further policy and guidance issued more recently.³⁷ Early on in the process of introducing PbR, some of those responsible for its implementation were positive that the clustering process gave them new information about the people they were treating, leading to a better understanding of where quality and outcome improvements could be made.³⁸

The potential for a new payment system in mental health leading to a more personalised approach was made clear:

The Care Pathways and Packages approach that is being used for mental health [has] the potential for embedding personalisation into mental health services. By focusing on individual needs it potentially lends itself to commissioning for outcomes and this will be developed further. The “results” should ultimately be more personalised services and improved outcomes.³⁹

The relationship between what the mental health payment system and personalisation seek to achieve is summarised in Table 1.

³⁶ Key steps for successful implementation of Mental Health Payment by Results, DH, February 2013:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214914/09-Key-steps-for-successful-implementation-of-mental-health-PbR.pdf

³⁷ Mental health currencies and payment: 2014/15 guidance, NHS England and Monitor, December 2013: <https://www.gov.uk/government/publications/mental-health-currencies-and-payment-guidance>

³⁸ Mental Health PbR Readiness Review, NHS Confederation, 2011: <http://www.nhsconfed.org/Publications/reports/Pages/Payment-by-Results.aspx>

³⁹ *Ibid.*

Table 1: How the mental health payment system supports personalisation

What good, personalised mental health support looks like from the point of view of people who use services	How an effective mental health payment system supports this
<p>Integrated and person-centred assessment and planning, and flexible care and support</p>	<p>People achieving person-centred, whole-life outcomes through their support</p> <p>People’s capabilities and skills recognised</p> <p>Integrated and simplified assessment planning and systems that save time and money and are more efficient and effective</p> <p>Care, support and treatment is available that responds to people’s individual needs</p> <p>Care pathway reflects all phases of mental health support, not just secondary care</p> <p>A better, joint understanding of where quality and outcome improvements can be made</p>
<p>Enabling choice and control over support, including through creative commissioning, procurement and market development</p>	<p>Good information, advice and signposting about what is available</p> <p>Clearer understanding of care and support options and pathways available in a local area</p> <p>More individual and community-based care, support and treatment options</p> <p>Market development keeps pace with the vision for change represented by the payment system</p> <p>Jointly building community capacity and provider diversity</p> <p>Co-production in commissioning and a focus on outcomes</p> <p>Better understanding of local need</p> <p>Better commissioning informed by higher quality data</p> <p>Easily accessible health and social care budgets with more transparency and costs</p> <p>Better value for money</p>

What good, personalised mental health support looks like from the point of view of people who use services	How an effective mental health payment system supports this
	Awareness of opportunities, risks and challenges to voluntary and community sector providers
A whole-system approach, achieved through inclusive, integrated partnership working	<p>Joint working between commissioners in health, social care and public health and providers from all sectors</p> <p>Mature and inclusive relationships between people with mental health problems, carers, staff, commissioners and providers</p> <p>An environment that supports and rewards providers to innovate and find different and better ways to do things</p> <p>Time, space and capacity created to develop new ways of working and new systems, supported by training</p> <p>Creative and pooled use of resources, including different local payment methods that shift away from block contract arrangements</p> <p>The opportunity to include support related to prevention and early intervention in care pathways</p>
System and culture change, achieved through good leadership, workforce development and risk enablement	<p>Good leadership with a shared, clear and persuasive vision for integration</p> <p>Champions for change at all levels and area of business, including clinicians, social care, public health, informatics and finance professionals</p> <p>The workforce engaged, trained and supported from the beginning of the change process</p> <p>Creating the right environment for risk enablement, shared between partners</p> <p>Transparency in determining local payment system and resulting contractual arrangements</p>

However, it remains unclear how a new mental health payment system fits with personalisation. As implementation progresses, this report provides an opportunity to reflect on whether the change will lead in practice to real improvements, choice and control for people or whether it will perpetuate a medical model of mental health, rather than taking into account a range of social care outcomes.⁴⁰ Such a deficit approach to mental health – through, for example, using HoNOS measures – may gear the mental health payment system away from promoting recovery-based approaches – a concern expressed by the Royal College of Psychiatrists:

The College recognises that social, economic and cultural influences will have a large impact on outcomes... Likewise, the College's determination to support recovery principles and service user empowerment emphasises a focus on patients' strengths and skills which are currently absent from the care clusters.⁴¹

If the care clusters focus too exclusively on intervention and treatment they may miss the opportunity for the mental health payment system to be an:

added ingredient to make it possible to achieve a culture that embraces personalisation, recovery and a whole systems approach, with person-centred integrated planning, easily accessible personal budgets for health and social care, whole system creative commissioning in partnership with people and communities and recognising the contribution they make, and a personalised PbR system that will reward recovery and inclusion as well as activity and efficiency.⁴²

The Association of Directors of Adult Social Services (ADASS) also noted at a system level the need to take a whole-systems approach to mental health problems, or otherwise risk "unwittingly undermining some of the innovative partnerships, services and associated health and social care outcomes for people."⁴³

4.2 Practice

As highlighted in Section 2, NDTi visited 5 areas throughout 2013, including an update in February 2014, to generate a snapshot of how aspects of the mental health payment system and personalisation were working together.

Observations from this snapshot against the framework set out in Table 1 are presented below. These observations do not create a comprehensive picture of everything that should be in place in an area – instead they highlight progress made by the areas we visited against particular aspects of the framework. Reflections include both successes and challenges in the practice identified, as well as common themes that were noted by participants in each area.

⁴⁰ Payment by Results: How can payment systems help to deliver better care? The King's Fund, 2012: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/payment-by-results-the-kings-fund-nov-2012.pdf

⁴¹ Payment by Results for mental health: Position Statement, Royal College of Physicians, 2014: http://www.rcpsych.ac.uk/pdf/PS01_2014x.pdf

⁴² Getting it together for mental health care: Payment by Results, personalisation and whole system working, NDTi, 2012: http://www.ndti.org.uk/uploads/files/Pbr_and_pers_Final_v2.pdf

⁴³ Payment by Results for mental health as a driver for personalised services: Joint ADASS and DH position paper, ADASS, 2009: http://adass.org.uk/AdassMedia/stories/Mental_Health/payment.pdf

Full details of the work each site completed on the mental health payment system in relation to personalisation, as well as the main learning and success factors identified, are included in Annexes 1-5.

