Developing an outcomes-based payment approach for IAPT services

Detailed guidance

Published by NHS England and NHS Improvement

January 2017

Contents

How does this document support mental health payment development?

This guidance will support commissioners and providers to implement an outcomes-based payment approach for Improving Access to Psychological Therapies (IAPT) services. It complements other guidance on mental health payment development (see Figure 1 below).[1]

It follows NHS Improvement's publication of the 2017/19 National Tariff Payment System (2017/19 NTPS).[2] Rule 8 mandates the use of an outcomes-based payment model for IAPT services from 1 April 2018. Providers and commissioners are expected to shadow test their preferred outcomes-based payment approach in 2017/18.

Figure 1: Mental health sector support offer

This support material has been published and is available on the NHSI Mental Health Payment Development webpage

Support material is yet to be published

First phase completed and resources from workshops/webinars/meetings are available on the NHSI Mental Health Payment Development webpage. Further support via these approaches is ongoing

*Local payment examples include; capitation, outcomes based payment for mental health and multilateral gain/loss sharing

[1] https://improvement.nhs.uk/resources/new-payment-approaches/
[2] https://improvement.nhs.uk/resources/national-tariff-1719/

Summary

For 2017/19, NHS Improvement changed the local pricing rules to require commissioners and providers of IAPT services to adopt an outcomes-based payment approach from April 2018.[3] Providers and commissioners are expected to shadow test their preferred outcomes-based payment approach in 2017/18.

An outcomes-based payment approach consists of:

- a basic service price component reflecting activity: includes an amount for assessment and an amount for the mental health cluster-based package of care or episode of care

- an outcomes payment component: based on the performance of the service against the 10 national quality and outcome measures (further measures can also be agreed locally).

Moving to an outcomes-based payment approach can help commissioners and providers better understand the care they need to provide and the resources necessary to deliver that care. It can help better meet the Five Year Forward View (5YFV) mental health objectives. This includes supporting more efficient and effective evidence-based care, earlier intervention, prevention and improved patient outcomes.

NHS England has developed an outcomes-based payment approach under the rules set out in the 2017/19 national tariff that commissioners and providers could use.[4] This guidance will support contracting, pricing and finance professionals to develop and implement this outcomes-based payment approach for NHS-funded IAPT services.

Commissioners and providers will need to work through six key elements when developing and implementing this approach:

- understanding service user severity and complexity and quality of provision

- agreeing quality and outcome measures and establishing relative outcome weightings

- agreeing local prices and how to link quality and outcome measures to payment

---

[3] Rule 8 requires the use of the 10 IAPT national quality and outcome measures if providers and commissioners agree an alternative outcomes-based payment approach under Rule 4 of the local pricing rules.
[4] https://improvement.nhs.uk/resources/national-tariff-1719/

- agreeing financial gain/loss-sharing arrangements

- agreeing an approach to monitoring and feedback

- considering the service in the context of local system factors.

1 Introduction to the outcomes-based payment approach

This guidance supports commissioners and providers to develop and implement an outcomes-based payment approach for IAPT services.

The payment approach is part of wider efforts to strengthen the link between the payment system and improvements in quality and outcomes for patients and service users. Payment linked to quality and outcome measures can better support greater accountability and transparency in patient outcomes in the mental health sector. It can also better help patients make meaningful choices between available providers. A local price will allow money to follow the patient and support more active choices.

Through incentivising the delivery of effective, evidence-based treatments an outcomes-based approach has the potential to bring about widespread quality and efficiency improvements.[5] If meeting the needs of people using services and the local population is at the centre of payment, resources and service delivery will be shaped to better meet those needs.

We recognise that commissioners and providers across the country have different levels of data quality, technical capability, resources and IT infrastructure. The payment approach set out here can, however, be adopted by all commissioners and providers.

The mandated use of an outcomes-based payment approach for IAPT will bring benefits to:

- **people using services:** by including the clinical and non-clinical outcomes that matter most to service users, eg recovery, employment and impact on overall wellbeing

- **providers:** by reimbursing them fairly and transparently for activity with clear incentives for continuous improvement

- **commissioners:** by supporting them to identify, specify and incentivise local priorities, and commissioning accordingly, eg improving access for older people or ethnic minorities, or improving readiness for employment.

---

[5] www.health.org.uk/publication/need-nurture-outcomes-based-commissioning-nhs

2 What is the IAPT outcomes-based payment approach?

The IAPT outcomes-based payment approach balances the need to pay for activity, taking into account case complexity and severity as a driver of cost, with the need to incentivise good outcomes. It builds on the IAPT model[6] and the data that all providers of IAPT services are required to collect and submit to the national IAPT minimum dataset.

The approach consists of:

- a basic service price component reflecting activity: includes an amount for assessment and an amount for the mental health cluster-based package of care or episode of care

- an outcomes payment component: based on the performance of the service against the 10 national quality and outcome measures (further measures can be agreed in addition locally).

