IAPT Payment
Implementing an outcomes-based payment approach for IAPT

Robert Finnin | Project Manager
Mental Health Clinical Policy & Strategy Unit, NHS England
robert.finnin@nhs.net | 07584 27 55 44

Sue Nowak | Head of Pricing Development
Pricing Team, Strategic Finance, NHS England
s.nowak@nhs.net | 0113 824 9353

3 May 2017

NHS England

Strategic context

Five Year Forward View for Mental Health

- Recommended payment system that will increase transparency in the payment system and support improvements by linking payment to quality and outcome measures

Increased transparency

- "…the continued use of unaccountable, ill-defined, block contracts by mental health commissioners is detrimental to patient access to mental health services" IMHSA Policy Paper…"

Move towards commissioning based on quality and patient outcomes rather than historical service provision.

- "…payment mechanisms that enable person-centred approaches to care and parity between physical and mental health. Payment agreements for mental health services are to be transparent, consider the needs of patients and ensure accountability…"

Enhancing quality through allocative efficiency

- Using the payment system to incentivise adoption of practice that promotes sustained recovery, in the most appropriate setting
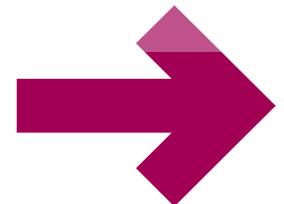
# 2017/19 national tariff and IAPT payment

Local pricing rule 8 requires:
- the adoption an outcomes-based payment approach
- use of the 10 national outcome measures collected in the IAPT data set

From April 2017 commissioners and providers should be shadow testing an outcomes-based payment approach

By April 2018 commissioners and providers should have implemented an outcomes-based payment approach
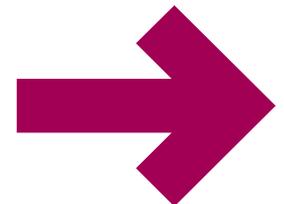
10 national quality and outcome measures

- Local pricing rule 8 requires the use of the 10 national measures:
    1. Waiting times (Access)
    2. Black, Asian and minority ethnic (BAME) (Access)
    3. Over 65s (Access)
    4. Specific anxieties (Access)
    5. Self-referral (Access)
    6. Clinical outcomes
    7. Reduced disability and improved wellbeing
    8. Employment outcomes
    9. Satisfaction (Patient experience)
    10. Choice of therapy (Patient experience).
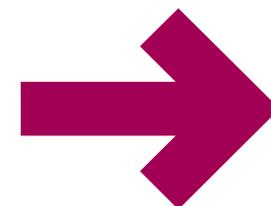
IAPT payment approach principles

- **Transparent**
  - Framework for commissioner-provider discussions

- **Support improved quality and outcomes**
  - For service users, providers and local systems

- **Appropriate incentives**
  - Recognises activity, case-complexity and outcomes
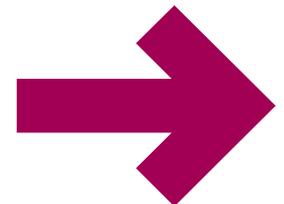
National IAPT payment approach

Aims:

1. To reimburse providers for the costs of providing evidence-based episodes of treatment
2. To reward providers for performing well against agreed quality and outcome measures
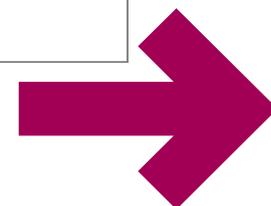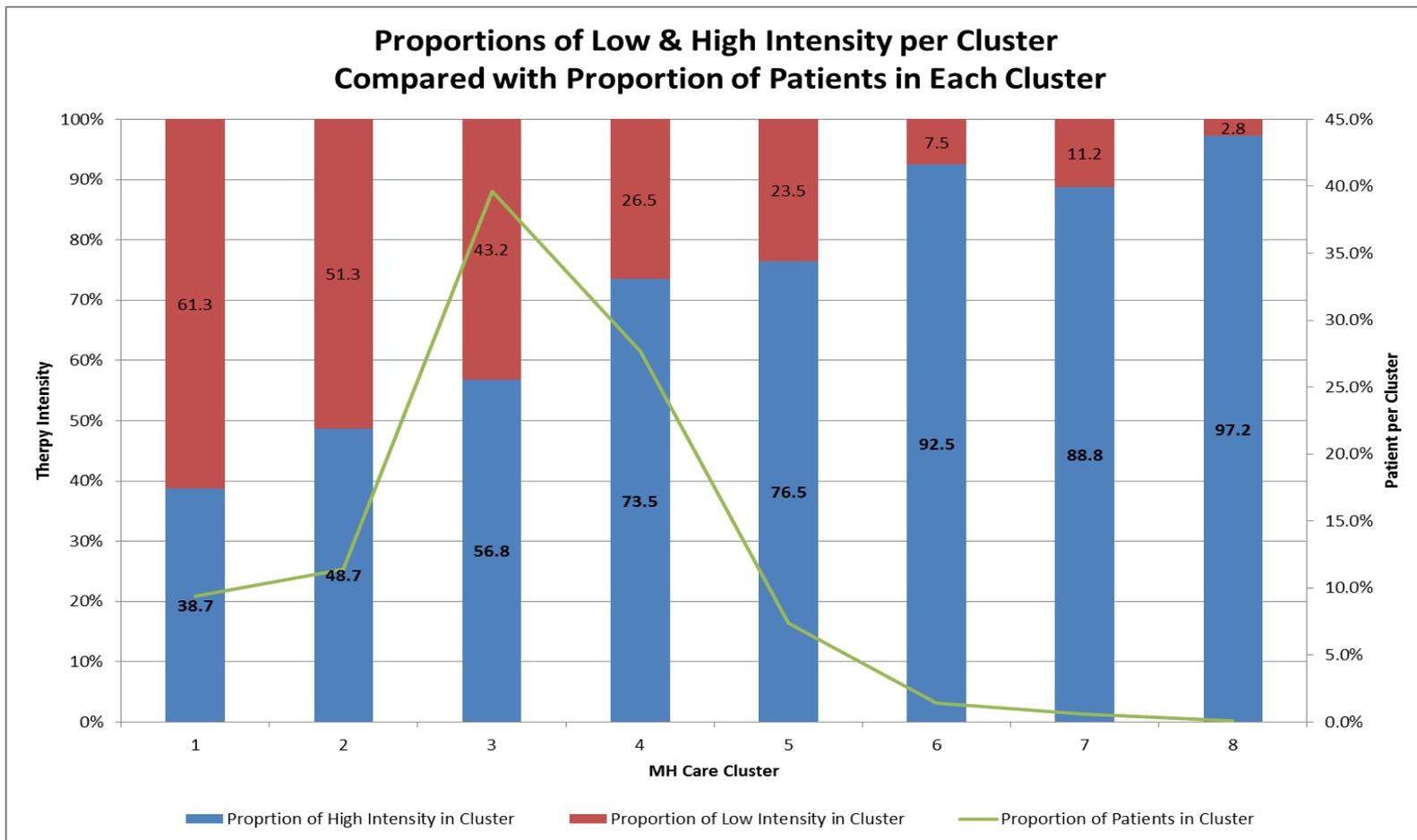
www.england.nhs.uk
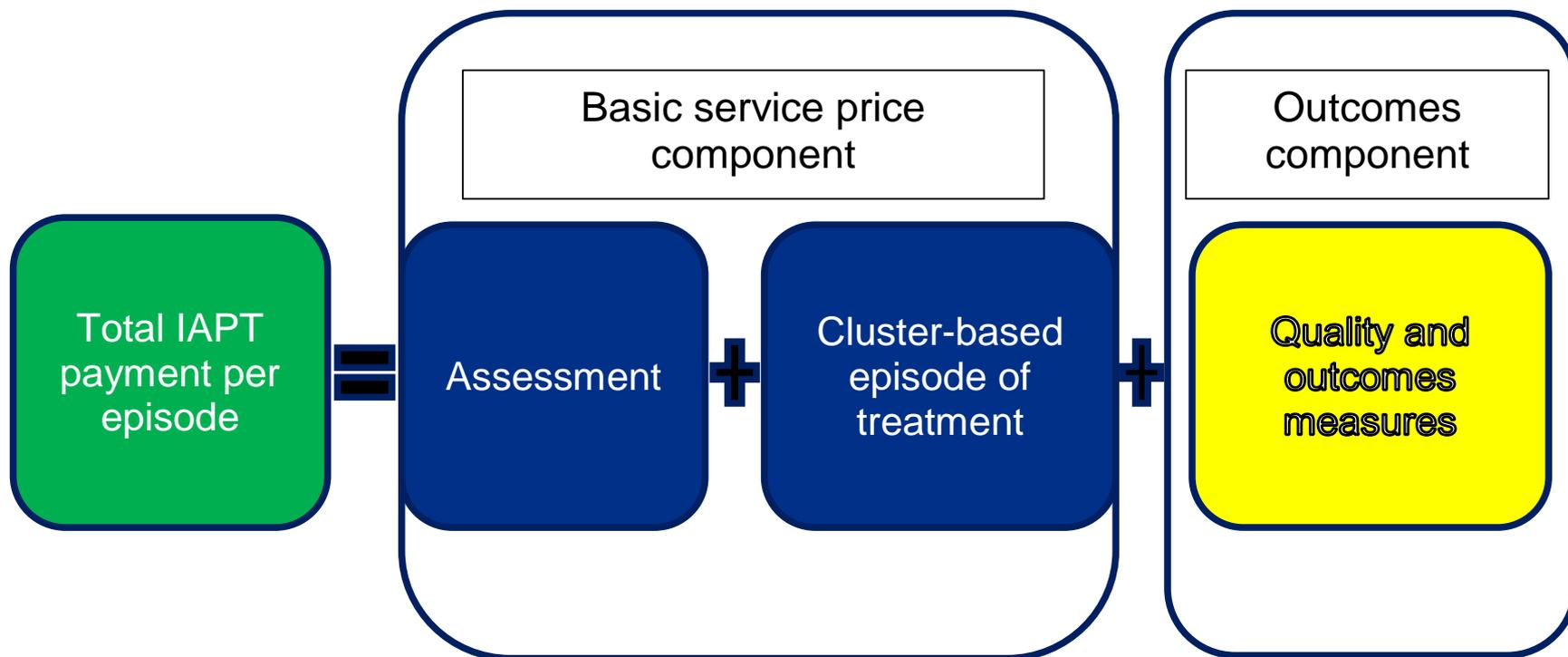
Basic service price (activity)

