Mental Health Network NHS CONFEDERATION

Centre for Mental Health

Mental Health Economics Collaborative

Bringing care back home

Evaluating the New Care Models for children and young people's mental health

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Contents

Acknowledgements

Centre for Mental Health is highly appreciative to all those involved in this report. The six pilot sites, steering groups and management boards; NHS England; and the Mental Health Economics Collaborative founded by Mental Health Network, part of NHS Confederation, who co-funded this report.

This report refers to New Care Models as they were known at the time of writing. From April 2020, they will instead be known as Provider Collaboratives.

About NHS England and Provider Collaboratives

NHS England leads the national health service in England. From April 2020 Provider Collaboratives commence, with Lead Providers assuming the commissioning role for a local Provider Collaborative. Complete national coverage is planned to be in place by April 2021. This requires a shift in processes, behaviours and culture, with regional NHSE commissioners taking a more strategic commissioning role and Provider Collaboratives undertaking the operational commissioning tasks with a renewed clinical focus.

The introduction of Provider Collaboratives will create a change in approach to commissioning specialised mental health, learning disability and autism services from both NHS providers and the Independent Sector. They will introduce more local commissioning, whilst maintaining a national overview of the sector, in terms of sustainability, quality and price.

The Lead Provider's role will involve understanding their local population and empowering local clinicians and Experts by Experience to design improved pathways of care. The Lead Provider will sub-contract other providers, manage contracts, assure the quality of services and lead the necessary reporting regionally and nationally to NHS England and Improvement.

About the Mental Health Economics Collaborative

The Mental Health Economics Collaborative (MHEC) is an exciting partnership between the NHS Confederation Mental Health Network, Centre for Mental Health and the London School of Economics Personal Social Services Research Unit.

MHEC aims to support the identification and spread of innovative approaches to delivering high quality, efficient mental health services. It highlights the importance of economic measures of success and provides the opportunity to test, prove and celebrate promising service models.

Executive summary

The NHS England New Care Models (NCM) Programme aims to improve outcomes for people in acute care. Six NCM Pilot Sites have focused on children and young people who are being treated for their mental health out-of-area, often long distances from home. Their aim is to prevent children from having to travel long distances to hospital by providing the necessary care and support locally.

'Our aim is that every child in our area receives the best mental health treatment close to home, where loved ones, practitioners and physicians are right there with them, keeping them on their road to recovery.' (Northumberland, Tyne and Wear NHS Foundation Trust).

This economic evaluation describes the quantitative changes which have been observed in these six pilot sites, including changes in out-of-area bed use, length of stay and distance from home. It focuses on the financial impact of investing in new, community-based services which offer treatment locally in place of out-of-area beds.

By investing in local services, each of the sites has achieved reductions in overall spending at the same time as a significant expansion of community-based care with comprehensive offers of 24 hour availability of highly skilled teams and innovative models of support.

Each area identified small numbers of young people whose treatment was comparatively expensive. This ranged from 22-49 people with annual treatment costs totalling £7.5m and £13.4m (or £187,000-£514,000 per person).

The NCM programme enabled areas to make significant changes in expenditure. They achieved overall reductions of between £1.1m and £4.1m for 2017/18; a total of £15.3m that can be reinvested in local services.

This change was driven by reductions in Out-of-Area Bed Days and Lengths of Stay in hospital, by varying degrees between the six areas.

There was a correlation between the percentage of budgets invested in alternatives to acute care and the reduction in overall expenditure. In other words, the larger the investment, the greater the reduction in expenditure observed.

The sites do not operate in a vacuum and there are other factors, other funding streams and other programmes which will also have had an impact on these statistics. Nonetheless, the findings within the pilot sites are encouragingly consistent that the NCM approach is making a difference.

The secondary aim of this report is to describe the qualitative learning from staff teams. It charts the sites' journey from pioneers, surviving the slings and arrows of positive risk-taking, culture change and new commissioning structures, to being the 'new normal' with greatly enhanced offers of community-based, local treatment services. Key learning points from this process include:

- The importance of giving primacy to patient outcomes and clinical judgement over financial pressures
- The benefit of strong and persistent commitment from local leaders
- The need to establish 'principles, not rules' that encourage challenge, flexibility and innovation
- Change is risky; it benefits from highly experienced, reputable staff who 'hold' that risk and its accompanying responsibility.

It is important that the principles of the pilot NCM programme are maintained as it expands nationwide. The programme has the potential to benefit children, young people and families in every part of the country if it is implemented in this form.

1. Policy context

Approximately 4,500 young people were admitted to specialist child and adolescent mental health (CAMHS) inpatient units in England and Wales in 2016/17. This number is double that of 10 years earlier (Ougrin, Dennis, *et al.*, 2018).

In 2013, NHS England became the commissioner of Tier 4[1] (inpatient) services, while Tier 3 (community) services remained the budget responsibility of newly formed clinical commissioning groups (CCGs). This created a framework where relatively similar health care services were being paid for by two different organisations. This, in turn, financially incentivised local commissioners to change their behaviour: from the perspective of local commissioners, Tier 4 provision had become a zero-cost item, while Tier 3 remained as a local cost. The logical response, from a financial perspective, is for a CCG to substitute their Tier 3 provision with 'free' Tier 4 provision. And whilst financial incentives are not the sole driver, increasing use of Tier 4 services became a financially rational decision (O'Shea, 2019).

NHS England recognised this problem and in the Five-Year Forward View for Mental Health set out plans for a New Care Model (NCM) for Tier 4 CAMHS and some adult inpatient services where budgets were delegated to local systems with Lead Providers taking responsibility. An aim of this programme, which was expanded in the NHS Long Term Plan into the renamed 'provider collaboratives', was to end the perverse incentive for local systems to shift costs to NHS England.

NHS England launched the NCM programme in 2016 and it was open and clear about its objectives:

'In recent years, there has been an increase in the number of mentally ill young people and adults being sent for treatment to units many miles from their homes. This practice, known as out-of-area placements, can make visiting very difficult for local clinicians and friends and family. This in turn can affect a person's recovery and lead to increased lengths of stay. Furthermore, this trend has increased expenditure and put additional strain on mental health commissioning budgets.' (Call for applications, Phase 1 to Chief executives of NHS and independent sector mental health providers, May 2016.)

It was also clear about the solution.

'Over the last few decades, mental health providers and commissioners have led a revolution in the way services are delivered. Within the career lifetimes of some mental health professionals, treatment and care has moved from an institutional setting to one in which most service users now access community-based services through a network of local providers. Unfortunately, many of those who require tertiary mental health services are still experiencing delays in accessing NHS funded services and, increasingly, are being sent long distances from home for their treatment.

'The New Care Model programme is an opportunity for mental health providers and commissioners to demonstrate their talent for innovation and ability to transform services for the benefit of service users and their families.

[1]It is noted that the language used to describe these services no longer commonly refers to 'Tiers'. However, this report uses agreed terms of the time for consistency, particularly when quoting directly from NHS England documents from 2016-19.

'The programme aims to put local clinicians and managers in charge of both managing the budgets and providing high quality treatment. Currently, secondary mental health providers and local clinical commissioning groups (CCGs) have no responsibility or control over expenditure on tertiary services. This programme will give them the incentive and responsibility to put in place new models of care which strengthen patient pathways; reduce the length of in-patient stays, improve the community care and support available locally; and eliminate clinically unnecessary out of area placements.' (Call for applications, Phase 1 to Chief executives of NHS and independent sector mental health providers, May 2016.)

The programme – which also includes adult secure and adult eating disorder services – works (at the time of the evaluation) with six pilot sites that are seeking to reduce use of acute beds for children and young people. The ambition is that NHS England can, by working closely with the sites, learn what is required to roll out the programme nationally in order to bring care closer to home and invest in new community services.

2. The Pilots: A summary

Six NCM pilots are considered within this evaluation report. Two areas began in 2016 (Phase 1) and four more in 2017 (Phase 2). A seventh pilot site in Kent, Surrey and Sussex is due to begin soon. Four of the sites involve multiple NHS partner organisations and each has a Lead Provider (see table 1).

The pilots work with a variety of patient groups as determined by local need and contained within their original business plans. For example, young people placed in hospitals because of severe learning disabilities or autism are included in Newcastle, Tyneside and Wear, while Hertfordshire encompasses community as well as inpatient service users (Table 2). Whilst this complicates comparative analysis, it reflects the ability of the NCM programme to work flexibly.

Table 1: Area, lead and partners

Name	Lead	Formal partners
North East and North Yorkshire – Phase 1	Tees, Esk and Wear Valleys NHS FT	n/a
North West London – Phase 1	West London Mental Health NHS Trust	Central and North West London NHS FT; NHS England North West London Team; Priory Group
Northumberland, Tyne and Wear – Phase 2	Northumberland Tyne and Wear NHS FT	Tees, Esk and Wear Valleys NHS FT; West Park Hospital, Darlington
West Yorkshire – Phase 2	Leeds Community Healthcare NHS Trust	Bradford District Care NHS FT; South West Yorkshire Partnership NHS FT; Leeds and York Partnership NHS Trust
South London – Phase 2	South London and Maudsley NHS FT	Oxleas NHS FT; South West London and St George's NHS Trust; NHS London Region
Hertfordshire – Phase 2	Hertfordshire Partnership University FT	n/a

Table 2: Area, client groups and cohort size

Name	Client group	Number of young people in cohort, April 2018
North East and North Yorkshire	General Adolescent including children and young people with learning disabilities and/or autism	36
North West London	Acute Adolescent Inpatient, Eating Disorder Inpatient	49
Northumberland, Tyne and Wear	General Adolescent, children and young people with Learning Disability and/or Autism	26
West Yorkshire	Tier 4 Adolescent services	22
South London	General Adolescent, Eating Disorder	44
Hertfordshire	Tier 3 and Tier 4 pathway	40

All the pilots provide alternatives to acute care beds, with varying service offers depending on need and local facilities. Table 3 summarises the main components of each area's model.

The pilot sites are all different and they began with different challenges – for example how many acute beds they had locally, geographical size, existing practice and budgets. Consequently, the aim of this report is to decipher the common learning between the areas and the programme as a whole, in order to determine which elements are core to this work, irrespective of differences in implementation. It is independent of other evaluations of New Care Models.