Figure 2: Overview of the IAPT payment approach
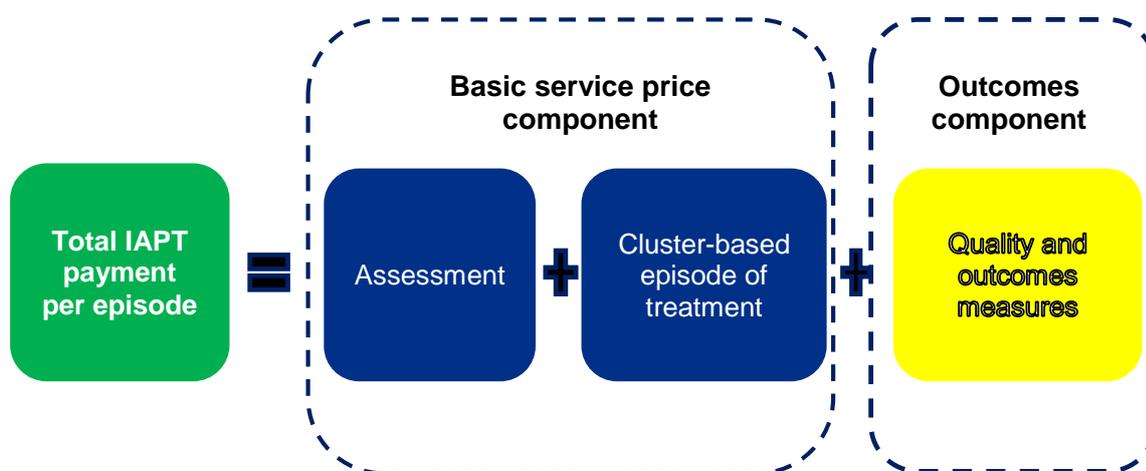
2.1 Activity component

This incorporates discrete payments for both initial assessment of a service user and the episode of treatment provided. It takes into account the severity and complexity of the needs of the person being treated and should support delivery of evidence-based episodes of treatment.

---

[6] www.england.nhs.uk/mentalhealth/adults/iapt/

Assessment payment

Following a referral, an assessment using the mental health clustering tool[7] should be completed to determine the level of a person's complexity and severity of need as this will have a direct impact on the level of resource required.[8]

The proportion of payment made available for the assessment should therefore be enough to ensure a robust assessment of need and a sound decision about an IAPT package of care that properly addresses the level of need of the service user.

We recognise that as a primary/community mental health service, IAPT services have an increasing role not only in the treatment of those in most need, but also in preventing the worsening of a person's wellbeing which would be expected to take place if no support were provided.

Where initial assessments indicate that a person's needs may not appropriately be met by IAPT services, they may still have a role in supporting wellbeing. In these circumstances, covering the cost of assessment is expected to ensure that IAPT providers will be remunerated for the activity delivered at this stage such as advice, guidance, signposting and onward referral if and when needed.

Cluster-based episode of treatment payment

People allocated to higher clusters at assessment are significantly more likely to require more resource-intensive episodes of treatment. Adequate resourcing is important to support the delivery of the appropriate National Institute for Health and Care Excellence (NICE) evidence-based intervention structured to meet a person's needs.[9]

Local prices should reflect the severity and complexity of need of people using services. These cluster-based episode prices can help avoid creating a perverse incentive for providers to pick less complex cases.

Commissioners should ensure that payment incentivises delivery of an appropriate episode of care that will best support sustained recovery. Incorporating routine follow-up and re-assessment at a given point after discharge can support this. Ensuring the payment approach retains a focus on quality and outcomes that

---

[7] Annex C: Technical guidance for mental health clusters
https://improvement.nhs.uk/resources/national-tariff-1719/#h2-annexes
[8] Most IAPT patients will fall between clusters 1-8. Where clusters 8+ are not indicated at assessment, it is acceptable to use a brief version of the tool as an alternative to completing the full mental health clustering tool which includes all must-score and expected-to-score items for clusters 1–8. It would not be appropriate to use this brief clustering tool as an outcome measurement.
[9] NICE only recommends high intensity therapy for post-traumatic stress disorder and social anxiety disorder, even for cases in the low cluster range.

encourage sustained recovery will have the greatest benefit for people accessing services and, in turn, will minimise the need for re-referral.

Where the initial assessment indicates that a person's needs are below the clinical threshold[10] for an intervention, IAPT services may still have a role in supporting that person's wellbeing. However, as no clinical recovery may be observed, the clinical outcomes portion of the outcomes payment should not be applied to that episode of care.

2.2 Outcome component

This must be based on data for the 10 national quality and outcome measures captured as part of an episode of treatment. IAPT treatment programmes are designed to aid clinical improvement and social inclusion, including return to work, meaningful activity or other occupational activities. This requires the collection of routine sessional clinical, social, employment and patient experience data as part of a provider's submission to the IAPT minimum dataset.

The 10 national quality and outcome measures routinely collected in the IAPT dataset are:

- Access:

    1. Waiting times

    2. Black, Asian and minority ethnic (BAME)

    3. Over 65s

    4. Specific anxieties

    5. Self-referral

- 6. Clinical outcomes

- 7. Reduced disability and improved wellbeing

- 8. Employment outcomes

- Patient experience:

    9. Satisfaction

    10. Choice of therapy.

---

[10] See Table 4 in Annex 1 outlining standardised clinical assessment scales.

We recognise that these measures are not exhaustive. Extra local measures can be agreed[11] to support progress on local objectives but providers of IAPT services will still need to submit the full IAPT dataset to NHS Digital.[12]

Commissioners and providers should agree weightings for the 10 national quality and outcome measures, as well as any extra measures agreed locally to reflect local priorities.

To support local health economies, NHS England, with NHS Improvement and NHS Digital, have designed and tested an outcomes-based payment tool that will be available from April 2017. This tool will support shadow testing through 2017/18 and implementation of the payment approach in 2018/19.