- Guiding principle…

- This includes prices for an assessment and a cluster-based episode of treatment

Intensity of treatment by cluster

Proportions of Low & High Intensity per Cluster
Compared with Proportion of Patients in Each Cluster

Costs by cluster

**Average Cost by Cluster,
Based on 2012/13 pilot services ref costs &
2012/13 sample of MH Cluster (proportions step 2 and step 3)**

MH Care Cluster	Average Cost
1	£508.66
2	£565.16
3	£610.92
4	£705.28
5	£722.23
6	£812.63
7	£791.72
8	£839.18
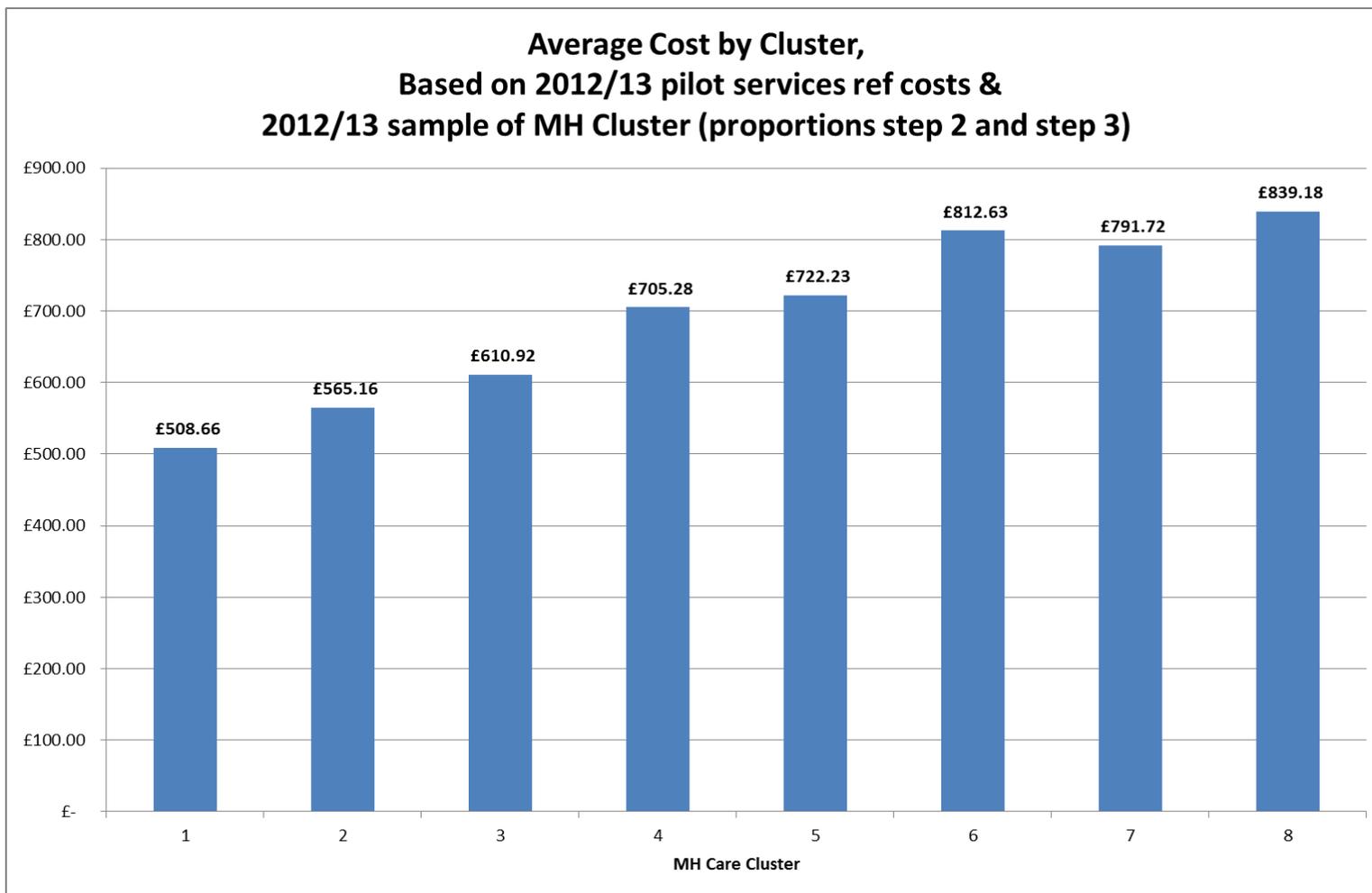
Cluster weighted average cost £619.94
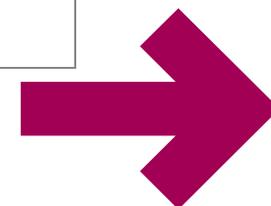
Cluster-based episode of treatment price