4.2.1 Integrated and person-centred assessment and planning, and flexible care and support

Assessment

Where work has already started to align local authority social care assessment processes with mental health assessments (e.g. through the Care Programme Approach), this provides a good foundation for introducing the new mental health payment system. The opportunity to map payment system clusters to FACS eligibility criteria and vice versa can lead to integrated assessments which benefit service users, practitioners and commissioners alike. Similarly, where assessment across local authority and health authorities isn't well developed, establishing the mental health payment system provides a good new opportunity to explore this.

Similarly, where established tools for good planning with people are in place – through, for example, the use of the Recovery Star or Wellness Recovery Action Plans (WRAP) – they provide a solid foundation for the shift to the mental health payment system.

Data

It could be argued that the main focus so far of the rollout of the mental health payment system is the collection and submission of data. However, the reliability of data remains an issue, for example in validating clustering decisions for payment purposes and testing the validity of indicative costs. It is a challenge to balance cost and quality and arrive at tariffs that deliver value for money and do not compromise quality or undermine the sustainability of the provider.

Outcomes

Beyond activity-level data, more work is needed on outcomes development and evaluation, to get a clearer idea of the impact of the mental health payment system on people's lives and experiences. It is easy to lose sight of some real opportunities for developing the mental health payment system alongside personal budgets in health and social care.

4.2.2 Enabling choice and control over support, including through creative commissioning, procurement and market development

Commissioning

Innovation should be promoted and supported by commissioners. Shifting the commissioning focus towards outcomes gives more room for innovation and potential for providers to demonstrate new ways of doing things.

Commissioners need to be aware of the impact on the voluntary and community sector of mental health payment system contracting that pays some or all of the money at the end of the contract period when agreed results have been achieved. Voluntary sector providers may have limited reserves and may not have the ability to raise loans to cover the gap. This would effectively exclude them from taking on those contracts, or put them at risk of being unable to sustain themselves as organisations. Ways of overcoming this are still being considered, with a limited number being tried and tested. For example, social investment could offer a solution to this problem by offering investors who are able to take financial risks the chance to support organisations by providing working capital. Investors would get a financial return when agreed social outcomes are delivered. New approaches like this involve new thinking about the balance of risks.⁴⁴

Procurement

Different models of contracting are being explored in health and social care where traditional ways of contracting, involving competition between providers, can undermine the collaborative working that is needed for a personalised approach. Lengthy and expensive competitive tendering can also make it difficult for smaller specialist providers to take part, even though they have the skills and experience to deliver what is needed. An example of a different approach is the collaborative contracting model used in the construction industry, where it is vital that providers work closely together. This is usually called Alliance Contracting and means that there is one contract with a number of providers who need to work collaboratively. An Alliance Contract has been set up in Stockport that requires two voluntary sector providers to work together to deliver the contract aims and targets for a service.

Market development

Focusing on systems change to support the new mental health payment system and personal budgets can sometimes mean that insufficient attention is given to market development and innovation to offer choice and diversity. Systems change and market development need to keep pace if real change and choice is to be achieved.

4.2.3 A whole-system approach, achieved through inclusive, integrated partnership working

Whole system approach

Developing and sustaining change is more likely to be successful if there is a clear understanding of the overall context, vision and values, and wider strategic aims and plans. A whole-system approach reflects the interdependence of different aspects of development, such as systems and culture change, workforce development, market development, partnership, good information, and new ways of doing things

Integrated partnership working

Collaboration and integration between health and social care is a key ingredient for success. However, it is important not to get too hung up on organisation and employment arrangements. Good collaboration and integrated pathways and systems can work well in

⁴⁴ Funding good outcomes: Using social investment to support Payment by Results, Charities Aid Foundation, 2012: <http://www.cafonline.org/pdf/Funding%20Good%20Outcomes.pdf>

different models, with different degrees of integration and for different purposes. There is no evidence that one form of integration is better than another. It is more productive to concentrate on what works for people and gets results.⁴⁵

Where partner organisations are at different stages in their development it can affect joint working. For example, if resource allocation systems in social care are already well developed and established, it may be more difficult to unpick them and backtrack in order to develop alongside the new mental health payment system or PHB systems in partner organisations. However, this will be more productive in the longer term.

Some partners are significantly larger than others and can be perceived as having disproportionate influence and power. It is important to understand this and pay attention to attitudes and approaches, in order to build relationships and trust. Flexibility is needed in service and system design in order to embrace the complexity of mental health. The scope for moderating systems and services, to take account of this, needs to be built in.

Some key challenges in service design were highlighted, for example:

- Changing the balance of resources and activity towards prevention
- Changing the balance between secondary and primary care
- Developing more informal ways of accessing services
- Developing a greater diversity of solutions and choices (e.g. local, community, self-help, peer support)
- Putting in place good navigation, signposting and information support.

Inclusion

Co-production is at the heart of successful change. Working with experts by experience is productive in every aspect of commissioning and provision, service and systems design, the development of care packages, outcomes measures, and evaluation. Similarly, involving experts by experience in change management and training can be a positive experience for everyone. People's stories are a powerful demonstration of the impact of changes in systems and approaches. Providing support and capacity for a strong peer support programme⁴⁶ is a key ingredient for success and has been shown to lead to positive outcomes for all concerned.⁴⁷

⁴⁵ See Making integrated care happen at scale and pace, The King's Fund, 2013:

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-integrated-care-happen-kingsfund-mar13.pdf

⁴⁶ Mental Health Foundation website: <http://www.mentalhealth.org.uk/help-information/mental-health-a-z/P/peer-support/>

⁴⁷ See ImRoc Briefing: Peer Support Workers, Theory and Practice, CMH and NHS Confederation, 2013

<http://www.nhsconfed.org/Documents/ImROC%20Peer%20Support%20Workers%20Theory%20and%20Practice.pdf>

4.2.4 System and culture change, achieved through good leadership, workforce development and risk enablement

Leadership

The leadership, vision and commitment of senior managers in partner organisations is an important ingredient for success in supporting new ways of doing things. It is a driving force for development when senior managers acknowledge that there will be problems, and that they will need to hold onto the vision and solve those problems together.

It is very important to involve the full range of people who will be affected by change from the beginning, for example, people using services, carers, clinicians and practitioners, care managers, business and IT managers. Thinking things through together with all these different perspectives can lead to new and positive solutions. It can also help everyone understand how changes will help them achieve their own personal or professional aims and goals.