The tool brings together available clinical and non-clinical activity data to calculate performance in line with this payment approach. This should minimise the burden on commissioners and providers of moving to an outcomes-based payment approach while enabling consistent assessment and national benchmarking.

3   Implementing the payment approach

Implementing this payment approach requires commissioners and providers of IAPT services to collaborate to meet the needs of people accessing services in a local health economy.

NHS England and NHS Improvement expect this payment approach to be implemented in shadow form for 2017/18. This will enable the robust design, testing and iterative refinement of pricing and outcomes locally ahead of full implementation in 2018/19. Annex 2 outlines a high-level operational flowchart for implementing the payment model.

As a process, implementation can be broken down into six elements outlined earlier and described in more detail in the rest of this section:

- understanding service user severity and complexity and quality of provision

- agreeing quality and outcome measures and establishing relative outcome weightings

- agreeing local prices and how to link quality and outcome measures to payment

---

[11] Framework for developing outcome measures, published by NHS Improvement and NHS England: www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/mh-quality-outcome.pdf
[12] NHS Digital IAPT dataset: http://content.digital.nhs.uk/iapt

- agreeing financial gain/loss-sharing arrangements

- agreeing an approach to monitoring and feedback

- considering the service in the context of local system factors.

We do not expect they will all be carried out in sequence, and there will inevitably be a need to revisit some or all of these suggested elements based on learning from the shadow year and to ensure the payment approach reflects local needs and priorities.

3.1 Understanding service user severity and complexity and quality of provision

The starting point for implementing the IAPT payment approach will be developing an understanding of the current service: both the complexity and severity of the needs of those who are accessing the service and the quality of provision.

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.

The IAPT dataset should be drawn on to understand the quality of IAPT services currently provided against the 10 national quality and outcome measures.

3.2 Agreeing quality and outcome measures and establishing relative outcome weightings

Annex 1 provides more detailed guidance on how the 10 national quality and outcome measures should be incorporated in the payment approach.

Extra outcome and quality measures may be agreed locally to support progress on local objectives. Commissioners and providers should agree the outcomes to be linked to payment. NHS England and NHS Improvement have published guidance to support commissioners seeking to develop quality and outcome measures[13] and link them to payment for mental health services.[14] Commissioners and providers do not have to link extra outcome and quality measures to payment. Collecting and monitoring outcomes can support improvements in the quality of care or system change without linking to payment.

When agreeing extra local quality and outcome measures commissioners and providers will want to:

---

[13] www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/mh-quality-outcome.pdf

[14] https://improvement.nhs.uk/uploads/documents/Linking_quality_and_outcome_measures_to_payment_for_mental_health_FINAL.pdf

- agree the priorities for any changes to the delivery model with providers, taking into account what is feasible in the short and long terms

- co-produce the outcomes and priorities with people using services, ensuring they reflect local needs and priorities

- consider the robustness of data and the burden of any extra data collection when thinking about which outcomes to incentivise

- consider the experience of other areas in setting outcomes-based payments, (some key lessons are set out in The Health Foundation report *Need to nurture*).[15]

For the 10 national quality and outcomes measures and extra measures agree locally providers and commissioners should also reach agreement on the relative weighting of outcomes and thresholds for performance based on local and national priorities. During the shadow year commissioners and providers should explore the impact of flexing the proportions of payment allocated to various aspects of the model to reflect local needs and strategic ambitions for factors such as access and non-clinical benefits. Figure 2 outlines an illustrative example of how the 10 national outcomes measures can be presented to support local engagement and discussions.

3.3 Agreeing local prices and how to link quality and outcome measures to payment

In this section, we use hypothetical information to explain how activity prices covering assessment and cluster-based episodes of treatment can be determined through understanding the resources required to treat different groups of people accessing IAPT services.

To shadow and implement this payment approach providers and commissioners will need to agree:

- price for an assessment and cluster-based episode of treatment provided to a service user

- percentage of the overall price contingent on achieving agreed outcomes

- weighting of each outcome.

---

[15] www.health.org.uk/sites/health/files/NeedToNurture_1.pdf

Establishing the price

The starting point is likely to be the contract value for 2016/17. Where available, patient-level costing data would be best, but reference cost data can also provide useful information for cost benchmarking and the cost of delivery to inform local price-setting. Commissioners and providers should bear in mind that the reported costs of each cluster may vary from provider to provider because of different service specifications and different levels of investment in mental health services.

Local provider data systems should be used to produce a report for a defined period of time such as the most recent financial year, and should include:

- patient ID

- cluster allocated

- number of appointments

- staff band.

Using this information and details of staff pay, it is possible to calculate a cost for the staffing resource used across the selected cluster (see Table 1).

Table 1: Calculating the activity component (activity, rates and prices are for illustration only)

Patient	Activity component (assessment /cluster-based episode of treatment)	Hourly sessions per episode	Staff hourly rate (£)	Cost of assessment (£)	Cost of cluster-based episode of treatment per patient (C*E) (£)	Total cost of activity component (£) (E+F)
A	B	C	D	E	F	G
#11	Assessment	1	100	100	-	100
#11	No cluster package	N/A	N/A	-	0	
#12	Assessment	1	100	100	-	900
#12	Cluster 3 package	8	100	-	800	
#13	Assessment	2	100	200	-	1400
#13	Cluster 4 package	12	100	-	1200	

In the above example, we capture costs for service user #11 who does not proceed beyond assessment, service user #12 who has an assessment and a package of care appropriate to their level of need assessed as cluster 3, and service user #13 who requires an extended assessment and a package of care appropriate to their level of need assessed as cluster 4. The example assumes sessions are an hour long. Commissioners and providers will need to ensure that local calculations reflect the length of sessions per episode.