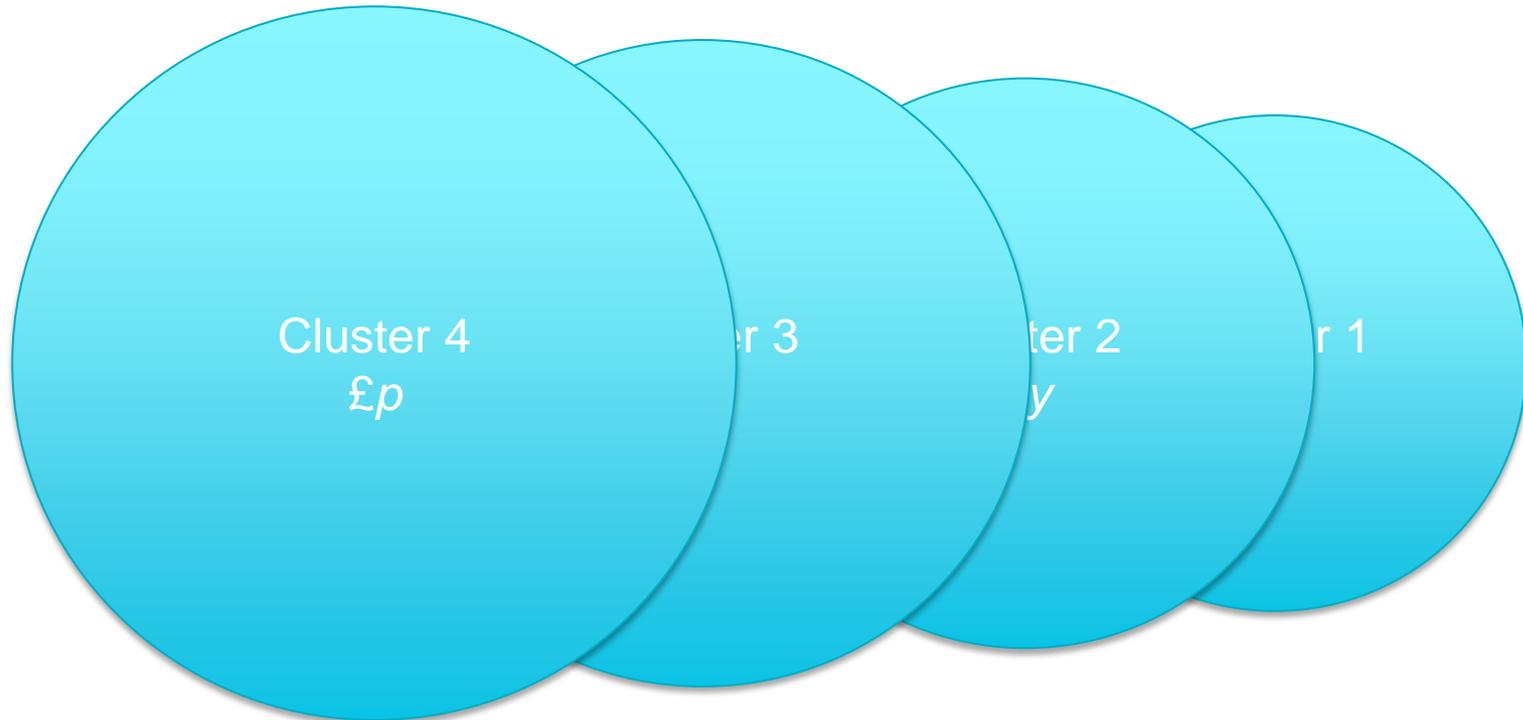- Commissioners and providers should agree cluster prices to cover the efficient costs of delivering evidence-based IAPT episodes of treatment
- Price levels can also be adjusted to incentivise activity in relation to people with a specific complexity of need in response to local priorities.

