MENTAL HEALTH’S MARKET EXPERIMENT:

COMMISSIONING PSYCHOLOGICAL THERAPIES THROUGH ANY QUALIFIED PROVIDER

Steve Griffiths, Joan Foster, Scott Steen, Professor Patrick Pietroni

REPORT NO.1

Centre for Psychological Therapies in Primary Care
Faculty of Health and Social Care
PREFACE

The Health and Social Care Act (2012a) radically altered the organisation of the NHS. However, the most important changes were not in the Bill as it went through Parliament.

In July 2011, the Department of Health (DH) published its Operational Guidelines on Extending Patient Choice of Provider (DH, 2011d). The concepts of Any Qualified Provider (AQP) and Payment by Results (PbR) were outlined as the method of service delivery and contractual agreement between commissioners and health service providers.

The expressed rationale for introducing AQP and PbR were that it would:

(i) Extend patient choice.
(ii) Raise both service quality and efficiency through competition between providers.

The Department expected all Primary Care Trusts (PCTs) and their replacement Clinical Commissioning Groups (CCGs) to select at least three service areas in which these models of commissioning and contractual arrangements would be utilised. During 2012 twelve PCTs chose to implement these new guidelines for the commissioning of psychological therapies in primary care.

The Centre for Psychological Therapies in Primary Care (CPTPC) was established at the University of Chester in August 2012. Its committed priority was to undertake research on the impact of the 2012 Health and Social Care Act (2012a) as it was being implemented.

Griffiths and his colleagues have undertaken a series of research studies, two of which have already been published (Griffiths & Steen, 2013a, 2013b).

This more detailed and extensive report is based on qualitative interviews with providers and commissioners in the first tranche of areas opting for AQP. It sets that narrative evidence in its evolving policy context.

It is the first such comprehensive study to be published. The implementation of such a complex policy is bound to have “teething problems”. However, the researchers were surprised at the consistency of the themes that emerged in the responses, which were often critical.

We are proposing to hold a consensus conference in the Spring of 2014 to examine and further interrogate the recommendations made in this report.

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FINDINGS AND RECOMMENDATIONS

INTRODUCTION

This research project examines the impact of the introduction of a market system for the provision of psychological therapies in primary care. The Centre for Psychological Therapies in Primary Care (CPTPC) carried out qualitative interviews with providers and commissioners in the first tranche of areas implementing the Government’s Any Qualified Provider (AQP) policy. Our report sets this qualitative evidence in the context of a changing policy, evidential and operational landscape, and reaches conclusions to support the future development of an effective framework in England for commissioners wishing to invest in improved mental health and wellbeing.

FINDINGS

1. In the seven Primary Care Trust (PCT) areas or clusters opting to enter the AQP process examined by the research, the number of providers contracted ranged from one to 12 (effectively meaning that some areas initiated AQP but did not implement it) (Chapter Two).

2. The combination of tariff structure and Payment by Results (PbR) produces widespread perverse incentives for providers and perverse outcomes for patients (Chapter Three, Part B). Distortions described include:
   - tariff and PbR as a factor in the decision to take patients on, and the type of treatment to offer (B4, B5)
   - destabilisation and some deterioration in service (B4, B6)
   - destabilisation of provider organisations affecting their viability (B4, B6)
   - the pressure of mechanistic throughput of patients affecting decision-making and quality (B5)
   - financial incentives to misuse measurement scales within therapy to improve measured outcomes and trigger payment – measurement scales that were not designed or validated as a payment method (B5, and Part C).

3. There is widespread concern about whether AQP is a viable model for small organisations. Providers spoke about the risk of investment in the range of interventions demanded by some service specifications while there was no work guaranteed; about the wisdom of investment in required infrastructure, particularly IT, given the risk involved in zero value contracts; and in a number of cases about unpredictability in the flow of patients. In several cases this combination of circumstances was seen to be unsustainable (Chapter Three, Part B).

4. Providers interviewed generally thought that the levels of tariff were causing severe strain in AQP areas, affecting the type of work providers undertook, often against their professional judgement. For several of the providers interviewed, this was
reason to question the viability of contracts. The frequent exclusion from the tariff of significant and increased administrative costs, non-attendance by patients, holidays, and the cost of inputting weekly outcome measurements, were a major financial challenge for many providers (Chapter Three, Part B).

5. Zero value contracts came up repeatedly. The volume of patient “throughput” was crucial, with the result that AQP finances only broke even when a threshold of provision was reached. Providers could not be expected to maintain a skilled workforce in the expectation of patients being referred, particularly with unrealistic tariffs. Because there was no reserve workforce given the volatility of the market, high demand in a context of insecure income flow created an incentive to hurry patients through the system. This view was endorsed by a commissioner who spoke of “a sausage machine, getting as many people through the system as you can – with a risk of relapse” (Chapter Three, B4-B6).

6. The employment status of therapists had a significant impact on the financial viability of AQP tariffs, with higher costs ascribed to those employing staff under normal working conditions such as holiday pay and a degree of job security, and to organisations with self-employed, highly skilled and experienced therapists - while those using volunteer or trainee staff were at a competitive advantage. Zero value contracts for providers meant zero value contracts for individual therapists. One commissioner held that new providers were ‘blossoming’ because they were able to keep costs down by not employing staff on secure employment contracts, which were not viable under the AQP model. This had major implications for retention, continuity, and maintaining levels of skills (Chapter Three, B4, B11, B14).

7. Several interviewees had withdrawn from AQP provision for these reasons, or were considering doing so, and one commissioner reported withdrawal by a major provider. Another acknowledged that tariffs had been set unrealistically low, and when a major provider reported a threat of insolvency, a risk articulated by others, had felt obliged to recommission the entire service, at considerable expense. A third commissioner felt that with its hidden extra costs, the whole system was vulnerable, and reported that the larger number of providers meant greater administrative burdens of contract monitoring (B4).

8. The three commissioners interviewed all reported significant reductions in waiting lists for therapy, with some dynamic providers responding to changed demand in terms of type of treatment and to geographical variations in need, and others proving less flexible and successful. This was ascribed both to market forces and to creative and flexible commissioning. Waiting lists at the start had meant a high volume of patients. As they were dealt with, lower volume was creating issues for providers with zero value contracts, and creating some market instability (see above). A key unresolved question is whether competition was a positive factor in these achievements in the context of increased public investment (Chapter Three, B14-15).

9. Another major concern was the use of outcome measures at every session, a requirement which is general across Improving Access to Psychological Therapies (IAPT) services. Concerns raised included the intrusive effect of patients feeling overly measured, disruption of limited session time, disproportionate and unpaid administrative burden, and the perception that some patients can struggle with a weekly exercise that requires them to list how poorly they are doing, which can result in increased low mood (Chapter Three, Part C).

10. There was considerable scepticism about over-reliance on the measures. Several interviewees thought this raised fundamental questions about the assumptions on
which IAPT is based, particularly in terms of measurement being a snapshot in time which might produce quite different results within 24 hours; perverse incentives and unfair ethical pressures created by payment depending on a positive outcome; and non-recognition of fluctuation in well-being during a course of treatment, with an incentive to declare the patient recovered on the basis of one outcome measurement (Chapter Three, Part C).

11. Several providers and a commissioner raised limitations in the scope of outcome measures used in IAPT, with concern about whether they reflected low self-esteem, social anxiety, panic attacks, and particularly Obsessive-Compulsive Disorder (OCD), with narrow scoring not reflecting wider improvements which may be far-reaching, for example in psychological conditions that might be related to physical disorders (Chapter Three, Part C).

12. Providers and commissioners described how linking outcome measurement to recovery payment created pressure to manipulate the former – and indeed to manipulate patients’ completion of these measurements. For example, payment can be jeopardised at the end of a long treatment by a sudden, temporary dip in outcome measurement, with the result that that treatment becomes unpaid. The result can be, where there is doubt or difficulty, that the patient is avoided or rejected. It was reported that such pressure was widespread. The point was made that outcome measures were designed to assist clinical judgement, not as a payment structure, which was how they were being used through PbR; and that it is wrong to assume because patients did not return that they were or were not recovered, an assumption integral to IAPT. According to some providers and commissioners, this was leading to selection by providers of those patients most likely to recover: choice of patients rather than patient choice (Chapter Three, C4).

13. Commissioners identified conflicts of interest where:

- there was a single point of entry to services, where that assessment agency also provided services at Levels 2 and 3, creating a danger that more complex cases would be referred to other agencies, and more profitable, easier, cases, would be retained by the Level 1 agency; and where
- organisations provided single level services and held onto patients when they needed to be stepped up (Chapter Three, B15).

14. There was widespread anger about disproportionate demands, inefficiency and cost occasioned by requirements to adopt and link up to NHS IT systems, a requirement seen as largely unnecessary and discriminatory towards small organisations with limited resources. Two commissioners interviewed had provided logistical and financial support to enable small providers to meet the requirement (Chapter Three, B7).

15. One strand of providers’ response to AQP acknowledged that some commissioners had comprehensively recognised the need to understand local conditions, and that this was consequently recognised in the nature and breadth of provision. There was an example of a strong commissioning engagement with both equity of access and with wider determinants of mental health as part of a continuing, developmental process, successfully adapting therapies such as low-intensity psycho-social support to the needs of deprived communities which had high levels of need for mental health services but little knowledge of, or access to, psychological therapies. This is an approach that could be replicated, strengthening agendas to reduce health inequality (Chapter Three, B10).
16. Evidence in the report suggests that the term ‘patient choice’ can be understood in a number of ways, and that AQP and PbR may have some unintended consequences that are detrimental to patient choice and in turn to patient outcomes, in particular that the payment model led to providers rejecting those unlikely to fit in to a recovery model – a reduction of choice for those patients. On the other hand, the expansion of provision in itself, leading to reductions in waiting lists, created a choice by offering a service where there was previously none. In this context, the absence of a genuine voice of patients in the evolution of psychological therapies in primary care was striking (Chapter Three, B12).

17. An analysis of AQP service specifications found significant inconsistencies in their scope which will affect patients’ access to appropriate services and create a postcode lottery. This is likely to affect more areas than those that have opted for AQP, since these issues are not specific to the new market arrangement. Monitor, the sector regulator for health services in England, need to take action to create a level playing field, and Clinical Commissioning Groups (CCGs) need to look to their own areas’ service provision. They affect issues such as the age threshold for access by young people to adult psychological therapies, the level of need at which patients only have access to secondary care, and what happens when referrals are rejected (Chapter Four).