Joint investment in the capacity to lead and manage change is a key driver. Differences in the leadership capacity of partner organisations can be a problem in developing systems together

Workforce

Good communication in organisations means that problems can be dealt with at a strategic level. Progress will be hampered if practitioners are getting double messages or are left to try and work round things that in practice are not supporting the vision. An example of this would be where new services are set up to offer individual community choices, but care managers are still under pressure to make placements in block contracted vacancies. It is important to recognise and understand what demands new systems make on the workforce. Looking at how things are currently working and adapting and streamlining systems, rather than adding new ones, can avoid workforce overload

There are differences in language and culture that can create barriers. Concentrating on recognising what is similar rather than what is different is a helpful way forward. For example, RAS and mental health payment systems are both about allocating resources and there are synergies to be found.

Risk enablement

Introducing a new mental health payment system takes time and focus to develop, and appears to be making more progress where there is dedicated leadership and a support team. The roles and responsibilities of commissioners and providers need to be clear in developing the new payment system. There can be a conflict of interest for providers if they are developing the mental health payment system and are also in any way involved in approving care packages that could include services they are providing. All partners need to be sensitive to this and ensure they act transparently.

Times of significant change are inherently risky, and different areas will adopt different approaches to tackling change. Some may try and get things worked out thoroughly before going live, taking time to get details and funding sorted. Others may just go ahead and try things and learn from the experience in order to work out the details. There are strengths and challenges inherent in each approach, but the main message remains, whatever the approach, go ahead and try and make progress.

Even after a healthy and successful start, culture change for personalisation needs ongoing work and refreshment in order to continue to develop and sustain it.

Financial pressures could lead to more efficient and innovative solutions, but they could equally de-rail some positive developments and introduce risk. It is becoming increasingly difficult, for example, for commissioners to support the shift to personalisation, prevention, personal budgets and the mental health payment system with a longer term financial view. This may require new investment that will mean double funding to sustain existing systems and provision in the meantime. Even though the evidence for new approaches might demonstrate real potential for savings, immediate financial pressures may lead to short-term budget decisions that undermine developments.

There are financial and organisational losses in running parallel systems, for example in assessment for resource allocation in social care and clustering for the mental health payment system. This adds an unnecessary complexity and cost, and will lead to a difficult experience for people trying to access care and support.



PART B: PRACTICE

Case study 1: Lambeth

Partners and local arrangements

- Lambeth Council (<http://www.lambeth.gov.uk/>)
- South London and Maudesly NHS Trust (<http://www.slam.nhs.uk>)
- Southside Partnership (<http://www.certitude.org.uk/>)
- Disability Advice Service Lambeth (<http://www.disabilitylambeth.org.uk/>)
- Vital Link (<http://lambethandsouthwarkmind.org.uk/lambeth/>)
- Service Users in Training/Education (SUITE)
(<http://lambethandsouthwarkmind.org.uk/directory/suite-service-users-in-training-education/>)
- Lambeth Clinical Commissioning Group (<http://www.lambethccg.nhs.uk/>)

Lambeth is one of 14 local authorities that make up Inner London. It is one of the most densely populated of inner London boroughs, with a population of around 303,000. It has recently been re-organised into a 'co-operative council' – involving local people in decision-making and budget allocation. <https://cooperativecounciltoolkit.wordpress.com/>

South London and Maudsley NHS Trust provide a wide range of mental health and substance misuse services, serving a population of around 1.1 million people, in 7 borough councils. SLAM is a Personal Health Budgets site which has given some focus for personalisation. A working group on developing personalisation has been set up with 4 different boroughs relating to SLAM.

Previous joint arrangements for Community Mental Health Teams are being replaced by a new approach called the Living Well Network (see under Practice Highlights).

Southwark and Lambeth Integrated Care (<http://slicare.org/>) is a partnership between local GPs, King's College Hospital, Guy's and St Thomas' Hospitals, the South London and Maudsley Mental Health trust, social care in both local councils, and Lambeth and Southwark Clinical Commissioning groups.

The partnership focuses on co-ordinated preventive care and enabling people to take an active role in their own health and choices.

Practice highlights

Lambeth have co-designed a Living Well Network as a result of the work of The Collaborative⁴⁸, a group of people who use mental health services, carers, GPs, commissioners and providers from the public and third sector. There was strong support for The Collaborative from senior managers in partner organisations and a wide range of stakeholders who have been meeting regularly for the past two years. The work was also supported as one of the two mental health sites included in the Nesta People Powered Health Programme.⁴⁹

The Living Well Network was co-produced in a series of events over 9 months to 'radically improve well being by enabling people to better recover, choose and participate'.⁵⁰ Development was based on a preventive approach to support people before they reach crisis and reduce the need for more expensive specialist mental health services. A prototype has been tested and the model is being further developed.

The 'front door' of the Network is called a Hub. People are introduced, or introduce themselves, without the need for a formal 'referral'. After developing a recovery and support plan they will be able to access a broad network of services, therapeutic support, a personal budget and peer support. Personalised networks are developed to build or rebuild links with family, friends, communities and organisations. The aim is to also help people access acute services when they are needed but keep them connected to a broader range of support for when they return to their homes and communities. There is also a plan to widen the current range of services for people experiencing acute mental distress.

The Network is based on very early intervention with a range of social and clinical responses based on four principles:

1. Introduction: Simplified direct access
2. Engagement: Assessment, Action and Planning (AAP), an idea developed through co-production. It is a way of ensuring that people can move very quickly through and between processes to get the support they need
3. Facilitation: Using people's personal strengths and all the assets of the system to facilitate a coordinated personal and, if appropriate, clinical recovery and support plan.
4. Connections: Making personal connections with people, services and communities

Personal budgets are a key part of the design. Since December 2012, personal budgets and the Care Programme Approach have been integrated into a single Recovery and Support Plan which has been developed through a SLaM-led project group. Lambeth, having been a Personal Health Budget pilot site, have invested in work on a model of integrated health and social care personal budgets. There are currently about 13 people with integrated budgets,

⁴⁸ The Collaborative, Lambeth: <http://lambethcollaborative.org.uk/>

⁴⁹ Nesta People Powered Health Programme: Lambeth Living Well Collaborative http://www.nesta.org.uk/areas_of_work/public_services_lab/health_and_ageing/people_powered_health/assets/features/lambeth_living_well_collaborative

⁵⁰ Lambeth Living Well Network Brochure: <http://lambethcollaborative.org.uk/about/living-well-network>

with around 30 in the process stage.⁵¹ There are 2 FTE posts providing support for integrated budget planning. Budgets allocated range between £700 and £30k. About 45% of budget holders take some or all of their budget as a direct payment.