Cluster 4
£p

er 3

ter 2
y

r 1

Performance price (outcomes)

- Guiding principle…

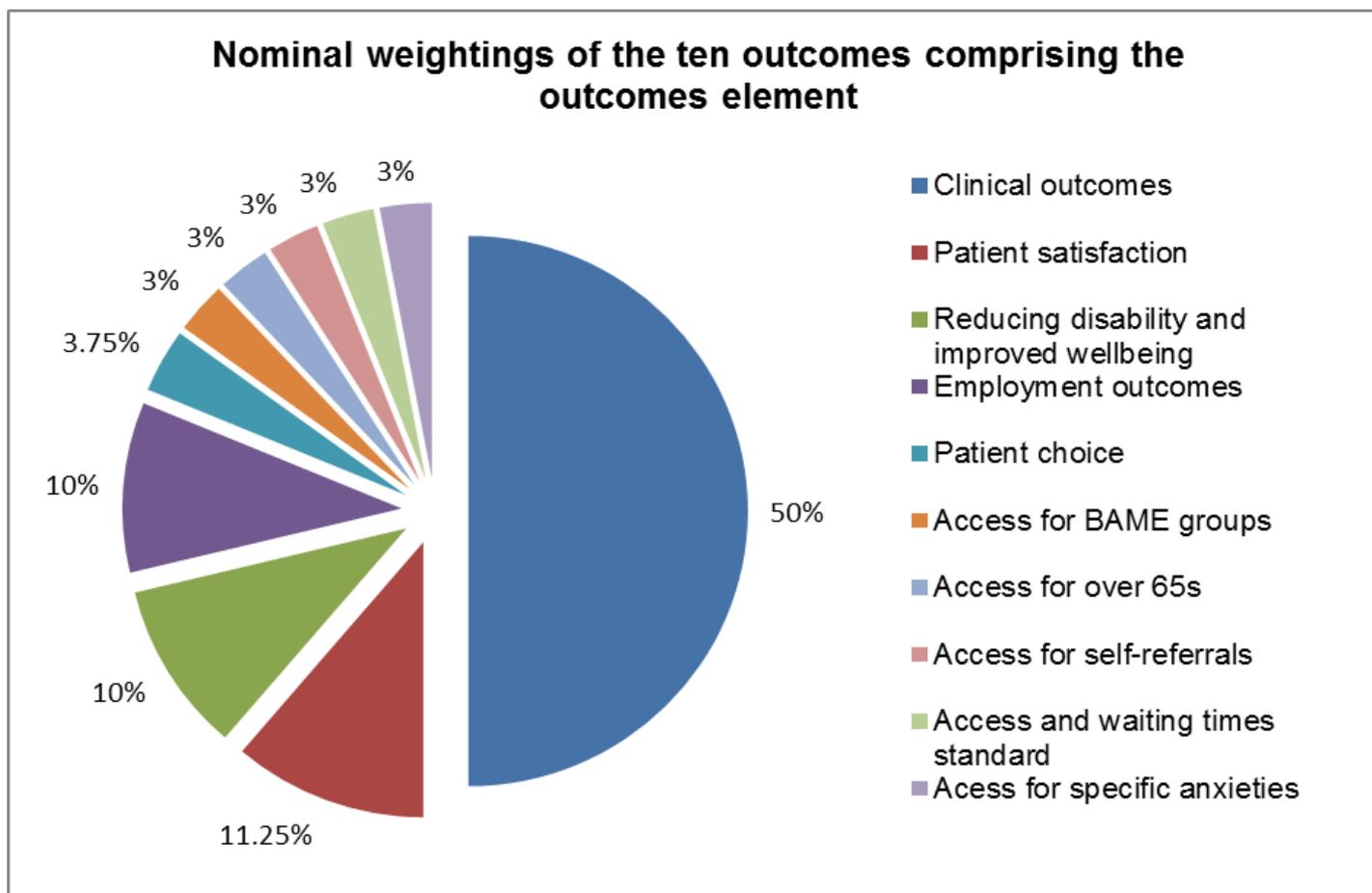- This includes weighted prices for the 10 national quality and outcome measures

Value of the outcomes component

- Our guidance with NHS Improvement recommends the value of the outcomes component being set at a minimum of 5% of contract value initially.