Table 3: Area and clinical models

Name	Clinical models and strategies
North East and North Yorkshire	Intensive home treatment Crisis care teams Reconfigure existing Tier 4 facilities
North West London	Increase acute beds in area Clinical support teams at Emergency Departments Crisis intervention and home support teams Intensive community support Out of hours crisis response
Northumberland, Tyne and Wear	Reconfigure existing acute bed estate Care navigators Out-of-hours Emergency Department liaison
West Yorkshire	Care navigators 24/7 crisis care service Intensive outreach programmes
South London	Use existing acute beds for local children and young people Crisis support line Home assessments and support Dialectical Behaviour Therapy New treatment pathways for all CAMHS Tier 4 groups
Hertfordshire	72-hour admissions using in-area acute beds Dialectical Behaviour Therapy Crisis and home treatment service

3. Literature review

The purpose of this literature review is to evaluate the current evidence base for community-based care, especially in comparison to inpatient services, for children and young people with mental health needs. Of particular interest are outcomes such as clinical effectiveness, patient satisfaction and costs. In considering the evidence, the most weight will be given to findings from recent (post-2000), UK-based randomised controlled trials (RCTs) comparing community-based treatments to inpatient care.

Inpatient care

Inpatient mental health care for children and adolescents has been shown to be associated with clinically meaningful improvements (Green *et al.*, 2007; Lee *et al.*, 2018; Hayes *et al.*, 2018). It can also be valued by families and young people when it provides:

- Supportive relationships
- Feeling understood by others
- Feelings of safety
- Having a shared experience with other inpatients
- Reliable structure and routine
- Time out from their personal life
- Respite for families (Moses, 2011; Gill, Butler & Pistrang, 2016; Reavey *et al.*, 2017; Dubicka *et al.*, 2019).

However, research has also identified drawbacks to inpatient care. These include:

- Loss of support from the child's local environment
- Presence of adverse effects within the inpatient environment and from repeated admissions
- Effects of admission on family life
- Disruption of relationships, education and sense of self
- Loss of autonomy
- Greater potential for stigma
- Increased rates of readmission
- Difficulty readjusting to 'normal' life after discharge

(Green *et al.*, 2007; Tulloch, 2008; Kurtz, 2009; Moses, 2011; Babalola *et al.*, 2014; NHS England, 2014; Edwards *et al.*, 2015; Gill *et al.*, 2016; Stanton, Lahdenperä & Braun, 2017; Reavey *et al.*, 2017; NHS, 2018; Dubicka *et al.*, 2019).

These drawbacks multiply when the system is under-resourced. This situation gives rise to out-of-area placements, placements in adult facilities or paediatric acute wards, delayed admission/discharge and the now rare (and unlawful) use of police cells as 'places of safety' (Frith, 2017; Dubicka *et al.*, 2019). This suboptimal care is associated with higher costs and poorer outcomes (Worrall *et al.*, 2004; Dubicka *et al.*, 2019).

Therefore, although inpatient care has proven benefits, it also has drawbacks, especially at times of funding pressures, workforce shortages and bed shortages. Although there are some young people for whom, owing to the nature of their needs, an admission will be the best option, the overall recommendation that emerges from the research is that inpatient care should be the last resort (NHS England, 2014; Frith, 2017; Dubicka *et al.*, 2019).

Community-based care

For the purposes of this review, community-based care refers to mental health treatment that partially or fully replaces an inpatient admission. Some of the most widely researched community-based models of care are assertive community treatment, intensive home-based treatment, multisystemic therapy and supported discharge services. While these are distinct models of care, the current evidence base is not sufficient to allow a more fine-grained analysis of their relative pros and cons.

Clinical outcomes

Trials of community-based treatments for young people, both in the UK and abroad, have reported good clinical outcomes (Grimes *et al.*, 2011; Rhiner *et al.*, 2011; Adrian & Smith, 2014; Ougrin *et al.*, 2014; Tan & Fajardo, 2017; King *et al.*, 2019). Moreover, although there is some variation in the results from RCTs, overall the findings indicate that these outcomes are comparable to those of inpatient treatment (Boege, Copus & Schepker, 2014; Kwok, Yuan & Ougrin, 2016; Ougrin *et al.*, 2018). There is also some evidence that the clinical improvements associated with intensive community treatments are equally stable at follow-up as those associated with inpatient treatment, although further research is needed to establish this more firmly (Mattejat *et al.*, 2001; Schmidt *et al.*, 2006).

Views of patients, families and carers

Research that has explored young people's views about their mental health care have reported preferences for greater accessibility of services, for more help with self-reliance to manage their health, and for shorter inpatient stays (although, for this, the evidence is mixed) (NHS England, n.d.; Plaistow *et al.*, 2013; Reavey *et al.*, 2017). While these preferences are heavily based on interviews with adolescents, as opposed to children, they suggest that community-based care – or, where an inpatient admission is necessary, a supported discharge service – would be acceptable to many patients and carers. And, where patients' and carers' experiences have been studied, community-based care has generally met with good levels of acceptance and satisfaction (Boege, Copus & Schepker, 2014; Ougrin *et al.*, 2014; Kwok, Yuan & Ougrin, 2016).

However, there are findings that pull in a different direction: for example, Salamone-Violi, Chur-Hansen and Winefield (2017) found that carers perceived inpatient units as the most desirable and appropriate form of care for their child. Further research is needed to establish in which circumstances and for which young people community-based care is the preferred option, and whether there are differences between the treatment preferences of young people and their parents.

Hospital use

By definition, community-based care replaces (in full or in part) a hospital admission; therefore it is always initially associated with fewer occupied bed days. More meaningful is the fact that this reduction in bed usage appears to be sustained at follow-up. Several controlled trials comparing treatment as usual to alternatives to inpatient treatment have found that young people who received community-based care had significantly lower hospital use (Boege, Copus & Schepker, 2014; Kwok, Yuan & Ougrin, 2016; Ougrin *et al.*, 2018). However, not all evidence supports this conclusion: a review of six studies looking specifically at the impact of community-based care on emergency service use found the evidence to be inconclusive (Kirkland, Soleimani & Newton, 2018).

In these studies, the follow-up period at which hospital use was measured was short (typically 6-12 months). Longer-term RCT data is lacking; however, the results of one service evaluation with a 10-year follow-up does support the conclusion that community-based care is associated with lower hospital use (Adrian & Smith, 2014).

At least one study has found that, although community-based care is associated with lower hospital use, it is also associated with higher readmission rates (Duffy & Skeldon, 2012). This was not a controlled trial and it may be relevant that it concerned a newly established service which may have been experiencing teething problems. However, it is a reminder that there is more than one path to lower hospital use: one is sustained clinical improvement; the other is discharging patients too early, the longer term consequences of which may be harmful. Therefore, in interpreting hospital use data, it is important to ensure that shorter admissions are not providing a quick fix at the expense of longer term outcomes.

Costs

Several studies have attempted to quantify the costs of community-based care. The methodological limitations and heterogeneous measures of early studies (pre-2000) make it difficult to draw general conclusions (Burns *et al.*, 2001; Foster & Conner, 2005). More recent studies have attempted to overcome these limitations (for example, Foster & Conner, 2005; Lamb, 2009; Grimes *et al.*, 2011; Hamilton *et al.*, 2017). There is still a paucity of commensurable, high-quality evidence relating to the cost-effectiveness of community-based care. However, the evidence that does exist appears to support the conclusion that community-based care is cost-effective and may even represent savings compared to inpatient care (Sheidow *et al.*, 2005; Grimes *et al.*, 2011; Rehberg, Furtstenau & Rhiner, 2011; Kwok *et al.*, 2016; Tan and Fajardo, 2017; Ougrin *et al.*, 2018).

In interpreting cost data, it may be necessary to apply the caveat outlined in the section on hospital use: namely that there is more than one path to savings. One is providing high-quality care in a way that is more economically efficient; another is to withhold necessary care or to provide (cheaper) substandard care. As Hamilton *et al.* (2017) note, cost-saving is not necessarily the same as cost-effectiveness. Again, to guard against a false economy in which savings are made at the expense of patients' quality of care, it is important to ensure cost data are set against corresponding clinical and social outcomes.

Clinical frameworks

The previous sections discussed community-based care as an alternative to inpatient care. However, a recent review of services for adolescents and young adults with severe, persistent and complex mental illness has drawn attention to the fact that an optimal model may be one that flexibly combines inpatient and community-based care (Woody *et al.*, 2019).

The review concludes that:

"[n]o single service type was seen as sufficient to deliver the broad range of interventions and services required to meet the needs of this target group. The available evidence suggests effective community care (assertive community treatment, wraparound services and multisystemic therapy) integrated with inpatient treatment of short duration is the optimal clinical framework."

And it recommends that future research "examine the effectiveness of comprehensive clinical frameworks", exploring how different services combine synergistically, instead of considering them in competition or in isolation from one another. The importance of taking a 'joined-up approach' has been recognised elsewhere and is likely to be a key feature of any effective clinical framework for children and young people with mental health needs (Department of Health, 2015; Dubicka *et al.*, 2019).

Conclusion

Research demonstrates that community-based treatment performs similarly to inpatient care across a range of meaningful measures. Moreover, some studies indicate that community-based treatment may outperform inpatient care for certain demographics in certain contexts, but additional research is needed to establish these findings more firmly. On the strength of the current evidence, it is possible to conclude that both community-based treatment and inpatient care can be effective interventions for young people with mental health difficulties.

However, logistically, there are greater barriers to providing timely, appropriate and cost-effective inpatient care than to community-based treatment. Inpatient care requires the right number of beds of the right specialisation to be available in the right places at the right time to meet demand; and, when this isn't the case, higher costs and poorer clinical outcomes can result. Community-based treatment, on the other hand, can be administered more flexibly.

Therefore, even if the two models perform to a similar standard in optimal conditions, it is possible to speculate that the quality of inpatient care will be more adversely affected by suboptimal conditions.

Understanding how well the different models perform in suboptimal conditions may be particularly important, given the challenges facing children and young people's mental health provision in the UK. Pressures on local funding, workforce shortages and the logistical difficulties of changing the location of beds to meet demand are factors that commissioners are obliged to contend with when choosing between services. In the case of inpatient care, this has led to expensive and often overly long out-of-area placements and to young people being admitted to facilities unsuited to their age or needs. If community-based treatment is less adversely affected by such challenges than inpatient care, this may count strongly in its favour.

