Care Packages & Pathways/Payment by Results for mental health services for adults
Implications for Psychological Services

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Executive Summary

The aim of this paper is to provide concise information and strategic advice in relation to the new mechanism for payment for mental health services in England; Care Packages & Pathways (CPP) and Payment by Results (PbR). Links to sources of more detailed information are also provided. As this field is developing rapidly, it is important to acknowledge that this paper should be regarded as a ‘work in progress’ and can only provide an introduction to the area. This paper has been written in the hope that it will be useful to professional and managerial leads of psychological services, particularly across England. However, the principles of introducing service redesign to address client need systematically using evidence-based interventions, and working strategically to influence these processes, are applicable across the four nations. It is hoped therefore that this paper will also be of interest to all psychological practitioners working in mental health services.

CPP & PbR are in the process of being implemented in England for mental health services for adults of all ages (the first stage went live in April 2012). This has significant implications for mental health services in terms of standards of good and evidence-based practice, a needs-based rather than a diagnosis-based model for service design, and a completely new payment mechanism. There are significant opportunities and risks for psychological services in this.

- Opportunity to use CPP/PbR as a lever to implement evidence-based interventions recommended by the National Institute for Health and Clinical Excellence (NICE), including psychological interventions, in areas where this has not yet been achieved.
- Opportunity to use CPP/PbR as a lever to design multidisciplinary care packages based on bio-psycho-social formulations rather than unidisciplinary models.
- Quality & outcome measures will become mandated – opportunity to demonstrate quality & effectiveness of psychological services both independently and as part of good quality multidisciplinary care.
- Opportunity to demonstrate the need to grow and develop the psychological workforce, with appropriate governance to ensure safe and effective provision.
- Risks of responsibility for delivering psychological interventions being assigned to staff without appropriate training and/or supervision. This would put service users at risk, and also psychological services establishments at risk of being further eroded.
- Risk of psychological direct and particularly indirect input (e.g. supervision, consultation, training) not being costed and therefore not being funded.
- Risk of being implemented as purely a financial model without any genuine service redesign or quality improvement.

Psychological services need to approach the implementation and evaluation of CPP & PbR strategically in order to maximise the opportunities and pre-empt or manage risks.
1. Introduction

1.1 What is CPP? Background and development
Care Packages & Pathways (CPP) is a clinical model aimed at defining needs-based care for people with mental health problems. It is not a diagnostically driven model, nor is it financially driven. By an iterative process, 21 clusters of need have been derived, through cluster analysis of data re. adults of all ages with mental health problems, from a range of mental health service providers, originating with the work of Roland Self, Associate Director of Psychology in South West Yorkshire (Self et al., 2008; Paxton et al., 2007). The aim of this work was to identify groupings of service users with similar needs, in order that packages of care could be designed to meet those needs (based on the best available evidence), and that services could be designed to provide these care packages effectively and efficiently. The model was also intended to consider pathways of care that a service user might follow to facilitate smooth transitions between different packages of care required along the pathway.

1.2 Development of the Mental Health Clustering Tool (MHCT)
The MHCT (ISB, 1078) is a tool which has been developed to produce a summary of the assessment of each service user’s needs that can be mapped onto the profile of each cluster to obtain the best match. This tool is based on HoNOS (Wing et al., 1999), and includes additional items concerning historical data not covered in HoNOS. The MHCT incorporates items from the Summary of Assessments of Risk and Need (SARN, itself based on HoNOS) (Self et al., 2008), in order to provide all the information necessary to allocate individuals to clusters.

The MHCT is not intended to replace a clinical assessment; it is a tool which summarises the assessment and assists in deriving the appropriate cluster for the service user. Clinicians are not bound to allocate the service user to the cluster indicated by the MHCT profile if they judge that the care package for this cluster would not be the most appropriate care package for this particular service user.

1.3 Mandated care clusters and care packages
The mandated care clusters are those which have been approved for national use for PbR for adults. They have been refined over a period of several years, during which time a number of provider organisations have piloted clustering, and expert clinicians have assisted in the refinement of the clustering tool and the defining features of clusters. The current model consists of 21 clusters (though cluster 9 is now blank; this was formerly substance misuse). The clusters, broadly speaking, address range of needs, severity of needs, and complexity of needs. Clusters 1 – 8 cover mild, moderate and severe mental health problems excluding psychoses. Clusters 10 – 17 address the needs of people with psychoses, ranging from first episode of psychosis, through to people with enduring problems with low or high symptomatology and disability. Clusters 18 -21 are the organic clusters.
For each care cluster, providers can design a care package which encompasses assessments, interventions, care coordination etc. which are designed to meet the needs of the majority of people within the care cluster. These care packages should be based on available evidence (e.g. NICE guidance) and local views of best practice. For individual service users, the care package is a starting off point from which an individualised care plan can be negotiated and agreed. Template care packages for the mandated clusters are available (but not compulsory), see section 3.3 below.