The cost of assessment and cluster-based episode of treatment per patient (G) can be used to derive the average cost per patient clinical care package by care cluster. These costs can then be converted into relative resource intensity (RRI), relative to the lowest cluster cost (see Table 2).

Table 2: Calculating relative resource intensity of cluster-based episodes of treatment (activity, rates and prices are for illustration only)

Activity component (assessment / cluster-based episode of treatment)	Total staff cost of activity (£)	Number of episodes	Cost per patient episode (H/I) (£)	RRI (cluster cost (J)/lowest cluster cost (J))
	H	I	J	K
Assessment	600,000	5000	120	0.5
1	125,000	500	250	1
2	350,000	1000	350	1.4
3	1,250,000	2500	500	2
4	1,100,000	2000	550	2.2
Total	3,425,000	10,000	-	-

RRI is an indication of the relative resource use of a cluster. Table 2 shows that, on average, IAPT services for someone in cluster 3 are twice as resource-intensive as for someone in cluster 1.

Based on an understanding of the costs of delivering care adjusted for the complexity of service user needs, commissioners can begin to define prices that adequately reflect complexity and severity of need.

This approach to developing prices aligns with published guidance on developing an episodic payment approach. [16] Providers and commissioners can use it to help determine prices for episodes of care that appropriately reflect resource intensity for

---

[16]

https://improvement.nhs.uk/uploads/documents/Developing_an_episodic_payment_approach_for_mental_health_FINAL.pdf

working-age adult and older people mental health services. It may be helpful to read that alongside this guidance.

Linking payment to outcomes

NHS England and NHS Improvement recently published guidance on linking quality and outcome measures to payment for mental health services.[17] The approach taken locally on IAPT should remain consistent with the recommendations in this.

Moving to payment by activity and outcomes is a significant change. We recommend only a small proportion of payment should be linked to quality and outcome measures initially, with further changes to be phased in over time. The shadow year is a chance for commissioners and providers to test the impact of this payment approach.

IAPT is an area of care where activity is expected to rise, both through the requirement to meet access and waiting-time standards, and a national commitment to expand services. It is therefore important the resources required to care for any one person are well understood, as this is an area of healthcare where commissioner spend is also expected to rise.

3.4 Agree financial gain/loss sharing arrangements

To mitigate the financial risks of moving to the suggested IAPT payment approach, commissioners and providers may consider implementing gain and loss sharing arrangements. Gain and loss sharing arrangements should target 'utilisation risk'.[18] They should set out how savings (gains) or overspends (losses) generated through lower or higher than expected utilisation of IAPT services under the new payment approach are shared between commissioners and providers.

Gain and loss sharing arrangements in the contracts can be used to mitigate the financial risk exposure shared between commissioners and providers. The shadow implementation period should be used to inform the level of financial risk exposure and the development of contractual arrangements accordingly. Any such arrangements in the contract should be designed with flexibility to incentivise continuous quality improvement while balancing financial risk exposure between commissioners and providers. Gain and loss sharing should not apply to the outcomes component.

---

[17] https://improvement.nhs.uk/uploads/documents/Linking_quality_and_outcome_measures_to_payment_for_mental_health_FINAL.pdf

[18] Utilisation risk: the risk that services are used more or less frequently than predicted for a given population size and patient casemix.

3.5 Agreeing an approach to monitoring and feedback

As part of the shadow testing and implementation of this payment approach, it is essential that commissioners and providers monitor its impact. In the short term this will inform the iterative testing and refinement of pricing and outcomes locally ahead of full implementation in 2018/19.

All IAPT providers are required to continue reporting IAPT data, including both cluster, and quality and outcomes data, on a monthly basis to NHS Digital. As mentioned above, a tool has been developed to support implementation of the suggested payment approach for IAPT services. This tool will support commissioners and providers with feedback on services and performance of providers to help improve service delivery.

Integrated governance

To monitor implementation during the shadow period we recommend that an integrated commissioner and provider governance group is established, if one does not already exist, and is accountable for the quality of care being provided to patients through the IAPT payment approach.
The governance group should have appropriate representation from primary care, community services and acute physical and mental health services, along with user representatives and those from the social and volunteering sector. It should include clinicians and managers and meet regularly in the year. The group should review the current status of the service and any risk-related issues, and take part in evaluation, audits and implementing any service changes that lead to improvements.

Evaluation

Commissioners and providers should monitor, learn from, refine and evaluate the potential impact of the payment approach during the shadow year. This will help to inform the exact shape of the payment approach implemented in 2018/19.

We also encourage commissioners and providers to systematically evaluate their services to:

- identify areas of strength locally to be expanded and further developed
- use data and other information collected through the model to understand whether the benefits being realised outweigh the cost/investment in the service and to make robust decisions on service implementation
- refine the existing model to ensure it delivers the agreed outcomes – this will help to ensure services are flexible and responsive to 'on the ground realities' (eg changing environment, meeting unmet needs)
- identify where implementation falls short of best practice and support the roll-out and scale-up of successful approaches.

While there are many forms of evaluation, the approach and methods will depend on the purpose, the priorities of the local health economy, and the resources available locally and timeframe.

