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IAPT Payment by outcomes
A commissioning perspective

Claire Maguire

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DH Care Clusters and the Mental Health Clustering tool (MHCT)

- Care cluster approach developed by South Yorkshire
- Focus on characteristics of an individual rather than on diagnosis or what service they receive
- To inform service delivery - to better organise services
- Used HoNOS to allocate and measure outcome

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Taken on by DH for potential use in MH PbR:

- Developed into 21 (+ Zero) care clusters for use in Working aged adults (inc. EIT) and older peoples services
- Aim for national consistency in use of clusters and assessment tool but do not define interventions and treatments
- Potential benefits:
  – increase understanding of needs of service users and improve quality of care
  - create more informed operational and strategic decisions for MH services
- Effectively payment by intervention (Medical/Pharmacological/Psychosocial)
- Needs to be linked to Evidence Based interventions

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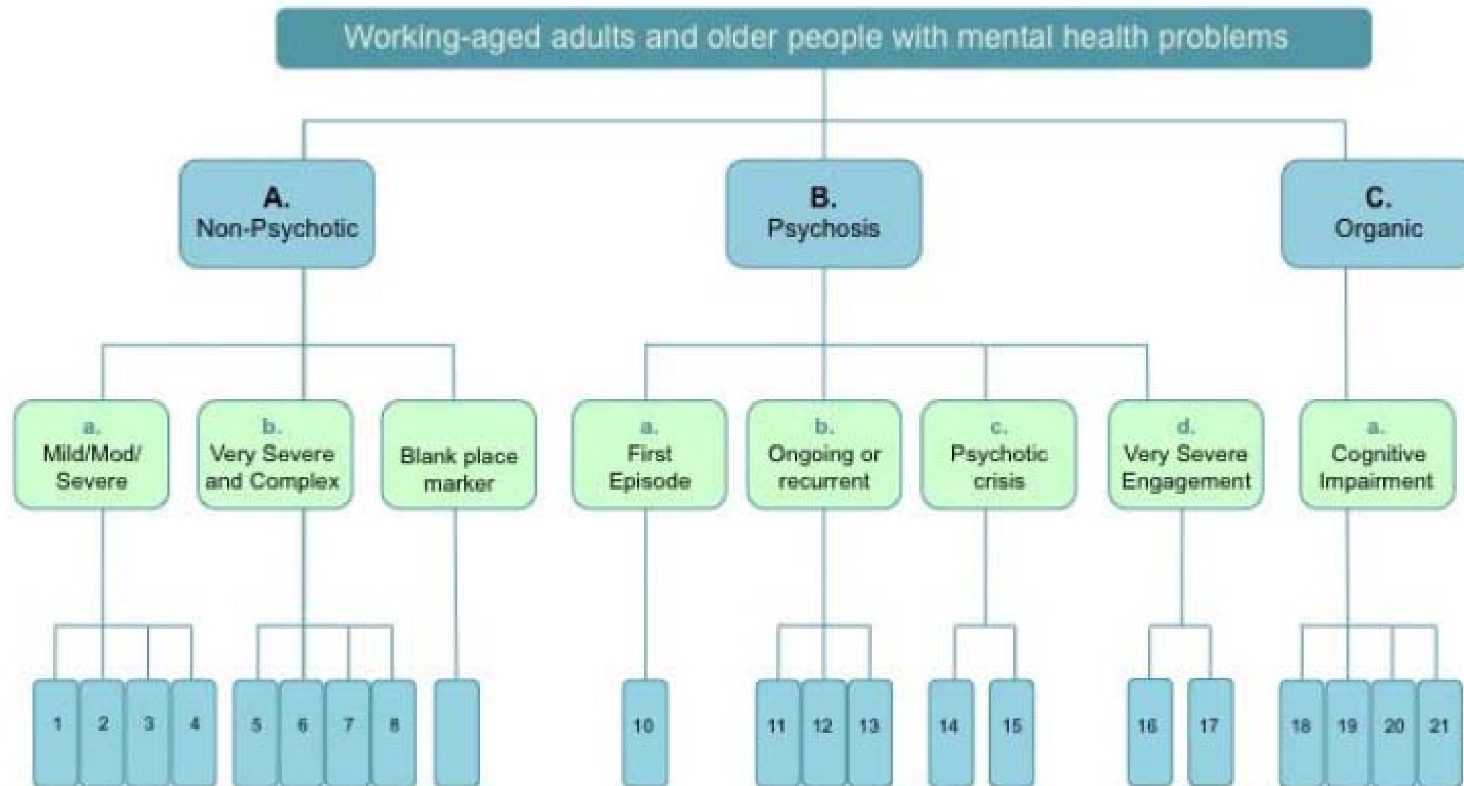
Decision Tree and Care Cluster Relationships