The 21 mandated clusters are derived from analysis of adults of all ages, and therefore apply to adults and older adults. However, many older adults clinicians consider that the care packages for adults often require adaptation to meet the needs of older adults, particularly those with long-term and/or severe physical health comorbidity. Guidance concerning such adaptations will be provided via the IMHSeC web-tool (see section 3.3.2).

1.4 Strengths and weaknesses of the CPP model

Key strengths:
- It is a needs based approach.
- Clusters are not defined by diagnosis.
- The model is not owned by any one profession and is thus more acceptable to all disciplines.
- The cluster model provides a common language for providers and commissioners.
- The clusters fall into natural groupings which can become the basis for service redesign to meet the needs of the client groups.
- Use of the cluster model allows providers and commissioners to quantify demands linked to needs and estimate resources needed to meet these needs.

Weaknesses:
- It can be perceived as fitting people into ‘boxes’.
- Its main focus is in identifying needs that equate to mental health problems; it may not give sufficient weight to contextual and environmental factors.
- It cannot account for all potential mental health service users & families. Up to 10 per cent of people’s needs don’t fit with the clusters as they are currently described.
The Care Packages and Pathways Project, a consortium of organisations in the Yorkshire and Humber and North East SHA areas, was established in 2008, aiming to develop a model that could be used for PbR in mental health that was needs based rather than diagnostically driven.

CPP was selected because it consists of care packages which designate evidence-based interventions and best practice required to meet needs within each cluster group. These care packages can be operationalised, and can either be costed from first principles or, alternatively, a charge for a package of care can be derived from the staff grades and time involved in service delivery to each cluster. The latter approach is obviously much less satisfactory, as only current practice would be funded, rather than best practice. Two examples of care packages; for cluster 3 (non-psychotic mental health problems, moderate severity) and for cluster 8 (non-psychotic chaotic and challenging disorders) are shown in Appendix 1.

The 21 clusters (excluding cluster 9 as noted in 1.3 above) have been mandated for national use in England for adult services (including older adults), with effect from April 2012. All such services have been required to cluster clients during 2011–12 in preparation. An overview of the 21 clusters is shown in the following diagram.

**Figure 1:** Mandated clusters diagram
2.1 Expansion of CPP to other client groups: CYP, LD, Forensic

The 21 mandated clusters have been developed for adults and older adults utilising mainstream mental health services. The need to develop an appropriate framework for PbR for other client groups within mental health and disability services has been identified, but unfortunately the timescales for the implementation of PbR in mental health have not given sufficient scope for an equally empirical process. Instead, a number of ‘early adopter’ services and relevant professional bodies have been developing possible cluster models for use in mental health services for children and young people (CYP), services for children and adults with developmental and learning disabilities (LD), and people receiving forensic mental health and disability services.

For CYP, the developing framework is based on a distinction between psychological and organic disorders. For LD, the framework may be able to fit alongside the existing organic clusters, with a distinction between difficulties associated with the learning disability itself, and mental health problems in the context of a moderate to severe learning disability. For forensic services, additional sub-categories of cluster 8 (severe non psychotic mental health problems, high disability) are being developed.
3.0 Implementation of PbR

3.1 Timescales for clustering and payment

2010/11
- The MHCT and clusters have been made available for use by providers.
- Reference costs from early implementers have been returned to the CPP project group on a cluster basis. This information has been used to help develop the costing model and tariff.

2011/12
- All service users accessing mental health care (post GP or other referral) that have traditionally been labeled working age (including early intervention services from age 14) and older people’s services, to be allocated to a cluster by 31 December 2011.
- Local prices should be agreed for use in 2012/13 and this will require understanding of local costs per cluster.

2012/13
- The clusters (with local prices) become mandatory for contracting and payment purposes.

2013/2014
- The earliest possible date for a national tariff for mental health (if evidence from the use of a national currency presents a compelling case for a national price).

The priorities for 2012/13 will be:
- Use of care clusters as the basis for contracting.
- Local prices are agreed based on cost collection and current contract value.
- Risk sharing mechanisms should be built in to recognise issues with the quality of cost and activity data.
- Continue to improve the consistency of clustering service users.
- Use of care transition protocols.
- Use nationally agreed cluster payment periods.
- Improve quality of cost data
  (from presentation by Martin Campbell, head of PbR at the DH, November 2011).

3.2 Payment model (in brief)

An important part of the work of the CPP project group has been the development of a costing model for PbR, in order to make it possible for a price or tariff to be agreed for provision of care for a particular cluster, over a designated period of time, and delivered to an agreed quality standard. The tariff should be based on the expected cost of providing a care package over an agreed period (e.g. one week, one month, six months), including the time of staff with the appropriate levels of skill, costs, e.g. for hospital admission if required as part of that care package, and an element of organisation overhead cost. The payment the provider should receive for providing care to an individual service user who follows a pathway of care with transitions between care packages could be illustrated by Figure 2.
It is possible to calculate the cost of care delivery either by:

(i) adding up the cost of each planned component, e.g. 2 hours’ assessment, 20 hours of therapy and 6 hours’ liaison/record keeping/receiving consultation and supervision, by a staff member at Band 7 plus 2 hours’ consultation and supervision from a staff member at Band 8a, plus overheads for accommodation, IT and Trust infrastructure, or,
(ii) Ensuring all service users within services have been allocated to a cluster, and dividing the overall service delivery and overhead costs among the clusters proportionally.