Community-based care is also relatively free from some of the drawbacks of inpatient care, such as disruption to the lives and relationships of young people and their families, and potential negative effects of the inpatient environment. However, it does present problems of its own, and these may be particularly marked for patients who, for example, lack family support, or those who are severely unwell. More clearly delineating the relative advantages and disadvantages of different models of care, and understanding how these interact with the needs of different demographics, is a job for future research.

Inpatient care will always be the most suitable option for some young people, owing to the nature of their needs. But, for others, the evidence indicates that admission to an inpatient unit could be fully or partially replaced with community-based treatment, without any detriment to meaningful outcomes – and even, potentially, with greater clinical improvement and reduced cost. This is especially likely to be true when community-based treatment replaces a suboptimal inpatient admission, such as an out-of-area placement. Moreover, at a time when CAMHS are seeing young people with increasingly complex presentations, it is especially important that the limited number of beds are available for those who most urgently need them. However, there is insufficient evidence to conclude which service, or combination of services, will be most appropriate for which young people.

It appears likely that the optimum model of care will be a clinical framework that has a strong emphasis on community-based treatment, while also including inpatient care, which can be flexibly adapted to meet the needs of different demographics. But the details of this framework – for example, which model of community-based treatment is most effective and which young people stand to benefit most from which models of care – cannot be established on the strength of the evidence that is currently available. More research is needed before firm conclusions can be drawn.

4. Quantitative findings

This section describes the main outcomes observed for the six pilot sites. It contains 10 graphs on all aspects of the pilots' work. These are displayed as column graphs with one set of columns per pilot. Our focus in this report is trend data – what happens over time. For this reason, the monthly statistics are shown so that by looking left-to-right for each area it is clear to see whether numbers are rising, falling or showing no pattern. In each case, the leftmost column corresponds to the earliest data set available for each pilot (the date of the first month varies from site to site owing to the different start dates) and the rightmost column for all pilots is March 2019.

The data for the Phase One pilots (North East and North Yorkshire, and North West London) begins six months after their inception (April 2017) due to changes in data collection at a national level. This means that some of the initial effects are not described here and this may lead to an underestimation of the impact of the sites' work given the patterns observed in the remaining four areas where improvements are rapidly observed. Data for the remaining sites are presented from the month of inception.

There are several limiting factors about the data presented:

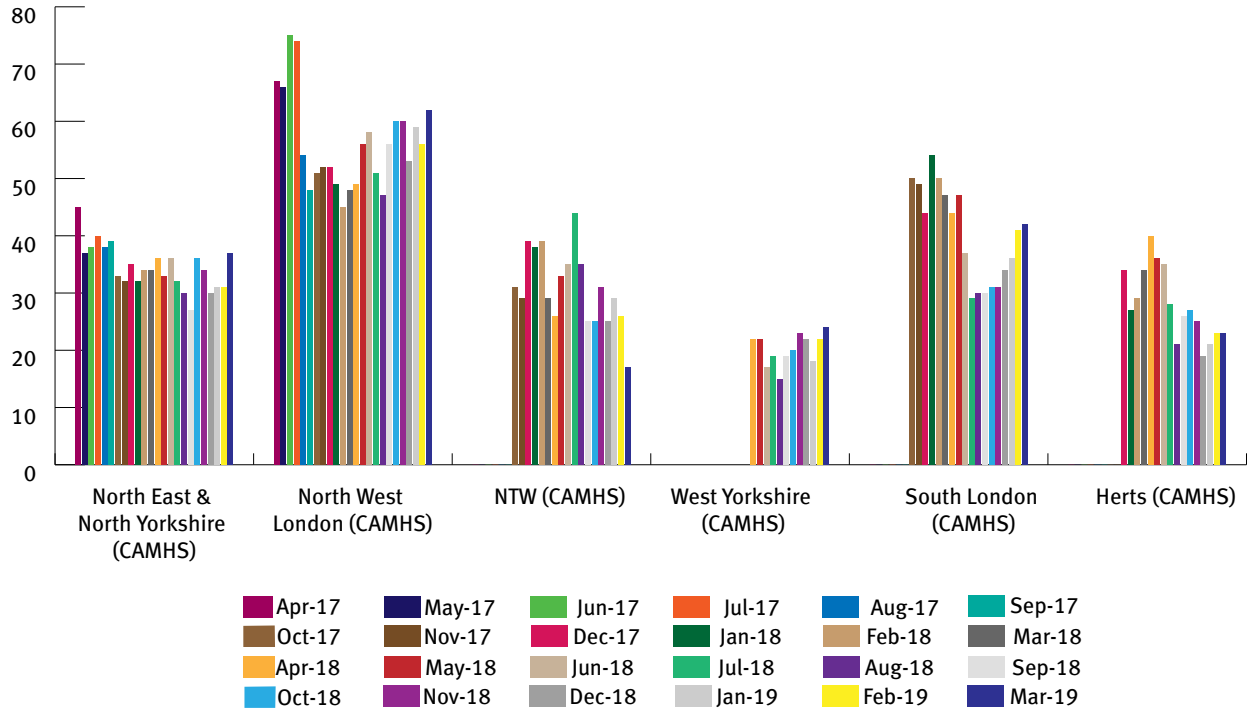
- The samples are small (approx. 35 children and young people per area)
- The areas are implementing different responses to acute bed use
- External factors, such as changes to acute beds within each area, will impact on outcomes
- This is not a randomised controlled trial.

However, whilst this restricts the concrete conclusions that can be drawn from the data alone, the qualitative data provides a narrative to accompany the results and what those working directly in the sites feel is driving any changes observed.

Data Analysis

Cohort size: The number of children and young people in each cohort is relatively small. In April 2018, there were 217 young people in the six-area cohort (range: 22-49 people). In relation to population size, the areas are focusing on less than 0.005% of the youth population.

Figure 1: Number in cohort



Progress – Key indicators

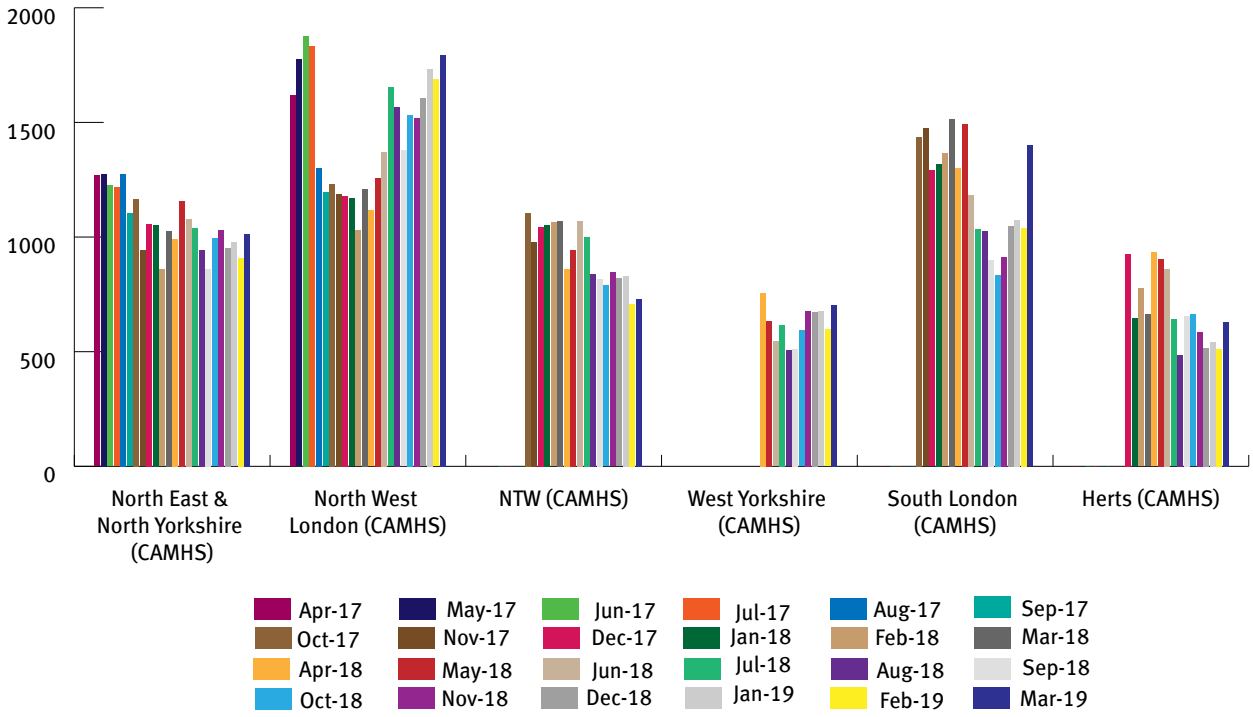
Occupied bed days

A key aim of the programme is to reduce the number of occupied bed days (OBDs) whilst improving clinical outcomes for young people. There are several factors which complicate the analysis of this data, including seasonal variations in admission and discharge rates, and changes to the cohort size. For example, North West London increased its cohort size in 2018 which has driven the increase in bed days. The other pilots show a general decline in bed days over time and all agreed that there were two primary reasons for this:

1) A focus on the number of young people in acute beds. Even in the absence of additional community services, simply focusing on this cohort and questioning when they could be discharged led to significant falls in occupied bed days. All sites have experienced fluctuations in OBD rates and suggest that the antidote has been a renewed focus on mapping where children are and working with clinical teams to ensure that if patients can be discharged from acute beds, or moved to one in-area, then they are. The gains from this approach were predominately at the beginning of the pilot programmes when the focus was new.

2) The impact of additional community services, such as weekend and evening support, has been seen later in the pilots' development. Their design and implementation took several months and so the corresponding impact arrived later too.

Figure 2: Occupied bed days



Average length of stay

The data demonstrate the differences between pilots in how reductions in acute care beds have been achieved (see figure 3). In North West London, length of stay has been the key driver in reductions of OBDs seen in the first half of their data. This has been partially reversed in the second dataset by an increase in cohort size. This is in stark contrast to South London, which had comparatively low durations to start with, and where a drop in patient numbers has driven further reductions in OBDs. There is a general trend of reduction in length of stay across the pilots, with the exception of West Yorkshire, where an increase has been observed.