0 = NOT MATCHED – VARIANCE CLUSTER

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Super Group		Care Cluster
A Non-Psychotic	a. Mild / Mod / Severe	1. Common MH problems (low severity) 2. Common MH problems (low severity with greater need) 3. Non-Psychotic (Moderately Severe) 4. Non- Psychotic (Severe)
	b. Very Severe and Complex	5. Non-Psychotic Disorders (Very Severe) 6. Non-Psychotic Disorder of Over-valued Ideas 7. Enduring Non-Psychotic Disorders (High Disability) 8. Non-Psychotic Chaotic and Challenging Behaviour
	c. Substance Misuse	9. Substance Misuse - Now Blank Place Marker
B Psychosis	a. First Episode	10. First Episode Psychosis
	b. Ongoing or Recurrent	11. Ongoing or Recurrent Psychosis (Low symptoms) 12. Ongoing or Recurrent Psychosis (High Disability) 13. Ongoing or Recurrent Psychosis (High symptoms and disability)
	c. Psychotic Crisis	14. Psychotic Crisis 15. Severe Psychotic Depression
	d. Very Severe Engagement	16. Dual Diagnosis 17. Psychosis and Affective Disorder – Difficult to engage
C Organic	a. Cognitive Impairment	18. Cognitive Impairment (low need) 19. Cognitive Impairment or Dementia Complicated (moderate need) 20. Cognitive Impairment or Dementia Complicated (high need) 21. Cognitive Impairment or Dementia (high physical or Engagement)

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MHCT SUMMARY

For use in

- Adults of working age
- Older Adults (65+)
- Children under 18 when in specialist adult MH service

Exclusions

- **Substance misuse** *(in development)*
- **Learning disability** *(in development)*
- **Liaison psychiatry**
- **Acquired brain injury**
- **IAPT** *(in development)*
- **Secure MH services (high. medium, low)**
- **CAMHS** *(in development)*

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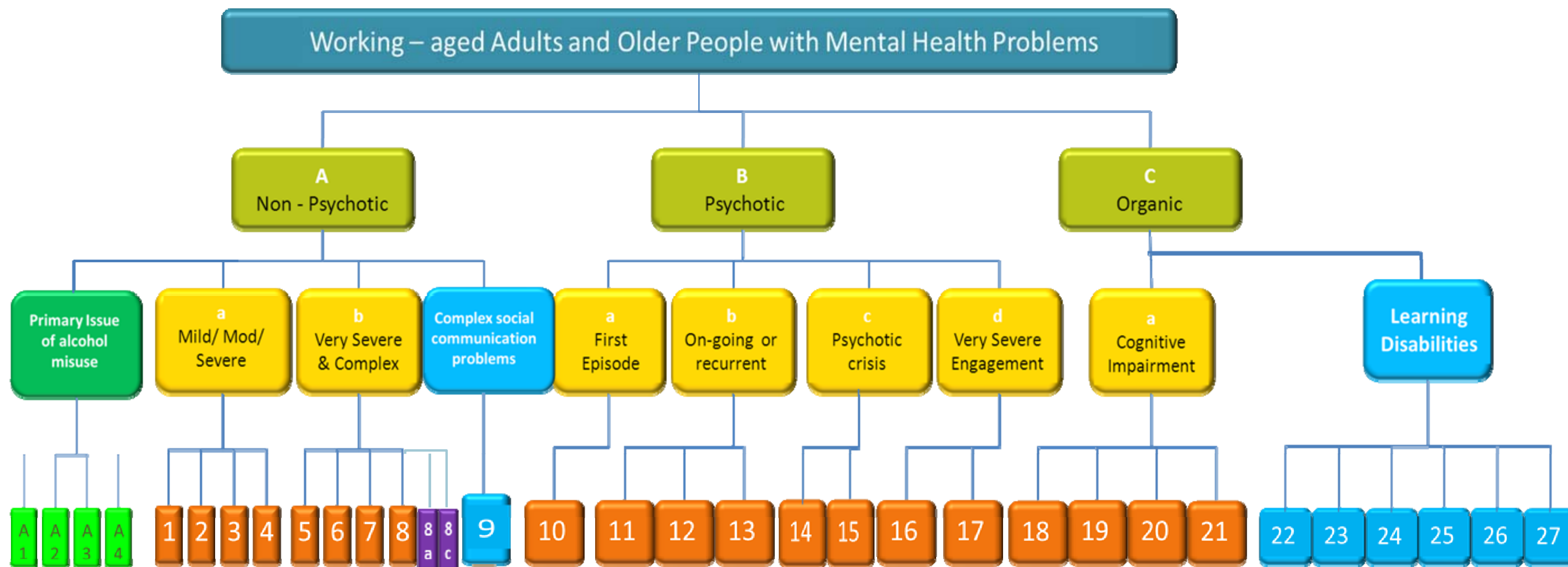
Relationship between mandated and proposed forensic clusters