It is assumed that the second approach is being used to develop reference costs, which is pragmatic, but runs the risk of embedding the status quo in terms of service quality. There will be other drivers to improve quality however (see below).

The composition of a hypothetical caseload is shown in the following diagram:

Figure 3: Hypothetical caseload illustration from currency paper available at www.cppconsortium.nhs.uk

The development of the currency model is nearly complete (see http://www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/index.htm for further information).
3.3 Quality and Outcomes Group & IMHSeC project

The National Mental Health Quality and Outcomes Group was established in 2010 with the primary objective of identifying indicators/measures specifically linked to payment by results (PbR) currency groups, and to recommend how these could be utilised as an integral part of the currencies. The group was convened by the DH and the Care Packages and Pathways Project, and has been jointly chaired by David Daniel (DH) and Carole Green (CPP). The group has the following objectives:

a. Test and recommend the use of quality indicators linked to the 21 clusters that form the basis of the currency model, using metrics that are currently collected consistently on a national basis as part of the Mental Health Minimum Data Set (MHMDS).

b. Establish a web-based tool that will provide guidance on the content of care packages for each of the 21 clusters, linking NICE guidance and quality standards, evidence and best practice.

c. Produce a plan for how other data, including the individual items within the Mental Health Clustering Tool (MHCT), could be used to augment the approach identified in (a) above.

d. Produce a proposal that demonstrates how gaps in the overall framework for outcomes for each of the 21 clusters that may be filled. Approaches may include the mandating of new tools and data items, and will ensure a focus on Patient Reported Outcome Measures (PROMs).

The group produced a report in October 2011 summarising the progress made towards these objectives during the previous 12 months; this is available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131578.

For pragmatic reasons, the group decided that its initial approach would be to consider measures from the existing Mental Health Minimum Data Set only (measures had to be selected which were already consistently collected nationally). This ‘top down’ approach means that the majority of the measures that are proposed in phase 1 are not specific to particular clusters, but rather apply to all clusters without distinguishing between them (e.g. employment status). Exceptions are the IAPT KPI outcome measures, which apply to specific clusters.

The next phase of work of the Q&O group will consider appropriate clinical outcome measures, PROMs and Patient Rated Experience Measures (PREMs). Initial scoping work by the group suggests that the following are likely to be put forward (see table opposite).

However, it has been agreed that each cluster needs to be considered separately, in order to agree on what the most appropriate measures or indicators would be to demonstrate quality of provision, good outcomes and positive service user experience for that client group. The aim is to agree on at least one appropriate quality measure, one outcome measure, one PROM and one PREM for each cluster by 2013/14.
3.3.1 First stage quality and outcome indicators

Candidate measures from the MHMDS were evaluated against the following criteria:

i. The indicator demonstrably reflects quality or outcomes that are relevant to the service user, practitioner, provider or commissioner.

ii. Data is available at all levels and can be fed back to practitioners/teams.

iii. Evidence/proof that the data required to demonstrate the indicators can be collected and evaluated.

iv. They must support the high-level indicators, which are likely to include employment, mortality, suicide and recovery.

v. They have nationally agreed definitions.

vi. They fit with Commissioning for Quality and Innovation scheme (CQUIN).

vii. They are specific to currency group(s).

viii. A link can be made between needs (both physical and mental health), interventions and outcomes.

Data from a number of providers who were clustering all clients of their services were analysed.

The following indicators were thought to demonstrate acceptable data quality, and to be appropriate to be recommended for use:

- Indicator 2: Proportion of people on CPA
- Indicator 4: IAPT KPI indicators
- Indicator 5a & b: Accommodation status
- Indicator 6a & 6b: Employment status
- Indicator 12a: Average number of bed days

For use at a national level the following indicators were thought to be promising but to require more work:

- Indicator 7: Equity of access for ethnicity
- Indicator 9: Section Usage
- Indicator 11: Readmission rates.

Standards have not yet been proposed for these indicators; the first step would be for data from all providers to be analysed against cluster for these indicators. Appropriate standards/targets for each indicator for different clusters could then be proposed. For example, one would expect a higher target for employment in clusters 1 and 2 (mild common mental health problems) than in cluster 13 (ongoing/ recurrent psychosis, high symptoms and disability). It must also be noted that many people in all clusters may not be
available for paid employment anyway, due for example to being past retirement age, caring for young children, other caring responsibilities, etc.

### 3.3.2 The IMHSeC project and web-based tool: template care packages for the mandated clusters

The IMHSeC group (a partnership between the Pharmaceutical Serious Mental Health Initiative (PSMI), the Department of Health Mental Health Directorate and the former National Mental Health Development Unit) is working with the PbR Quality and Outcomes Subgroup.

