

Paying for quality and outcomes: IAPT case studies

**A joint publication by NHS England
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Introduction

The [2017/19 National Tariff Payment System](#)¹ requires commissioners and providers to implement an outcomes-based payment approach for IAPT services (Improving Access to Psychological Therapies) from April 2018 onwards.

To support providers and commissioners to implement outcomes-based payment approaches, we provided an example of such an approach based on mental health care clusters in *Developing an outcomes-based payment approach for adult IAPT services*.²

Since then we have become aware of a number of providers and commissioners that have developed or are developing local outcomes-based payment approaches. This document sets out five case studies of such local payment approaches.

The original payment example, together with these case studies, are intended to provide a helpful starting point for commissioners and providers negotiating the implementation of an outcomes-based payment approaches for IAPT services.

Commissioners and providers should ensure that the payment approach they implement locally complies with the national tariff rules for local pricing arrangements.

¹ <https://improvement.nhs.uk/resources/national-tariff-1719/>

² Available from: <https://improvement.nhs.uk/resources/new-payment-approaches/>

Birmingham CrossCity CCG

Background

Birmingham Crosscity CCG (co-ordinating commissioner on behalf of Birmingham South and Central CCG, Solihull CCG, Sandwell and West Birmingham) has the fourth largest population of any CCG in England; a mainly urban population of approximately 710,000 people. It commissions Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT), Forward Thinking Birmingham, and The Living Well Consortium to provide IAPT services.

What was the problem?

Currently, IAPT services are commissioned on a cost and volume basis. The CCG is concerned about managing provider performance at a national level as it is currently difficult to tackle real time issues due to the delay in nationally published reports.

What was the solution?

Birmingham Crosscity CCG plans to progress, with its providers, work to implementation an outcomes-based payment approach for IAPT services. The implementation will be staggered by provider, starting with BSMHFT. This plan has been prompted by national guidance from NHS England and NHS Digital, and a commitment to support improvements in:

- Care quality
- Data quality
- Service stability and expansion.

Outcomes-based payment approach

The CCG wants to invest in IAPT services and start to develop quality and outcomes approach and will work with providers to determine how the outcomes are linked to payment.

Components of the payment

In line with national IAPT payment guidance, the following payment components will be considered as part of work with providers on an outcomes-based payment approach for IAPT services in Birmingham.

- **Core payment (assessment and treatment)**
 - 95% of the total payment is for assessment and mental health cluster³ based Episode of Treatment price
- **Outcomes payment**
 - 5% of the total payment is awarded for achievement of quality and outcomes measures



Quality and outcomes measures

Birmingham Crosscity CCG is taking a pragmatic approach to implementing their outcomes-based payment to ensure that the data it depends on is of good quality and implementation is smooth. It has agreed a Service Development and Improvement Plan (SDIP) (see [Appendix A](#)) as part of its contract with IAPT providers.

The following quality and outcome measures are of a good data quality:

- Over 65 access
- Black, Asian and minority ethnic (BAME) access.

The final quality and outcome measures to be linked to payment have not been agreed at this stage. However, the measures that will be chosen will need to have good data quality.

³ For information about mental health clusters, see Annex C of the 2017/19 National Tariff Payment System: <https://improvement.nhs.uk/resources/national-tariff-1719/>

What were the learning points from Birmingham CrossCity CCG?

- **Data**
 - Good quality, reliable data is central to the development and implementation of an outcomes-based payment.
- **Project management**
 - The SDIP is being used to ensure provider and commissioner readiness for the outcomes-based payment approach in 2018. The SDIP comprises four 'schemes': quality, data, finance and monitoring
 - In addition, Birmingham Crosscity CCG feel that stronger national guidance on the technical specification for an IAPT outcomes-based payment approach would be useful in aiding them in developing their new payment approach

The CCG believes that engagement with NHS England to inform policy could lead to refinement of the new payment approach, for example by calling for non-mandatory IAPT prices, and refreshment of the guidance and technical specification of the quality and outcomes measures.

Find out more

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Humber NHS Foundation Trust

Background

Humber NHS Foundation Trust (NHSFT) is commissioned by East Riding of Yorkshire CCG to provide IAPT services to a predominantly rural population of 335,000 people. Hull CCG and Vale of York CCG also commission the trust to provide additional subcontracted IAPT services.

What was the problem?

Before April 2014, Humber NHSFT was commissioned to provide IAPT services under a block contract. The trust, along with East Riding of Yorkshire CCG, recognised that this contract did not support a strong focus on recovery, patient choice and access and waiting times.

What was the solution?

From April 2014, East Riding of York CCG began commissioning Humber NHSFT, along with other providers, to provide IAPT services under any qualified provider (AQP) contracts. These contracts set out local IAPT prices with an element of payment linked to quality and outcome measures.