18. Charities which had become companies limited by guarantee were the most successful organisation type in securing AQP contracts, comprising 43% of contractors. Private limited companies were less successful, with only seven out of 30 achieving contracts. Previously existing contractors did well, and made up 42% of AQP contractors – which meant that more than half of the 46 providers contracted were new (Chapter Two).

19. The overwhelming view of the providers and commissioners interviewed was that the online AQP qualification process was wasteful, bureaucratic, stressful and poorly structured and defined, demanding disproportionate resources and organisational change, particularly for small organisations (Chapter Three, Part A).

20. Providers’ assessment of the quality of commissioners’ support through the qualification process was extremely mixed, ranging from ‘awful generally - smoke and mirrors’, to reports of well-structured and thorough consultation and support. Commissioners as well as providers had struggled with unclear definition of requirements. In one case, well-implemented consultative processes had been developed into continuing support and feedback through provider forum meetings, which were praised (Chapter Three, A4).

**RECOMMENDATIONS**

1. Extension of a payment by results system for psychological therapies should be suspended pending development of a sustainable form of provision and a payment system that enhances effective provision.

2. An independent inquiry should be charged with:
   - examining, in the context of available evidence, the effects on the therapeutic process of weekly use of outcome measurement;
   - identifying factors such as therapeutic approach in combination with type and use of measurement tool that enhance or hinder the therapeutic process; and
• proposing a sustainable and non-intrusive means and frequency of measuring recovery in combination with, or divorced from, as the weight of evidence may suggest, a sustainable payment structure which can support effective, diverse and inclusive provision of psychological therapies.

3. Further work needs to be done on whether some of the strengths described in this report can be replicated through a more sustainable and integrated system of provision of psychological therapies which avoids the unanticipated risks identified with the introduction and functioning of the new market system.

4 (i) The relationship between patient choice and the consequences of AQP and PbR should be examined in greater depth, in order to ground future policy in a coherent relationship with patient outcomes.

(ii) A research evidence base should be developed to reflect the experience of patients, in order to inform development of a sustainable policy framework.

(iii) Structures should be created to allow both provider and patient feedback and input, using this to improve accountability and transparency.

5. The commissioning of psychological therapies should be set in the context of integrated strategies to address the wider determinants of mental ill health and reduce the inequalities that lead to poor mental health, adding a sustainable, innovative and inclusive dimension to such a process, as some commissioners have demonstrated can be done.

6. Further work should be done to develop an alternative model of provision which addresses the weaknesses described in the report, perhaps beginning with one interviewee’s vision of a system entailing:

• a cost per volume contract in place of PbR, with fewer providers closely performance-managed so that waiting lists do not build up;

• payment based on an average number of sessions that can be varied by the provider according to need and circumstances;

• providers organised by area;

• a straight line of accountability within one provider for supervision, case management, step-up, and outcomes, simpler to commission and fair on providers;

• flexible arrangements to deal with high demand where waiting lists exceed an agreed level.

7. To support an alternative model of provision, work should be undertaken:

• to identify a method of performance management of cost per volume contracts which will support the best and most consistent patient outcomes, service sustainability, and cost-effectiveness, learning lessons from practice-based evidence;

• to ensure replication of the evident success of new approaches in commissioning for previously excluded communities, and integrating this provision with broadly based measures to address the wider determinants of inequalities in mental health and well-being.

8. There should be evaluation of the impact of IAPT, PbR and AQP on the employment status of therapists, their remuneration, the skills range of the therapy workforce and its appropriateness and adequacy to meet patient need, with a view to creating a
workforce best able to achieve good therapy outcomes, in the light of the findings of this study.

9. Measures need to be taken to address significant inconsistencies in the scope of AQP service specifications found by this research which will affect patients’ access to appropriate services and create a postcode lottery. This is likely to affect more areas than those that have opted for AQP, since these issues are not specific to the new market arrangement.

10. If AQP is proceeded with, regard needs to be had:

- to the finding widely shared by providers and commissioners that the online AQP qualification process was wasteful, bureaucratic, stressful and poorly structured and defined, demanding disproportionate resources and organisational change, particularly for small organisations;
- to the widespread concern about whether AQP is a viable model for small organisations, particularly regarding the risk of investment in the range of interventions demanded by some service specifications while there was no work guaranteed; about the wisdom of investment in required infrastructure, particularly IT, given the risk involved in zero value contracts; and in a number of cases about unpredictability in the flow of patients;
- to the need to adopt tariff structures that offer a degree of sustainability for providers, particularly concerning remuneration for treating patients who do not move towards recovery, and the risk of large volume unpaid administration by providers;
- to the removal of disproportionate demands, inefficiency and cost occasioned by requirements to adopt and link up to NHS IT systems, a requirement seen as largely unnecessary and discriminatory towards small organisations with limited resources; and the provision of logistical and financial support to enable small providers to meet what should be a reduced requirement.

11. The themes reflected in these recommendations should be explored and developed in a recorded policy seminar to be organised by the CPTPC in 2014, with a follow-up publication.
CHAPTER ONE
INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

Purpose

This research project examines the impact of the introduction of a market system for the provision of psychological therapies in primary care. The Centre for Psychological Therapies in Primary Care (CPTPC) carried out qualitative interviews with providers and commissioners in the first tranche of areas implementing the Government’s Any Qualified Provider (AQP) policy. Our report sets this qualitative evidence in the context of a changing policy, evidential and operational landscape, and reaches conclusions to support the future development of an effective framework in England for commissioners wishing to invest in improved mental health and wellbeing.

1.2 EMERGING CONTEXT - KEY TERMS

IAPT

The landscape of provision of psychological therapies in primary care has been transformed. Between 2006 and 2011, promoted by Professor Lord Richard Layard of the London School of Economics, and later by senior politicians including two Prime Ministers, the programme known as Improving Access to Psychological Therapies (IAPT) became the dominant vehicle for delivery of therapy at primary care level (Layard, Clark, Knapp, & Mayraz, 2007, DH, 2011a), with significantly increased resources.

The IAPT programme has sought to deliver evidence-based therapeutic interventions to people suffering from common mental health problems, principally depression and anxiety disorders. It proposed an outcome-focused methodology which aimed to reduce the pressure of mental illness on the economy. The service would effectively “pay for itself” through an increased number of people returning to work and a reduction in the use of health care resources (Layard et al., 2007). This is the rationale behind a programme pursued by the last two Governments, which has seen the Coalition Government invest up to £400 million over the four years to 2014/15 into the IAPT programme (DH, 2011a).

Payment by Results

The chosen vehicle for payment for psychological therapies in primary care is Payment by Results (PbR), which is under development, though already widely implemented through zero value contracting in areas adopting AQP. No Health Without Mental Health (DH, 2011a) sets out the principles underpinning PbR, but does not define it. In common parlance, it is widely understood to mean payment related to successful outcomes. However, the Department of Health’s (DH) Code of Conduct for Payment by Results in 2013-14 (DH, 2013a), states “Under PbR, activity is paid for on the basis of the number and complexity (i.e. case mix) of cases treated” (authors’ emphases). It has been pointed out that the DH is in a minority (even in Government) in using the term to mean “payment for activity” (Callan & Fry, 2012). This report uses the term in its commonly understood meaning, “payment related to successful outcomes”.
IAPT are developing a model for PbR (IAPT, 2013) which visualises adoption of payment based on five types of outcome:

- Access Outcomes (15%)
- Clinical Outcomes (50%)
- Work & Social Adjustment Outcomes (10%)
- Employment Outcomes (10%)
- Patient Satisfaction & Choice Outcomes (15%)

At the same time, Monitor has issued some challenging principles for the implementation of PbR (NHS & Monitor, 2013). See Chapter Five of this report, particularly Box 2 and discussion, for more on this.

**Any Qualified Provider**

In 2010, the NHS White Paper *Equity and Excellence: Liberating the NHS* (DH, 2010a) set out a range of proposals to give people “greater choice and control over their care and treatment”. These were described in more detail in the subsequent consultation document *Liberating the NHS: Greater choice and control* (DH, 2010b). These introduced the concept of choice of ‘any willing provider’ wherever relevant, with the intention that “choice of treatment and healthcare provider (would) become the reality in the vast majority of NHS-funded services by no later than 2013/14”. It is this vehicle, now renamed “Any Qualified Provider”, which is the primary focus of this research, although its impact cannot be entirely divorced from the aims and operation of IAPT, or of PbR.

In July 2011 the Department published its “Operational Guidance on Extending Patient Choice of Provider” (DH, 2011d), which reiterated the vision, and set out the detailed route for introducing the AQP approach to primary care services. The term was defined thus:

*By choice of Any Qualified Provider (AQP) we mean that when patients are referred (usually by their GP) for a particular service, they should be able to choose from a list of qualified providers who meet NHS service quality requirements, prices and normal contractual obligations.*

This was “intended to empower patients and carers, improve their outcomes and experience, enable service innovation and free up clinicians to drive change and improve practice”.

The goal was “to enable patients to choose any qualified provider where this will result in better care”; to introduce “patient choice of Any Qualified Provider for services where there is a strong pull from patients….. We will ensure lessons are learned from each stage of the rollout”. The approval process to qualify for the AQP scheme “requires meeting an onerous and extensive list of specifications”

A requirement that Primary Care Trusts (PCTs) should each select three service areas in which AQP would be applied was seen as a means to “kickstart” a reconfiguration and extension of a market for healthcare providers.

Each PCT was to implement AQP by September 2012 in at least three kinds of service provision, chosen from a list of eight kinds of services, one of which was adult psychological therapy services. During 2012, 12 PCTs opted to pursue AQP for psychological therapies.

In the same year, the CPTPC received some early evidence from a range of sources which led it to undertake research into the early impact of AQP on the configuration and delivery of psychological therapies in those PCT areas choosing the approach.
Unfolding policy developments during 2013 are summarised in the setting of context for discussion of this report’s findings in Chapter Five.