The IMHSeC project group is working on a web-based tool that will provide guidance on the content of the care package for each of the clusters. This is a key piece of work that will establish a benchmark standard of the components of care that should be available in each care package. This is very important in order to ensure that the introduction of CPP and PbR can be used as a lever to improve quality and outcomes. Each component of each care package will be linked to the underpinning NICE guidance and standards. This work is being done in partnership with a wide range of stakeholders, including Don Brechin and Suzanne Heywood-Everett, who are compiling a detailed paper aligning the psychological interventions evidence base to clusters.

The IMHSeC project group has selected the template care packages developed in the West Midlands. These templates map a service user’s journey within each care package, and specify the components of care at each of the key stages and across the following domains: assessment; enabling interventions; therapeutic interventions; role support; family/carer interventions; accommodation; monitoring and care coordination.

They specify core elements that should be provided for all service users in the cluster, and additional elements that can be implemented flexibly according to need.

The templates also specify the overarching therapeutic aims, the underpinning values, and suggested quality and outcome indicators for each cluster (NB: the latter are yet to be cross-checked with the emerging work from the Q&O subgroup, but appear to have good face validity).

The web tool can be accessed at [www.mednetconsult.co.uk/imhsec/](http://www.mednetconsult.co.uk/imhsec/) and an example is given at [www.mednetconsult.co.uk/imhsec/index.php/therapeutic-interventions3](http://www.mednetconsult.co.uk/imhsec/index.php/therapeutic-interventions3).

### 3.4 PbR and IAPT

The most appropriate payment model for IAPT is under consideration at the time of writing, and two projects are developing and testing possible solutions.

The CPP project group is investigating whether it is possible to derive the clusters from the existing IAPT metrics, and/or whether it is possible to design a short version of the MHCT suitable for use in IAPT services. The latter would be of particular benefit in facilitating the movement of Service users through to the most appropriate service, if IAPT were not to be appropriate for them.

The central IAPT team are exploring an alternative model, viz. a payment model based on actual outcomes: recovery rates, employment outcomes, service user satisfaction and
proportional access in relation to the population served (e.g. of different age groups, gender, BME). This model would take PbR to the next stage (payment by ‘real’ results). However in order to ensure that perverse incentives are not set up, it is likely to entail an increase in data collection and more complex analysis compared with the present KPI requirements.

At the time of writing, IAPT services have been excluded from the national directive to use the MHCT to cluster all their service users; however, the IAPT PbR pilot study is using clustering to provide additional information about the range of needs of clients accessing IAPT services, and it is anticipated that IAPT services will be expected to use clustering in the future. Those providers who are offering an integrated IAPT and primary care mental health service are likely to find it appropriate to use clustering, as it is difficult to define the ‘dividing line’ between IAPT and primary care mental health, due to the significant overlap between the two.
4.0 Implications for psychological services

For mainstream mental health services clustering and PbR are not optional – they are mandated for implementation. How organisations implement this is up for discussion both internally and with commissioners. This means that there are a range of opportunities for Psychological Services which should be pursued where possible. PbR also brings risks and threats, which should be considered, and pro-active and pre-emptive action taken.

4.1 Opportunities for psychological services

The CPP model is needs based, not diagnosis based. It therefore presents an opportunity to emphasise the importance of holistic bio-psycho-social formulations, as the most appropriate way to understand an individual, family, or group’s difficulties, in the context within which they live and their previous experiences (as explicated in the DCP Good Practice Guide on the Use of Psychological Formulation, 2011). Taking this approach should help to avoid pathologising peoples’ experiences, and to optimise engagement and outcomes. Furthermore, there is a strong emphasis on psychological assessment and interventions in most of the care packages, and a strong emphasis on delivering evidence based practice and high quality processes and outcomes.

There should be a recognition in most if not all provider organisations that they currently have insufficient psychological resource to contribute to bio-psycho-social assessments and formulations and to deliver the specified psychological interventions. Demand for psychological interventions in this context should be seen as organisation issue versus a psychology issue, and organisational solutions sought (e.g. workforce development, retention of psychological services establishments, perhaps even development of new posts). CPP and PbR therefore bring the following opportunities:

- Opportunity to use CPP/PbR as a lever to implement NICE recommended evidence based interventions, including psychological interventions, in areas where this has not yet been achieved.
- Opportunity to use CPP as a lever to implement NICE recommended evidence based psychological interventions (first line treatments).
- Opportunity to use CPP/PbR as a lever to implement evidence-based practice second line treatments and multi-factorial formulation-based interventions (e.g. where the research evidence is less clear but the knowledge and experience of the therapist are required).
- Opportunity to use CPP/PbR as a lever to design multidisciplinary care packages based on bio-psycho-social formulations rather than uni-disciplinary models.
- Quality and outcome measures will become mandated – opportunity to demonstrate quality and effectiveness of psychological services both independently and as part of good quality multidisciplinary care.
- Opportunity to demonstrate the need to grow and develop the psychological workforce, with appropriate governance to ensure safe and effective provision.
- Opportunity to re-establish the need for roles in expert assessment, consultation, supervision and selective clinical work.
4.2 Risks for psychological services

In organisations that favour a uni-disciplinary (e.g. medical) model or are driven by finance rather than quality and clinical effectiveness, the implementation of CPP and PbR could bring the following risks:

- Risks of responsibility for delivering psychological interventions being assigned to staff without appropriate training and/or supervision. This would put service users at risk, and also psychological services establishments at risk of being further eroded.
- Risk of psychological direct and particularly indirect input (e.g. supervision, consultation, training) not being costed and therefore not being funded.
- Risk of being implemented as purely a financial model without any genuine service redesign or quality improvement.