Humber NHSFT undertook a demand, capacity and activity exercise to predict the impact of the new contract, allowing the workforce to be deployed where demand is greatest. Several exercises have been embedded in the routine management of the IAPT service:

- **Service sustainability**
A financial matrix has been developed which predicts the number of patients the trust must treat to ensure financial sustainability. This incorporates staff modality, annual leave, sickness, training, etc.
- **Patient flow**
Statistical process control charts based on patient flow patterns over a number of years ensure that enough data is available to accurately reflect demand and capacity.
- **Waiting lists**
Waiting lists are sub-divided by treatment intervention to accurately identify which type of therapy is required in each location, allowing treatments to be targeted where they are needed most.

Outcomes-based payment approach

The new contract uses a stepped care model (see [Appendix B](#)). This sets out prices for the seven IAPT services lines delivered by Humber NHSFT (steps 2a, 2b, 2c, 3a, 3b, 3c, and 3d). There are three payment triggers for each service line, generating a total of 21 potential IAPT prices. East Riding of York CCG developed these prices by adapting existing similar contracts from other regions for their local area.

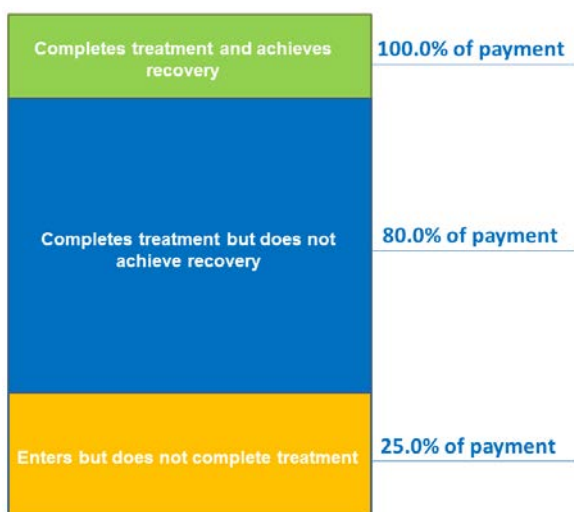
Components of the payment

The three payment triggers correspond to service users who:

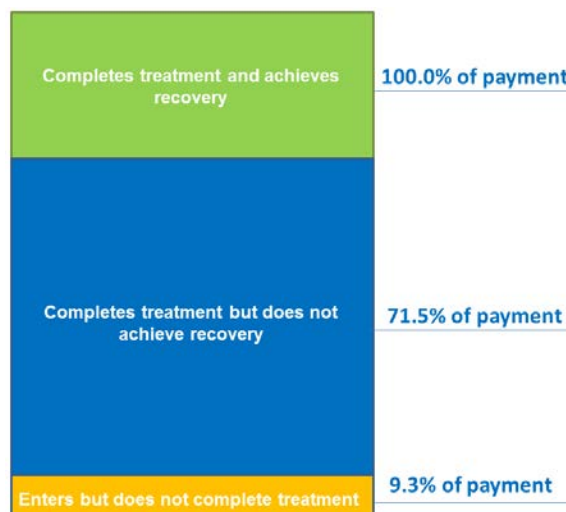
- enter but do not complete treatment (lowest payment)
- complete treatment but do not achieve recovery
- complete treatment and achieve recovery (highest payment).

As well as differing maximum payments for each service line, the proportion of payment awarded for each trigger also varies depending on the service line. For example, providers are paid a higher price for service users at step 3a compared to step 2b, and the proportions of payment awarded for completing treatment and achieving recovery are as follows:

Step 2b: low intensity group therapy



Step 3a: high intensity therapy (Cognitive Behavioural Therapy, Interpersonal Psychotherapy, Counselling for Depression etc.)



Treatment dosage for each service line is compliant with NICE guidelines, unless recovery is achieved and sustained in fewer sessions. In addition, service users completing treatment are offered a 'booster' session post-discharge if recovery is not sustained.

Outcomes and quality measures

- **Recovery**
Currently the only measure linked to payment. This payment is calculated and awarded at the service-user level.
- **Future measures**
From April 2018, patient choice and 95% patient satisfaction rate (determined by Patient Experience Questionnaire (PEQ) at assessment and end of treatment) will also be incorporated in the outcomes component of the payment.

In order to encourage access to IAPT services for underrepresented groups (BAME, over 65s, LGBTQ etc.), Humber NHSFT actively monitors providers' performance on access for these groups, although this outcome measure is not currently linked to payment.

What were the results?

Since the introduction of the outcomes-based payment approach in 2014:

- referrals have increased and waiting times have decreased
- recovery rate is stable, around 60%
- 'do not attend' rate has stabilised and is beginning to decline
- patient satisfaction rate has increased to 95%
- efficiency savings and increased income have allowed the trust to expand the workforce; the number of full-time staff has increased from nine under block contract to around 100, including 60 therapists
- the implementation of the new business model has led to increased access and sustainability of the service
- workforce planning has improved, including professional development and retention.

What were the learning points from Humber NHSFT?