1.3 AIMS

The fundamental question addressed in the research is whether emerging evidence supports the claim that AQP, configured as it is, will “empower patients and carers, improve their outcomes and experience, enable service innovation and free up clinicians to drive change and improve practice”; and particularly whether the proposed process and organisational (market) structure, now under way, appears from early indications to be supporting such outcomes.

Thus the research aims:

- to increase the understanding, at both local and national levels, of the changed landscape that is emerging,
- to identify issues, including strengths, weaknesses, tensions, tested assumptions and unintended consequences that might inform principles to support effective future commissioning of psychological therapies.

The project aims to create an effective conduit to communicate the experience, concerns and achievements of those at the sharp end to inform the future development of the delivery of psychological therapies. It is hoped to use this to support a collaborative process that contributes to the achievement of effective commissioning; and to provide a secure forum for reflection among both providers and commissioners with similar challenges. The Centre’s research products will provide a learning platform for the changing commissioning narrative - and for the policy framework and its implementation to be subject to critical, and enabling, analysis.

1.4 METHODOLOGY

Several perspectives were used to examine the development of AQP:

1. Consideration of the policy and research context of the expansion of provision represented by IAPT, including the Centre’s own recent research, paying particular attention to the IAPT programme’s policy aspirations, their outcomes, and their relationship to AQP.
2. A profile of the providers that expressed interest in qualification under AQP, tracking their success, failure, or withdrawal, using a Freedom of Information request.
3. Analysis of the AQP service specifications of each PCT choosing the approach, in order to understand the aims of each commissioning body and how they were pursued.
4. Interviews with a small sample of providers of psychological therapies to understand how they experienced the qualification process, and how they now view its impact on their services and on patients, seeking to understand strengths and weaknesses in the approach taken, and to identify best practice that might be replicated, and policy and practice that may be counter-productive.
5. To the same end, interviews with a small number of commissioners involved in the same process

1.5 LIMITATIONS OF THE RESEARCH

In this report, a small sample of in-depth interviews with providers and commissioners is used to communicate a range of experiences and views of the implementation of a new kind
of market for provision of psychological therapies. The grouping of responses by theme emerges organically from analysis of the interviews. In Chapter Five, perspectives shared by a number of providers and commissioners, and some individual testimonies which suggest critical insights into the nature of the changes, are examined in their policy context, particularly in terms of stated policy aims.

It should be stressed that qualitative evidence from a small interview set cannot, and is not intended to, support a burden of proof. What the approach can do, however, is to gather insights informed by frontline experience which may together amount to persuasive evidence of conceptual or functional flaws or solutions. It may also provide material to inform the future development of commissioning and good practice in the provision of psychological therapies in primary care. Where qualitative evidence can be set in a context of robust quantitative data, that is introduced.

This approach can be characterised as “practice-based evidence”, described by Guy et al. (2011) as complementary to the quantitative, and dominant, Randomised Control Trial-based approach to evidence. A United Kingdom Council for Psychotherapy (UKCP) report (Ryan & Morgan, 2004, cited in Thomas, Stephenson, & Loewenthal, 2006) suggests that:

*It gives voice to practitioners and service users, recognising that they have first hand knowledge and experience of what works and alternatively what needs to change, and how it may change.*

In summary, this approach aims to communicate a meaningful body of opinion informed by experience, which it is hoped that both policymakers and commissioners will wish to consider.

### 1.6 CONFIDENTIALITY

Neither providers nor Trusts are identified by name in the rest of this report in order to protect confidentiality. Efforts are made to disguise characteristics which may tend to identify them. The report’s use of thematic grouping of qualitative material to establish structure aids confidentiality; nonetheless, some individual circumstances may be recognisable to fellow professionals.

### 1.7 BACKGROUND: RESEARCH LITERATURE

#### Prevalence and trends

In the UK, mental disorders account for the largest single burden of disease (22·8%), as measured by disability-adjusted life-years, and this figure is an under-estimate since it does not include several mental disorders, such as generalised anxiety disorder (which affects 4·7% of adults), phobias (2·6% of adults), antisocial or borderline personality disorders (0·7%), or pervasive development disorder/autism (1%) (McManus et al., 2009, quoted in Campion, Bhugra, Bailey, & Marmot, 2013).

Suicide is an important indicator for overall mental health in a population, and the Office for National Statistics (ONS) recently reported that male suicides are now at their highest rate for nearly a decade – and that the rate among men aged 45-59 is at its highest since 1986 (ONS, 2013).
Socio-economic inequalities and mental ill health

A recent article in *The Lancet* (Campion et al., 2013) summarises recent findings in relation to mental ill health and inequality. Some key extracts are reproduced here, with sources referenced.

Socio-economic inequalities are associated with increased risk of mental disorders in two ways. First, more pronounced income inequality within wealthy countries is associated with increased prevalence of mental disorders (Pickett & Wilkinson, 2010, quoted in Campion et al., 2013); second, the degree of socioeconomic disadvantage that people experience is associated with proportionately increased risk of developing a mental disorder (Green et al., 2005, McManus et al., 2009, quoted in Campion et al., 2013).

Some of the excess morbidity and mortality associated with unemployment may be a result of people in poorer health being more likely to become unemployed, rather than vice versa. The evidence suggests that selection of unhealthy people into unemployment does indeed occur, but it is not the dominant factor explaining the observed relationship between unemployment and excess risk of ill-health. It does, however, illustrate the double disadvantage that people with chronic sickness or disability may face: their ill-health puts them at greater risk of unemployment, and the experience of unemployment in turn may damage their health still further (Acheson, 1998).

The burden of mental illness is likely to increase as the economic downturn increases socioeconomic inequalities (Campion et al., 2013).

The graded relationship between socioeconomic position and educational outcome has significant implications for subsequent employment, income, living standards, behaviours, and mental and physical health. Insecure and poor quality employment is also associated with increased risks of poor physical and mental health. There is a graded relationship between a person’s status at work and how much control and support they have there. These factors, in turn, have biological effects and are related to increased risk of ill-health. Work is good – and unemployment bad – for physical and mental health, but the quality of work matters. Getting people off benefits and into low paid, insecure and health-damaging work is not a desirable option (Marmot et al., 2010).

Fear of job loss has increased sharply, especially over the period following the recession of 2008-09. Men are consistently more worried about job loss than women. But the increase in concern about job loss has been particularly great among female employees. In 2012 just under one third (31%) of employees were anxious about unfair treatment at work. Just over half of all employees (52%) reported anxiety about loss of job status. In the past both fear of job loss and fear of unfair treatment at work were far more common in the private than in the public sector. In 2012 fear of job loss was higher in the public than in the private sector, while fear of unfair treatment had become more similar to the level in the private sector. Fear of status loss was also higher in the public sector. Fear of unfair treatment and fear of loss of status were both increased by the experience of technical and organisational change in recent years. An important factor offsetting fear at work was the degree of participation allowed to employees with respect to organisational decisions (Gallie, Felstead, Green, & Inanc, 2013).

The cost of poor mental health

The cost of mental illness in England has been projected to cost around £105.2 billion a year. This is the result of a strain on health care resources, loss in economic output and a reduction in a sufferers’ quality of life (CMH, 2010). These costs are expected to continue rising in the coming years with increases in morbidity of an aging population (Callan & Fry,
2012) and increasing trends of antidepressants and antipsychotic use over the last decade (Ilyas & Moncrieff, 2012).

**Wellbeing**

A key document in the context of the development of IAPT is Layard’s *Happiness: Lessons from a New Science* (2005) which led indirectly to the development of IAPT (see below).

However, there is a much broader and more ambitious approach to wellbeing which is concerned with the wider determinants of health, and particularly with inequality. Marmot’s *Fair Society, Healthy Lives* (Marmot et al., 2010) is the key document of this larger strand. It defines the territory of wellbeing thus:

The Commission on Social Determinants of Health (2008) concluded that social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources.

These social and economic inequalities underpin the determinants of health: the range of interacting factors that shape health and well-being. These include: material circumstances, the social environment, psychosocial factors, behaviours, and biological factors. In turn, these factors are influenced by social position, itself shaped by education, occupation, income, gender, ethnicity and race. All these influences are affected by the socio-political and cultural and social context in which they sit.

When we consider these social determinants of health, it is no mystery why there should continue to be health inequalities. Persisting inequalities across key domains provide ample explanation: inequalities in early child development and education, employment and working conditions, housing and neighbourhood conditions, standards of living, and, more generally, the freedom to participate equally in the benefits of society. A central message of this Review, therefore, is that action is required across all these social determinants of health and needs to involve all central and local government departments as well as the third and private sectors. Action taken by the Department of Health and the NHS alone will not reduce health inequalities.

The update of the Government’s Public Health White Paper, *Healthy Lives, Healthy People* (DH, 2011c) emphasises the importance of this wider approach:

The White Paper argued that if we are to meet the public health challenges of the twenty-first century we cannot go on as we are. In particular, we cannot make progress in addressing the issues raised in Professor Sir Michael Marmot’s Report *Fair Society, Healthy Lives*. [Responses to consultations] have reinforced our conviction that the scale of the challenge is substantial, that we should be ambitious and reform the system to give public health a clear focus at national and local level.

It refers to a forthcoming mental health strategy which became *No Health Without Mental Health* (DH, 2011a) (see below). Chapter Six of that strategy, *Improving outcomes in mental health: promoting equality and reducing inequality*, appears to significantly diminish the scope of the stated ambition.

There is a substantial body of evidence for the benefits to physical and mental health of good social relationships and participation in a community. The Health Empowerment Leverage Project (HELP) has assembled core evidence for this (Fisher, 2011). References include:
National surveys of psychiatric morbidity in adults aged 16-64 in the UK show that the most significant difference between this group and people without mental ill-health problems is social participation (Jenkins et al, 2008). There is strong evidence that social relationships can reduce the risk of depression (Morgan & Swann, 2004).

Community empowerment and engagement initiatives can produce positive outcomes for the individuals directly involved including: increased self-efficacy, increased confidence and self-esteem, personal empowerment, improved social networks; a greater sense of community and security and improved access to education leading to increased skills and paid employment........ Research evidence reports significant health benefits for individuals actively involved in community empowerment/engagement initiatives including improvements in physical and mental health, health related behaviour and quality of life (Plachaud, Bennett, Nazroo, & Popay, 2009, Grady, 2009).