In order to make good use of the opportunities and safeguard against the threats and risks, a strategic and pro-active approach is recommended. The implementation of PbR together with the move to commissioning through Any Qualified Provider (AQP) will have a significant impact on how services for people with mental health and disability problems are funded, purchased, designed and delivered.
5.0 Strategic approaches

A number of events have been organised recently through the DCP Leadership and Management Faculty during which it has been possible to consider the question of strategic influence, and how to address the barriers which often exist. These questions are by no means confined to consideration of the implementation of CPP and PbR; they are relevant to the broader challenges for psychological services of effective working within complex organisations, and the ‘marketing’ of psychology and psychological services by demonstrating their value. These issues must be urgently addressed if psychological services are to thrive and survive in the current climate.

From our discussions, three principles have evolved:

● Assessment of how psychological services are regarded in your organisation.
● Assessment of what are the key objectives/levers and key mechanisms of influence at present in your organisation and/or for commissioners.
● Formulation of a strategic plan based on the above.

5.1 Assessing influence and tailoring approaches

Firstly, we suggest utilising a version of the Model of Change (Prochaska & DiClemente 1986). How are psychological services regarded in your organisation? Is your organisation at the stage of:

● **Precontemplation:** largely unaware of what psychology is and what psychological services can offer, not recognising the need to do something about this.
● **Contemplation:** aware that psychological services are important, but unwilling to address the issues of insufficient provision or involvement.
● **Decision:** overtly setting objectives of involvement and enhancing service provision, but nothing has been implemented as yet.
● **Action:** psychological services are well integrated and valued, and issues of under-provision are taken seriously, and action is taken (though not necessarily to the desired extent).

Strategic planning needs to take this assessment into account, and the strategies used to help a service user move round the cycle could be helpful. For example, providing information at the precontemplation stage may not be effective because it may not be heard/assimilated. Providing arguments about evidence based practice at the decision stage may not be helpful as that has already been heard – there may be a different barrier to address (e.g. one or more key people within the organisation are not on board, financial targets have changed).

A similar assessment could be made of the organisation’s approach to CPP and PbR, perhaps using a different model such as Rogers’ innovation adoption curve (Rogers, 1962). Is the organisation an innovator or early adopter, part of the early/late majority, or lagging behind? Hopefully psychological services are already engaged in CPP development and implementation in the innovator and early adopter organisations. If not, then analysis of the work done to date on NICE guidance implementation within care packages would highlight areas for development for psychological services, through training and
supervision as well as direct provision, in order to achieve optimal clinical outcomes and standards expected by Monitor (for Foundation Trusts). For organisations which are lagging, research based on Rogers’ model indicates that engagement is best brought about by input from those who are just a few steps ahead (e.g. in the ‘late majority’). The availability of templates for care packages from the IMHSeC web resource (section 3.3.2) is also likely to be helpful.

A third mode of assessment relates to the organisational dynamics, opinion leaders, actual and potential allies, and those with opposing views and influence (overt and covert). Strategies for managing the latter have been proposed by Olivier (2002) in his transformational leadership model.

Together with these assessments it was recognised in our discussions that there is a wide range of information and resources that is needed to design and implement a strategic plan to promote the implementation of CPP and PbR. The aim being to address any organisation barriers to maximise quality of care and outcomes for service users, and in so doing make the most of the opportunities for psychological services.

The most significant points can be summarised as:

- Show how psychological services can help achieve organisational/commissioner objectives.
- Be ready and willing to help with issues that are not priorities for psychological services in order to demonstrate the above.
- Keep the emphasis on quality and clinical effectiveness.
- ‘Step into authority’ as regards governance issues.

The conclusion of these discussions was that a formulation and toolkit are required to tackle the challenges described. A summary is shown in the table overleaf.

This approach obviously extends beyond the specific issue of CPP implementation, and will overlap with the more general issues of maintaining and developing psychological services within a challenging climate of organisational, political and financial change and constraints.
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<td>Service line reporting links to clustering and redesign. Flexibility 'teams will tend to have clients who are...'</td>
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5.2 Case vignettes

Two examples of how psychological services have been involved pro-actively in developing CPP and PbR in their organisations:

- In Trust A, psychological services are well regarded by most managers and colleagues from other disciplines, and relationships and the demonstration of the value of psychological expertise and contribution have been built up over a long period. However, a number of posts have been lost over recent years as part of the Trust’s cost savings programme, and resources fall short of the current demand; if unmet needs were more explicit this gap would be even greater. The organisational positioning for psychological services is fairly strong, but psychological services do not have direct representation at senior management team or board level; instead they are represented by an executive director.