Distance

Average distance from home data for all patients in the cohort show relatively small improvements (see figure 4). This is mainly due to the median distance being used as the measure, rather than the mean. Again, there is a repeat pattern of larger falls in the initial phases, followed by a less predictable pattern over the longer-term.

Figure 3: Average length of stay in days

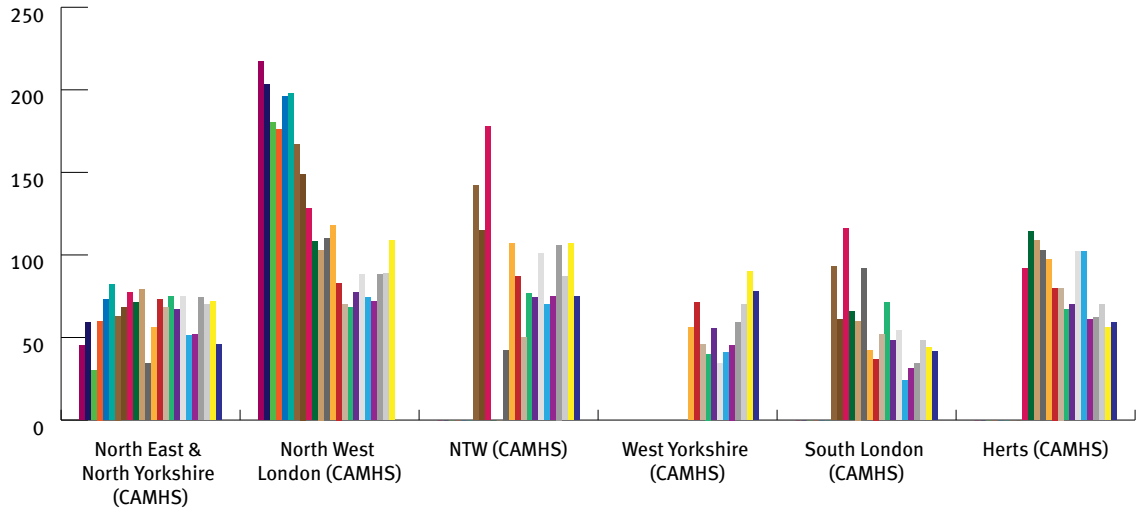
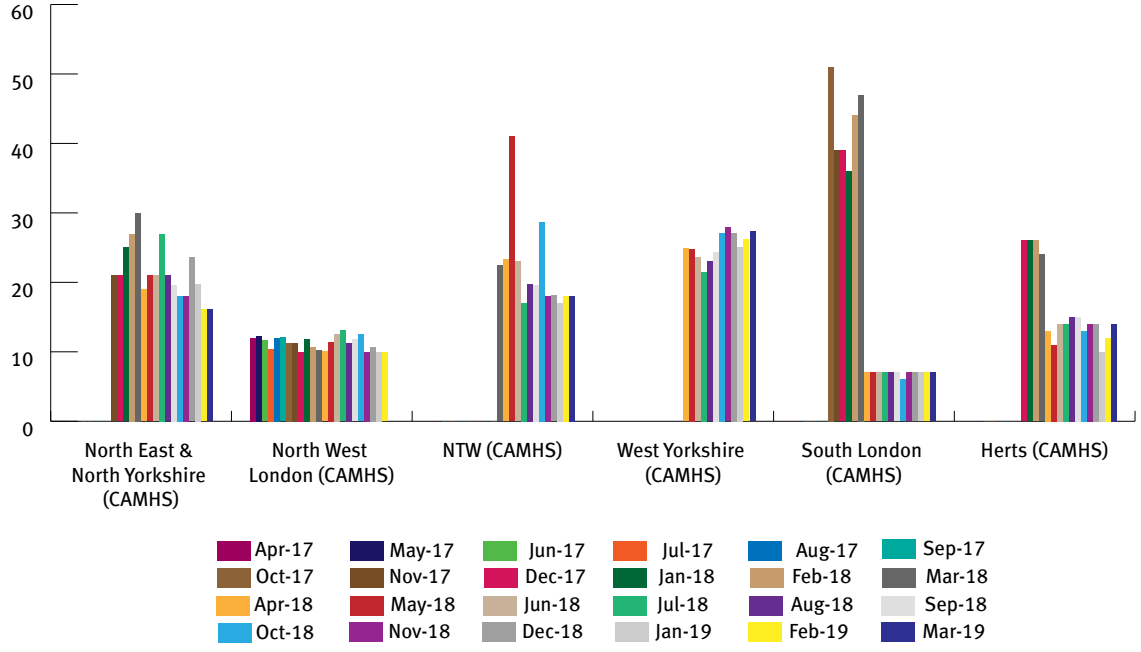


Figure 4: Distance from home in miles



Out-of-area placements

This is a key variable. The two primary drivers are:

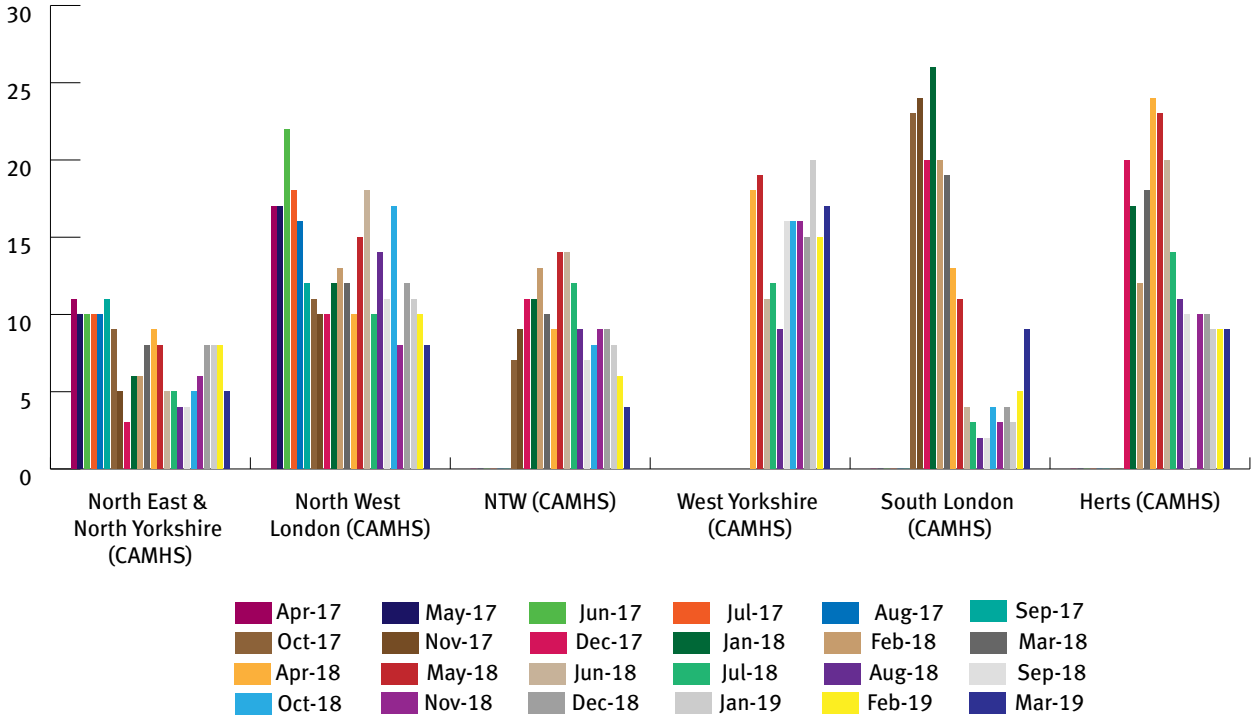
- The number of acute beds within each area that patients can be admitted or transferred back to
- The ability of community support to enable patients to be treated at home.

North West London had no acute beds and West Yorkshire had very few given the size of its cohort. Clearly, in cases such as these, capacity is a restricting factor, and whilst there are some creative solutions, the number of beds within an area will have an impact on the number of out-of-area placements.

Hertfordshire has used three-day admissions followed by transfer back into the community with clinical support. This short burst of intensive support means that they can increase the number of patients using their beds because average length of stay has fallen, which in turn leads to less demand for beds elsewhere.

In South London, there has been a significant fall in patients going out-of-area. Initially, this was the result of simply focusing on where children and young people were being treated and assertively repatriating those who could be moved to provision nearer to home. South London has the capacity to do this, with 47 in-area beds (compared to West Yorkshire's eight).

Figure 5: Number of out-of-area patients



Number of out-of-area bed days

Out-of-area bed days follow a similar pattern (see figure 6). These data are important because, if someone needs to receive specialist treatment that is only available outside a pilot site, then clearly this is a correct clinical decision. However, ensuring that a patient is out-of-area for the optimal (shortest) time before coming back to local provision is a key goal for each of the sites.

All areas have shown a fall in bed days, although for sites such as West Yorkshire, the length of data capture is short and a further year will be more revealing. Large falls in bed days are particularly striking in South London (769 days in Oct 2017, 70 days in Feb 2019) and Hertfordshire (611 days in Dec 2017, 225 in Feb 2019).

Out-of-area bed days as a proportion of the total

The percentage change in children staying out-of-area as a proportion of total bed days falls over time in five of the pilots, with particularly strong reductions in South London and Hertfordshire. Staff we spoke to at the pilot sites said this had been facilitated by the ability of an area to use local beds as alternatives to out-of-area care. Where this was not possible – either because of total bed numbers, or a lack of some specialist provision, such as a psychiatric intensive care unit (PICU) – the challenge was greater. North East and North Yorkshire began with 28% of all OBDs being out-of-area, achieved a low of 11% by December 2017, and finished March 2019 with 19%. South London began with 54% in October 2017, achieved a low of 7% across several months and finished March 2019 with 17%. West Yorkshire has seen a rise in the percentage of out-of-area bed days which it ascribes to having limited acute beds within area.