In 2012, HELP produced a cost benefit framework for a resident-led community partnership applying this evidence base (Griffiths, 2012).

A discussion of the potential of whole-system commissioning which sets counselling in a context of community needs analysis and prioritisation of the development of social capital, with a particular focus on work in Sandwell, can be found in the Commissioning Guide to Happiness (Wilkinson, Walton, & Hill, 2013).

**IAPT**

Milestones in the development of IAPT include:

- Department of Health, (2011a). *No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages*.

For a series of conceptual and practice-focused challenges to the case for IAPT and its formulation, see a collection of articles in *The Psychologist* (Vol. 22, No. 5, May 2009), particularly:

- *The Challenge of the Layard initiative* (Marzillier & Hall, 2009), which charges IAPT with a naive view of psychological problems and their treatment;
- *Moving beyond cognitive behaviour therapy* (Gilbert, 2009), which examines the wider context of the model of Cognitive Behavioural Therapy (CBT) favoured in IAPT;
- *Beyond words – the role of psychoanalysis* (Casement, 2009), which examines groups that may not be helped by CBT, and “the effectiveness of a therapy that seems to suppress or change symptoms rather than to understand them”;
- *Alternative ways of working* (Hall & Marzillier, 2009): “constructive suggestions for moving the agenda on”.
Given the scale of development of IAPT in the past four years, the critique offered by these articles might offer a starting point for revaluation based on criteria other than outcome data.

**Outcome /cost**

In addition to the cost-benefit claims of Layard’s 2007 analysis and the early work on recovery rates in Glover et al. (2010) and Gyani et al. (2011) the CPTPC has published two analyses:

- one challenging the claims of a 45% recovery rate for IAPT by emphasising the need for commissioners to be informed of outcomes of all the patients they refer rather than only those who complete treatment, and for a strategy for mental well-being to address the needs of all those who are referred, only 12% of whom are “moving to recovery” under IAPT (Griffiths & Steen, 2013a); and
- a second which finds a higher sessional cost than that posited by the DH Impact Assessment, suggesting that IAPT cost estimates are only sustainable in the context of lower numbers of sessions delivered than are recommended by the National Institute for Health and Care Excellence (NICE) or assumed in Layard’s original cost-benefit analysis. The lower number of sessions has implications for sustainable recovery rates (Griffiths & Steen, 2013b).

**Payment by Results**

See 1.2 above, and discussion of findings in their policy context in Chapter Five.

**Competition**

There is no identified research into the impact of the introduction of competition to community mental health services. Research into the effect of competition introduced to acute services has been carried out, but any conclusions regarding applicability to psychological therapies are speculative. The Chief Executive of Monitor has remarked on the paucity of research to support change in this field (see Chapter Five of this report). Qualitative evidence concerning the impact of competition in the form of AQP is discussed in that chapter, and providers’ and commissioners’ experience and views of the new competitive environment are presented in detail throughout Chapter Three.

**Patient Choice**

Davidson et al. (2012) demonstrated that when patients are given a choice in provider they are more likely to engage with the treatment. Choice provides control, and with control, or at least the perceived sense of it, the severity of mental illness can decrease (Elliott, Maitoza, & Schwinger, 2011). Lack of control can be the cause for a lot of our anxieties (Bolyn, 2009) – note Marmot’s remarks above about the relationship between status and levels of control and support at work.

Advocates of the choice rationale argue that when a person chooses their provider, they gain a sense of control and become an integral part of their journey to recovery. Ninety five per cent of people feel “they should have choice over where they are treated and the kind of treatment received” (NatCen, 2009).

The question is whether “patient choice” through the means of competition under the AQP policy is a reality that benefits the care and engagement of patients through improvement in the delivery of psychological therapies. The findings of this report are discussed in response to this question in Chapter Five.
The Economic Case

The economic case for IAPT is encapsulated in the abstract of Layard and colleagues’ *The Depression Report* (LSE, 2006). Discussing the impact on the one in six of the population suffering from depression or chronic anxiety disorder, it states:

*at least half of them could be cured at a cost of no more than £750.*

*For depression and anxiety make it difficult or impossible to work, and drive people onto Incapacity Benefits. We now have a million people on Incapacity Benefits because of mental illness – more than the total number of unemployed people receiving unemployment benefits. At one time unemployment was our biggest social problem, but we have done a lot to reduce it. So mental illness is now the biggest problem, and we know what to do about it. It is time to use that knowledge. But can we afford the £750 it costs to treat someone? The money which the government spends will pay for itself. For someone on Incapacity Benefit costs us £750 a month in extra benefits and lost taxes. If the person works just a month more as a result of the treatment, the treatment pays for itself. So we have a massive problem – the biggest problem they have for one in three of our families. But we also have a solution that can improve the lives of millions of families, and cost the taxpayer nothing.*

The Benefits Realisation section of *Talking therapies: A four-year plan of action* (DH, 2011b) uses an approach based on the same conclusion:

*The investment of £400 million in talking therapies over the next four years will result in the following: over £700 million of savings will be made to the public sector in healthcare, tax and welfare gains.*

The detailed *Cost–benefit analysis of psychological therapy* (Layard et al., 2007) makes the case using three pillars which recent work calls into question:

- the 45% recovery rate claimed. It is posited in Griffiths and Steen (2013a) that the appropriate rate in the context of GP commissioning is 12% of those referred, not 45% of those completing treatment, given the importance, recognised in the Depression Report, of the wider population base of those affected, as well as the referrers’ legitimate interest in all those patients referred.

- an assumption of roughly ten IAPT sessions per patient. A second paper by Griffiths and Steen (2013b) arrives at a mean number of sessions (excluding one assessment session) of 3.94. Given this paper’s estimate of a much higher revised sessional cost confirmed by Radhakrishnan et al. (2013), the Layard cost estimate is only met on the basis of fewer sessions at higher cost. The tendency to offer fewer sessions than recommended by NICE is the subject of concern in the *National Audit of Psychological Therapies* (RCP, 2011). Qualitative evidence of perverse incentives affecting the number of sessions is discussed in this report (see Chapter Three, B5, B8 and elsewhere for evidence, and Chapter Five for discussion).

- use of savings resulting from patients no longer receiving Incapacity Benefits as a key component of savings in the public sector. But it is established that hundreds of thousands of claimants, many with mental health problems, have been wrongly disentitled from these benefits through the use of a widely discredited Work Capability Assessment. It is an unreliable outcome measurement, and this undermines the projection of savings (Griffiths & Steen, 2013b).
CHAPTER TWO

PROVIDER ORGANISATIONS ENTERING THE AQP PROCESS: SETTING THE QUALITATIVE INTERVIEWS IN CONTEXT

2.1 TRUSTS OPTING FOR AQP

Twelve Primary Care Trusts opted to pursue AQP for psychological therapies. Data were sought concerning all organisations entering the AQP process through a Freedom of Information Request. Two of the organisations (Surrey and Cornwall) denied the request on the grounds of commercial confidentiality. These denials were not challenged due to time constraints. Surrey and Cornwall were excluded from the rest of the study.

Several of the remaining ten formed partnerships with neighbouring trusts for the purposes of the AQP process. The ten are listed in their seven groupings below:

- Kent and Medway
- Dorset
- Tees
- Nottingham City and County
- Hertfordshire
- Derby City and County
- Bristol and South Gloucestershire

2.2 ORGANISATION TYPES: THOSE CONTRACTED IN THE CONTEXT OF ALL WHO ENTERED THE AQP PROCESS

Analysis identified 11 categories of organisation entering the AQP process from these seven clusters. One hundred and two out of 109 provider organisations were allocated a category, as in Table 1 below. Of these 102, 46 were awarded contracts. Table 1 sets out the proportion of each category awarded a contract.

The number of providers awarded contracts in each of the seven clusters ranged from one to 12.

See Chart 1 for a graphic representation of relative success by organisation type.

Findings

Charities which had become companies limited by guarantee appeared to be the category of organisation most successful in achieving AQP contracts. They comprised 35% of those entering the AQP process; and 43% of successful contractors.

All four Not-for-Profit limited Companies entering the process were successful.

Private limited companies were less successful: they comprised 29% of those entering the process, but only 15% of those achieving contracts: only seven out of 30 were successful.
TABLE 1 - TYPES OF ORGANISATION ENTERING AQP PROCESS, 2012*

<table>
<thead>
<tr>
<th>Categories of organisation**</th>
<th>All entering AQP process</th>
<th>%</th>
<th>Contracted</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not for Profit Limited Company</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>NHS Trust</td>
<td>17</td>
<td>17</td>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>Private Limited Company</td>
<td>30</td>
<td>29</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>Community Interest Company</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Charity + Company limited by guarantee</td>
<td>36</td>
<td>35</td>
<td>20</td>
<td>43</td>
</tr>
<tr>
<td>Limited Liability Partnership</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Company limited by guarantee</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>NHS General Practice</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Charity</td>
<td>2</td>
<td>2</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Independent/Provident/Friendly Society</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Individual</td>
<td>2</td>
<td>2</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>102</td>
<td>100</td>
<td>46</td>
<td>100</td>
</tr>
</tbody>
</table>

* Information obtained by Freedom of Information request from ten PCTs. Surrey and Cornwall declined to comply with the request
** Seven organisations entering the AQP process were not definable in the terms selected.

CHART 1 – PROVIDERS CONTRACTED AND NOT CONTRACTED THROUGH AQP
2.3 THE TEN QUALITATIVE PROVIDER INTERVIEWS: ORGANISATION TYPE

The ten qualitative interviews carried out were broadly consistent with this pattern, breaking down as follows:

<table>
<thead>
<tr>
<th>Organisation Type</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charity and Company Limited by Guarantee</td>
<td>3</td>
</tr>
<tr>
<td>Private Limited Company</td>
<td>3</td>
</tr>
<tr>
<td>Community Interest Company</td>
<td>1</td>
</tr>
<tr>
<td>Company Limited by Guarantee</td>
<td>1</td>
</tr>
<tr>
<td>NHS Trust</td>
<td>1</td>
</tr>
<tr>
<td>Independent / Provident / Friendly Society</td>
<td>1</td>
</tr>
</tbody>
</table>

2.4 ENGAGEMENT OF PROVIDERS WITH PCT AND AQP PROCESS

The engagement of providers with the PCT and the AQP process was examined through FOI data. Data regarding providers entering an AQP contract, and those not successful or withdrawn, were grouped separately and the two groups compared.