The Recovery Star is being used at the moment as an outcomes measure, along with clustering data, HoNoS scores and Patient Reported Outcomes Measures. These measures have shown improvements of about 50% in most areas. Outcome measurement is currently under review to support a streamlined structure that doesn't add too much weight to the current level of paperwork. The POET outcome measurement tool is currently being tested as part of the Going Further Faster programme.⁵²

The aim is to eventually link personal budgets with the mental health payment system, but costings are still in development. In the meantime, budgeting relies on the social care Resource Allocation System, with some flexibility around the health care element. A new RAS is under development through a SLAM-wide project developing a new integrated health and social care assessment.

Lambeth Council and SLAM are working to improve the links between systems to share core information about individuals across organisations and teams. The intention is that professionals will have access to the right information immediately, and in a safe and secure manner. This means that when a person comes into contact with a local professional they can have the confidence that all the relevant information is available. They also want to support those people who want to take more control of their health and well being by owning the information in their health and care records. As new IT for health and social care professionals is provided they are looking into the potential for local people to have access to their own records.

Mental health payment system and personalisation: main learning and success factors identified by participants

- One of the biggest challenges has been moving on from a system where managing medication compliance and crisis demand has taken up a significant amount of time, to one that has a more preventive approach. It is important to spend time and invest in a change management programme, engaging staff in the development process at an early stage
- This is linked to the challenge of changing the balance of resources between secondary care (which has the largest amount of resource investment) and primary care.
- It is important to revisit and re-invigorate personalisation to make sure that there is a common understanding and commitment to this way of working

⁵¹ Integrated health and social care personal budgets: Airdrina's Story
<http://lambethcollaborative.org.uk/recoverystories/airdrina%E2%80%99s-story-integrated-health-and-social-care-personal-budgets>

⁵² Going further faster programme:
<http://www.personalhealthbudgets.england.nhs.uk/News/item/?cid=8607>

- It is helpful if developments and thinking around Personal Health Budgets and Self-Directed Support are aligned at an early stage. It is more difficult if one or other have already made progress and have to backtrack to achieve a new alignment
- Integrated health and social care budgets are achievable and do make a difference in improving people's lives, and in their experience of accessing help and support
- Psychiatrists in the Trust have had initial exposure to the personalisation agenda and work is underway to promote it further. It was helpful that the Association of Directors of Adult Social Services and Royal College of Psychiatrists published a joint statement⁵³ supporting an integrated health and social care assessment process, an integrated support plan and review and integrated health and social care personal budgets.
- Having someone with a dedicated role in developing Personal Health Budgets was a key factor in making progress, and it is helpful that that role will continue beyond the pilot. Lambeth Clinical Commissioning Group are the hosts and sponsors for the PHB pilot. The PHB co-ordinator is based within the Trust in a team focused on driving recovery-based practice. This will need to be reviewed when PHBs are scaled up to be available to more people.
- It is important to understand how large public sector organisations might be perceived in partnership work. SLAM, for example, has a very wide scope and significant resources, works across more than one local authority and could be seen as having disproportionate influence and power in partnership work and co-production. It is therefore important to pay attention to attitudes and approaches, building relationships and trust, and having some consistency in terms of people engaged in partnership work and co-production.
- It is important that IT and business managers are involved and on board from the beginning of the development process. They have a lot to contribute and are key in supporting the design and successful implementation of new systems and different ways of doing things.
- Scaling up from the pilot requires more clarity about costs, funding sources and responsibilities. There can be some flexibility about this on a small scale, but it has a significant financial and organisational impact on a larger scale if these issues are not sorted out at an early stage.

⁵³ The integration of personal budgets in social care and personal health budgets in the NHS: Joint position statement of the RCP and ADASS, 2013:
<http://www.personalhealthbudgets.england.nhs.uk/News/item/?cid=8643>



Case study 2: Northamptonshire

Partners and local arrangements

- Northamptonshire Healthcare NHS Foundation Trust (<http://www.nht.nhs.uk/>)
- Northamptonshire County Council (<http://www.northamptonshire.gov.uk/>)
- Nene Clinical Commissioning Group (<http://www.neneccg.nhs.uk/>)
- Corby Clinical Commissioning Group (<http://www.corbyccg.nhs.uk/>)

Northamptonshire Healthcare NHS Foundation Trust provides community physical and mental health services for Northamptonshire, which has a population of around 700,000. Northamptonshire County Council also covers the whole of Northamptonshire. The Adult and Older People section is placed in a Social Care and Public Health Department. There is a Section 75 agreement with a pooled budget (but not for personal budgets). Social workers on Community Mental Health Teams are employed and managed by the local authority and are part of multi-disciplinary teams that are co-located. There are joint commissioning arrangements for mental health services between the local authority and Nene Clinical Commissioning Group (which covers 8 localities) and Corby Clinical Commissioning Group.

Practice highlights

Personalisation is well developed in Northamptonshire County Council. A personalisation team was set up to lead the work which included, for example, market development days, the development of a website with a directory of local information, services, organisations and activities⁵⁴, commissioning independent brokerage to support personal budgets, and a provider to develop community connections. About 3,640 people have personal budgets and of these about 2,000 have released some or their entire budget as a direct payment. Organisational change and other pressures slowed down the drive to further develop personalisation for a while, but it is now being refreshed and re-invigorated. Personalisation is also developing well in the Trust. Co-production and the influence of experts by experience has become part of the culture of the Trust.

Northamptonshire was a Personal Health Budgets in-depth pilot site and was an NHS England Going Further Faster. The Trust has a Personal Health Budgets Project Manager.

⁵⁴ Support4u, Northamptonshire:
<http://support4u.northamptonshire.gov.uk/kb5/northamptonshire/asch/home.page>

Indicative budgets have been developed and there are currently 16 people with PHBs. The Trust is working with 20 more people this year, from different cluster bands. The system is being tested to see how well the indicative budgets work. Outcome measures are still in development and are being tested, for example by comparing clinician rated measures and experience measures. The impact and benefits of PHBs still remain to be evaluated.