The importance of out-of-area percentages is that, as would be expected, all pilots said it was far easier to create a community package of care once someone was in a local bed than hundreds of miles away. The pilots compare favourably to the national average for non-NCM sites where 50% are out-of-area and that ratio has been static (Niche, 2019).

Figure 6: Number of out-of-area bed days

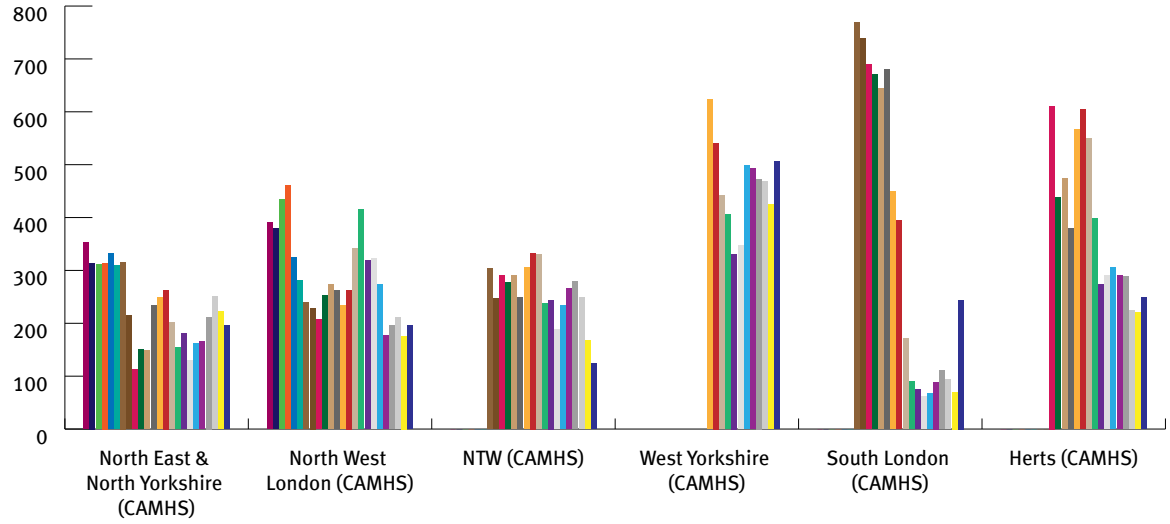
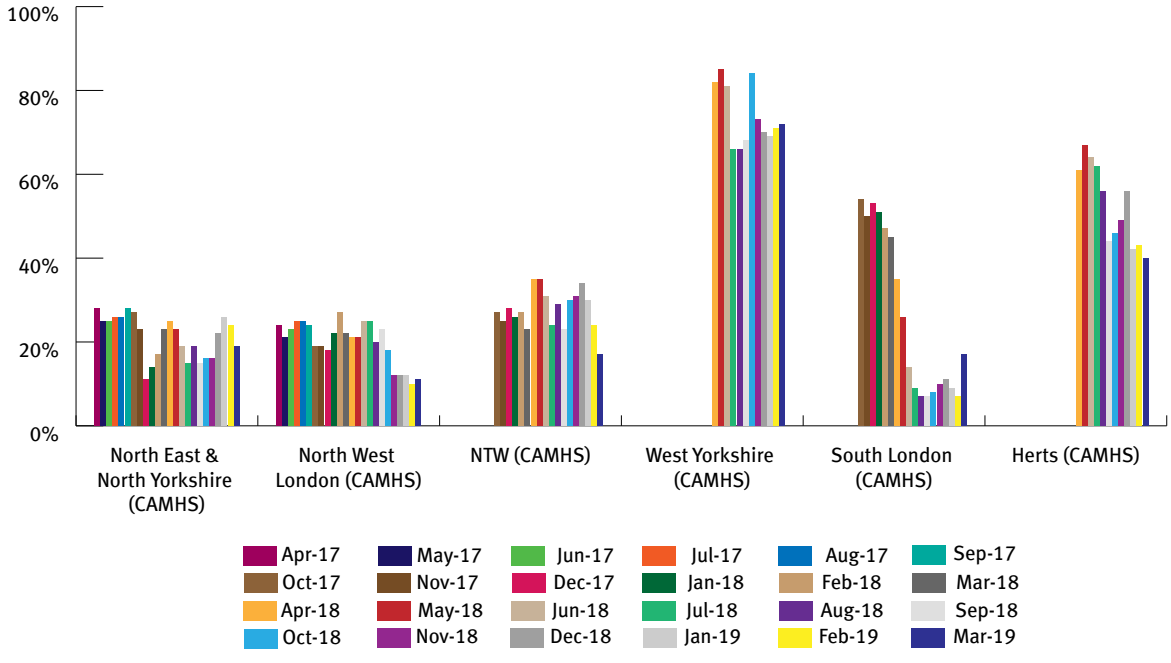


Figure 7: Out-of-area bed days as a percentage of occupied bed days



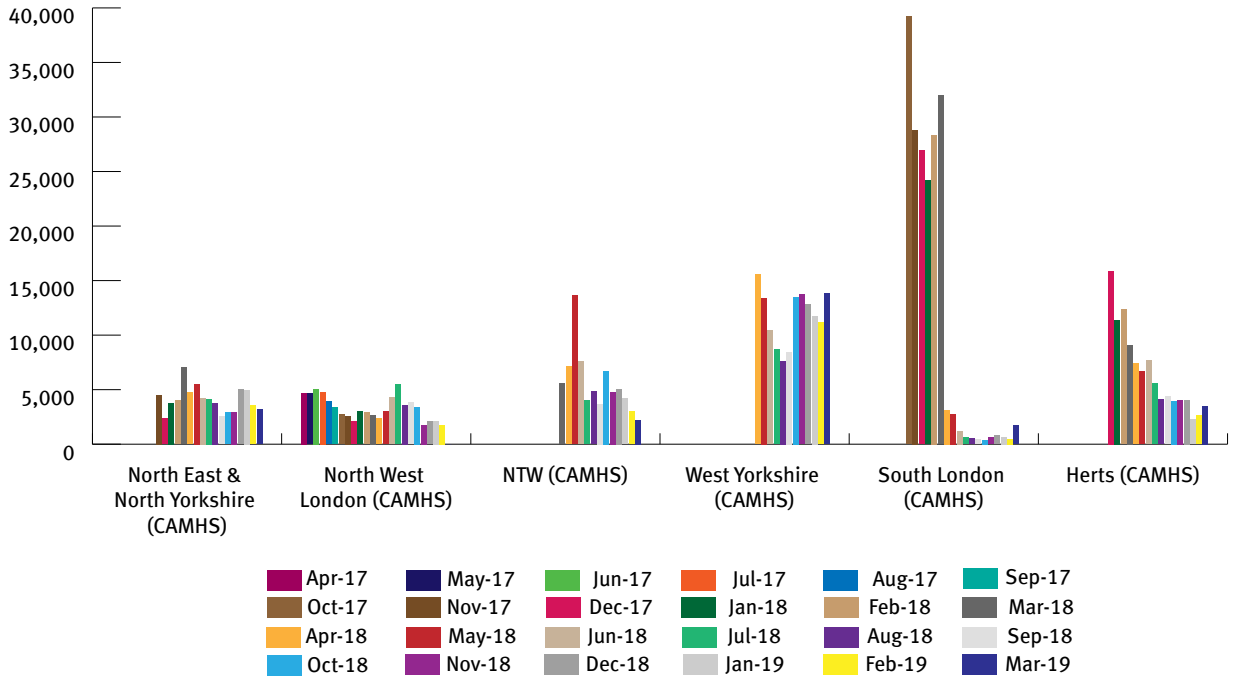
Distance x number of out-of-area occupied bed days

Multiplying the distance from home by out-of-area occupied bed days combines the most adverse effects of out-of-area placements: how far away someone is, and for how long. This magnifies the scale of both in order to magnify the scale of difference between pilot areas and the change over time. Clearly South London has made the most gains, but it also started from the most challenging position. The graph shows that it had not only high numbers of out-of-area bed days, but that the distances from home were large. Areas such as North West London and Hertfordshire had comparable proportions of people out-of-area but the average length of stay was much shorter.

Summary

Overall, the pilots have made good progress in reducing bed days, out-of-area numbers and distance from home. There are variances in the rate of change, with areas such as South London and Hertfordshire making the most sustained gains. West Yorkshire's rate of change is the most variable of the sites across the outcomes. The reasons for differences in outcomes are discussed in Chapters 5 and 6.

Figure 8: Distance from home in miles x out-of-area occupied bed days



5. Financial Data

The financial data for NCMs is comprehensive. This chapter summarises the key information and findings. As two pilot sites (North East & North Yorkshire and North West London) began earlier than the other four, this report does not capture earlier expenditure changes.

Expenditure

The expenditure on services by pilot areas ranges from £7.5m to £13.3m in 2018/19. Consequently, the baseline spending is, on average, between £187,000 and £513,000 per patient per year. These are significant sums of money and demonstrate the solid financial premise on which the programme is based, namely:

- To identify patients whose current treatment is very expensive
- To determine if this care leads to the best outcomes for them
- If not, provide new care and treatment
- Measure the outcomes and costs.