3.6 Consider the service in the context of local system factors

Implementation of this payment approach will be shaped by a variety of local factors and priorities. Although this section is not an exhaustive exploration of potential local factors, it highlights some that commissioners and providers should explore, as well as others they may identify locally:

Integrated pathway – step-up/down arrangements

IAPT services are delivered on a stepped-care basis. This means that the outcome of the assessment process will determine whether treatment may be delivered at low intensity in the first instance and stepped up to higher intensity as required. This stepped-care pathway is in line with NICE guidance and offers considerable efficiency and flexibility in line with service user needs and preferences.

However, where the stepped pathway is split between providers, commissioners will need to ensure that reward for activity and outcomes is appropriately shared across the pathway to encourage appropriate stepping-up/down that supports the service user. This may be best delivered through a lead provider arrangement.

Data and information management

Robust data and information management is important in developing and improving services, and measuring costs to inform local prices. Collecting, analysing and interpreting performance information enables commissioners and providers to continuously monitor the impact of the service, to see where the service is working and where it is not, and to identify the associated costs and benefits.

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. For example, 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.

The outcomes-based payment tool from NHS England, NHS Improvement and NHS Digital mentioned above draws on the 10 quality and outcome measures captured in the IAPT minimum dataset, which are to be used as the basis of the payment

approach and assesses performance against parameters that have been set locally and submitted to NHS Digital.

Use of the outcomes-based payment tool will mean that no patient identifiable data will flow between providers and commissioners operating the IAPT payment approach. However, commissioners and providers will need to continue to adhere to all information governance and data protection obligations as set out in relevant legislation, particularly if seeking to use extra outcome and quality measures locally.

Annex 1: IAPT quality and outcomes measures and how these are used to calculate payment

Ten quality and outcome measures are used as the basis of the payment approach. These are:

- Access:
    - 1. Waiting times
    - 2. Black, Asian and minority ethnic (BAME)
    - 3. Over 65
    - 4. Specific anxieties
    - 5. Self-referral
- 6. Clinical outcomes
- 7. Reduced disability and improved wellbeing
- 8. Employment outcomes
- Patient experience:
    - 9. Satisfaction
    - 10. Choice of therapy.

Table 3: Summary of IAPT outcome measures, weightings and business rules

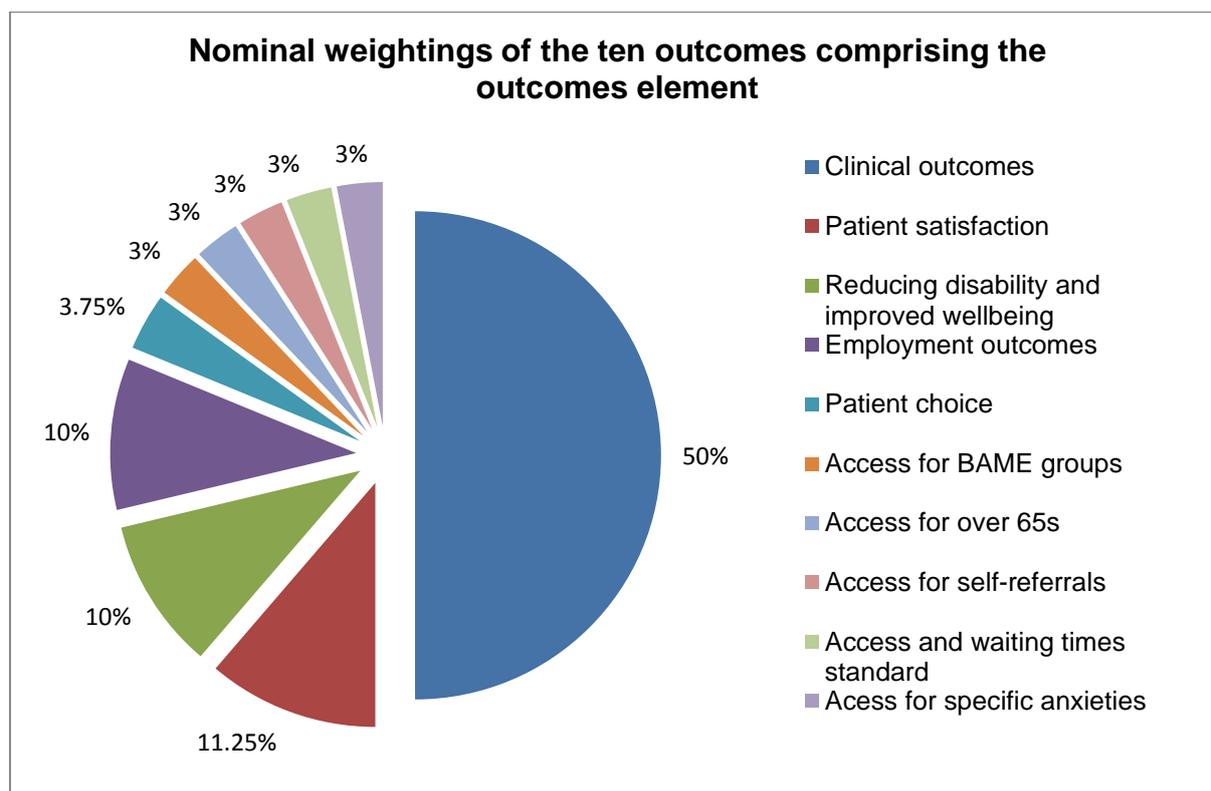| Measure	Weighting	Level	Source	Expected performance	Business rules
Waiting time standard	To be determined locally	Calculated at service level	IAPT MDS	In line with national standards	No payment for partial achievement
BAME access	To be determined locally	Calculated at service level	IAPT MDS	Locally agreed threshold	No payment for partial achievement
65+ access	To be determined locally	Calculated at service level	IAPT MDS	Locally agreed threshold	Pass/Fail
Self-referral	To be determined locally	Calculated at service level	IAPT MDS	Locally agreed threshold	Pass/Fail
Specific anxieties	To be determined	Calculated at service	IAPT MDS	Locally agreed	Pass/Fail