  Trust A set up a steering group for CPP/PbR some years ago within its adult services, as Trust A is a CPP pilot site (and hence could be described as an ‘innovator’ for this area of work). The Trust’s professional head of adult psychological services was invited to be a member of this steering group and worked with that group towards meeting its initial objectives (developing training in clustering, piloting clustering in specific areas, identifying clinicians who could contribute to the further development of the MHCT, etc). Following on from this it was possible to engage with the group in thinking about wider questions of service redesign. The Trust’s programme director for CPP/PbR was tasked with engaging multidisciplinary colleagues in developing care packages for the mandated care clusters, and the Trust’s professional head of psychological services was invited to co-lead workshops for clusters 1-3, 4-5 and 6-7. Other psychological services leads and senior clinicians were invited to co-lead other workshops for the majority of the remaining clusters. In these workshops, the psychological interventions evidence base was presented and discussed along with other relevant evidence (e.g. medical, occupational) and good practice models (e.g. recovery model). The workshops produced collaboratively agreed care packages based on bio-psycho-social assessment and formulation and including relevant psychological evidence based interventions and best practice. Subsequently, the Trust professional head joined the Trust-wide CPP/PbR implementation board, and co-facilitated a number of engagement events with local commissioners and other local providers. Trust A is working on service redesign plans which will incorporate principal community pathways based around cluster groupings.

- In Trust B, psychological services are very well positioned, with the head of psychological services being a director on the board. Psychological expertise has been shown to be central to clinical governance and quality and clinical effectiveness, with staff encouraged to ‘step into their authority’ in these areas. Trust B was not a pilot site for CPP/PbR, but was an ‘early adopter’, and took the view that their implementation model needed to be collaboratively agreed with commissioners and GPs from the outset. They have together chosen to use the ‘Map of Medicines’ online resource to develop jointly agreed care packages for the mandated clusters.
6.0 Resources

Useful resources include the following:

- Care cluster package templates on IMHSeC web tool, linked to evidence http://www.mednetconsult.co.uk/imhsec/
- Care packages and Pathways Project: www.cppconsortium.nhs.uk
- Payment by Results currency development www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/index.htm

7.0 Summary & conclusions

Care packages and pathways, clustering and PbR are mandated for implementation for mental health services for adults. The model is under further development for implementation with other groups including children and young people, learning disabilities and forensic services. How organisations implement care packages and pathways is up for discussion both internally and with commissioners. This means that there are a range of opportunities for psychological services which should be pursued where possible. In particular, CPP brings the opportunity to improve quality of care and outcomes for service users, as it is a lever for building increased capacity to deliver evidence based psychological interventions and psychologically informed care. PbR also brings risks and threats, which should be considered, and pro-active and pre-emptive action taken. Working strategically within and between organisations is challenging, but clinical psychologists bring transferable skills to this arena.

Acknowledgements

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References


Mental Health Clustering Tool, Information Standards Board (ISB 1078)


## Appendix 1

Two examples of care packages: for cluster 3 (non-psychotic mental health problems, moderate severity) and cluster 8 (non-psychotic chaotic and challenging disorders).

### Care Pathway Cluster 3

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access Phase</strong></td>
<td>Within 3 working days being received</td>
</tr>
<tr>
<td>Referral received and logged onto electronic patient information system (RiO)</td>
<td></td>
</tr>
<tr>
<td><strong>(Re)Assessment &amp; Formulation Phase</strong></td>
<td>Within 3 working days of referral being received</td>
</tr>
<tr>
<td>Standardised telephone triage undertaken and recorded (including baseline symptom assessments and details of any previous treatment)</td>
<td></td>
</tr>
<tr>
<td>Patient given appropriate information about other relevant agencies and pure self-help</td>
<td></td>
</tr>
<tr>
<td>Patient clustered</td>
<td><strong>Within 28 working days of referral being received</strong></td>
</tr>
<tr>
<td>One to one assessment session with high intensity worker using appropriate assessment format</td>
<td></td>
</tr>
<tr>
<td>Collaborative formulation produced including a collaborative problem statement</td>
<td></td>
</tr>
<tr>
<td><strong>Treatment Phase</strong></td>
<td></td>
</tr>
<tr>
<td>Treatment programme explained and appropriate choice made in the light of previously unsuccessful interventions from:</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>G.A.D.</td>
</tr>
<tr>
<td>16–20 sessions of CBT/IPT/Behavioural Activation/Couples Therapy</td>
<td>16–20 sessions of CBT</td>
</tr>
<tr>
<td>Treatment commenced (including intermediate review(s))</td>
<td></td>
</tr>
<tr>
<td><strong>Review phase</strong></td>
<td>Within 26 weeks of allocation to cluster 3</td>
</tr>
<tr>
<td>Repeat of initial baseline symptom assessments completed (individual review of attainment against previously agreed aims where indicated). Where treatment has been unsuccessful, patient should be re-clustered, and the appropriate care pathway offered/referral arranged</td>
<td></td>
</tr>
<tr>
<td><strong>Discharge phase</strong></td>
<td>Within 28 weeks of allocation to cluster 3</td>
</tr>
<tr>
<td>Need for follow up session(s) considered and scheduled if appropriate</td>
<td></td>
</tr>
<tr>
<td>Patient satisfaction questionnaire sent</td>
<td></td>
</tr>
<tr>
<td>Standard discharge letter sent to patient and copied to referrer</td>
<td></td>
</tr>
<tr>
<td>Discharge recorded on electronic patient information system (RiO) and episode closed</td>
<td></td>
</tr>
</tbody>
</table>