The aim was to gauge whether there were significant differences in previous or existing engagement between the two groups.

**TABLE 2 – INDICATORS OF ENGAGEMENT WITH PCT AND AQP PROCESS: PROVIDERS ACHIEVING CONTRACT AND THOSE NOT ACHIEVING**

<table>
<thead>
<tr>
<th></th>
<th>Provider with AQP contract</th>
<th>No contract</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Known or existing provider</td>
<td>36</td>
<td>75</td>
</tr>
<tr>
<td>Attend a briefing event organised by PCT</td>
<td>37</td>
<td>77</td>
</tr>
<tr>
<td>Were an existing provider of primary care psychological therapy to the PCT</td>
<td>20</td>
<td>42</td>
</tr>
<tr>
<td>Participated in discussion of service specification initiated by commissioning team prior to formal tender announcement on S2H*</td>
<td>24</td>
<td>50</td>
</tr>
<tr>
<td>Participated in discussion of pricing initiated by commissioning team prior to formal tender announcement on S2H*</td>
<td>24</td>
<td>50</td>
</tr>
</tbody>
</table>

* S2H is NHS Supply2Health, an online resource that advertises opportunities to provide “Part B clinical services commissioned by the NHS in England”.

Information obtained by Freedom of Information request from ten PCTs. Surrey and Cornwall declined to comply with the request.

**Findings**

- Providers achieving a contract through AQP were slightly more likely to be known previously to the PCT, or to be a previous provider.
• There was no significant difference between the two groups in likelihood of attendance at a briefing event about AQP, or early involvement in discussion of the service specification or of pricing.

• Previously existing providers of primary care psychological therapies to the commissioning PCT were far more likely to achieve an AQP contract than organisations who were not previous providers. At the same time, 58% of those achieving contract fell into the latter category.

2.5 PROFILE OF THE TEN PROVIDERS INTERVIEWED USING THE SAME DATA SOURCES

• Eight out of ten were known to the PCT or were previously existing providers (three in the latter category).
• Eight out of ten attended a briefing event
• All completed the AQP online qualification process and were evaluated.
• Seven achieved qualification
• Six entered a contract with the PCT; one withdrew at that point, and one before achieving qualification.
• Six took part in early discussions of the service specification, and in preliminary discussions of pricing.
CHAPTER THREE

EVIDENCE FROM THE QUALITATIVE INTERVIEWS WITH PROVIDERS AND COMMISSIONERS

PART A – THE INTRODUCTION OF ANY QUALIFIED PROVIDER FOR PSYCHOLOGICAL THERAPIES

A1 How Commissioners viewed the local decision to opt for AQP

Commissioners were asked about the reasons for their Trust adopting AQP.

There were known concerns around the existing provision of IAPT. I’m not really sure what led to the decision, and certainly the people who made it then left it for other people to figure out how it would work. Here, anecdotally the notion is there’s more psychotherapists per square mile than anywhere outside of Belsize Park in North London, but who were not part of the NHS - if you happen to live in a well-off neighbourhood and have a fair amount of money you can have access to this service, but there’s lots of people in more deprived areas who would positively benefit from the service who weren’t getting it. So I think that was one of the things, to open that up, in the context of the existing provider not achieving what we expected. It wasn’t an ideological thing that we thought, AQP is a good thing in itself therefore we’ll roll it out, it was a directive we must do, and this seemed to be the best of a number of options.

This commissioner, like several other interviewees, mentioned backlogs and waiting lists as a factor:

Another frustration with the previous provider was that GPs had people in their surgery that they could see would benefit from psychological therapies, but either they didn’t have the right threshold or the waiting list was too long. It was a traditional IAPT service, that said I’m not sure they ever had the right level of funding, but even with that, they just seemed to give therapy, and then some more therapy, and then some more therapy, so what happened was that a majority of people moved up from low level intervention to medium, to high level to quite intensive and long term. What that meant was that it clogged up the system very quickly and then there were lots of people waiting to get in to services who couldn’t.

Whereas the model that we wanted to introduce inverted that triangle, so the vast majority of people had short term, focused interventions that helped them, and it didn’t become a life-long pathway. Which then in theory frees up the capacity for the few people who do need the quite high intensity, longer term treatments. There is a majority of people who need a lighter touch, effective for teaching the CBT-type coping skills interventions. So the previous provision didn’t mean our needs.

This specific reference to the stepped-care approach being clogged up was echoed by another commissioner, as a reason for opting for AQP, in effect to refresh the market:

Some [providers] had really good models with no waiting lists and all very quickly seen or signposted and good links to GPs, other built up quite large waiting lists, I don’t think they made the best of the stepped approach with the least intervention first time.

Another commissioner spoke of AQP being used to get out of a particularly unsatisfactory commissioning arrangement:
The procurement was going out for the final two-thirds of the service [the first one-third being an earlier, separately commissioned IAPT service]. We contracted with one provider for the two-thirds, who then sub-contracted that work back to the existing providers. The contract under-performed consistently against the PCT targets. We issued performance breaches and things like that to try and improve performance. It did start to improve but it was too late in the day. Performance was poor, the communication between the parties had broken down. We couldn’t have justified not procuring it on an AQP. And the SHA [Strategic Health Authority] didn’t force us, but they suggested that this should be our line, because it performed so poorly.

A2 The AQP qualification process - how providers heard about it

Most of those interviewed were notified about the AQP opportunity, whether they were already providers or not. Two were not, and felt ignored and unsupported:

‘No contact, we were not approached, we happened on it really by accident. A partner service in X alerted us by email. We were very late in, we clocked that it was only two weeks before the closing date. ...... GPs know that they’re sending their clients to us. And when the discussion started about this, what was the dialogue between the practitioners on the front line and the people designing the service spec? If I were doing that, I’d be going to GPs and saying, who do you refer to? We have very few self-referrals, overall our referrals are coming from health visitors, midwives and GPs. You’d want some kind of net to make sure services didn’t slip through when they were being used’.

‘I knew that something was coming up, I think I just happened upon it. There was no contact at all prior to it. Before it all started, I did try to contact people to find out what was going on in X. That was like knocking on doors that were closed. I did sign up for Supply2Health, I signed up for the alerts and never got them. Then, I filled out the application myself, without any assistance at all. And sent it off’.

A3 Online application

Only one of our provider interviews was positive about the on-line qualification system for AQP:

On line registration was fine. It was a very professional system, with questions coming back from the commissioning organisation, that was very professional. We put aside three days to get it in. We had no prior information, we hadn’t been to any of the workshops or consultation events.

Criticisms centred on what most interviewees saw as a repetitive and confusing system which was frustrating to use:

The on-line application system was very difficult to negotiate, and caused anxiety.

It was time-consuming and time-pressed, too little information with high expectations and tight deadlines. The NHS website was difficult to get on to, and kept crashing which was frustrating. All alongside running a busy service: a 30,000-word document to prove what we were already delivering. There were very repetitive questions without logic frequently, some of which read more like A level questions.

This response communicated the scale of personal engagement demanded – and the level of frustration:
I had some reservations about the questionnaire; specifying word count was influencing and giving cues as to the depth and detail required; due to differences between them this skewed the response somewhat. Each section was marked by different bodies; in some sections I wanted to put “as already clarified”, but couldn’t, so I had to reword what had been said. It was very time-consuming and frustrating. It felt like there wasn’t one person seeing the overall application. There was more than one place for specific answers, so it was confusing what to put where. A lot of times I wanted to start the whole process afresh. I spent days and nights for a number of weeks doing this. You couldn’t just start and get on with the application: I had to research definition of terms, for example, ‘Clinical governance’ – I made multiple attempts to understand exactly what that meant in this context. I sought outside opinions; does this refer to quality assurance, clinical supervision?

Unclear requirements and lack of recognition of complexity had far-reaching implications:

Some requirements didn’t fit the psycho-social model IAPT+ that area X have commissioned. For example how to demonstrate the competency of staff who are not registered with any professional body nor need to be. The level of clinical governance required wasn’t necessarily appropriate for the psycho-social interventions. Consequently we became a lead provider with the option of sub-contracting to other smaller agencies who do not provide clinical services but who can provide psycho-social interventions.

Inconsistent and unrealistic requirements exercised respondents considerably:

Up to a week before the tender we’d been told we didn’t need to attach policies, then for some reason suddenly we did, so we had to write very, very quickly, but they didn’t seem necessary or relevant.

This criticism was shared by commissioners:

The whole process was very bureaucratic. The Supply2Health system that the DH set up was complicated. Each provider would put a bid in, and within that bid would be 20 or 30 sections, but it wasn’t as if you could scroll down immediately, you had to come out of one to go to the next, and come out of that to go the next. And then the people doing the accreditation had to log in for each of those individual things and say yes, pass fail or whatever, so that was very labour- and time-intensive.

This commissioner shared that view, and drew attention to a frustrating design failure:

The biggest bugbear of mine is the system, when a provider had their bid in a Word document, you had to put it into a text box. When the provider pasted it in it lost its formatting, so bullet points were all hidden within the body of the text, so if you copied it out back into a Word document to print you had pages and pages of just solid blocks of text with no formatting. So we wasted a lot of time with that.

A4 Commissioner support, information and consultation

Providers’ assessment of the quality of commissioners’ support was very mixed, ranging from:

Awful generally, - smoke and mirrors. One-off defensive consultation meeting

to:
Communication was excellent. There were a lot of meetings pre- and post-AQP application, so they provided us with a lot of support and information on the whole process, and were very helpful in terms of responding via email if anybody had any enquiries. Somebody was brought in who had actually gone through the tender process so was able to give us some very clear guidance on how to complete the sections because it was quite a lengthy tender, and in depth, requiring a lot of information. Some of the terminology was unfamiliar given that we’re not an NHS provider, so it’s helpful to have that very clearly explained.

Commissioners were seen as a bridge to an online process that was not thought through:

I felt that the commissioner tried but the whole process was incredibly complex. When they didn’t know, I had to resort to the service specification once more. I made use of multiple sources (including other providers/colleagues) to interpret the meanings of questions – there was a high degree of confusion with regards to the wording. I appreciate the commissioner tried to help but I considered the answers to my queries not up to scratch. For example, they asked for details of accreditation of a mindfulness group. What does this mean? How would it apply to this type of group? What accreditation can you have for a mindfulness group? No answer from commissioners.