Humber NHSFT emphasise the importance of data quality and modelling, both before and after implementing an outcomes-based payment approach.

- Before implementation, data should be gathered on:
 - referral volume
 - attrition rate
 - ‘do not attend’ and cancellation rates
 - mental health clusters data
 - staffing levels, training plans and staff retention history.
- Modelling should be used to examine the impacts of the payment approach on the service, and current and expected capacity, demand and activity should be systematically reviewed:
 - **Finance:** The likely impact on income should be modelled. Humber NHSFT were running at a significant loss for the first nine months after implementation, until the service delivery model was altered and staffing levels increased.
 - **‘Do not attend’ and cancellations:** As these are no longer paid for under the new system, it should be determined (before implementation) whether the current rates will be sustainable, and if not, how this can be managed.
 - **Waiting lists:** It should be considered beforehand how patients still on waiting lists under the old payment system will be paid for. Humber NHSFT had 1,000 people still on waiting lists when the new payment system went live. These people were not paid for until a lump sum was negotiated with the CCG.
 - **Patient flow:** The flexibility of the service should be reviewed to identify, respond to and overcome blockages to patient flow. For example, referral volume should be reviewed to determine if levels are sustainable.
 - **Workforce:** The skills mix of the workforce and trainee pipeline should be reviewed to determine whether there are sufficient numbers of qualified clinicians and/or trainees within each modality. If not, recruitment, training and retention plans should be set out.
- To ensure shared understanding of the contract, the CCG and provider should review the service specification and payment approach together, line by line.

Find out more

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South Staffordshire and Shropshire Healthcare NHS FT

Background

South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSS NHSFT) provides mental health, learning disability and specialist children's services to a predominantly rural population across parts of Staffordshire, Shropshire, Telford & Wrekin, Wirral and Thurrock. This includes the delivery of IAPT services to over 25,000 people, 16,000 of whom complete treatment.

SSS NHSFT is currently commissioned to provide IAPT services using a mixture of block and cost and volume contracts by seven clinical commissioning groups (CCGs):

- East Staffordshire CCG
- North Staffordshire CCG
- South-East Staffordshire and Seisdon Peninsula CCG
- Shropshire CCG
- Telford and Wrekin CCG
- Thurrock CCG
- Wirral CCG

What was the problem?

SSS NHSFT and its commissioners want to introduce new contracting arrangements supported by a new payment approach. Together, these will take account of the intensity of resource required to meet the range of service users' clinical complexity. There is a shared recognition of the potential benefits of linking an element of payment to quality and outcomes that matter most to local service users.

What was the solution?

With commissioners, SSS NHSFT is finalising the design of an outcomes-based payment approach for IAPT services. This will be shadow-tested for 12 months from 1 April 2018.

Shadow-testing will enable SSS NHSFT to introduce changes that will allow completed episodes of treatment to become the contracting currency.

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SSS NHSFT will use their own cluster reference costs to calculate the costs of an assessment and a completed episode of treatment. This new payment approach should more accurately reflect the resource intensity and complexity of need.

The outcomes component of the payment will represent a maximum of 5% of the total treatment price. SSS NHSFT believes this payment approach will:

- incentivise higher quality of care with improved outcomes and recovery
- reimburse SSS NHSFT fairly for the cost of treatment provided
- support commissioners to achieve best value for the money they spend commissioning IAPT services.

A joint evaluation will be undertaken between the commissioners and SSS NHSFT by March 2019. This evaluation will help to enable a decision to be made by the trust and commissioners regarding inclusion of the new outcomes-based payment system into future contracts.

Outcomes-based payment approach

Components of the payment

- **Assessment component**
 - SSS NHSFT would like to use two different costs associated with the member of staff conducting an assessment, i.e. a higher price for assessments completed by high-resource-intensity staff and a lower price for assessments completed by low-resource-intensity staff.
 - Commissioners, however, would prefer to use one average assessment price
- **Treatment component**
 - 95% of the completed episode of treatment price for each service user will be based on the assigned mental health cluster for each service user.
 - The IAPT services have agreed clinical pathways which are compliant with NICE guideline treatment dosage levels.
- **Outcomes payment**
 - 5% of the completed episode of treatment price will be dependent on quality and outcomes measures.

The plan is to include these components in the contracts with all CCGs, with some flexibility to reflect local circumstances.

Outcomes and quality measures

- Commissioners will use five of the 10 national quality and outcomes measures⁴ reflecting specific commissioner priorities.
- The weightings for the five quality and outcome measures have not yet been finalised. Each commissioner is likely to use different weightings to reflect their priorities.

What were the learning points from SSS NHSFT?

Project management

- SSS NHSFT set up a trust project entitled 'outcomes-based payment approach for IAPT services', which is subject to strict project management processes.
- The trust prepared spreadsheets for commissioners showing a cluster analysis of 2016/17 IAPT activity for assessments, completed episodes, and cluster days. SSS NHSFT is currently preparing similar spreadsheets showing projected 2017/18 IAPT activity for the same data items.
- SSS NHSFT has also shared with commissioners the 2017/18 budget cost, contract income and activity for each IAPT team.
- SSS NHSFT recognised the importance of ensuring governance and assurance from the outset.