	locally	level		threshold	
Clinical outcomes	To be determined locally	Calculated at patient level	Disorder specific clinical assessment scales*	In line with disorder-specific clinical assessment scales	Must be statistically reliable change

Partial compliance rewarded as per scale of movement towards clinical recovery |
| **Reduced disability and improved wellbeing** | To be determined locally | Calculated at patient level | WSAS | Statistically reliable movement towards wellbeing | Must be statistically reliable change.

To be rewarded as per scale of movement towards wellbeing |
Employment	To be determined locally	Calculated at service level	IAPT MDS	Locally agreed level of net movement towards employment	Partial compliance rewarded in line with level of performance
Choice	To be determined locally	Calculated at service level	IAPT PEQ	Locally agreed level of performance	Pass/Fail
Satisfaction	To be determined locally	Calculated at service level	IAPT PEQ	Locally agreed level of approval	Pass/Fail

*See Table 4: Standardised Clinical Assessment Scales

During development of these measures, nominal weights were assigned for each of them along with nominal targets. In practice we expect commissioners and providers to agree targets up front. They should also agree a process for adjusting targets, where this is appropriate, to support continuous service improvement. This may be at more frequent intervals during the shadow year. A suggested approach to

applying weightings to the discrete quality and outcome measures is illustrated below. It allocates certain percentages of the total price paid to achieving outcomes for particular measures. The following sections elaborate on the individual targets and domains.

Figure 2: Illustrative example of allocation of measures for IAPT outcomes element of payment approach

Nominal weightings of the ten outcomes comprising the outcomes element

- 3%
- 3%
- 3%
- 3%
- 3%
- 3.75%
- 10%
- 10%
- 11.25%
- 50%

- Clinical outcomes
- Patient satisfaction
- Reducing disability and improved wellbeing
- Employment outcomes
- Patient choice
- Access for BAME groups
- Access for over 65s
- Access for self-referrals
- Access and waiting times standard
- Acess for specific anxieties

Equity of access

Service commissioners and providers should act to ensure compliance with their obligations under equalities legislation. This includes the need to reduce health inequalities with respect to accessing IAPT services.

The IAPT dataset captures data that may inform indicators and accepted quality standards that are critical to ensuring delivery of evidence-based interventions, as well as ensuring that commissioners are meeting the needs of their local population.

By linking reward to these indicators commissioners will enable delivery of effective, evidence-based treatments in a consistent manner that will improve clinical recovery rates, realising a range of clinical and non-clinical benefits such as employment and/or wellbeing improvements for the individual, their families, local communities and the wider economy.

How is this used in the suggested IAPT payment approach?

In the suggested IAPT payment approach equity of access is measured at a service level for all the patients discharged each month and has five related measures:

- **Access and waiting times standard**[19]

  To ensure no one waits longer than necessary for a course of treatment, the suggested IAPT payment approach reflects the mandated commitment whereby services ensure that:

  A. 75% of people referred to the IAPT programme begin treatment within 6 weeks of referral

  B. 95% of people begin treatment within 18 weeks of referral.

- **Access for BAME groups and Access for over 65s**

  Service commissioners and providers should be acting to ensure compliance with their obligations under equalities legislation. This includes the need to reduce health inequalities with respect to accessing IAPT services.

  The suggested IAPT payment approach reflects these obligations by rewarding progress services make towards achieving rates of access for those from BAME groups and those aged over 65 in line with expected local prevalence of depression and anxiety in these cohorts and the proportion of these cohorts in the local population.

- **Access for self-referrals**

  Ensuring services are available to self-referrals will mean that people are able to access services directly, without needing to go through their GP or other intermediary, a key barrier in the way of many people accessing IAPT services.

  The suggested IAPT payment approach incentivises a commissioner-provider agreed proportion of people discharged who had referred themselves.

- **Access for specific anxieties**

  IAPT is an effective pathway for the treatment of a range of specific anxieties.

---

[19] More guidance on the business rules underpinning the application of this standard is available from NHS England at: www.england.nhs.uk/wp-content/uploads/2015/02/iapt-wait-times-guid.pdf

The suggested IAPT payment approach reflects this by rewarding services for achieving a commissioner-provider agreed rate of access for those presenting with specific anxieties (excluding general anxiety).

Clinical outcomes

A quantitative assessment of the outcome of treatment is based on comparison of the first and last scores on the relevant clinical scale for measuring symptoms for each patient and is used at each session. There are different IAPT scale measures specific to a person's presentation.

