WC3 CAMHS Screening for Paediatric Patients with Long Term Conditions

Scheme Name	WC3 CAMHS Screening for Paediatric Patients with Long Term Conditions
Eligible Providers	35 specialised children's providers (those receiving specialised children's top up).
Duration	April 2016 to March 2019.
Scheme Payment	CQUIN payment proportion [Locally Determined] should achieve payment of c. £30 for each additional patient targeted to receive SDQ mental health screening, An additional locally negotiated fixed sum CQUIN payment to cover the expected expansion of CAMHS liaison service to cover revealed need should be included. 2017/18 Target Value: Add locally 2018/19 Target Value: Add locally

Scheme Description

Increase in the number of paediatric patients on whom a mental health screen (using the SDQ Tool[1]) has been completed to a minimum of 30% for **4 long term condition areas chosen with commissioners.**

The aim is establish screening and provision of mental health services for specialised paediatric **inpatients** who have a chronic severely disabling medical condition e.g muscular dystrophy, renal failure. Long term Conditions which could be considered include:

- Renal
- Congenital heart
- Rheumatology
- Asthma (complex difficult to manage)
- Metabolic disorders
- Neurology/neurodisability (e.g. Epilepsy)
- Gynaecology
- Gastroenterology (IBS)

This is not an exhaustive list however services where a best practice tariff applies (eg: diabetes / cystic fibrosis) will not be permissible.

The SDQ is used as a Mental Health screening tool, see (from PHE):
http://www.chimat.org.uk/resource/item.aspx?RID=114105

The target payment is £30 for each additional patient to receive SDQ mental health screening:

[1] www.**sdq**info.com/

- The payment is set as £30 x the number of additional patients targeted to receive screening each year.
- Actual payment is then determined by the proportion of the targeted number who actually receives screening (capped at 100%).
- There is a minimum number of patients to be targeted: 30% of the patients in the selected conditions. For which the denominator: Number of admissions in the LTCs identified.

The scheme is designed to incentivise an increase in the screening practice. Therefore, it is necessary to calculate the proportion of patients in any LTC who were being screened in the baseline period (probably 2015/16 – depending upon data availability). The targeted number of patients for incentivisation is:

- In 2016/17, the number of patients ***in addition*** to those who would have been screened were baseline period percentage screening sustained into 2016/17;
- In 2017/18, it is number of patients ***in addition*** to those who would have been screened were the projected 2016/17 percentage screening sustained into 2017/18.
- In 2018/19, it is number of patients ***in addition*** to those who would have been screened were the projected 2017/18 percentage screening sustained into 2018/19.

EXAMPLE:

- A provider expects the following admissions per year for paediatric patients:
  - Renal 1000
  - Congenital heart 1250
  - Asthma 800
  - Neurology 600
- In the baseline year, 10% of renal patients had been screened, none of the others.
- The minimum target is 30%, but the commissioner proposes a target of 40%. Thus 1460 patients (40% of 3,650) are to be screened, but this is an increase of only 1360 as 100 of the renal patients would have been screened on existing practice. This gives a target payment of £40,800.

If in the outturn 1360 patients or more are screened, then the full payment is made. If less than 1360, then the payment is reduced pro rata.

Additional payment to address CAMHS need

A possible requirement in addressing the psychiatric conditions revealed by the SDQ is the creation or expansion of a CAMHS liaison service within the hospital to address inpatient needs, particularly for out of area patients.

Liaison services are one of the main focuses in the recent MH taskforce report and areas should be increasing capacity and providing a 24/7 response, however their focus is on adults and older people so would not readily provide a solution to increasing CAMHs capacity. (HRGs do allow for a higher payment where a patient has additional complexities and hospitals may code accordingly in these cases, but this will not work for all cases.) It is important to encourage acute providers to support MH issues just as we want MH providers to support physical health care needs.

Hence – an appropriate stretch element for this CQUIN may be to kick-start funding of a CAMHS liaison service – with the expectation that the costs would in future be included in overheads for relevant services (akin to anaesthetics), with costs recouped through reduced

length of stay etc.

The provider and commissioner should agree what expansion might be required, and funding can be agreed under the CQUIN scheme to cover costs plus 50%. Local triggers should be constructed to ensure that the service is successfully set up and is addressing need.

Measures & Payment Triggers

Increased number of paediatric patients on whom a mental health screen (e.g. SDQ Tool) has been completed to a minimum of 30% for the **4 long term condition areas chosen with commissioners for focus.**

On this basis, provider and commissioner should agree a target number of patients with the selected conditions to be screened, focused upon those thought at highest risk, with an agreed cap in overall numbers. The payment trigger is then the proportion of that number for whom screening takes place through the year.