### Appendix 2

Two examples of care packages: for cluster 3 (non-psychotic mental health problems, moderate severity) and cluster 8 (non-psychotic chaotic and challenging disorders).
<table>
<thead>
<tr>
<th>Access Phase</th>
<th>Within 3 working days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral received and logged onto electronic patient information system (RiO) system (Patient record checked for current open referrals and any paper records requested)</td>
<td></td>
</tr>
<tr>
<td>Level of risk and urgency clarified by telephone with referrer and/or patient if necessary (NB: competency required for triage at least 2 years at practitioner level, basic KUF Awareness Level training and receiving appropriate supervision)</td>
<td></td>
</tr>
<tr>
<td>Appropriate assessment appointment offered (Timescale, venue, number of staff (i.e. double-handed) and professional background of assessor dictated by information available to date regarding risks and needs)</td>
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<tr>
<td>Initial triage decision made re: signposting/shared care with urgent care/forensic services</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment &amp; Formulation Phase</th>
<th>Within 28 days of referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holistic assessment of needs and risk (NB: competency required for triage at least 2 years at practitioner level, basic KUF Awareness Level training and receiving appropriate supervision)</td>
<td></td>
</tr>
<tr>
<td>Information, signposting, advice &amp; support offered to carers (and formal carers assessment offered where appropriate)</td>
<td></td>
</tr>
<tr>
<td>MHCT scored and patient clustered as 8 (with MDT input if required)</td>
<td></td>
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<tr>
<td>Early decision made regarding the engagement strategy and whether the primary need is managing self harm, and or other impulsive behaviours</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment &amp; Formulation Phase</th>
<th>Within 3 contacts of referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster specific assessment of levels of: severity; risk; chaos, functioning (including problematic relational patterns) and personality structure undertaken by appropriately trained staff with ongoing cluster 8 – focused clinical supervision. Holistic assessment to identify long-term developmental need as well as immediate problematic symptom presentation</td>
<td></td>
</tr>
<tr>
<td>Further baseline condition-specific outcome measure(s) completed (e.g. PDQ4+, CORE, BSI, CTQ)</td>
<td></td>
</tr>
<tr>
<td>If a number of intervention phases have been delivered with insufficient effect, for those service users who have particularly complex needs and/or high levels of risk consider a multi-dimensional psycho-diagnostic assessment</td>
<td></td>
</tr>
<tr>
<td>Liaise with relevant colleagues to provide advice, consultation and ‘scaffolding’ if required</td>
<td></td>
</tr>
<tr>
<td>Bio-psycho-social formulation (including treatment goals) collaboratively developed and recorded with input from the appropriately skilled members of the MDT (Place particular emphasis on complexity and co-morbidities such as substance misuse)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Phase</th>
<th>Overall treatment phase to be reviewed at least 6 monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>COORDINATION OF CARE:</td>
<td></td>
</tr>
<tr>
<td>(To be undertaken by Care Coordinator/Lead Health Care Professional)</td>
<td></td>
</tr>
<tr>
<td>• Offer appropriate patient information (about condition and services)</td>
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</tr>
<tr>
<td>• Agree aims of interventions and produce individualised treatment plan (taking account of current presentation &amp; any previous interventions). Plan will address identified biological, psychological and social needs and will have one or a combination of interventions from those detailed below, in a clinically appropriate sequence.</td>
<td></td>
</tr>
<tr>
<td>• Ensure care/treatment plan:</td>
<td></td>
</tr>
<tr>
<td>o Specifies who is responsible for each element.</td>
<td></td>
</tr>
<tr>
<td>o Identifies short-term treatment aims and how to achieve them and long-term realistic goals which should underpin the long-term treatment strategy.</td>
<td></td>
</tr>
</tbody>
</table>
Includes a crisis plan that identifies potential triggers that could lead to crisis, specifies self management strategies and provides information about how to access services (phone nos. for crisis teams etc).

Ensure management and interventions are delivered by an integrated and coherent multi-disciplinary ‘whole system’ of care, by appropriately trained staff who receive supervision, consultation and support throughout all interventions.