All clinical scales have a certain amount of measurement error. A change from one occasion to another is only considered real (ie statistically reliable) if it exceeds the measurement error. The amount of first to last treatment change a patient needs to show on each IAPT measure for the improvement to be deemed statistically reliable is given in Table 4 (with 0 being the score of someone displaying none of the characteristics of the disorder):

Table 4: Standardised clinical assessment scales

Measure	Disorder	Range	Caseness	Statistically reliable change
PHQ-9	Depression	0-27	10	≥ 6
GAD-7	Generalized anxiety disorder (and unspecified anxiety problems)	0-21	8	≥ 4
OCI	Obsessive-compulsive disorder	0-168	40	≥32 (distress scale)
SPIN	Social anxiety disorder	0-68	19	≥10
sHAI	Health anxiety (short version: 14 items)	0-42	18	≥ 4
MI	Agoraphobia	1-5 (item mean for avoidance alone)	2.3 per item average	≥ 0.73
IES-R	Posttraumatic stress disorder	0-88	33	≥ 9

Recovery is classified as moving from a score at or above caseness on the PHQ-9 **and/or** the GAD-7 or appropriate Anxiety Disorder Specific Measure (ADSM) at the first appointment, to a score below caseness on both the PHQ-9 **and** the GAD-7 or appropriate ADSM at the last appointment.

Statistically reliable improvement is calculated by measuring whether or not the amount a score decreases on the PHQ-9 and the GAD-7 or an ADSM is equal to or higher than the statistically reliable change.

Other clinical outcomes, such as the Work and Social Adjustment Scale, are used to monitor change, but not to calculate recovery.

How is this used in the suggested IAPT payment approach?

The suggested IAPT payment approach rewards the clinical outcome at the service user level. It also reflects a focus on reliable change, and reward is only triggered if the amount of improvement exceeds the minimum that would be considered *statistically reliable*. The size of the payment will then depend on how far the person has moved towards recovery:

A. If a service user achieves statistically reliable change **and** recovers then the full clinical outcomes payment is awarded.

B. If a patient achieves statistically reliable change but does not recover, the following formula is used to determine what proportion of the payment for clinical improvement should be awarded:

$$\frac{first\ score - last\ score}{first\ score - caseness}$$

If a service user has both depression and an anxiety condition, ie is above caseness on the PHQ-9 scale and one of the anxiety scales, then the improvement/recovery (or not) in both are taken into account in the calculation of payment.

Reduced disability and improved wellbeing

People's conditions sometimes affect their ability to do day-to-day tasks. To reflect this broader impact, the IAPT dataset includes the Work and Social Adjustment Scale (WSAS), a simple, reliable and valid measure of impaired functioning. The WSAS consists of five questions; each question can be scored from 0-8. A movement of 13 or more in the total score is statistically reliable.

How is this used in the suggest IAPT payment approach?

The suggested IAPT payment approach reflects a focus on reliable change. As such, change on the WSAS will only trigger a payment if it is sufficiently large to be statistically reliable; this is a movement of 13 or more in the total score. If the change shown by an individual is statistically reliable, the amount of payment received for

that individual will be related to the percentage improvement compared to pre-treatment, calculated using the following formula:

$$\frac{first\ score - last\ score}{first\ score}$$

Employment outcomes

Supporting people back to work from a period of sickness absence or on a sickness-related benefit has been a central aim of the IAPT programme since it began. There has also been a clear focus on early intervention and keeping people in work by providing well co-ordinated employment advice in the IAPT service model. Retirement should be considered as distinct from unemployment.

Meaningful activity, including volunteering and long-term study, should be accounted for. While retirement should be considered as distinct from unemployment, retirement should not automatically be thought of as including meaningful activity.

How is this used in the suggest IAPT payment approach?

The suggested IAPT payment approach rewards the impact on employment at the service level. This outcome is calculated on a monthly basis and measured by net movement of service users into employment or other meaningful activity against a commissioner-provider agreed target. Through this mechanism local circumstances should be reflected and the role of IAPT in supporting employment may be accounted for. This is calculated each month according to the following calculation:

$$\frac{Net\ movement\ to\ employment\ for\ service\ users\ discharged\ in\ month}{(Number\ of\ discharges\ in\ month\ \times\ \%'age\ Commissioner\ Net\ Employment\ Target)}\ \times 100\%$$

Service user experience

The IAPT dataset incorporates two dimensions of service user experience: choice and satisfaction, both of which are sampled routinely through the patient experience questionnaire (PEQ).[20]

There are two points at which patients are asked to provide feedback on their experience. The first is after they have been assessed, a decision to treat has been made and a treatment plan has been put into place. At this point, an assessment questionnaire is administered. It consists of three questions on choice and one on satisfaction. The second point is a post-treatment satisfaction questionnaire.

---

[20] http://webarchive.nationalarchives.gov.uk/20160302154833/http://www.iapt.nhs.uk/silo/files/patient-experience-questionnaire.doc

How is this used in the suggest IAPT payment approach?

The suggested IAPT payment approach incorporates both choice and satisfaction measured and rewarded separately at the service level.

Patient choice

The choice questions are calculated as outlined in Table 5. Each has a yes/no answer and question 3 also has a N/A option. All possible combinations and the associated score are outlined below:

Table 5: Patient choice questions calculation

Q1: Were you given information about options for choosing a treatment that is appropriate for your problems?	Q2: Do you prefer any of the treatments among the options available?	Q3: Have you been offered your preference?	Score
Yes	Yes	Yes	Full reward
Yes	No	N/A	Full reward
Yes	Yes	No	Partial reward
No	Yes	Yes	Partial reward
No	Yes	No	No reward
No	No	N/A	No reward

Choice is a service-level measure and the overall score will be applied to payment calculations for all discharges in the period. The overall reward achieved for each service user returning a questionnaire will be divided by the total number of patients submitting questionnaires in the period. Commissioners and providers should set a threshold for performance that reflects local expectations and also agree a minimum number of service users to be sampled in the period to capture a representative sample on a systematic basis.