On the other hand, support was sometimes direct and personal:

When we were turned down, our commissioner was fabulous, I couldn’t fault him at all, he was brilliant, he was very responsive to us. I had two phone calls to go through exactly why we had not gone through in that round. The commissioning process I wouldn’t fault. The members of whatever the AQP panel is, that were looking at the applications, I would have a question about. It emerged that we were turned down on two spurious grounds, first that we couldn’t assure them that we only use accredited counsellors; but we had actually provided the number of counsellor accreditations, so that was confusing; and the other thing was that we hadn’t addressed being a single gender organisation. So in our second application we were very clear, and we quoted research papers on why gender-specific organisations work very well for women. And we also put across the point that in terms of culture, we have women accessing here who couldn’t access any service elsewhere - we are a women only site, and that’s very important for meeting the needs of particular members of our community. So the first time round we felt a bit sore.

One recurrent theme was the challenge the process represented to very small providers:

There was some support and help. There were some meetings that we were only told of within days of them happening, and by that time, you know, if you’re running a caseload, you can’t do that. So that didn’t really work. My husband went to one meeting, and picked up information for me, and networked for me, which was useful. I went to one meeting, but I wasn’t really clear who were the people I needed to be speaking to. It was Q&A. There were a lot of people expressing distress in the audience.

There was praise for AQP provider forum meetings:

Now we’re regulars. Part of those meetings are to talk about any clinical issues arising from the work, and also about issues around IT, and other areas that the group feel are important. These things we need to discuss, because it’s a fairly new service for everybody.

A commissioner was emphatic about the importance of this:

The provider forums are essential to continue the learning and development. We have them on a monthly basis at the moment, all of the providers attend.
Unprompted, one commissioner emphasised the importance of consulting with users from the beginning, and building on that as the service develops:

There was some limited carer input. There were some service users on the project team, and also we took it out to service users, for consultation. One of the challenges with service users, as is always the case in mental health services, is that representatives are not always people who would be accessing primary care psychological therapies - they tend to be the secondary care, severe and enduring population. Nevertheless, through those networks they were able to put us in contact with people.

This commissioner reported that their consortium was now:

In the process of developing a service user group for the wellbeing therapists service.

He was also keen to emphasise the involvement of GPs:

At least three GPs were actively involved in the design… and from the three localities within one CCG so there was GP representation across the board.

He thought there had been flexibility about the model in a context of considerable consultation:

The model itself was tweaked, there were all sorts of things about how you access, who accesses, what level can you have, open access or not, could you go straight in a Level 2 or Level 3, and how you'd manage that system. There was lots of discussions that went backwards and forwards, it did change, in light of feedback. I think sometimes we strive to be so inclusive that we have everybody in the room and everybody has an opinion and meetings just take so much longer. Now some would argue the outcome is worth that, because it stops people coming back at a later date and unpicking things, but whilst in the middle of those sessions they feel like they can go on forever. “Is that fair?”, we have to ask everybody, we have to ask 17 times, and circulate everything - but maybe that’s the price to pay.

Another commissioner reflected a diametrically opposite view. There was no prior consultation. The commissioner interpreted this as proper, arm’s length procedure:

How did we identify providers? We didn’t. We went through the procurement process and advertised the opportunity, on the national Supply2Health system. That was just the way that you had to do it. It had to be an open tender process. In terms of engagement with us during that process, we didn’t get heavily involved in terms of dialogue with providers. Any questions they had around AQP, they had to come through Supply2Health so it was all official, so we couldn’t be challenged that we were favouring any party.

This commissioner identified such engagement further down the road as an aspiration, though he still seemed doubtful whether it was permissible:

Potentially, if we would be allowed to do it, I’d like to see engagement with providers. An engagement event, for example, to run that tariff structure by people. Even the service specification: we got clinical engagement on the service specification that we used, but maybe to use that as part of provider engagement – a workshop day or afternoon where we advertise and invite interested parties to come and discuss, question and answer session, one-on-one and things like that. There was nothing like this the first time round. We did the spec, we did the tariff, we advertised it. That’s how we did it.
**A5 Impact on the organisation**

Interviewees spoke of large-scale organisational change, turbulence and again of inconsistency:

*We had to form a limited company and completely revise our way of working to comply with the specification. We are still in a period of settling down and attempting to comply with requirements that keep changing.*

This was particularly a concern for providers from small organisations who felt subject to disproportionate demands:

*I had somebody working for me at the time, a clinical psychologist, and she did some of it. So I was paying for her to do it, and it took many hours. You have to get huge amounts of information. If you’re already a largeish organisation, and you’ve got it all in place then that makes it straightforward. But if you’re an individual, I can’t see how on earth you can do it. I mean how can you talk about clinical governance, risk procedures, and things like that? It seemed to me as though it was aimed for providers that were already set up as fully-fledged organisations who had an HR department who have all these procedures and whatever in place.*

*After the process, I told another service what I had done on the application mostly on my own and they were shocked. They had five managers working on it for weeks. It was a huge relief to get rid of it – it was harder than doing a degree in some respects, and was much like a degree in that it involved a wide scope of my own research.*

Several respondents talked about a high level of personal stress:

*In terms of being a smaller organisation it had a quite significant impact on our staff resources. The initial AQP registration process involved a lot of time, my time, primarily as director. I had input from trustees and the clinical manager, but I actually wrote the tender and it took many hours. I found it quite personally stressful. And it has not been easier since submitting the application, in terms of implementation and setting up systems of delivery and service and staff training: it’s been a lot of resources. In terms of IAPTus, that’s a whole new system for us, so it’s been a lot of investment.*

This view of disproportionate demands was not confined to small organisations. One interviewee from an NHS Trust was very critical:

*The lead from the Business Development Unit was imperative in the overall bid. The Clinical Director and Operational Manager were involved in content production, which was very time-consuming and diverted essential staff away from the current service leadership and management, to bid writing. This was an unnecessary waste of NHS resources.*

This commissioner endorsed the view of many of the providers:

*A lot of the questions gave a word count, and although this was not mandatory, a lot of the providers felt obliged to do it, and some of the smaller providers just have a manager and a couple of clinicians. So to feel obliged to write thousands and thousands of words could have put some of them off bidding. Our big Foundation Trust have got whole teams of people who just do bids.*
PART B – IMPLEMENTATION: THE IMPACT OF AQP

B1 Small organisations and AQP

There was widespread concern about whether AQP is a viable model for small organisations.

Providers spoke about the range of interventions in the service specification, about the wisdom of investment given the risk involved in zero value contracts, and in a number of cases about the lack of inflow of patients:

The reality seems to be that a small number of big providers are doing the bulk of the work. Some smaller providers fell out of the process. The ‘no guarantee of any work’ model is very challenging for the voluntary sector as we don’t have the capacity to manage loss leader work. The tariffs are also very challenging and may not be sustainable.

Small providers would have found it difficult to provide the full specification.

This small provider, not now contracted to work under AQP, believed:

The range of interventions identified in the service specification didn’t encourage a wide enough range of providers. We went for it, but a lot of organisations dropped out. It put a lot of small groups off, they didn’t have the resources to take a gamble, and then there’s a zero value contract, no guarantee of any work at the end.

Another, who had not gone ahead with qualification, felt there was some opening for smaller providers, though this was contradicted by other interviewees:

AQP only offers suitability for those small enough for there to be minimal risk, or large enough to cover that risk. Those in the middle cannot compete.

IT investment was a particular worry for small providers. This is the view of another provider who did not proceed:

There were IT things that we would have ended up being liable for, and that was quite a large sum of money. In some ways that stopped me from putting our toe in the water, because I was thinking, well if it didn’t work out we’d still be liable for that sum of money if we didn’t provide so much service.

See more in section B7 below on adopting NHS IT systems.

Another recurrent theme was of rigid expectations by NHS commissioners that did not recognise small organisations’ differences of scale and culture:

Although we were accredited initially, we did not get the go-ahead to provide courses because the clinical governance lead overseeing the process decided that although our psycho-education courses were going to be delivered by professionally supervised, trained counsellors and PWP’s, the fact that the coordinator of the service (me) was not a professionally trained clinician meant that risk might not be adequately managed. My only feed-back would be that this should have been made explicit before we put so much time and resources into becoming accredited.

The point was made in discussion that there are parallels to this provider’s position within the NHS: many NHS managers are not clinicians. However, a commissioner believed that there
was a wider issue of culture in small organisations that clashed with the requirements of NHS commissioning:

_They were quite a few services who didn’t reach the threshold for clinical governance qualification, that the Strategic Health Authority expected of them. So some of the possibly more soft touch approach organisations weren’t successful. There were also some therapists linked to these who have their own ways of doing things; but we’re an NHS organisation so we expect certain clinical and note-keeping standards to be kept, and to be accessible to others requiring them, and there were some therapists very clear, saying, no it’s confidential, what’s said in the room stays in the room - actually fine and legitimate, but that doesn’t fit with NHS commissioned services._

However, this commissioner did acknowledge that:

_It hadn’t been made clear by the DH, by the SHA, what the clinical governance thresholds would be, and so you had small providers that didn’t have BACP [British Association for Counselling and Psychotherapy] accredited therapists but their therapists were experienced and they had qualified, but then weren’t successful at the bid phase - but put so much time and energy in and then when you approach them further down the line to maybe work collaboratively with one of the successfully accredited providers, they’re very reticent. I think that has had a significant impact. And the relationships in the community are very important._

A number of interviewees from small organisations expressed a sense of exploitation. This is expanded on in the next section on tariffs, though it appears to be wider and deeper than a concern about financial viability, as if they had responded to an offer based on mis-apprehension:

_It feels at times like we’re being used by the NHS without recognition of our professionalism. There’s a resistance to recognising that whatever we provide costs money. We’ve got to have staff to do the management. The thing is that it’s the voluntary sector, part of the “Big Society”, but actually volunteers have to be managed; someone has to put the lights on, and to provide supervision. We do feel a little bit dumped on by the NHS at times._