Communication

- Effective communication, openness and transparency between IAPT clinical leads within the trust is essential to ensure clear understanding of the new payment approach.
- SSS NHSFT has engaged with commissioners throughout the development of the new payment approach, as they recognised implementation would be hindered by lack of commissioner buy-in.

⁴ *Developing an outcomes-based payment approach for IAPT services*. NHS England & NHS Improvement, January 2017

- Monthly highlight reports are sent to the trust's senior management team and regular updates are sent to commissioners and finance colleagues.

Data and modelling

- SSS NHSFT recognises the need to continue to improve the collection, quality, interpretation and reporting of IAPT service data.
- The trust has developed a robust data vetting system for producing and checking the monthly IAPT reports and submissions to NHS Digital.
- SSS NHSFT has developed an IAPT model which brings together staffing, finance, activity and contracting information. This model highlights the financial differences between contract values and budget costs for each commissioner, and a comparison with reference costs.
- The trust and commissioners have begun to review the 2017/18 budget costs together, to provide a shared and clear understanding of costs in advance of locally agreeing future prices.

Next steps

During the shadow year SSS NHSFT and CCGs will look to finalise:

- agreement on variations to the components of the payment by CCG
- agreement on the measures to be linked to payment for each CCG.

Over the next three years SSS NHSFT will continue to focus on service expansion:

- Four of SSS NHSFT's IAPT seven teams are currently delivering an access rate of above 16.8% of those with relevant disorders, and are predicted to achieve the 2020/21 25% national access standard before this time; for example, the North Staffordshire team is currently delivering greater than 20% access in 2017/18 and plans to deliver the 25% access target in 2018/19
- Five of SSS NHSFT's IAPT teams are long-term condition pilot sites. These teams have an increased focus on providing psychological services for a wide range of people with long-term physical health problems. A large proportion of these people are elderly; a group typically underrepresented among those accessing IAPT services.

Find out more

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South Tees CCG

Background

NHS South Tees Clinical Commissioning Group commissions IAPT services from four independent sector providers under an any qualified provider (AQP) framework. These organisations provide IAPT services to a population of 293,000 people living across both urban and rural areas in the North East of England.

What was the problem?

South Tees CCG represents a relatively economically deprived area, with high unemployment and income inequality. In this context, IAPT services have found it particularly difficult to meet the needs of these groups:

- Black, Asian and Minority Ethnic (BAME) service users
- Older people i.e. those over 65.

What was the solution?

South Tees CCG began commissioning IAPT services on an activity basis, supported by a payment approach with an element of payments to providers linked to quality and outcomes measures. This quality and outcomes element operates on a penalty basis, with funding penalties triggered when contracted targets have not been met.

South Tees CCG continues to engage local communities to explore how services can be better commissioned to respond more directly to user needs.

A Commissioning for Quality and Innovation (CQUIN) scheme was also introduced to incentivise increased access for BAME and over 65 service users. This CQUIN was a national measure, and was in place in South Tees for 2015/17.

Since 2017, the CCG more closely monitors 43 other measures to track provider performance, though these are not linked to payment.

Outcomes-based payment approach

Components of the payment

South Tees CCG commissions IAPT services on an activity basis, with one standard price paid for the assessment and treatment of each service user;

regardless of clinical complexity. This was a three-year contract, with three components to the IAPT payment:

- **Assessment component**
- **Treatment component**
South Tees CCG expects providers to deliver treatment dosage levels in line with NICE guidance.
- **Outcomes payment**
This payment is in the form of a retrospective penalty. Although providers initially receive 100% of the payment for assessment and treatment of each patient, failings in quality and outcomes targets result in retrospective payment recovery by reducing the following year's payment, or offsetting this against payments made for CQUIN achievement.



Outcomes and quality measures

Two quality and outcomes measures have been linked to payment penalties:

- **Recovery rate**
 - Service users who score above a threshold of seven for Generalised Anxiety Disorder (GAD) and nine on the Patient Health Questionnaire (PHQ) at assessment, then after treatment score below caseness are classed as 'recovered'.
 - For each month where the proportion of 'recovered' service users does not meet the national standard of 50%, a financial penalty is incurred proportional to provider's performance in relation to this target.
 - A worked example using substituted numbers demonstrates the calculation of this penalty:

IAPT price = £100 per service user
100 service users enter treatment

→ Payment before penalty: £100 x 100 = £10,000

40 of the 100 service users recover

→ 10 additional service users required to meet 50% recovery standard

Half of IAPT payment for 10 service users applied as penalty

→ $0.5 \times 10 \times £100 = £500$

Total payment received by provider = total IAPT payment – penalty

→ $£10,000 - £500 = \mathbf{£9,500}$

- **Waiting time**

- If providers do not meet national waiting time targets of 75% of people referred to IAPT services receiving treatment within six weeks of referral, and 95% receiving treatment within 18 weeks of referral, then further financial penalties are incurred
- A 1% penalty is applied to the total monthly contract value for failure to meet each of these measures. Therefore, for months where a provider fails to meet the 18 week target the CCG applies a penalty of 2% of the IAPT payment for that month

In line with national guidance, waiting times measures are based on people entering treatment; however the data is only recorded and becomes apparent following discharge, resulting in a lag effect on the chronological relevance of monthly data.