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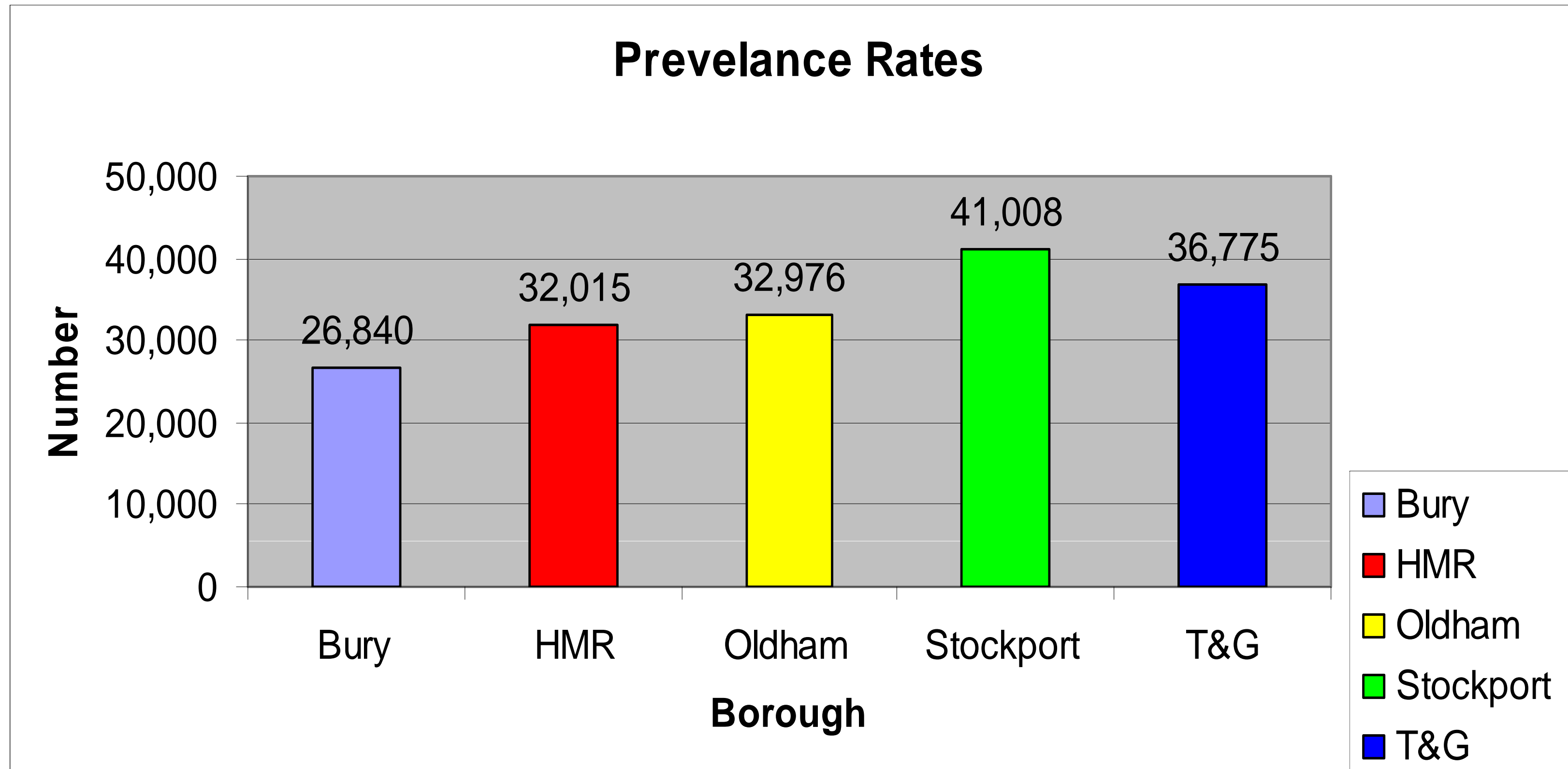
Prevalence Rates for IAPT Services within Pennine Care