The potential for integrated health and social care budgets is being tested by looking at 2 of the next tranche of Personal Health Budgets to see how it can work for those individuals, and what can be learned from this for further development.

The mental health payment system is well developed, with 90% of people having gone through the clustering process. Validation work has been undertaken with an Expert Validation Group. This has led to the review of some clusters indicating where the focus needs to be for further work. The two streams of work (PHBs and the mental health payment system) were initially seen as separate projects until indicative budgets for Personal Health Budgets began to be developed. Although they still have separate steering groups, there is more awareness about the links, and the need to have a coordinated approach in developments. The conclusion locally is that the mental health payment system does help with PHBs – not just for mental health, but for all long term conditions.

In Northamptonshire a Personalisation Peer Network is developing. Peoplehub⁵⁵, the national PHB Peer Network, has been commissioned to facilitate this development. Members of the network already sit on the CCG PHB Steering Group and the Trust's Operational Group. It is hoped that they will choose to be involved in effecting the cultural changes through training and in commissioning providers who offer support with writing personal plans, brokerage and advocacy.

Northamptonshire Healthcare NHS Foundation Trust is developing a Data Warehouse to provide better management information that will improve the accuracy of costing for the mental health payment system and Personal Health Budgets.

Mental health payment system and personalisation: Main learning and success factors identified by participants

- The Personal Health Budget pilot has been successful in improving people's lives. Moving on to scale up beyond the relatively small number in the pilot (so that PHBs become the usual way things are done) presents some significant challenges. There are particular challenges around the financial implications of individual costing, for example in testing out the validity of indicative costs. Variations can be contained and managed on a small scale, but this would have a more serious impact on a larger scale, particularly where there are as yet no sound comparators for accuracy. Based on experience in the pilot that shows some people needing more, and some less than the indicative cost, the Trust are looking at building in some measurable flexibility either side of the basic indicative cost.
- Involving care managers in personalisation development from the beginning is important, as it involves changes in practice that directly impact on new systems. For

⁵⁵ Peoplehub: <http://www.peoplehub.org.uk/>

example, practitioners may continue to place people in current vacancies, even though new opportunities are available, such as a Community Connections team to link people with a range of options. However, it is important also to recognise where practitioners may be receiving mixed messages, for example pressure to meet existing contract arrangements, and fill vacant beds, and at the same time the expectation to make use of new and different resources. If these issues have not been dealt with at a strategic level practitioners will be left with this dilemma.

- One of the practical issues with PHBs is in costing and reviewing non-medical services (with the variety of options people are choosing to spend their budgets on) alongside the existing range of medical services and services the Trust provides. It is important to try not to just add on new systems, for example around reviewing, but rather to integrate and adjust existing systems. A whole system approach is needed, with a single assessment and care planning system that looks at someone's whole life, and brings health and social care together.
- Another issue is about resource allocation for PHBs, and the maintenance of levels of support where what is happening in people's lives fluctuates over time. One PHB holder described how his initial resource allocation was attached to the original assessment, and how those resources are now keeping him where he is in terms of better mental health. He expressed concern that he may now be considered to have recovered well, but if this support is taken away then he is likely to go back to where he was when the initial assessment was carried out. He felt that there should be an understanding of this need for a longer term view, and the need for maintenance and management of better health and that this should be seen as a partnership between patient and professional, based on mutual trust.
- The advantages for the individual are in having more stability, choice and control. Although these are still difficult to quantify, there are also advantages for the health system in terms of finance and capacity, if someone is able to manage their lives without having to rely to such a high degree on primary or secondary health care. This approach has helped commissioners and practitioners to think differently and in more positive terms about measuring people's health and wellbeing.
- There needs to be clarity about roles and responsibilities between CCGs and Trusts with regard to PHBs. There is a potential conflict of interest for the Trust if they are approving personal budgets that are being used to purchase their own services. A related issue is the need for the Trust and commissioners to think strategically about the implications of a drop in use of Trust services as the number of people using PHBs to purchase more diverse care and support increases
- The Trust has concentrated on the development of PHBs and the mental health payment system and there is still some way to go on thinking about a more streamlined approach with social care. This will be tested out in a limited way with one or two PHBs to see what the potential is for integrated health and social care personal budgets.
- It is important to have a good project structure for introducing the mental health payment system and good leadership. Frequent changes in leadership (usually to do with organisational change) can lead to lack of clarity, and hold back development and innovation. Having some capacity for mental health payment system development has meant that the Trust has been able to arrive at good data and

performance information that is well tested and robust. Previous work on costing with the PCT when it existed has also given a good basis to build on.

- Sometimes it is important just to try things (such as just going ahead and trying out integrated health and social care personal budgets in a limited way). But things do need time to evolve, and the learning needs to be absorbed and considered so that action can be taken before scaling up.
- It is useful for people using PHBs to have a role in change management and training. An example of this was the involvement of a PHB holder in working with finance managers. He was able to tell them directly how his life had improved and also: 'This is how much I spent on my personal budget, and this is how much I have saved the NHS'. It is helpful when finance managers or clinicians are able to see the direct benefits to people.
- The Trust has also found it useful in promoting PHBs locally that the government remained committed to rolling out the right to ask for a personal health budget in continuing health care from April 2014.⁵⁶

⁵⁶ Chief Nursing Officer Bulletin, March 2013: <http://cno.dh.gov.uk/2013/03/19/personal-health-budgets/>



Case study 3: Stockport

Partners and local arrangements

- Pennine Care NHS Foundation Trust (<http://www.penninecare.nhs.uk/>)
- Stockport Metropolitan Borough Council (<http://www.stockport.gov.uk/>)
- All Together Positive (ULO and social enterprise) (<http://www.alltogetherpositive.org/>)
- Stockport MIND (<http://www.stockportmind.org.uk/>)
- Stockport Progress and Recovery Centre (<https://sparc4me.wordpress.com/>)

Pennine Care NHS Foundation Trust provides mental health and/or community services to approximately 1.1 million people across 5 boroughs, one of which is Stockport Metropolitan Borough. Stockport MBC serves a population of about 284,000 and is the third biggest district of Greater Manchester. Adult Social Care is placed in a Health and Social Care Department. There is a Section 75 Agreement with a pooled budget for mental health. Social work staff on the Community Mental Health Team are employed by the borough council but managed through the Trust. GPs, health professionals and other agencies can refer to a Single Access Point that offers an assessment and signposting service. It is a route to support from the Community Mental Health Team or to acute mental health services. There is also a Recovery and Inclusion Team which is primarily for people who are working towards discharge from secondary care mental health services and where personal budgets can be accessed.