What were the results?

Effective Contract monitoring of the South Tees model has enabled the following key performance indicators to improve:

- **Recovery rate**

- Increased from 37.7% in March 2015 to 54% in November 2017

- **Waiting time**

- Waiting times are the shortest they have ever been, with 99% of service users are now accessing treatment within 18 weeks, and 83% within six weeks.

Providers have also improved in many of the 43 other measures being monitored, demonstrating that improvements may be sustained even in the absence of financial incentives. For example, assessment and treatment of BAME and over 65 service users has increased by all providers, despite lack on financial incentives since the removal of the CQUIN supporting this area in 2017.

What were the learning points from South Tees CCG?

Despite service improvements resulting from the adoption of the new payment approach, South Tees CCG recognises there is still progress to be made:

- Following a review by the CCG, the local prices for IAPT may be low in relation to some service user's clinical complexity. This may have been exacerbated by the penalty approach as evidence suggests that more complex cases are less likely to meet the recovery threshold:
 - To safeguard against the potential perverse incentive to treat services users with less complex clinical needs, the commissioner monitors providers caseload against a baseline in terms of the proportion of people assigned to each cluster.
 - South Tees CCG may negotiate higher local prices for IAPT with providers to better reflect service user complexity.
- The IAPT data set suggests that some service users are discharged and quickly re-entering treatment:
 - Another CQUIN scheme to incentivise a reduction in the number of repeat referrals and increase service user retention is being implemented for 2017/18, which will account for 2.5% of annual net outturn value of IAPT contracts.
- Currently 'reliable improvement' is not incorporated within the payment approach:
 - South Tees CCG may incorporate 'reliable improvement' into the outcomes-component of the payment approach in the future, so that it does not focus only on 'recovery', ensuring that the positive impact of providers is recognised.

Next steps

South Tees CCG is currently negotiating with four other nearby CCGs regarding plans to jointly commission IAPT. The five commissioners will work with potential providers to:

- Develop a new payment approach which will include financial incentives around a quality and outcomes component. The quality and outcomes component will link payment to more measures, potentially including reliable improvement.
- Use financial modelling to investigate the effect of having individual prices for each IAPT service area commissioned by South Tees CCG.
- Use local data to model and forecast how the use of different quality and outcomes measures with different weightings could impact CCG and provider sustainability.

The CCGs expect that their collaborative approach to payment development, and the benefit of economies of scale on procurement, will help to make contracts and transactions more efficient. These efficiency gains can be used to support the expansion of services and increase access, particularly for underrepresented groups.

Furthermore, the increased focus on quality and outcomes will sustain continual improvement of IAPT, generating benefits for service users, providers and commissioners.

Find out more

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Wakefield CCG

Background

Wakefield Clinical Commissioning Group (CCG) commissions mental health services for adults from South West Yorkshire Partnership NHS Foundation Trust, and Turning Point, a voluntary sector organisation, for a population of 365,000 people living over a large geographical area.

What was the problem?

Historically, Wakefield CCG commissioned IAPT services through a block contract. While the national recovery rate target of 50% was consistently achieved and patient satisfaction was reasonable, waiting times were long and the 2016/17 national access standard of 15% was not met. The CCG also felt it had limited contracting and payment levers to drive improvements in quality and outcomes. In this context, Wakefield CCG decided to move away from a block contract for IAPT services.

What was the solution?

A lead provider contract was put out to tender in 2015/2016, and was awarded to Turning Point to commence 1 September 2016. This contract included a new outcomes-based payment approach, with a proportion of payment linked to performance against agreed quality and outcomes measures. The CCG expected this would support improvements by promoting positive behavioural and cultural change at a clinical and provider level.

Outcomes-based payment approach

Components of the payment

Wakefield CCG has an 'intelligent' (weighted) block contract with payment dependent on the following components:

- **Core component (assessment and treatment)**
90% of the total contract payment is paid to the provider for delivery of the service (covering assessments and treatment).
- **Outcomes component**
10% of the total payment is dependent on achievement of three quality and outcomes measures: waiting time, patient satisfaction and recovery rate.
This payment is made quarterly in arrears and split as follows:

- Achievement of one outcome – 25% of outcomes payment is received (2.5% of total payment).
- Achievement of two outcomes – 50% of outcomes payment is received (5% of total payment).
- Achievement of three outcomes – 100% of outcomes payment is received (10% of total payment).