The SDQ tool needs to be applied with sufficient expertise and followed through with referral and intervention.

However, SDQ can be scored online with little or no training.
See http://www.sdqinfo.com/

SDQ should be completed by parent or child (aged 11+, using self-rating sdq). The mostly likely approach is for the parent to complete the form and the paediatrician to assess it – using the web resource that is freely available. This will not be too onerous for paediatricians, anyone can put answers for questionnaire onto computer which will give results as the analysing software is freely available and minimal training is needed: it is self-explanatory.

Partial achievement rules

As per trigger

In Year Payment Phasing & Profiling

Payment will be made quarterly – according to achievement each quarter.

Rationale for inclusion

There is a growing evidence base that those with co-morbid mental health and physical health problems present more frequently to hospital, recover more slowly and have shortened life expectancy.

A survey completed in 2015 for NHS England by Lee et al demonstrated very patchy provision for CAMHS/psychiatry in paediatric hospitals nationally. The implication is that this high-cost vulnerable group of paediatric patients are not receiving an appropriate assessment or subsequent intervention and support and a target of 30% is therefore being applied.

This CQUIN will aim to incentivise paediatric hospitals to identify mental health problems and provide input for this group. The aim is to improve the quality of care and reducing health costs by shortening length of stay and reduce co-morbidity.

Cost of patients to acute services would ultimately go down if they addressed their emotional needs, with reduced recurring admission etc, for those with somatisation, asthma, better diabetic control, concordance with treatment, reduction in stress etc.

Data Sources, Frequency and responsibility for collection and reporting	
It is likely that providers will need to identify internal systems to identify the patient cohort and record the data. It is likely that specialist nurses would be used as a resource to identify patients and support data collection. Exploration nationally of a new code in HES would be advantageous. These patients are in-patients and will be admitted to the specialty code. For those patients in the LTC, the provider would need to utilise specialist nurse input to identify the patients.	
Baseline period/ date & Value	To be reported by the Provider for the selected cohorts of patients with LTC. Baseline is the proportion of such patients screened for using the SDQ tool in the most recent year for which data is available.
Final indicator period/date (on which payment is based) & Value	The number of patients above baseline proportion receiving screening to be reported by provider.
Final indicator reporting date	Month 12 Contract Flex reporting date as per contract.
CQUIN Exit Route *How will the change be sustained once the CQUIN indicator has been retired?*	As the savings will be long term and recurring (and the cost savings will be primarily with the acute provider) the scheme should be self-sustaining.

Supporting Guidance and References

The 2015 NHS England survey demonstrated variable provision of CAMHS/ Psychiatry to paediatric departments across England. All paediatric inpatients are suitable, with particular benefit for those with chronic/severely disabling health conditions.

The following is an extract from *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing (DH 2015):*

- 12% of young people live with a long-term condition (LTC) (Sawyer et al 2007)
- The presence of a chronic condition increases the risk of mental health problems from two-six times (Central Nervous System disorders such as epilepsy increase risk up to six- fold) (Parry-Langdon, 2008; Taylor, Heyman & Goodman 2003).
- 12.5% of children and young people have medically unexplained symptoms, one third of whom have anxiety or depression (Campo 2012). There is a significant overlap between children with LTC and medically unexplained symptoms, many children with long term conditions have symptoms that cannot be fully explained by physical disease.
- Having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50% and doubles the risk of coronary heart disease in adults.
- People with mental health problems such as schizophrenia or bipolar disorder die on average 16–25 years sooner than the general population.
- The Birmingham RAID study demonstrated a 4:1 cost benefit for investing in Adult Psychiatric Liaison services (in this study an investment of £1.5m resulted in a savings of £6m)

Evidence of efficiency as a screening tool: (from the sdqinfo website:)

‘Screening. In community samples, multi-informant SDQs can predict the presence of a psychiatric disorder with good specificity and moderate sensitivity (abstract1) (abstract2).’

The abstracts suggest that multi-source completion should be preferred if possible, but that ‘A "probable" SDQ prediction for any given disorder correctly identified 81-91% of the children who definitely had that clinical diagnosis. There were more false positives than false negatives, i.e. the SDQ categories were over-inclusive. The algorithm appears to be sufficiently accurate and robust to be of practical value in planning the assessment of new referrals to a child mental health service.’
See also: http://www.scie-socialcareonline.org.uk/screening-efficacy-of-the-child-behavior-checklist-and-strengths-and-difficulties-questionnaire-a-systematic-review/r/a1CG0000000GexPMAS