Practice highlights

Stockport's mental health strategy and planning is based on co-production developed as part of a NESTA-funded People Powered Health programme.⁵⁷ Personal budgets and self-directed support are a key part of the strategy. About 400 people with mental health problems in Stockport have a personal budget. A risk enablement strategy was developed to support personal budgets and positive risk taking.⁵⁸

⁵⁷ NESTA People Powered Health Programme:

http://www.nesta.org.uk/areas_of_work/public_services_lab/health_and_ageing/people_powered_health/assets/features/people_powered_health

⁵⁸ SCIE has a video highlighting this: <http://www.scie.org.uk/socialcaretv/video-player.asp?v=riskenablement>

The Co-production Forum worked on links between personalisation, the mental health payment system and personal budgets and a Co-production Delivery Group are working on community development.

The Prevention and Personalisation Service is a new service managed by Stockport Mind and All Together Positive. It offers support to improve well being and promotes social inclusion, volunteering and employment. It has links to a range of social, cultural, sport, leisure and support networks. It is primarily a service for people who do not meet Fair Access To Care criteria or are moving on from service provision. The service also helps people to set up their own interest groups. An example of this is Crafty Needles, a peer-led knitting group that meets in the Wellbeing Centre. The group knit baby clothes and toys for the local neo-natal hospital ward, blankets for homeless people and have other knitting projects. Similar groups have grown from this and they are about to set up their own Constitution. The service is making links with GP surgeries, operating for short periods from one surgery with the intention of developing links with others. About 200 people have accessed the Prevention and Personalisation Service so far. One GP has reported that they have seen a 30% reduction in the number of people that would have been referred to the Single Access Point, and a significant reduction in the number of repeat appointments.

The Moving On Pathway, which is also part of the PPS, also provides specific support to help people who have been discharged make their final transition from services to independent recovery. This includes work to reduce anxieties around the loss of financial support such as bus passes, personal budgets and impact on welfare benefits as well as concerns around re-accessing future support at times of uncertainty rather than crisis. All services provided by the PPS, described above, are available to the person moving on, as well as the option to access a Fast-Track re-entry to support if required in the future.

The Co-production Forum has produced an Outcomes Framework for the service based on the Social Inclusion Outcomes Framework⁵⁹ and the Warwick-Edinburgh Mental Wellbeing Scale⁶⁰.

FLAG (For Local Advice and Guidance⁶¹) provides a service that puts people in need of practical or emotional help and guidance in touch with those local organisations and services best able to provide it. This is a generic service, but about 70% of people making contact are seeking guidance on mental health. FLAG work closely with the Prevention and Personalisation Service.

The Stockport Enablement and Recovery service aims to support people on their own individual road to recovery following mental illness. It is based on a personalised approach, focusing on people's skills and aspirations. An unusual and innovative aspect of this service is that it has been set up on the basis of an Alliance Contract⁶² with two voluntary sector providers. Alliance Contracts are used mainly in the construction industry, where co-operation between a number of providers is crucial. In this model there is only one contract between the owner (payer, financier, commissioner) and an alliance of parties who deliver a service or project. In health and social care there is usually a separate contract with each party, perhaps with different objectives, performance measures and incentives. In a single alliance contract, all providers work to the same objectives for an overall service or project and are bound by the same measures of success which are based on successful collaboration. In this case, providers were needed for a co-produced service designed to offer re-enablement and recovery, supporting people through from acute clinical services to a more inclusive life

⁵⁹ Social Inclusion Outcomes Framework, National Social Inclusion Programme, 2009:

<http://www.spn.org.uk/index.php?id=709>

⁶⁰ Warwick-Edinburgh Mental Wellbeing Scale (WMWBS), NHS Health Scotland, University of Warwick and University of Edinburgh, 2006: <http://www.healthscotland.com/documents/1467.aspx>

⁶¹ <http://www.stockportflag.org.uk/>

⁶² <http://haliiances.org.uk/the-first-alliance-contract-in-health-and-social-care/>

in their communities. The service needed the skills, local knowledge and experience of two different providers (Stockport Progress and Recovery Centre and Stockport MIND) working together. This model of contracting offered the best solution to ensuring the close collaboration needed to achieve the aims of the service.

A Wellbeing Centre has been developed in collaboration with a wide range of organisations from Stockport and Manchester. It is managed by Stockport MIND and offers a variety of services and events, including information and signposting, musical and creative activities, complementary therapies, support groups, personal and professional development courses, employment advice and support, internet access, a self-help library and volunteering opportunities.

Mental health payment system and personalisation: main learning and success factors identified by participants

- The development and success of a comprehensive co-production approach has been a major factor in the success of local development.⁶³ Having a co-produced strategy based on collaboration has also supported a whole system approach, and allows for each part to be developed over time with clear links to the whole picture.
- Funding has been secured to develop work on prevention, to provide hope and motivation, help grow resilience and combat loneliness and support people in alternatives to services. There is a growing demand for community-based alternatives to services.
- There are strong partnership arrangements between the Trust and local authority which have provided a good foundation for further strategic collaboration.
- It is important to involve practitioners from the beginning of developments, as they will be key in making changes and making new ideas work. It was helpful to have regular problem solving meetings so that things could be discussed and resolved quickly, and decisions made collectively. Investing time in people, and using the skills of the right people in the right places, is also important.
- Sharing people's stories is helpful. Small changes achieved through personal budgets can make a big difference in someone's life. For example, someone who suffered from domestic abuse used her budget to re-decorate her house. At face value paying for someone to have their house re-decorated might appear to be beyond the remit of social care. However, using the personal budget in this way
- changed and redefined the surroundings in which someone was seriously abused and so was intrinsic in helping her move towards recovery. Sharing these stories was helpful in widening practitioners' understanding of what could be achieved with personal budgets and the routes that could be taken.
- Good, strong and committed leadership from senior managers, politicians and commissioners is a key driver for change, and for sustaining change. Leadership in mental health commissioning in Stockport has been particularly strong and clear and the area is continuing to develop and strengthen outcome-based commissioning.