- Share treatment plan with the patient and their family/carers (with patient's consent)
- Provide written and verbal information to referrer and GP regarding outcome of assessment/review and proposed care pathway / treatment plan and generic information regarding personality disturbance.
- Provide stability by remaining actively involved throughout periods of structured therapy
- Encourage patient to be actively involved in problem solving during periods of crisis.
- Offer condition-specific psycho-education to patient (and carer where appropriate)
- Actively facilitate engagement with other appropriate mainstream providers to meet identified aims
- Ensure a contemporary electronic patient record is maintained (and written with the whole system of care in mind)
- Schedule regular formal reviews
- Ensure all relevant contributors to treatment plan are kept informed of progress and any significant developments which have an impact on their involvement
- Ensure all interventions are under regular review.

BIOLOGICAL INTERVENTIONS:

- Medication history and responses recorded
- Where appropriate (e.g. as part of the overall management of co-morbidities, psychosis or short-term sedation during crisis), a choice of medication is agreed with patient following discussion re anticipated benefits and potential unwanted effects
  (N.B. Drug treatment is not recommended specifically for Cluster 8 service users or for the individual symptoms or behaviour associated with Cluster 8 such as repeated self-harm, emotional instability, etc)
- Written information provided on any medication selected
- Baseline physical examination and tests performed / arranged
  (As dictated by presentation, physical health, known risk factors and proposed medication regime)
- Arrangements made for subsequent annual physical health checks
- Medication trial commenced and for long term treatments, monitoring appointment scheduled to occur four weeks from initiation
- If insufficient response is gained through the above, consider: trials of combination therapies; newly licensed medications and off-licence prescribing

PSYCHOLOGICAL INTERVENTIONS:

- Psychologically informed approach taken to all interventions using core psychological skills (development of therapeutic alliance, normalising, engaging, motivating)
- Psychological treatment programmes explained and appropriate choice made in light of presentation, and any previously unsuccessful interventions
- Formal interventions on offer should be evidence based, and adopt a developmental approach. (Long-term, (over 3 months) rather than brief psychological interventions should be offered)
- These should be delivered in a range of contexts depending on level of need, in individual, group, outpatient, community, day and inpatient settings and should be clinically supervised by appropriately trained staff
An explicit and integrated approach to treatment should be used by both the treatment team and the therapist, which is shared with the patient. In addition to more formal periodic reviews, the effects of treatment on a broad range of outcomes, including personal functioning, drug and alcohol use, self-harm, depression and the symptoms associated with Cluster 8 should be monitored on an ongoing basis.

**OCCUPATIONAL & SOCIAL INTERVENTIONS:**
Collaboratively work towards creating and maintaining meaningful and productive routines associated with productivity self care and leisure by addressing immediate and longer term social needs e.g.:
- Securing appropriate benefit entitlements
- Facilitating access to personal budgets
- Securing suitable housing / accommodation
- Meaningful occupation and activity
- Maintain and / or develop appropriate relationships and informal support networks to support independence normalise experience and promote recovery
- Attain / maintain an appropriate level of functioning.

**FAMILY / CARER INTERVENTIONS:**
- Delivery of interventions specifically intended to meet any identified carer needs

<table>
<thead>
<tr>
<th>Review Phase</th>
<th>To occur within 6 months of commencing each treatment phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress towards identified goals formally reviewed by service user, carer (where appropriate) and all professionals involved in delivering treatment plan</td>
<td></td>
</tr>
<tr>
<td>Repeat any baseline problem specific assessments completed in assessment phase</td>
<td></td>
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<tr>
<td>Review ongoing carer needs and any interventions. (Repeating/updating formal carer’s assessment as required)</td>
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</tr>
<tr>
<td>Collaboratively agree on need for discharge/further treatment &amp;/or involvement of regional or national specialists. (If discharge is appropriate continue to next phase; if not repeat/update interventions in assessment phase and deliver care according to relevant cluster)</td>
<td></td>
</tr>
<tr>
<td>All changes/endings in treatment/psychological intervention structured, phased and supported by the care plan which includes the opportunity to access crisis services if necessary (Where patients disengage prematurely from services ensure that they are still given the opportunity to actively participate in their discharge. Ensure that all members of the current care network and any other professionals / agencies likely to become involved are informed of disengagement)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharge Phase</th>
<th>Within 2 weeks of review (where decision to discharge was made)</th>
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</thead>
<tbody>
<tr>
<td>Collaboratively plan and work towards a phased ending of formal therapy (part of this may lead to engagement in PD specific support groups and / or involving other agencies, e.g. transition group)</td>
<td></td>
</tr>
<tr>
<td>Collaboratively agree a crisis / health and wellbeing plan which may include how and when to (re)access services if required into the future</td>
<td></td>
</tr>
<tr>
<td>Early engagement and joint discharge planning undertaken with primary care team (consider offering a consultative service during the phased transition from secondary care)</td>
<td></td>
</tr>
<tr>
<td>Written feedback provided to service user, GP, referrer, carer (where appropriate) and any other professional network that will be remaining involved</td>
<td></td>
</tr>
<tr>
<td>Care episode closed down on electronic patient information system (RiO)</td>
<td></td>
</tr>
</tbody>
</table>

Implications for Psychological Services