- **Penalty component**

Additionally, a penalty clause exists so that up to 10% of the core payment can be withheld should the provider not achieve the national access standard.

Outcomes and quality measures

Following service user engagement, Wakefield CCG decided to link payment to the quality and outcomes measures that matter most to local people:

Waiting time

- At least 75% of people begin treatment within two weeks of referral. In order to begin treatment, patients must have been assessed and have completed two treatment sessions.

Patient satisfaction

- At least 90% patient satisfaction based on a minimum response rate of 75%. A service user who scores at least 15/20 on Patient Experience Questionnaire (PEQ) is classed as 'satisfied'.
- There is a requirement for the PEQ to be given to all service users completing treatment or being discharged from the service.

Recovery or reliable improvement

- At least 50% of people entering treatment⁵ either make a positive reliable change (see [Appendix C](#)) or achieve recovery (defined as per IAPT guidance⁴); where a service user scores below the clinical threshold on depression and anxiety).

⁵ The national standard target for recovery is set at 50% of service users completing treatment. This CCG wanted to set a more challenging target for its providers.

Access

- At least 15% of the 42,000 adults in the population with relevant disorders using the service.
- If this target is not met, then the 10% penalty component is incurred. This is calculated quarterly and reconciled annually; in each quarter 2% is deducted from the core price for failure to achieve 1,700 people accessing the service, and an additional 2% penalty is incurred for failure to achieve 6,800 people entering treatment annually
- This target will increase in line with investment, in order to achieve a 25% access target by 2020.

Other measures, such as over 65s access, are also actively monitored, however, these are not yet linked to payment.

What were the results?

Year 1: 2016/17

Outcome	Target	Result
Waiting time	At least 75% of people begin treatment within two weeks of referral (assessment and two sessions)	Partially achieved Achieved in quarters 2, 3 & 4. Waiting times dramatically reduced – e.g. Counselling For Depression from 107 to 65 days; Interpersonal Therapy from 117 to 51 days; step 2 one-to-one therapy from 51 to 17 days
Patient satisfaction	At least 90% patient satisfaction, based on 75% response rate	Achieved
Recovery rate	At least 50% recovery or reliable improvement	Partially achieved Reliable improvement achieved
Access	At least 1,700 people per quarter, and/or 6,800 people per annum receiving treatment	Achieved 6,865 people using the service during 2016/17 (compared to less than 6,000 during the previous year under block contract)

What were the learning points from Wakefield CCG?

Before implementation

Data

- Wakefield CCG considers that good quality data, in which all parties have confidence, is essential when designing, implementing and managing an outcomes-based payment approach.

Governance and relationships

- A good provider–commissioner relationship is essential for ensuring clear understanding of the new payment approach and gaining provider buy-in.
- Information shared with providers about the contract and payment approach should be clear and concise.
- Wakefield CCG received 65 questions from providers about the new contract. Good engagement with providers can help anticipate and address questions early.
- Commissioners should model the impact of a proposed payment approach, including how it will work and implications for providers.

Outcomes and quality measures

- Measures should be thoughtfully selected to reflect local priorities. Wakefield CCG has initially selected the measures that matter most to local people before linking payment to additional measures recommended in IAPT guidance.⁶
- Care should be taken to ensure that chosen measures can be accurately and efficiently measured. For example, Turning Point measures patient experience by building the PEQ into the end of each session to ensure that this information is recorded.
- In order to increase the likelihood of receiving the full outcomes payment, providers may wish to begin implementing changes before the new system goes live. For instance, in aiming to achieve the access component, Turning Point began reducing their waiting list before the new payment model was adopted.

⁶ <https://improvement.nhs.uk/resources/new-payment-approaches/>

During and after implementation

- There has been a significant decline in recovery rate since the new payment approach was introduced. Wakefield CCG is exploring this with providers but it may be due to services users being recorded as 'not recovered' when referred on to other services after initial assessment. This underlines the importance of modelling and shadow-testing with provider(s) to predict potential impacts of an outcomes-based payment approach on all aspects of the service. Commissioners and providers may encounter issues despite shadow-testing and should work together to resolve them once the contract and payment approach is live.

Find out more

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Appendices

Appendix A: Birmingham CrossCity CCG Service Development and Improvement Plan

NHS STANDARD CONTRACT
PARTICULARS

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS E. Service Development and Improvement Plan