⁶³ Stockport People Powered Health Site: <http://www.innovationunit.org/blog/201211/how-are-recovery-pathways-different-people-powered-health-site-stockport>

- It has helped that Stockport started developing self-directed support in mental health at an early stage, and has been able to build on that success. Targets were set for mental health personal budgets and around 400 people now have a budget. A rich network of community provision has been developed with good navigation and signposting to services. The vision is for one pathway for health and social care personal budgets, with support co-ordinators working on an alliance contract basis to support recovery outcomes.
- Work on culture change to embrace personalisation and recovery needs to be ongoing and open to continuing discussion and creative thinking. Sustaining change and achieving consistency in approach needs ongoing attention.
- It is important to continually develop and widen the range of support and opportunities for people to improve their lives as well as, for example, opportunities for employment and volunteering.
- It is important to work closely with the voluntary sector and focus on local area contracting. Clinicians are working alongside the voluntary sector in a collaborative model.
- Some of the challenges have been:
 - Trying to reduce the amount of paperwork involved in bureaucracy and the funding structures that underpin it
 - Having the capacity and resources to support change, and differences in the capacity that partner organisations have available
 - Shifting the balance of service activity towards prevention
 - Managing big changes that have had to happen quickly
 - Avoiding the possibility that the voluntary sector and communities will struggle to be creative and personalised if funding continues to be reduced, and people are also experiencing the impact of welfare reforms
 - Developing the mental health payment system in tandem with Personal Health Budgets, and seeing the necessity to broaden the thinking to embrace social care
 - Having sufficient flexibility with clustering so that it can be more adaptable in day to day practice
 - Getting the costing for the mental health payment system right and being open about how costs are arrived at
 - Getting the mental health payment system data accurate and reliable
 - Making sure that market development is progressing actively alongside individual purchasing and pathways, so that it reflects the right range of choice and diversity
 - Being clear and open about risks (safety acknowledgements) and risk sharing.



Case study 4: Suffolk

Partners and local arrangements

- Norfolk and Suffolk NHS Foundation Trust (<http://www.nsf.nhs.uk/>)
- Suffolk County Council (<http://www.suffolk.gov.uk/>)
- West Suffolk Clinical Commissioning Group (<http://www.westsuffolkcommissioning.co.uk/>)
- Ipswich and East Suffolk Clinical Commissioning Group (<http://www.ipswichandeastsuffolkccg.nhs.uk/>)
- Great Yarmouth and Waveney Clinical Commissioning Group (<http://www.gywpct.nhs.uk/>)
- Suffolk Coalition of Disabled People (<http://www.scodp.org.uk/>)

Norfolk and Suffolk NHS Foundation Trust provides child and adult mental health services, alcohol treatment, learning disability and eating disorder services across Norfolk and Suffolk (around 23,000 people receive services from the Trust at any one time). Norfolk and Suffolk County Councils have different arrangements with the Trust and different systems to support mental health services. The project discussed here focused on Suffolk and the work they are doing with the Trust to streamline resource allocation systems. There is a Section 75 Partnership. There is an agreement in place between the organisations to deliver integrated health and social care services for people requiring secondary mental health services. Social care staff are managed by the Trust, but remain employed by the county council.

Suffolk County Council is working with the 3 Clinical Commissioning Groups in Suffolk to develop integrated commissioning arrangements where appropriate and personal budgets could emerge as a good area to focus on. Suffolk was not part of the national Personal Health Budgets pilot sites programme, but GY and Waveney CCG are now developing local personal health budget pilot sites and the Trust are working with them on this.

Suffolk Coalition of Disabled People is an umbrella organisation led by and for disabled people. It has been funded to develop peer support and mentoring arrangements to support the roll out of personal budgets in mental health.

Suffolk County Council serves a population of around 730,000 people. Adult social care is part of the Adult and Community Services section of the council that also includes, for example, libraries and the arts, employment and economic well being. Personalisation has been strongly promoted in SCC's recent re-organisation which includes the development of a

new community based approach. The Trust has re-organised into a 'service pathways through life' and family focused structure and aims to use expertise in integrated teams, drawing on various professionals as needed.

Practice highlights

SCC and the Suffolk part of NSFT have developed a single assessment process for mental health services that identifies Fair Access to Care eligibility, and also provides a financial trail for treatment via the mental health payment system. A FACS identification template has been developed which overlays the HoNoS cluster scores to indicate when a person may be FACS eligible and therefore eligible for a personal budget.

Table 2: Suffolk mapping exercise to test mental health clusters against FACS criteria

MH Cluster	FACS Moderate	FACS Substantial	FACS Critical
2.Suicide			6
3. Substance Misuse			
4. Cognitive problems			6
5.Physical Illness		5	5
6.Hallucinations/delusions			6
7.Depressed mood	1	5	5
8.Other			8
9.Relationships		13	13
10.Activities daily living		16	9
11.Living conditions			
12.Occupation/activities			
13.Strong unreasonable beliefs			10
A. Historical /agitated/expansive mood		5	17
B. Repeated Self Harm			12
C. Safeguarding		3	4
D. Engagement		5	9
E. Vulnerability		7	25

Financial forecasting and data analysis was undertaken in order to come up with a formula for converting HONOS scores into funding for a personal budget. The FACS identification template is weighted to give focus to the social care needs identified through completing the HONOS questions. The tool has been tested and piloted and is now in the process of being rolled out, supported with targeted. Additional consultancy support has been commissioned to provide capacity for support to practitioners and teams using the tool. There are some exclusions (e.g. individuals in high cost nursing, residential and high cost supported housing placements with highly complex needs). Experience in the trials has shown that the system needs a measure of flexibility built in to allow for some of the complexities of mental health treatment and support. It therefore allows for a 25% moderation up or down from the standard personal budget allocation. Suffolk is now well placed to move quickly towards integrated health and social care personal budgets because of the groundwork that has already been done in relation to the single assessment process, linked to the mental health payment system.

A project group that meets monthly to support the development and rollout of this initiative that is made up of a range of professionals from operational teams, finance and commissioning. The views of partners are being sought as part of this work.

Suffolk has developed a service (Suffolk Wellbeing Service) to enable people to experience improved emotional wellbeing and promote early recovery from mental health conditions, such as, low mood, stress, anxiety and depression. The aim is to have a continuum of services available that is well integrated and has the flexibility to allow for smooth transitions between services should the persons' needs change. There is a single point of referral via a dedicated website, telephone or written referral.