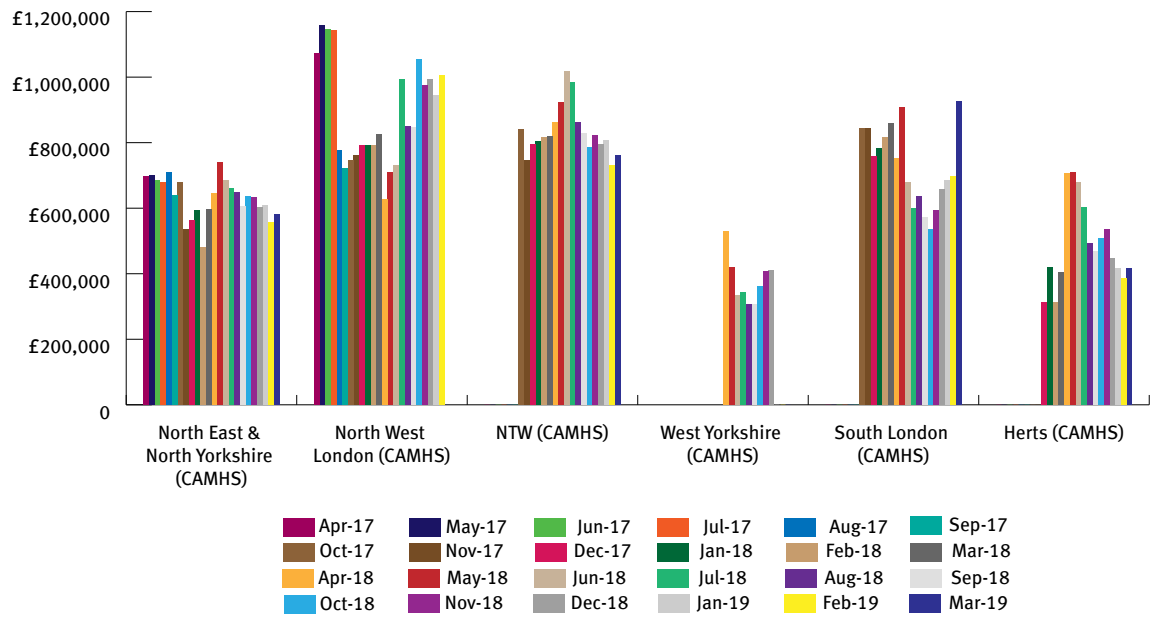
Area	Agreed budget	Cohort size in April 2018	Average cost per head
North East & North Yorkshire (CAMHS)	£9,897,418	36	£274,928
North West London (CAMHS)	£12,602,545	49	£257,195
Northumberland, Tyne and Wear (CAMHS)	£13,359,487	26	£513,826
West Yorkshire (CAMHS)	£7,571,514	22	£344,160
South London (CAMHS)	£12,331,452	44	£280,260
Herts (CAMHS)	£7,494,059	40	£187,351

Contracted services expenditure

This shows the money spent on acute care. Given the reduction in out-of-area occupied bed days, it would be expected to fall as consistently. However, the trend is much more variable, with both rises and falls in spending.

Pilots suggested that it was simply due to changes in the demand for admissions, which are also variable. The need for mental health care is neither static not linear (see chapter 3), with peaks in demand which lead to increased acute bed spending.

Figure 9: Contracted services expenditure



Investment in clinical services

This refers to alternatives to acute care and typically, per-month spending rises over time (see figure 10). This is expected because a key part of the pilot is to utilise the savings from acute care to create new support services that further lessen the demand for hospital beds. In all cases this takes time as areas have first to assess what services are required and how much they will cost.

Investment in governance

This is shown here for information (figure 11). Each pilot measures the spend on governance in a different way: for example, some include the full costs of everyone's time; others see governance as part of people's jobs and therefore not an additional cost. These differences make it difficult to make meaningful comparisons between the investment figures of different pilot sites.

Figure 10: Investment in clinical services

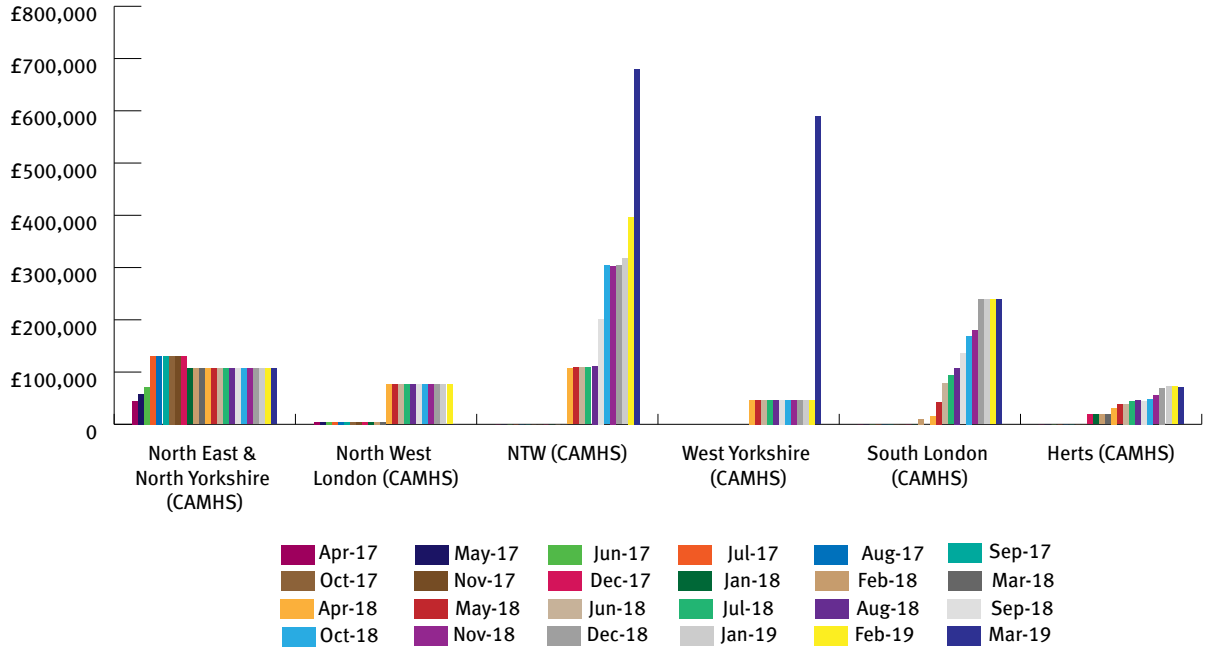
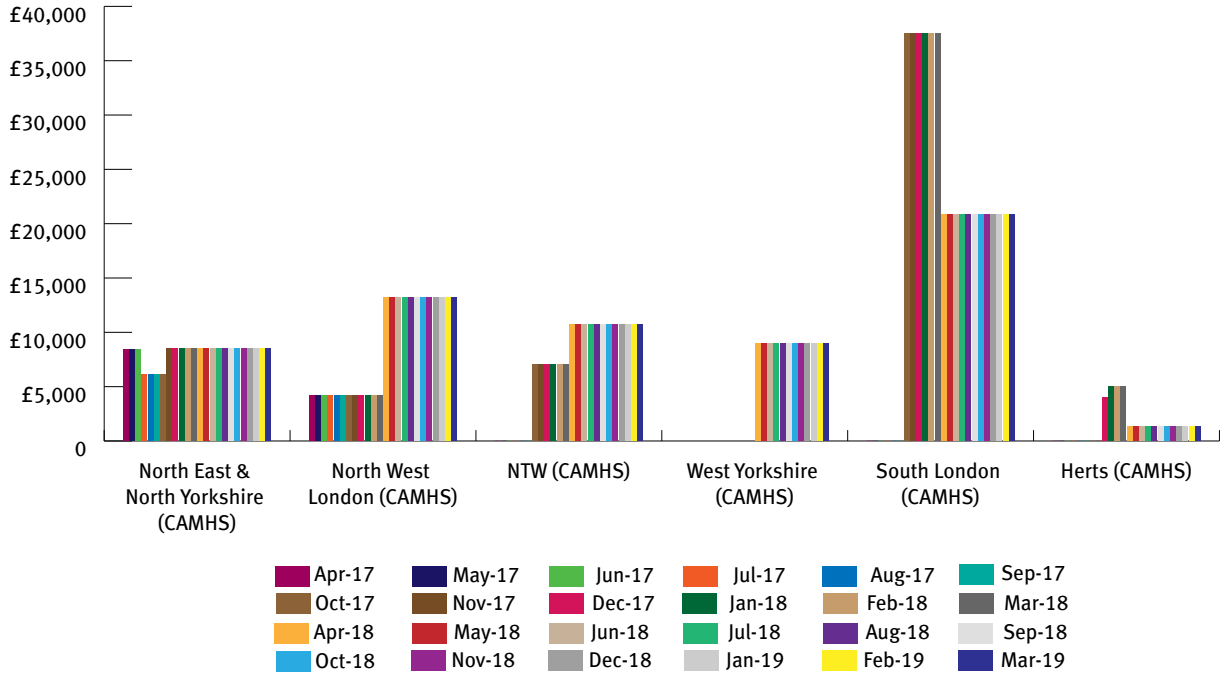


Figure 11: Investment in governance

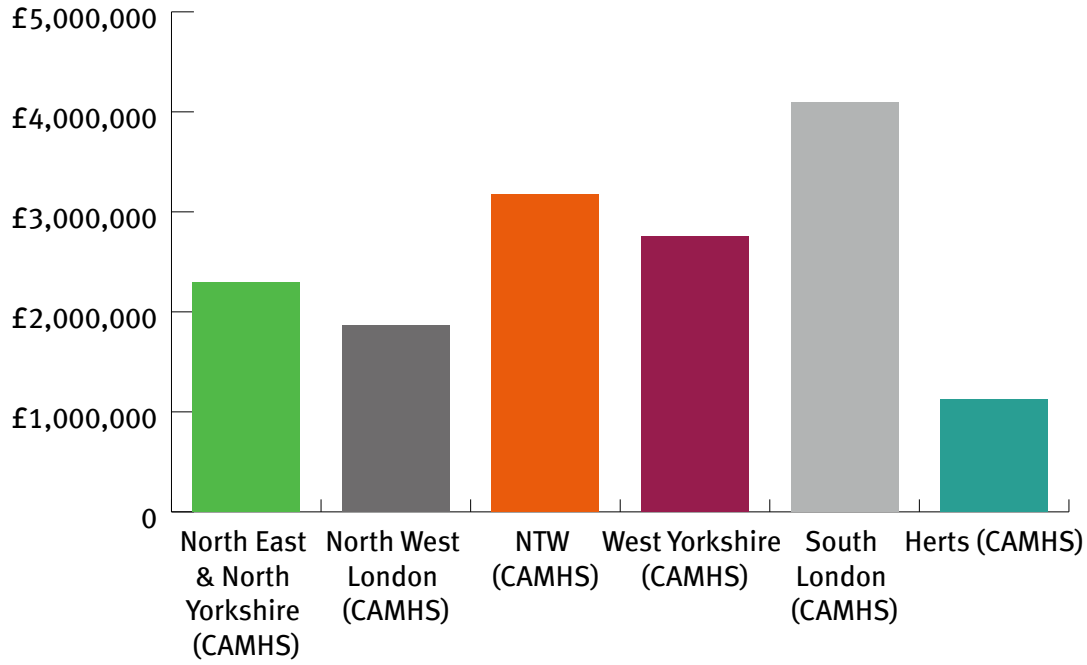


Total changes in expenditure 2018/19

All pilot sites are very clear that this programme is about providing better care for young people. However, the finances are relevant and arguably the second most important set of data. All the sites have achieved significant expenditure reductions during 2018/19 including £4m in South London and over £3m in Newcastle, Tyne and Wear. These are large sums of money, particularly when we are considering a small group of people with high levels of need.