*** Bury is an all age Service

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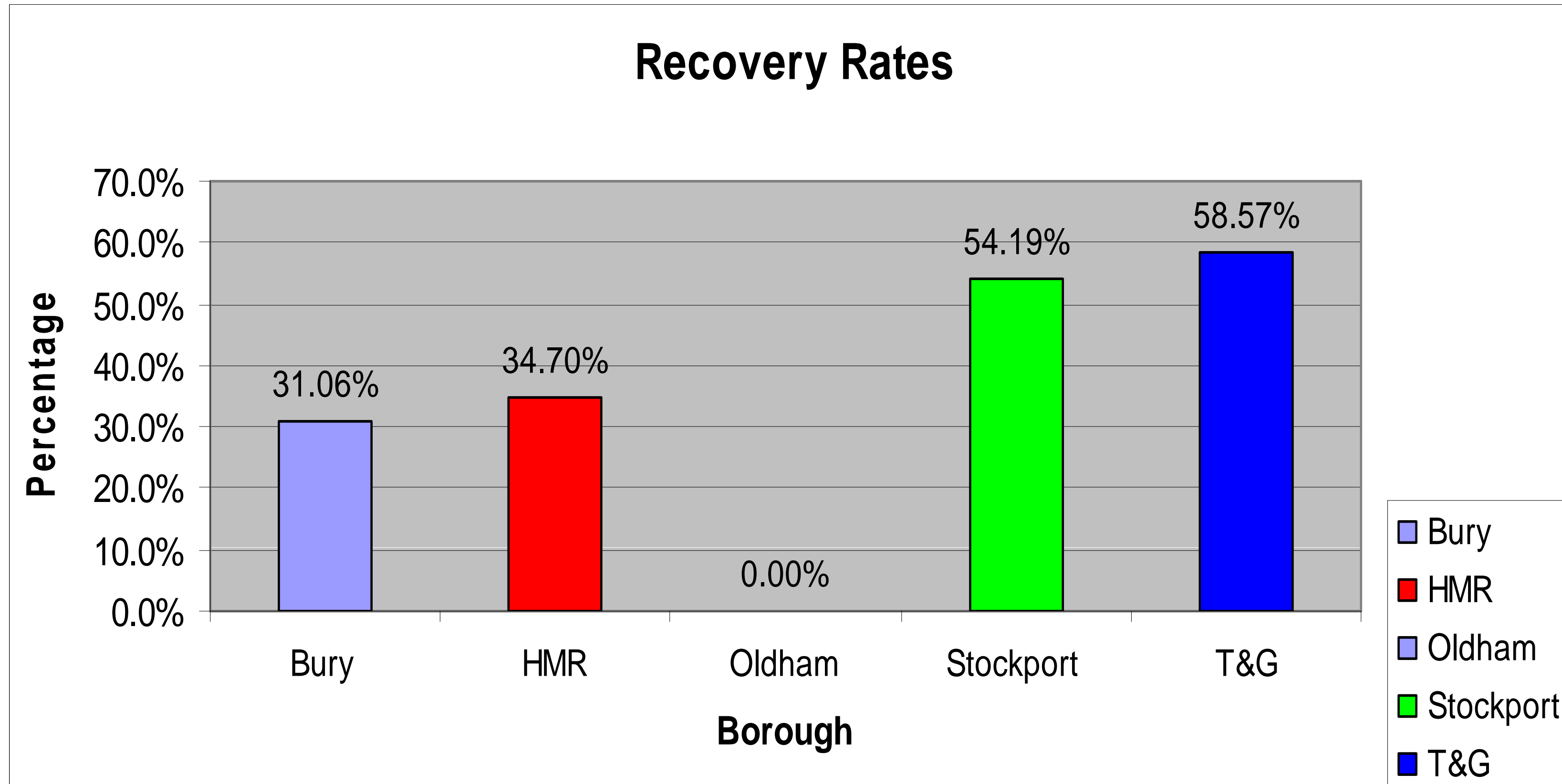
Recovery Rates for IAPT Services within Pennine Care