Mental health payment system and personalisation: main learning and success factors identified by participants

- The work was developed for very practical reasons. A previous pilot showed that the Resource Allocation System that was being used to assess other care groups did not work consistently in mental health. As the mental health payment system was being developed by the Trust at this time, it seemed a good opportunity to see if a Resource Allocation System for mental health could be designed to align with the clustering process. It was clear that running one system instead of two would streamline and improve the experience for people in the assessment process. It would also radically reduce the time staff were engaged in administrative work for systems support, thus freeing them up for more direct work with people.
- It is helpful that the aims and values of the work are supported by the broader context of the Supporting Lives and Connecting Communities development in the County Council and the new 'Pathways through life' re-design in the Trust.
- The development had backing from senior managers in the County Council and the Trust who shared the vision of a single access process that would reduce bureaucracy and provide a good experience for people. There was also a commitment to develop this vision together – acknowledging that there would inevitably be challenges and problems and that these would need to be jointly addressed.
- There was a commitment to stick with the vision, and take the time to get it right. The new system has therefore been 2 years in development, and although the County Council has been under pressure to deliver personal budgets for mental health quickly, it has adjusted pace in order to develop them alongside Payment by Results in the Trust. It was also important to take time to demonstrate to clinicians and practitioners that this is an approach that will support the care and treatment they deliver.
- Both organisations have enthusiasts for the development and creative listeners open to new ideas and ways of doing things. There were also enthusiasts among finance, business support and IT managers who were involved from the beginning. They were key in helping to design a more streamlined process, and showed a real desire to improve the way people were experiencing systems.

- The Trust operates different models for employment and management arrangements for social workers in Community Mental Health Teams. In Norfolk there was a TUPE transfer of social work staff which was reviewed and staff transferred back to the County Council. In Suffolk social work staff are employed by the County Council. It remains to be seen what impact any new arrangements in Norfolk will have on joint working arrangements, but so far experience has led both organisations to conclude that employment arrangements are not, of themselves, a key factor in successfully collaborating in a single system.
- The timing of developments could be a key factor in the potential for integrated approaches. Suffolk was at an early stage of development that allowed for a joint approach. If they had already invested in and successfully established a resource allocation system for mental health personal budgets it would have been more difficult to unpick financial and operational systems and develop these again alongside the mental health payment system developments in the Trust.
- Systems demands on the workforce can become unreasonable and self-serving. It is important to consider how things are currently done and make them leaner, rather than automatically generating new forms and processes that could lead to more, rather than less, bureaucracy.



Case study 5: Worcestershire

Partners and local arrangements

- Worcestershire Health and Care NHS Trust (<http://www.hacw.nhs.uk/>)
- Worcestershire County Council (<http://www.worcestershire.gov.uk/>)
- NHS South Worcestershire CCG (<http://www.southworcccg.nhs.uk/>)
- NHS Wyre Forest CCG (<http://www.wyreforestccg.nhs.uk/>)
- NHS Redditch and Bromsgrove CCG (<http://www.redditchandbromsgroveccg.nhs.uk/>)

Worcestershire Health and Care NHS Trust provides community and inpatient services to adults with Mental Health needs across Worcestershire. Worcestershire County Council serves a population of about 570,000. Adult social care is placed in a Health and Social Care department. South Worcestershire CCG is the largest of the three CCGs in Worcestershire, encompassing 32 GP practices, serving 292,000 people living across South Worcestershire. Redditch and Bromsgrove Clinical Commissioning Group (RBCCG) represents 22 GP practices across Redditch and Bromsgrove with a combined registered population of circa 170,000 patients. Wyre Forest CCG serves a patient population of 112,000, covering 12 GP practices.

There is a Section 75 agreement and mental health services have been integrated since 2000. There is no pooled budget as yet. The largest part of mental health resources are invested in the NHS Trust. Community mental health services are delivered through integrated health and social care teams. Worcestershire was not a Personal Health Budget site.

Practice highlights

Personal budgets have been in development for some time but the pace of progress has increased rapidly over the last 12 months. There are around 100 people with personal budgets, with about 33% taking their budget as a Direct Payment.

As part of service re-design around day centres, a re-ablement service has been set up to support people to be part of their communities. It is a collaborative approach between statutory and voluntary sector services. The process involves a new pathway through a re-ablement hub to access a range of opportunities, including work, education and training. Re-ablement coordinators work with people to creatively design a person centred, individual support plan. The aim is to support people back into their communities and help people increase their independence. The Recovery Star has been used as an outcomes framework.

Worcestershire's Foundation Trust is one of the Centre for Mental Health's 12 centres of excellence for employment support that demonstrate the successful implementation of Individual Placement and Support.

It has been helpful to develop Commissioning for Quality and Innovation targets for the mental health payment system. The CQUINs payments framework⁶⁴ was set up to encourage care providers to continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. The aim is to promote a better experience for patients and better outcomes by rewarding providers who achieve specific goals. In Worcestershire CQUINs have been used to introduce 3 enhanced primary care services.

A Payment by Recovery project has been set up involving mental health experts by experience and carers in monitoring the mental health payment system process and how people recover as a result of its introduction. The project group are in the process of co-producing a booklet for people that explains what the mental health payment system and clustering is – and what it means for them as they experience it.

Mental health payment system and personalisation: main learning and success factors identified by participants

- Collaborative working can be undermined by competitive tendering for new services, or when contracts for existing services working in collaboration come up for renewal. Creative commissioning and contracting is needed to support, rather than disrupt, collaborative working
- Providers are concerned about the impact of personal budgets on their ability to sustain themselves as financially viable organisations
- More work is need on the mental health payment system, for example to promote the benefits of the system with clinicians and provide the support needed to ensure full coverage, and to understand and address the variations in costs allocated via the cluster tariff and the actual cost of what was needed
- The development of a diverse range of support, care and treatment options needs to keep pace with the mental health payment system developments and personalisation. In the absence of creative market development, choice will remain limited to what has previously been available. Market development requires good partnership between commissioners and providers, and between providers so that everyone is clear what is wanted, and commissioners can support and tap into innovation. A dialogue is beginning in Worcestershire, about how to develop and stimulate the market.
- The mental health payment system can lose momentum if collecting data becomes too complex and time consuming and there are difficulties in calculating and validating costings. It can also be slowed down and hampered by organisational change and changes in leadership.

⁶⁴ Department of Health: Guidance on new CQUIN goals, 2013:
<https://www.gov.uk/government/news/guidance-on-new-national-cquin-goals>