In total, £15.3m of reduced expenditure was generated by the six pilot areas with a cohort of approximately 217 children and young people. That is an average of £70.6k per person. These are significant amounts which have resulted from good clinical decisions that are designed to improve the care and outcomes of young people, not to reduce costs.

Figure 12: Total changes in expenditure 2018/19



Site name	Total reduction in expenditure 18/19	Number of young people in cohort April 18
North East & North Yorkshire (CAMHS)	£2,291,982	36
North West London (CAMHS)	£1,868,535	49
NTW (CAMHS)	£3,179,612	26
West Yorkshire (CAMHS)	£2,756,336	22
South London (CAMHS)	£4,093,134	44
Herts (CAMHS)	£1,125,638	40
TOTAL	**£15,315,235**	**217**

The link to investment in new services

There are variances between areas in the percentage reduction in costs for each area which do not appear to correlate to success in reducing out-of-area placements, overall budget spending or cohort size. Instead, investment in alternative clinical services appears to be driving the savings, which is very encouraging because it shows a correlation between investment in community services and reduced expenditure on acute beds. If this can be sustained – that is, if the community care services succeed in reducing the demand for acute beds in the long run – then this is a classic invest-to-save case that will benefit children, young people and families both immediately and in the longer term.

Conclusion

The pilot sites have identified a small number of patients whose care is comparatively expensive – an average of £291.5k per patient. Through a combination of identifying where young people are in acute beds and focusing on offering alternative provision, all the pilot sites have been able to reduce their expenditure on acute beds – particularly those outside of their local area – and they have used a large proportion of it to invest in community services. There is a correlation between investment in new clinical services and the reduction in contract expenditure. The greater the investment in alternative provision, the larger the savings made in acute care. We cannot deduce whether the link is causal, however the association is certainly encouraging.

Site name	Percentage reduction in contract expenditure	Percentage spend on new clinical services
North West London (CAMHS)	15%	9%
Herts (CAMHS)	15%	10%
North East & North Yorkshire (CAMHS)	23%	17%
NTW (CAMHS)	24%	30%
South London (CAMHS)	33%	22%
West Yorkshire (CAMHS)	36%	23%

6. Qualitative learning

The qualitative learning has been captured through a series of semi-structured interviews with staff members at pilot sites. The first set of interviews discussed the individual aspects of the teams, how they work as a larger programme of six sites, the challenges faced and the successes achieved. It was necessary to understand what the teams thought was important about their work, what motivated them and the skills they felt were required. The second set of interviews presented teams with the quantitative data to determine whether they felt it contextualised the last two years of their work.

In addition, to understand the initiation and development of the pilot sites, documents from the initial NHS England NCM Programme were reviewed, alongside the sites' original business plans.

In each case, the emergent themes from the interviews are described through the lens of successes and challenges, with emphasis placed on items which pilot sites felt were important learning points.

The programme principles and management

In summary, staff working in the pilots were positive about being part of the NCM programme. There were several parts of the national programme that they felt had gone well, including:

1. A clear purpose
2. Focus on governance and leadership
3. Prioritisation of clinical decisions, not financial ones
4. The financial model underpinning the programme.

1. A clear purpose

The *Five Year Forward View for Mental Health* set out the rationale for developing new models of care for mental health:

- Promoting innovation in service commissioning, design and provision that joins up care across inpatient and community pathways (reaching across and beyond the NHS)
- Making measurable improvements to the outcomes for people of all ages and delivering efficiencies on the basis of good quality data
- Eliminating costly and avoidable out-of-area placements and providing high quality treatment and care, in the least restrictive setting, close to home.

(Call for applications, Phase 1 to Chief executives of NHS and independent sector mental health providers, May 2016.)

Pilots felt that these were clear and correct goals, which prioritised patient wellbeing and used clinical models to address a widely accepted problem.

2. Focus on governance and senior leadership

From its inception, the programme required senior leadership commitment, recognising that it would be needed to drive local cultural and clinical change. Early documents from NHS England were clear about the need for their involvement and this has continued as part of the programme.

"A call for applications will be sent to the chief executive of each NHS funded provider of secondary mental health services, with copies distributed to regional directors of commissioning and CCG chief officers. The call for applications will include a template detailing the information required and a timetable. Each application will require sign off by a lead person from each organisation involved in the delivery of the new care model. Applications will need to clearly describe the governance arrangements and how clinical and financial risk will be managed." (NCM Frequently Asked Questions)

This principle has run throughout the programme and been a pivotal part of the pilots' success.

3. Clinical decisions are more important than financial results

As part of the call for applications, NHS England made it clear that the programme was about outcomes and clinical success rather than the prospect of financial gain:

"NCM Frequently Asked Questions: Is the programme just about saving money?

No. Each of the selected sites will be required to demonstrate how they will safely implement their new care model and how they will improve patient experience and clinical outcomes. It is this clinical model that will enable the development of more robust local services and reduce expenditure on out-of-area placements."

That the reduction in acute bed use should be driven by clinical considerations has been a defining principle of the programme which has been successfully hardwired into the pilot areas.

4. Financial model underpinning the programme

NHS England worked with each area to agree a financial baseline of spending on acute beds. They guaranteed this income would be paid to each area for the duration of the pilot. This was effectively a risk-sharing agreement. If the sites reduced costs, then they could reinvest it. If costs rose, then the sites would bear the cost. However, in this case, their income was still guaranteed by NHS England at 2016/17 levels, which mitigated some of the risk by providing a financial floor. From an economic perspective, this is a rational model. It incentivises areas to save money, but also to invest in alternative provision wisely because, if the desired outcomes are not achieved, the additional costs of those decisions (exceeding the baseline spend) are faced by the site that decided them.

Pilots often felt that this gave them a level of financial safety which reduced the risks of changing established clinical practice. However, it clearly also led to a focus on ensuring local value for money and to an understanding of how their own financial models work.

The clearest advantage was that the reductions in expenditure– which accrued in all areas – were significant and remained within area. Site staff talked about how the additional money had enabled them to successfully reinvest in additional community support, which then led to greater commitment and involvement across the trusts.

Learning from the pilot sites

Sites described common priorities including:

1. The primacy of clinical judgement and the reward of positive risk-taking
2. Strong governance
3. A 'pilot mentality' with 'principles not rules'
4. Team leadership
5. A clear shared aim, communicated attractively
6. Commissioning versus facilitating.

Clinical judgement and positive risk-taking

As with NHS England, each site held clear core values of the importance of clinical decisions being the primary factor in deciding how best to treat a patient. This meant that the pilots maintained their professional integrity. There were challenges with this approach, however, as clinical judgements within the pilot were questioning long-term acute-care placements and seeking to offer alternative provision that was often seen as more risky if it was within the community. Generally viewed as a cultural change, holding the risk of new decisions was a key part of the teams' work. It was felt that, as the pilots had become more established and built up a track-record of successful treatment, it became easier to agree alternatives to acute beds.

Strong governance

All the pilots felt that senior-level commitment to the programme was key to their success because it provided a mandate for each team to pursue its aims. Teams frequently described their role as creating a culture change within an organisation and this required backing 'from the top'.

With the trusts' chief executives' names on the original bids, their involvement has continued and has fulfilled the roles of:

- Granting permission for the teams to challenge existing practice
- Building relationships within and between trusts
- Legitimising the role of the teams to try new things and change existing practice, even where there were risks associated.

The phrase 'providing cover' was used by two pilots to describe how the seniority of the chief executive protected them from colleagues who needed to be convinced of the rationale for doing something new or additional. Hertfordshire were particularly encouraged by the fact that their chief executive knew the names of all the team's front-line staff:

"It makes a big difference when the chief executive sees you on site, says hello and knows your name. Colleagues see him enquiring about our work and it raises our profile within the Trust."

A 'pilot mentality' with 'principles not rules'

This was a term used by areas to describe how they each tackled a common problem through a locally devised response, rather than implementing a prescribed model.

This was important because each area had specific challenges, assets and strengths. Consequently, all sites agreed that a significant factor in their success had been the ability to assess their local conditions, resources, challenges and advantages to determine what the specific response should be. All concurred that a common national model would have been a disaster and that, as Dr Cassell, Clinical Lead at SLaM NHS FT succinctly put it, 'We need principles, not rules'.

Common principles of the NCM pilots:

- To seek the best clinical outcomes for patients
- Treatment near to home and in the community are generally best for the patient
- Taking positive risks using clinical judgements to offer alternatives to acute bed-based care
- Senior leadership support and practically engage with this work
- Investing in relationships across trusts to ensure colleagues share our goal and understand the work
- The financial impact of NCMs are understood and reviewed; it is clear where improvements to community services result from reinvestment following reduced acute bed usage
- The challenge of acute bed use is national; the response is specifically designed locally.

Team leadership

Despite the differences in each area's approach, the teams have two striking similarities:

a. An authoritative, experienced clinician who is willing to confer with colleagues and listen, but is also no-nonsense, dauntless, and formidable

b. A finance lead who is able to keep track of spending and data, whilst reinforcing the view of the lead clinician that finances come a distant third to patient outcomes and clinical judgement priorities.

a) Clinical leads

The clinical lead shouldered the risk of testing new responses to the health of young people and children:

'Ultimately, we are the ones discharging a patient saying, "You are going to have home treatment" when the family, the ward, the nurses and the managers may be unconvinced. I believe it is clinically the correct thing to do, but the buck stops with me if [something goes awry].'

Two of the clinical lead physicians were nearing retirement and both felt that their length of service and range of experience (with the reputation that accompanied it) equipped them to lead these programmes. The level of risk management required created a palpable burden. One staff member described facing challenges on three levels:

- Direct concern for the young person in their care
- Making judgements to change their care when the path of least resistance is the status quo
- The financial implications (although this was always described as the least important of the three).