Outcomes component 5%

Activity component 95%
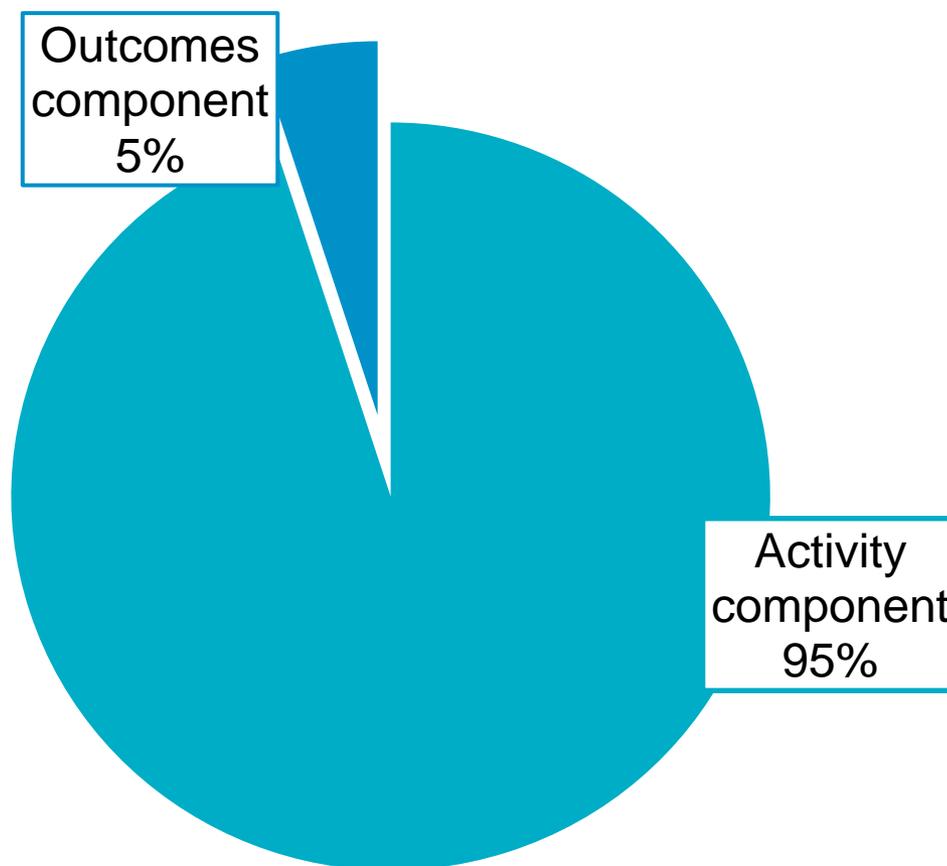
Quality and outcome weightings

- Commissioners and providers should agree quality and outcome measures weightings in line with local priorities

Nominal weightings of the ten outcomes comprising the outcomes element

- Clinical outcomes — 50%
- Patient satisfaction — 11.25%
- Reducing disability and improved wellbeing — 10%
- Employment outcomes — 10%
- Patient choice — 3.75%
- Access for BAME groups — 3%
- Access for over 65s — 3%
- Access for self-referrals — 3%
- Access and waiting times standard — 3%
- Acess for specific anxieties — 3%

Sub-caseness and prevention

- For those patients **admitted and discharged at or below caseness** there is **no payment beyond the basic service price** for each of the mental health clusters that IAPT services are expected to treat and the price for each assessment that the service undertakes.