Patient satisfaction

The satisfaction questions are outlined in Table 6.

**Table 6: Questions from the patient experience questionnaire**

Assessment questionnaire	A1	How satisfied were you with your assessment?
Treatment questionnaire	T1	Did staff listen to you and treat your concerns seriously?
	T2	Do you feel that the service has helped you to better understand and address your difficulties?
	T3	Did you feel involved in making choices about your treatment and care?
	T4	On reflection did you get the help that mattered to you?
	T5	Did you have confidence in your therapist and his/her skills and techniques?

Each satisfaction question has five options scoring 0 to 4, with a score of 4 being the most satisfied. Missing answers for any of the six questions are counted as zero.

The total score of the six questions is calculated for each service user and will range between 0 and 24, with a suggested score of 18 or higher representing an acceptable level of satisfaction.

Satisfaction is a service-level measure and the overall score will be applied to payment calculations for all discharges in the period. The total score achieved for all service users returning a questionnaire within a given period will be divided by the total number of patients submitting questionnaires in that period. Commissioners and providers should set a threshold for performance that reflects local expectations. They should also agree a minimum number of service users to be sampled in the period to capture a representative sample on a systematic basis.

Annex 2 IAPT payment approach: high level operational flowchart
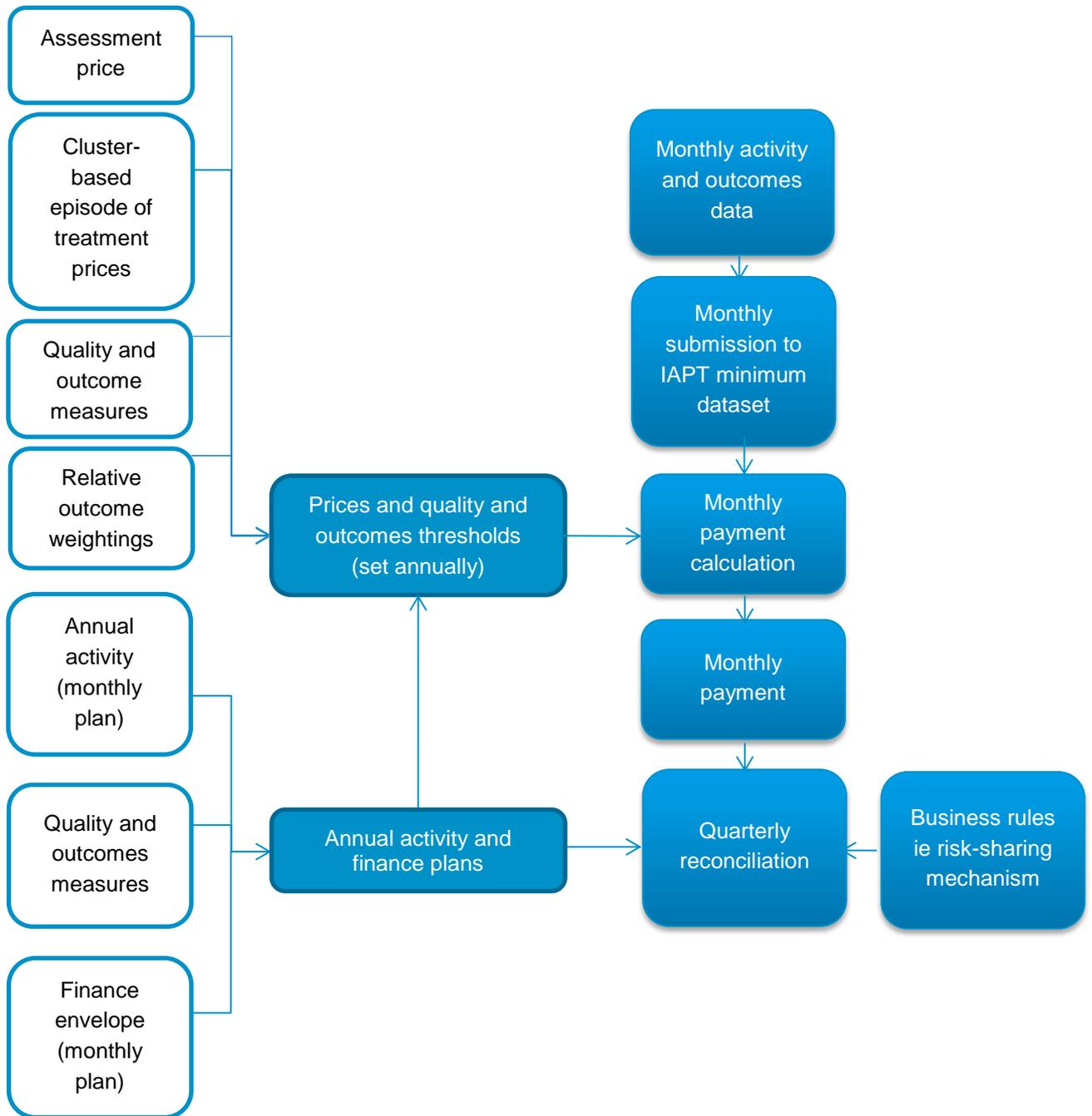
Contact us

This publication can be made available in a number of other formats on request.