Three of the sites are or will soon be changing clinical leads. All were confident about the transition because they felt that this work had been established locally as the 'new normal' and therefore was not as dependent on them personally to sustain the new culture of working.

b) Finance Directors

All the pilots have a senior finance lead. They may be part of the team (such as in South London and Maudsley) or take a strategic role such as chairing the Programme Board (such as in North West London). A strong working relationship between finance and clinical leads was advantageous – particularly where the finance lead can hold the financial risk and offer reassurance, to enable the lead clinician to focus on clinical care.

The leads also managed the relationship with NHS England Finance and communicated within their trusts the positive news about the savings made by NCMs, which enhanced good will and support. Reassuringly, all the finance leads were clear that care came first, money second. There was and is a genuine commitment to the shared vision of improving lives.

A clear shared aim, communicated attractively

All sites had understood that a new idea has to be marketed to colleagues. A clear shared aim on which all could agree was a key tool, for example:

'Our aim is that every child in our area receives the best mental health treatment close to home, where loved ones, practitioners and physicians are right there with them, keeping them on their road to recovery.'

As an interviewee from Newcastle, Tyne and Wear said, 'It's hard to argue with that, really.'

Teams described lots of face-to-face meetings within areas to establish consistent, trusting relationships with colleagues, employing simple tactics like offering tea and cake at meetings. 'Selling the idea' and 'diplomacy' were mentioned frequently.

Email was viewed with derision. It was ineffective at communicating the programme's work and it was felt that face-to-face was the only way to make progress. The strategies employed across the areas were similar – 'relentlessly positive and relentlessly relentless'.

Commissioning versus facilitating

A difference between pilots was that some – including both London pilots – had been able to act as a commissioner of all children's mental health inpatient services in a traditional 'we have the money; this is what we want' way. These pilots have demonstrated particularly strong results in terms of bed-use. West Yorkshire's model is more facilitative which means that, ultimately, care navigators can encourage, persist and remind clinicians of the need to focus on the numbers of patients in out-of-area acute beds but ultimately cannot demand it. Therefore, whereas some areas have both a carrot (encouragement) and a stick (money), others just have a carrot within their arsenal. This may explain some of the differences in bed-use statistics, although it should be noted that every pilot area has achieved significant reductions in contract spending nonetheless.

Keys to success

Focus on high-cost patients

It is prudent to identify areas where large amounts of money are being spent on small numbers of patients and to judge if the observed outcomes are value for money in comparison to alternatives. Within this programme, the NCM sites have been supported to make significant reductions on acute bed expenditure and, crucially, to invest that in comprehensive alternative care services, predominantly in the community, operating around-the-clock.

Auditing where young people are being treated

In many of the areas, there is a recognition that it was unclear why, where and for how long patients had been in out-of-area beds. Convening professionals who can locate those young people, review their care and organise their return has been felt to be a vital part of this work. Demonstrating this with collection of high quality quantitative data needs to be an ongoing part of the process.

Input of senior management

There are clear examples where the involvement and active interest of CEOs has been critical to the success of NCM sites. The relationships are so strong that some front-line workers are on first name terms with their CEO. It will be useful to describe their role in the formation and implementation of this work.

Local solutions

The pilot sites differ significantly in clinical models, services, existing provision, environment and scale. Some are commissioning services themselves; others are working with commissioners to encourage and enthuse them to focus on children in the acute care system. All of the sites agree that this is a prerequisite of responding to local need that is critical to success. All sites were clear that their work has been to address a shared problem, but through a response that is specific to the context and environment in which they are based. What this means for expanding the programme is that new sites should be guided by 'principles not rules'.

Funding mechanisms and risk sharing

There are different methods of sharing the financial risk of divesting in one service to fund another. There is also a risk that the alternative will not save money. The role of NHS England in underwriting some of this risk is important. There are lessons about how to strike a balance between incentivising areas to deliver success and adding pressure to clinicians who are already trying to manage a range of risks.

Positive risk taking and short admissions

Experienced and formidable lead clinicians who are prepared to discharge young people from an inpatient ward into community care are a key part of some services because they take responsibility for deciding to treat someone differently. This can mean opposing the wishes of the family, the young patient and other clinicians. Holding that risk takes a special person. What has helped with positive risk taking is the option of short (72 hour) admissions which act as a pressure valve. This will skew the readmission data, but we are alert to it and can explain its context.

Challenges

The challenges of piloting an NCM were also considered by the pilot sites. Five areas were identified.

A fall in demand for beds reducing service providers' income

The ability of the programme to save large amounts of money has largely been through the reduction in acute beds. By definition, if this were achieved nationally, the demand for acute beds would fall. Acute beds are a significant source of income for many trusts and private providers. For the pilot, NHS England has continued to pay each area the same budget that they received in 2016/17 and so budgets have been retained. This has cushioned the trust's experience of NCM. Other providers, however, will have experienced a reduction in income as the demand for their beds has fallen.

Increased levels of acute needs on wards

Clinical decisions to offer a patient community support in place of an acute bed tend to be possible mainly, although not exclusively, for those with comparatively lower levels of need. Those with high needs who present a very high risk of harm to themselves tend to stay in acute wards until a point where community provision becomes possible, particularly where patients are transferred from an out-of-area bed, back to an in-area one. The result is that the average level of need in wards increases. Staff members spoke of the risk of burnout where the level of need and risk in a ward suddenly increases.

The wider system – demand

Working within the context of a wider system remains a challenge for the pilot areas. Although much time and effort had been spent on engaging with health professionals and helping colleagues to understand their aims, external agencies, such as schools and social services, can present more of a problem. Many of the pilots were focused on how they managed demand for the new community services in order to prioritise people who would otherwise be in acute care. With new and comprehensive services on offer, schools and social services have begun to signpost young people to them as the first point of contact and quickest way to receive treatment. This has required teams to carefully triage young people to prioritise need, but there remains the challenge of where to refer young people who need a lower level of intervention which is not currently available.

The wider system – supply

There has been the challenge of engaging social care and education services – both of which have constrained budgets and limited resources – to help someone in acute care return to the community. Bluntly, there is an additional financial cost for multiple agencies to support a patient in the community, rather than in an acute bed, where all the costs are borne by the NHS. There is an observed reluctance of services to work quickly to repatriate a young person because of delays in accessing the resources needed for community care against a backdrop of austerity in local government in particular. The additional services provided by the NCM approach has ameliorated some of these factors, but they cannot mitigate them all.

Data collection

The level of data collection required to inform the financial settlements with NHS England is large and necessarily forensic in detail. It is also open to human error, with all pilots accepting that baseline recording processes and those that followed were not flawless. As a result of the resources devoted to measuring bed numbers and lengths of stay, measuring the quality of patient care as a cohort had been less of a priority. On an individual basis, young people were getting more clinical attention than before – particularly those in out-of-area beds whose cases were all reviewed. However at a pilot-wide level, the need to systematically collect data on patient care was only just starting to be addressed.

7. Conclusion

Whilst the sites are humble about what has been achieved, clear gains are being made which save money, bring vulnerable young people closer to home and result in practitioners feeling better about the standard of health care they are delivering. The sites have each taken their own approach with different offers, governance structures, commissioning arrangements and numbers of in-area beds. Although there are corresponding differences in the scale of changes between sites, it is clear that a focus on acute bed usage accompanied by clinical challenge and increased community support can radically reduce reliance on acute bed use.

The commitment of the teams is palpable. There is the human cost to managing new patient risks, challenges in 'venture funding' new community support from predicted savings, increased accountability to senior management and the task of convincing countless colleagues to try something new. In the early phases of a new programme, even one with such a laudable aim, the teams have withstood a great deal of pressure in order to deliver their aims. Personal determination and a strong shared vision have been very important to the continuing success of the teams.

The financial case for the NCM programme is clear, with large reductions in expenditure achieved. A key point is that a focus on groups where the individual costs of care are high can lead to significant savings by improving the care of a very small number of people. Here, a cohort of approximately 217 patients resulted in reduced expenditure of £15.3m. This can then be invested in community services.

Future challenges for the programme are likely to take several forms, not least protecting the values of good governance, leadership and local enthusiasm from the unrelenting pursuit of culture change. However, there is a strong evidence base that the programme delivers success for patients, for government and ultimately for the NHS, and the baseline of expectation has now been set.

Now is the chance for other areas to come forward with their plans to meet the aim 'that every child in our area receives the best mental health treatment close to home, where loved ones, practitioners and physicians are right there with them, keeping them on their road to recovery.' 'It's hard to argue with that, really.'

8. Recommendations

- The New Care Models programme should continue to ensure that optimising clinical outcomes for children and young people is the primary aim and goal of each team. Whilst financial and political factors are important, everyone participating in this process must be clear that they are secondary. The values of clinical excellence are enhanced by those of strong leadership and a desire to achieve organisational improvement and culture change.
- 'Principles not rules' have been a key factor in success, and this ethos should be continued in further sites. Flexibility to work within a given set of principles enables physicians and their teams to take positive risks based on years of experience and expertise. This distinction places trust in the team and favours deployment of clinical judgement in response to unique clinical cases, rather than referring to a manual of rules which may not deliver the same range of innovative solutions.
- NHS England should retain the application process for NCM so that areas have to actively opt-in to being a pilot site and are able to answer the important questions of governance, clinical leadership and motivation to change practice before embarking on this challenging work.
- It is helpful to ensure that the lead agency acts as a commissioner not just a facilitator. Whilst the sample of six is too small to determine the impact of this structure, the qualitative interviews highlighted that it was an important lever when those of goodwill and persuasion proved insufficient.
- Data should be streamlined to capture processes and improve aggregate information on treatment quality. Whilst data on individual patients is within their medical records, aggregating data across cohorts could be improved so that changes observed can be correlated with other measures such as bed days and distance from home. This could be a simple set of five questions asked consistently across the cohort at regular intervals and need not be burdensome in order to be effective.
- Finally, a general recommendation is to apply a similar principle in other areas of health care: identifying small groups of patients whose treatment costs large amounts of money and asking the question, 'Could this group experience improved health outcomes in other services that provide better value for money?'

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