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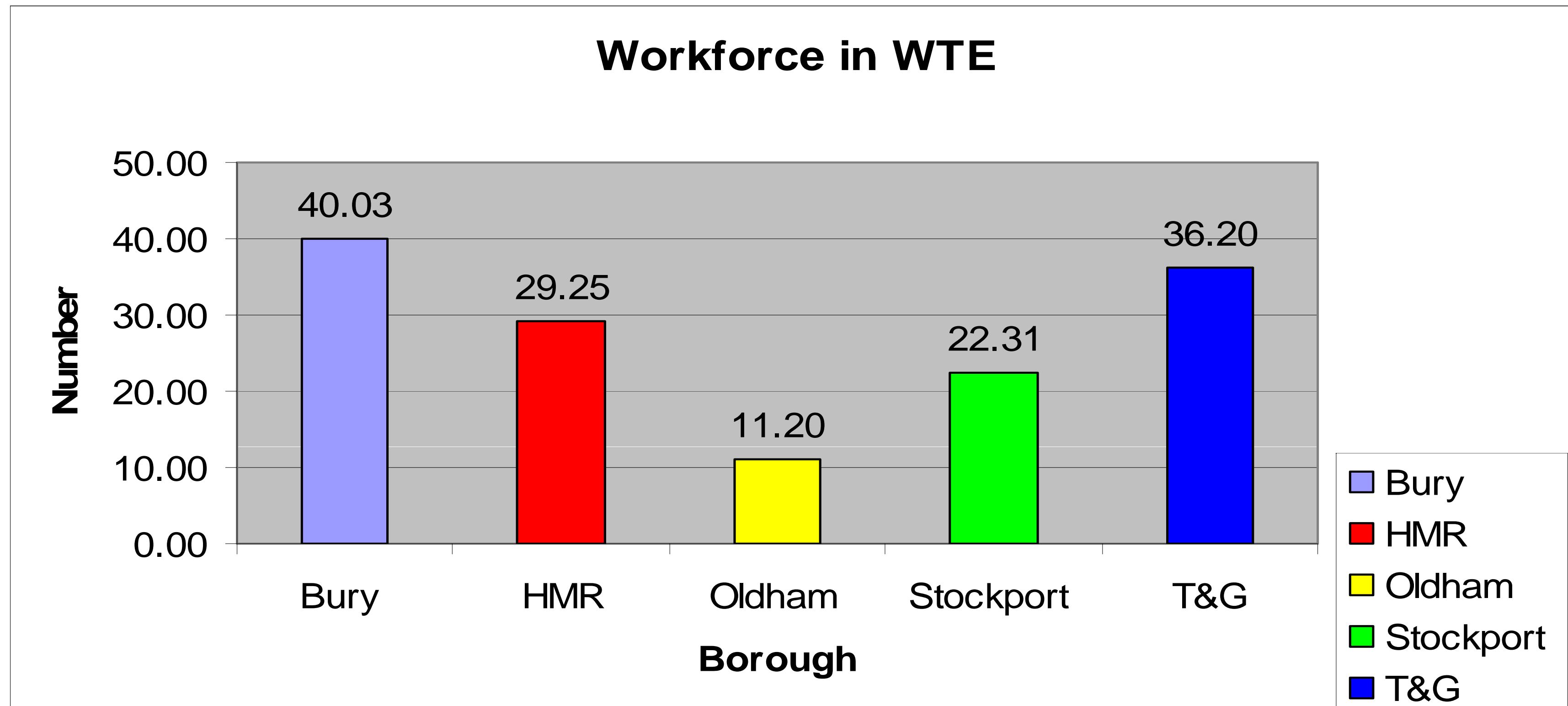
Workforce by WTE within Pennine Care IAPT Services



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Clinical Workforce within Pennine Care IAPT Services

Pennine Care's IAPT Teams are made up of the following clinical workforce:

- PWP's
- HIT's
- CBT
- Counsellors
- Clinical Psychologists
- Clinical Leads
- Psychotherapists
- CPN/Gateway Workers/MH Practitioners

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IAPT and Payment by outcomes

- Does not exclude the use of Care Clustering
- Is IAPT all about care clusters 1 – 3?
- Services can do well in different domains
- Commissioners can prioritise aspects of PbR
- Complexity of service configuration
- Step up/down within different providers?
- Importance of payment for assessment