Work stream	Mental Health	Project Name:	IAPT PbR Shadow		
Clinical Lead Provider:		Joanne Gill			
		Joanne Everill			
Clinical Lead Commissioner:		Dr Rod Macrorie			
Project Management Commissioner:		Ernestine Diedrick, JCT Birmingham			
Forum in which to monitor this SDIP:		Updates to be provided to the monthly Contract Review Group with provider			
Documents to be relied upon:		 IAPT_Payment_Guidance.pdf - Developing outcome based payment approach to IAPT services January 2017			
Description of Scheme	Milestones	Timescales	Expected Outcome	Consequence of Achievement/ Breach	
1. QUALITY	Understanding service user severity and complexity and quality of current service provision	Ongoing	<p>Identifying the complexity and severity of service user needs should be supported by use of the mental health clustering tool as part of the initial clinical assessment for all patients coming into an IAPT service.</p> <p>Provider to cluster all IAPT service users in line with national guidance (2+ treatment appointments) to show severity and complexity of service users. Report to be shared each month at PbR Business Intelligence Provider working group for Commissioner and Provider discussion monthly reporting will remain until Commissioners agree that full clustering has been</p>	<p>If milestone is not met, an exception report will be submitted in line with timescales.</p> <p>BSMHFT previously commented that the current reporting demonstrates that the clustering information is static from month to month, therefore this would be more appropriate to report</p>	

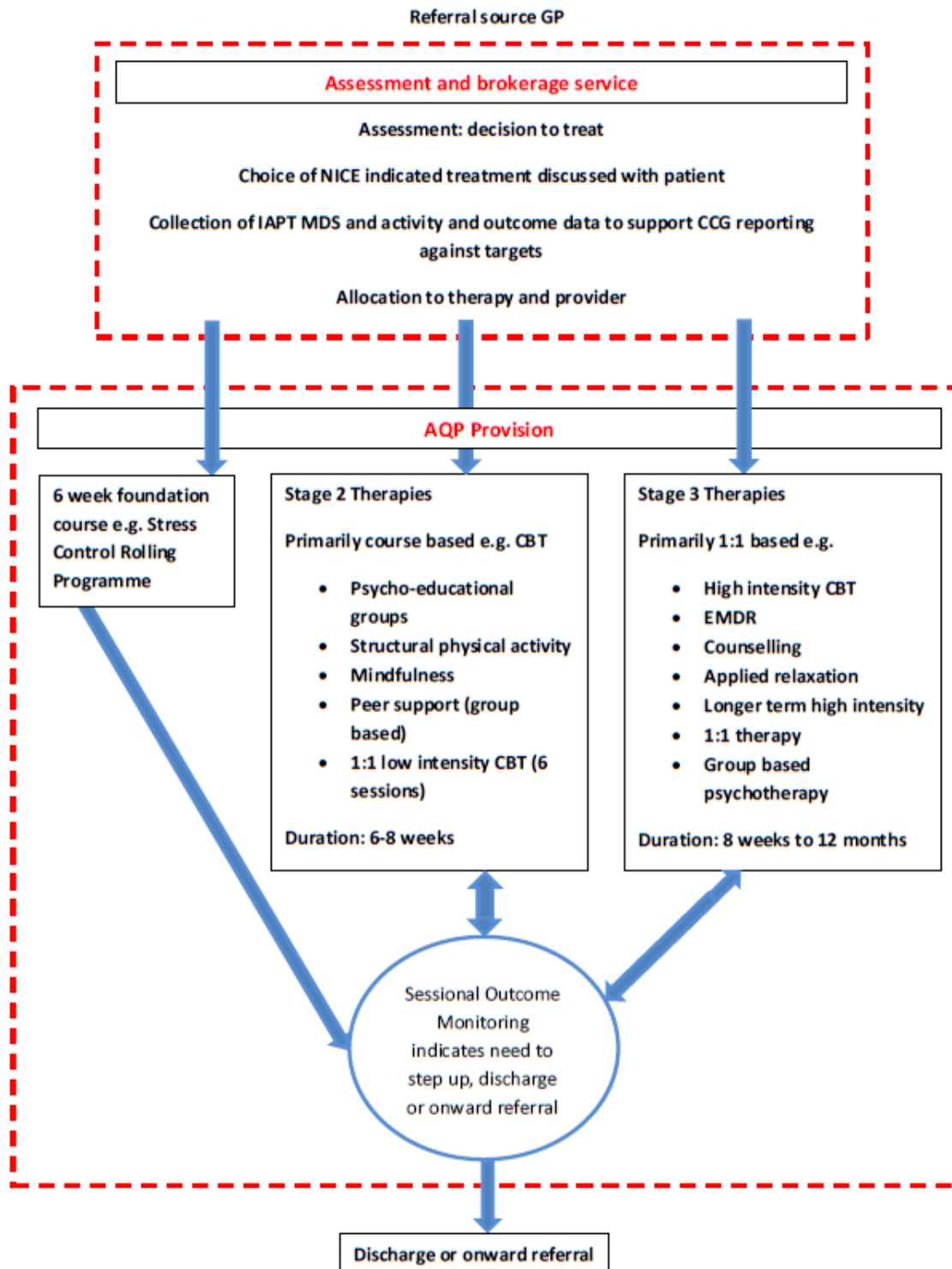
			<p>achieved. Terms of reference for the Business Intelligence Provider Working Group will be developed. Can commissioners please confirm the attendees, TOR and frequency of this group</p>	quarterly
		Q3 – by 30th November 2017	<p>Provider to table report to include what impact IAPT PbR may have on outcomes of patients with varying levels of complexity.</p> <p>Outcome Measures (see IAPT PbR Guidance page 8 for more information):</p> <ol style="list-style-type: none"> 1. Waiting time standard 2. BAME access 3. 65+ access 4. Self-referral 5. Specific anxieties 6. Clinical outcomes 7. Reduced disability and improved wellbeing 8. Employment 9. Choice 10. Satisfaction <p>Please note not all 10 outcomes may be measured further discussion will be held in order to determine weightings.</p> <p>Report to baseline ten outcomes measures noted within "Developing outcome based payment approach to IAPT services January 2017" document against 2016/17 Q4 and 2017/18 Q1, split by CCG ensuring that the source of information is based on nationally available data from NHS Digital (IAPT MDS).</p> <p>Patient level measures to be reported separately by cluster for each CCG.</p>	If milestone is not met, an exception report will be submitted in line with timescales