- No performance payment based on the clinical outcome can be made as there is no recovery and no statistically reliable change.

Implementation considerations

- **Shadow testing in 2017/18**
  - Bringing together payment approach and contracting
  - IAPT service model
    - Use of care clusters
    - Stepped pathway shared between providers
    - Data quality
  - Gain/loss share
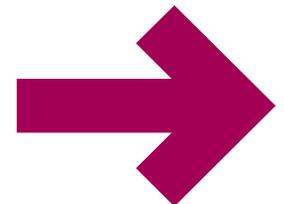
1. Planning / Design

Step 1: Define the aim of the testing project and the overall scope.

This should be informed by the initial proposals to form a new care model.

Step 2: Agree on a new payment model.

Given the new care model, identify the payment approach which will best deliver the aims. Local payment leads, NHS England or NHS Improvement can all help with this decision.

Step 3: Identify the key stakeholders to be involved and those who will make decisions based on the model's performance during testing.

Who is leading the testing and who is setting the agenda for it.

Step 4: Agree on the areas to assess.

Be clear on what answers are required from testing. This will provide steer on what areas will need to be assessed. Know what constitutes success and failure.

Step 5: Create an output to test!

For testing to begin, there needs to be something to test! This should be an early iteration of the new payment model.

2. Simulation

Step 6: Process historical data through the new payment model.

This is a practical step which will start to confirm or refute some of the expectations formed during the design of the new payment model. It won't wholly reflect reality, but it will give a good indication about performance.

Step 7: Will it be physically possible to implement the new payment model.

Termed 'Infrastructure Capability' in the guidance. This is when testing should be carried out to gauge whether the resources and physical infrastructure are in place to enable the new payment model to perform.

Step 8: Make further adjustments and refinements to the new payment model.

Collate the results for Step 6 & 7 and evaluate them. Do they suggest that any amendments are needed.

3. **Shadow**

Step 9: Process current, live data through the new payment model.

The main step. Parallel running of the current and proposed payment models - using the same inputs - to better assess any differences between them.

Step 10: Consider all the potential new arrangements.

Assume the new payment model is in use. Discuss what changes there may be and act out or role-play the situations which may arise.

Step 11: Make comparisons with the existing payment model.

Collate all the new information and compare it to existing processes.

Step 12: Understand the root cause of any differences.

From the comparison work in Step 11, ensure that the cause of all differences are understood.

4. Live

Step 13: Continue to test the new payment model while it is in use.

This promotes continual testing and the allowance for further modifications to the new payment model if required. There may be initial teething problems which further testing can help resolve.

Step 14: Refine and begin a 'version 2' if needed.

If Step 13 provides evidence that changes are required, put in place plans to action these. Have discussions about next steps and whether further iterations of the new payment model may be needed.

Step 15: The old model is retained as back-up.

It might be prudent to retain the old model in some form in case it is needed. Unforeseen circumstances may cause issues with the new payment model and the old model can be a useful 'safety net'.

29

IAPT payment guidance

- NHS England and NHS Improvement guidance
- Supports commissioners and providers to implement an outcomes-based payment approach by April 2018

Developing an outcomes-based payment approach for IAPT services

https://improvement.nhs.uk/resources/new-payment-approaches/
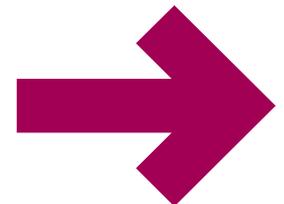
Summary

- 2017/19 national tariff published requires areas to implement an outcome-based payment approach by April 2018

- Payment approach should use the 10 national outcome and quality measures, but there may also be metrics which are locally important

- NHS England and Improvement have published guidance on an outcomes-based payment approach which has two components:
    1. Activity
    2. Outcomes

- NHS Digital are developing a tool for Spring 2017 to support implementation

- We can provide other resources which will help you to shadow the impacts of a new payment approach in 2017/18