**B2 How commissioners went about setting their tariffs**

Commissioners described how they went about setting their tariffs. This account is quoted at length, because it sets out the factors considered; but also because it is frank about the dangers of perverse outcomes, particularly financial incentives affecting clinical behaviour:

_We did the capacity and demand, expecting X number of people to go in at this level, X number of people to go in at that level. X number of people requiring that intervention or this intervention. And then, going to the NICE guidance and going okay, what therapy, what would be the acceptable number of sessions, or the range within the expected number of sessions. We tested that out with the SHA and various people. What would be the level of skill mix required to deliver that, factored in a level of X% for room hire, that sort of thing. And then arrived at a price: each of the interventions has a slightly different tariff. We also then put in some outcomes, then adjusted for a dropout rate. PbR for the groups was based on having a less than 44% dropout rate, and the PbR for the one-to-one tariffs is based on improvement on PHQ, GAD - and Edinburgh WSAS for the tariff applied to group psychotherapy… In the development there were lots of dilemmas and divisions within the team about what we’d pay for. There was one view that they shouldn’t get any payment until the outcome has been achieved; other people were saying, no it should be around per session. The latter means there is an incentive to keep the therapy going on and on. If you go purely for outcome, how do you measure that? There’s a tension between the two. So we wanted a cut-off, say 12 sessions. But then what’s to stop a therapist going up to 12, when if you pay_
on outcomes and the therapist achieves it in three sessions, you get four times the payment. Savvy providers will go for the outcome approach. The thing against that, clinically, a lot of people were saying that it’s not good, because it patches people up and you get providers who will be cherry-picking the easy ones, to get the quick win. So they’ll do the easy work, the ones that take three sessions, and send the other ones elsewhere, where you’d have to put in a lot of work. So that’s where the scale came in. The more intense you’ll get payment at a higher rate, and we still expect outcome but we tolerate longer periods. But how do you define what’s complex and what’s not? That’s pretty difficult to define so that’s how it became a fixed rate for a number of sessions with a premium for an outcome…

I think that what we are finding, we’re six months in, the one-to-one therapy especially is moving to using the maximum number of sessions within the tariff. Which is something we need to begin to look at - because we’ve been using the IAPTus system, you can actually plot and graphically represent it, to look at who’s in what level of intervention and how long they continue to improve… Does everyone miraculously get healed in week 11 because payment stops in week 12… or week six for the low tariff? I remember many events, where I was suspicious of the motivations of some of the clinicians, and I was harangued for such prejudice and you know, no clinician would ever extend a session beyond its natural clinical usefulness. Incentives kick in, and the need to pay the mortgage.

We will see how closely this reflects the way incentives skew provider behaviour – and how providers themselves are anxious about how this can distort the therapeutic process, when not to follow the money may mean that providers cannot provide a service at all.

**B3 Strains in the tariff structure: the commissioners’ perspective**

Commissioners were open about the experimental nature of the tariff structure – and that there were aspects that simply did not work:

All those perverse incentives, I don’t know how we address them but they’re going to be inherent.

One thought that despite perverse incentives, his structure was largely validated by the number of providers who applied for AQP status. He was concerned about one particular scheme:

We are having the greatest difficulty with the post-natal depression tariff: with not having, accounted for crèche provisions, within the tariff, or not to a sufficient extent for providers to wish to engage in running those courses.

Overall, he thought that the relatively low level of tariffs had a positive consequence:

What we’ve found though, is because the tariffs were perhaps lower than a number of providers would like, it encouraged the local smaller providers to enter the market, and those providers who did drop out were the big national or international players. It just wasn’t worth their while, because unless they could guarantee x thousand income it wasn’t worth opening a local office. Whereas your local providers were able to fill that space. I would suggest that it has worked really well with local providers because the majority of our providers are within walking distance from here, for me to go and meet with them frequently, which I think does improve the relationship you can have.

However, this commissioner disagreed:

I don’t think AQP has incorporated enough for the on costs for the providers. They just assume you are working out of a shoebox for no cost.
**B4 Providers’ response**

Across the board, there was strong concern about the tariff, which appears to be causing severe strain in AQP areas. It is affecting the type of work providers undertake, against their professional judgement; and it was reason for withdrawal, or questioning the viability of contracts, by several of the providers interviewed. See part 4.9 below for background data of variation in tariffs in PCTs opting for AQP, based on service specification analysis.

A recurrent theme was the increased administrative workload AQP entails, and the lack of financial recognition of this. This provider expressed the sense of exploitation referred to above, in the scale of unpaid administration staff have to undertake:

*We will need to employ the services of an administrator to maintain a database. No administration time has been included in the tariff, which means that the counsellors are having to collate data in their own time. There is no paid time allocated for administrative, managerial and supervisory input. The tariff is £40 per session, there’s no DNA [Did not Attend] paid, no cancellation fee paid, no holiday fee paid, of that £40 each counsellor’s paid £35, and £5 is paid into the company. These are negative consequences, that we are working under far more pressure with more paperwork, PHQ9, CORE and GAD 7, we have to fill in monthly activity sheets, listing everything about a patient, their NHS number, their age, every time we see them has to be recorded, it’s a very big undertaking doing that, in unpaid time. It makes us feel undervalued.*

Service specification analysis of payment or non-payment for DNA can be found in part 4.7 below.

This provider had decided not to proceed:

*Business-wise - we’re not doing it. We pulled out. Never did it. Because of the fees they were offering, it’s not possible to do that in the private sector. There’s an assumption I think, that the cost is what a cheaper-end therapist will charge. But there’s no provision for the administrative overhead, or the overheads of running a company. None at all. There has to be not only the administrative fee but there has to be an element there for the manager earning an income, and that’s just not in there.*

Several others were close to withdrawal (see more below):

*The tariff only covers the basic staffing cost; there are little or no overheads for management, clinical accommodation costs, supervision, office bases or admin. The tariff clearly cannot support the true costs of NICE-driven psychological therapies. Administration of the processes for invoicing and reporting are extremely time-consuming and are not cost-efficient. Data extraction, complex manual calculations for the reporting and invoicing, invoice validation per CCG area and national reporting for further validation all cause problems. We are pushing for a review of the tariff based on the real cost of delivering NICE guidelines, as we are currently running at a significant loss, which is unsustainable.*

A number of interviewees expressed strong views along similar lines:

*Does the tariff reflect the input of time by our organisation to each patient, including administrative, managerial and supervisory input? No – it’s too tight and we were forced to cut the service spec “cloth” to meet the tariff. Is the administration of tariffs for each patient time- and cost-efficient? No – we have had to employ a dedicated Business Director to manage this. Was there genuine consultation on setting a price? No, no, no. Despite persistent attempts to address the Step 3+ issues designed by the commissioners, no*
reasonable outcome was achieved and they failed to meet and discuss the issues. In the end we were forced to sign the contract or miss out on the opportunity.

Another respondent felt that it raised ethical issues for her as a manager, in terms of remuneration not recognising years of investment in qualification, and offering terms that she would not accept herself. Like several others, she expressed concern about the viability of the model in terms of retention of accredited counsellors:

*Does the tariff reflect the input of time by our organisation to each patient, including administrative, managerial and supervisory input?* No. It’s £40 an hour, we’re going to be paying counsellors £20 an hour, because there’s admin, reports, we don’t know how busy we will be, so at the moment we’re going to really struggle to break even and pay overheads. I have an ethical issue with this. In my own private practice, unless I’ve got one slot that’s low paid, I will balk at having all of my clients coming in and paying £20. I trained for six years, I worked hard to gain my hours and went through the accreditation process, all of the things you have to do to keep the practice going, our CPD and so on, there’s no way I’m going to work for £20 an hour, and I think that’s a slight concern for us. As a voluntary sector organisation, I have a slight concern that we might not hold on to our accredited counsellors. That shows me there’s a lack of recognition of the training and the energy and work involved in becoming accredited.

Like several of those interviewed, this respondent too seemed to be edging towards a conclusion that the tariff model might not be viable without subsidy from other workstreams:

*Does the tariff reflect the input of time by my organisation to each patient, including administrative, managerial and supervisory input?* Just about. We’ve had to use other funding, it’s hard to know because we’re still in the early stages. I’m going to be undertaking a review of the service because obviously we can’t be working at a loss over the longer term, we expect to make an initial investment but it needs to be at least covering the costs of delivering the work and contributing to core costs. And at this stage, to be honest I’m not sure if it does.

Several providers pointed to the variable impact of tariffs according to differences in employment status:

There are some organisations who are fine with the tariffs, fair enough. But because we don’t have employed staff, they are all self-employed, they charge an hourly fee, which is well over what an employed therapist would be charging. Some organisations have volunteer staff or they use trainees. We don’t, we use people who’ve got years of experience, and who expect to get paid a significant fee per hour providing psychological therapy privately.

Only one of this study’s interviewees felt that the model might be viable, though with significant caveats and a degree of apprehension about the AQP market:

I’m under the opinion that the NHS offered this tariff, and I knew what it was and worked towards this. If you go for the contract, you’re committed and you need to have understood it beforehand. I’m aware that some have attempted to renegotiate the price with the NHS, but before you apply, you make sure it reflects your time, otherwise you don’t go for it. I’m aware that there are more lucrative steps. More complex cases work out at less per session. Bonuses for recovery are split over sessions; you work within the tariff allocated. We are also a volunteer organisation, not tied to the banding of NHS, so that makes it somewhat easier. We recruited on this basis. I guess there are some advantages that we’re not NHS, but some disadvantages also. There have been no great surprises as there has been good preparatory work. The financial model for the future will be complex. On this
“paid per patient” basis, we don’t know our income, and we will have to forecast success rates and illness rates. We’re currently paying under £20 per session, but have seen others advertising at £30 per session which I think is incredibly optimistic. Some organisations are definitely bound to crumble.