2. DATA	Considering the service in the context of local system factors.	Q4 – By 30 th March 2018	<p>The delivery of IAPT services to people with both physical and mental health conditions requires effective communication between a number of teams within a provider and across a local health and care system. It is important that this is not impeded by incompatible IT systems, and that appropriate data governance controls are in place when sharing information.</p> <ul style="list-style-type: none"> Provider to work with CSU/CCG/Acute/Community providers to develop ways of appropriate information Sharing Protocols to enable effective communication between Acute and Mental Health providers. Information-sharing protocols should be agreed between the acute hospital provider and the mental health provider to enable the smooth flow of patient information on costs and outcomes to inform service delivery and the payment approach. <p>? ED for Comment</p>	<p>If milestone is not met, an exception report will be submitted in line with timescales</p> <p>BSMHFT asked for further clarification on this requirement as it is our interpretation that this relates to integrated IAPT.</p> <p>It would be helpful to have further discussions with commissioners with regards to the integrated working with other providers given that feedback from the National IAPT team is the focus is going to be on Wave 1 and 2 pilot sites and lessons learnt prior to any roll out of integrated IAPT.</p> <p>There is a requirement for further detail relating to the collaborative work to understand the framework.</p> <p>If work with acutes is required, there will need to be clearer context and processes due to the changes in information sharing agreements and use of personal data</p>
	Agreeing quality and outcome measures and establishing relative outcome thresholds	Q4 – By 30 th March 2018	Business Intelligence (CCG) and Provider to discuss quality/ outcome measures and technical definitions methodology from NHS Digital.	If milestone is not met, an exception report will be submitted in line with timescales
		Q4 – By 30 th March-2018	Business Intelligence (CCG) to work in collaboration with Provider to compare local and national datasets from NHS Digital, split by CCG, and identify points of discrepancy with provider to work towards aligning	If milestone is not met, an exception report will be submitted in line with timescales

			methodologies.	
		Q4 – By 30 th March-2018	Following review of discrepancies between local and national datasets from NHS Digital, findings to be tabled at the corresponding FbR Business Intelligence Provider working group meeting for Commissioner and Provider discussion.	If milestone is not met, an exception report will be submitted in line with timescales
3. FINANCE	Agreeing local prices and how to link quality and outcome measures to payment	Q4 – By 30 th March 2018	Commissioner and provider discussion to agree local prices and how to link quality and outcome measure to payment through CRG meetings. Agreement to be discussed and approved by end of Q4.	If milestone is not met, an exception report will be submitted in line with timescales
	Agreeing financial gain/loss-sharing arrangements	Q4 – By 30 th March-2018	Commissioner and provider discussion to agree financial gain/loss-sharing arrangements through CRG meetings. Agreement to be made by end of Q4.	If milestone is not met, an exception report will be submitted in line with timescales
4. MONITORING	Agreeing an approach to monitoring and continual review/feedback.	Q4 – By 30 th March 2018	<p>An agreed report detailing activity linked to outcomes between Provider and Commissioners.</p> <p>Regular discussions monitored via. Contract Review Group meetings.</p> <p>Agreed reports from CRG meetings to be tabled at Programme Delivery Board with Commissioner and Provider attendance.</p>	If milestone is not met, an exception report will be submitted in line with timescales

Appendix B: Humber NHSFT stepped care model pathway plan

Proposed Primary Care and Community Psychological Therapies Pathway



Appendix C: Wakefield CCG recovery and reliable improvement threshold

Measure	Disorder	Range	Caseness / clinical threshold	Reliable change
PHG-9	Depression	0-27	10	≥6
GAD-7	GAD	0-21	8	≥4
Anxiety disorder specific measures				
OCI	OCD	0-168	40	≥32 (distress scale)
SPIN	Social Anxiety Disorder	0-68	19	≥10
sHAI	Health anxiety	0-42	18	≥4
MI	Agoraphobia	1-5 (item mean for avoidance alone)	2.3 per item average	≥0.73
IES-R	PTSD	0-88	33	≥9