Some argued that this “hard-headed” approach involved distorting provision in a way that they considered indefensible – indeed, “you work within the tariff allocated” (above) suggests that clinical decisions may be affected by the tariff. The same interviewee recognised one of several possible perverse incentives:

*There is a distinct danger that I am aware of. In stepped care, if a client has only one session it is considered as no therapy and no payment. If it is two sessions, the therapy is considered completed and therefore the provider can claim a flat rate. It makes a slightly perverse model where some rogue organisation might be able to get a sizeable fee just by offering two sessions and claiming a flat fee. There’s a bit of a joke in some circles that “oh all I need to do is deliver my two sessions”.*

Others acknowledged that the tariff structure would affect what providers offered. One provider reported that at a consultation meeting:

> Most people in the room said they were far too low, for some of the interventions, but there were a lot of private organisations that would be charging a lot more for a therapy session, as opposed to some of the other organisations, particularly charities for example - we try and keep our costs much lower. So I guess it’s different for different people, and for us personally, I felt that we wouldn’t have applied if I felt that it wasn’t sufficient, but I knew that it would be tight. And it did dictate also what intervention we would offer, where I felt we could cover the core costs for this. Some tariffs I thought no, that really wouldn’t work for us. You have to be realistic.

*It’s a good IAPT service spec. – however it’s completely mismatched with an unreasonable tariff that has made the service spec undeliverable. There was no reasonable consultation process to address this or rectify it. Questions submitted were robotically responded to without any depth of understanding of the issues and implications. As for patient needs, the tariff doesn’t fund the service spec, which has undermined a good IAPT service. In terms of best practice, this has forced us in to a strict recovery driven model to financially survive. As for patient choice, this has forced us into rejecting those unlikely to fit in to a recovery model.*

There was a consensus that consultation on the tariff was not meaningful, though it did take place:

> Consultation? Well, there was discussion around what the tariff would be. So I’m not sure whether you could call that consultation. These are the tariffs, what do you think?

Indeed, one interviewee held the view that consultation belonged to an earlier era:

> There was not genuine consultation on setting a price: this was set. I’m aware that some IAPT organisations did try, but they were from old systems and had that way of thinking, to negotiate.

The view was held that the economic climate affected what providers would accept:

> The tariff is on the low side – at the low end of acceptable. Just enough to give it a go. Basically, lots of organisations are a bit desperate at the moment. Beggars can’t be
choosers. But other things we do are being cut. In better times a lot of people wouldn't have gone for it.

Several providers made the point that viability was dependent on volume, which was highly unpredictable given zero value contracts:

We have been capacity planning for AQP provision. This has shown that AQP finances only break even when a threshold of provision is reached. Under this threshold it is very difficult to obtain cost recovery and this will be the case for any smaller providers of AQP. The tariff has to cover all central costs, team admin, sufficient management time and rigorous supervision requirements set by the IAPT guidelines.

The views of commissioners were also mixed. This commissioner emphasised a high degree of planning and consultation:

One of the things that didn’t change very much was the suggested tariff and fees. The providers clearly wanted a lot more money for what was being offered. We were doing our separate capacity demand modelling, worked out how much it would cost per hour, and included renting a room etc., and built a tariff system up based on what we thought fair, and a number of therapists thought it was under-priced, however subsequently a significant number of providers still bid who think it was a fair price because there’s now many who have agreed to provide at the agreed tariff.

However, the uncertainty experienced by providers had created some major challenges:

One of the larger providers has decided that it is not financially viable to continue to provide the service, and is in the process of exiting as an AQP. Which has had a significant impact on our capacity, particularly for low-intensity CBT and also the level three, the more high intensity intervention.

For another commissioner, the inadequacies of the tariff adopted had meant that the entire service had to be re-tendered:

Lessons learned, our tariffs probably weren’t fair. It is something that we have had to change, going into this financial year. It was unfairly weighted to be honest, to be outcome-focused. One provider wrote to us to indicate they were at risk of going under, which forced our hand to look again at the tariff structure. The way it was focused was, for example, £300 for a package of treatment: if the patient recovered, they would get the full £300. If the patient went through a package of treatment and didn’t recover, they would only get 50%, so £150. So the provider was putting full resource into that patient, and potentially only getting half of the income, and then based on the national standard, that 50% should recover, we were setting them an almost impossible task. That’s where we fell down. It was spouted by a few people that AQPs could be a licence to print money for providers, so we went too cautious, in trying to protect the NHS money. We picked it up with all the other providers to see if they were under similar situations, requested all copies of trading accounts from all the providers to evidence that they were all running at a loss which they were. We then set about rebasing our tariffs based on a fairer option, and then we had to get the two clinical commissioning groups to approve that ahead of this year, which they did, and that change is now reflected in the contract. Because we materially changed the tariff we’re mandated to go back out to procurement, in case the tariff had put off providers who might have entered the market - who could have challenged us. The providers seem a lot happier with the change we’ve made.
**B5 Payment by Results – reflections on outcomes and the nature of therapy**

The tone of the interview responses to Payment by Results was largely uncomfortable and negative – and in some took the view that it was iminical to a therapeutic outcome. The theme of the financial regime influencing choices of treatment, and of patient, came up as it had in discussions of tariff:

*It is going to skew the way people take on cases, they are going to find a reason not to take a case if they think it is going to be difficult and they're not going to achieve a result. Also, when you become despondent about a client, and you're not going to get paid, it puts a demand on you that will have an impact, even if unconsciously, on the way you provide the therapy. That's cherry-picking, focusing on outcomes - I mean you can't afford to not get paid.*

The view that PbR can drive up standards was expressed, but rarely, and with strong qualification:

*I've got mixed views about Payment by Results. I think in some ways it's good to have Payment by Results because I think it drives up good standards, but there again, I've got some quite big reservations about it when you're working with people who are unwell: they're not commodities, not products. And, you know, things happen when you're working in mental health, which can affect the key performance which we're measured on.*

The more common view was hostile:

*Unethical. I think it puts an unnecessary dimension on the therapeutic encounter.*

*This is destabilising to local NHS providers, restrictive in what can be delivered under the cost. Destructive to NICE guidelines and high quality services. Services become financially driven rather than clinically driven. I would question the validity of this method for commissioning of psychological therapies.*

*We have adjusted to Payment by Results – and the process has been very unprofessionally managed by the commissioning team with high levels of chaos.*

This commissioner acknowledged the risks. He was aware of the attractions of standardisation for commissioners; but also of perverse outcomes:

*We know we've got a standardisation of service provision, and it's a benefit, knowing where you are with it, and being up to date. Rather than a mish-mash of all sorts of different services. The weakness is, because it is payment by results, some providers may opt to try and force the patients through the system too quickly. To try and get the turnover of patients through and almost take a punt that they are going to recover. So it's more of a sausage machine, getting as many people through the system as you can. With a risk of relapse.*

Another commissioner brought these concerns together, linking perverse incentives to tweak data with an effect on the therapeutic process itself:

*I think that the recovery payment as a percentage of their payment is quite high, I think it’s £100 for Step 3 and £50 for Step 2 – some are much lower. For me that introduces a potential for providers to jiggle the data, or to lean on clients to fill in their recovery forms – you can easily do it: “Oh, you’re much better now aren’t you – I’m sure that’s a six …. I think you’ve been doing much better this week, don’t you think that’s a two?”*. I think one of the sad things for me out of this is that IAPT probably has the best data anywhere in the world
on a recovery model - up till when you introduce Payment by Results. There are incentives for the data not to be accurate. Proving it, do you audit every case? You can look at the differences before and after, but they can say, well we just train our staff better now. It’s not like payment by results for a broken leg. My other concern is that the outcome measures were designed to assist clinical judgement – they were never designed as a payment structure. When whoever it was designed PHQ-9 and GAD-7, they didn’t do this as a payment basis, it was to assist professional judgement, and it gives us no information about the long term recovery of those people. You cannot assume because they didn’t come back that they were or were not recovered. So it’s become a payment method. If you want to design something, let’s validate it as a payment method, that’s fine but they were not designed for that. Their original purpose has been subsumed into something that it wasn’t.

See more findings about measurement scales in Part C below. The same commissioner gave an example of what may be called a perverse disincentive associated with PbR:

It has the potential to become a service of exclusion not inclusion. By that I mean the temptation for providers to only see people that they can be confident they can get well at session one. They will screen people out, rather than the earlier system of cost by volume, when the inclination was to take the risk. They may become risk averse about more complex cases. Because if I only get paid - say I take on a complex case, Step 3+ - I see them for 12 sessions, 13 or maybe 14 sessions; and at session 14 something happens and their score bounces up – that person has just made me a loss. Now that means I would have 14 hours of work but I would only get paid for four of them or five – what am I going to do? I would try and pre-empt the outcome at point A, not wait for point B.

What needs to be considered is how far this is a consequence of AQP, and whether the same factors are present in IAPT. It may be that a greater number of providers may result in greater flexibility and transparency – and that the consequences of such perverse incentives may be easier to hide in sole provider Payment by Results. On the other hand, given the challenge of monitoring larger numbers of providers, there may be particular risks to accountability in an AQP market. The risk may be inherent to any payment by results system.

This commissioner considered the feasibility of making such judgements:

Some people say you can’t tell an easy client. Well I can – his history, previous attempts at therapy, outcomes, if they’ve see three therapists, or been known to the mental health team…. but against that I plan ahead. I saw somebody who’d been known to the mental health team for about six years: they’d treated his depression, nobody’s treated his trauma. Six sessions – bloke couldn’t believe it. So you can get it wrong and you can exclude. The temptation is to go ‘they didn’t get well before – do I want to be the one that takes that risk - or give them the number of the other provider down the road, tell them we’re full up at the moment’. I can see gains – it could improve the experience of patients but it might not. But it is discriminatory against certain groups – potentially.

One provider went into greater depth about the focus on outcomes on which PbR depends:

From a therapeutic standpoint, a good result for a client may well be, in the interim, that their CORE-10 score is worse, their experience of life is worse. In my experience, and I don’t know how many counsellors I’ve talked to, you don’t come out the other end feeling happy, it’s not a sausage factory. The NHS has this belief that a good outcome is “happiness”. Once we’ve been through therapy, a good outcome is managing whatever’s going on in a person’s life, that they’re able to be open, and congruent, and look after themselves, and have an experience of life that is real. I worry a little bit that this model of seeing people comes from an idea that you come in this end sad, or anxious, depressed, or having panic
attacks, and what you’re supposed to push out at the other end is that you’re happy. I don’t know how many of my clients have said to me, “I just want to be happy” – and it’s always in the back of my mind to say, “Well, you’ve come to the wrong place - maybe pharmaceuticals might do it for you”. This is about resilience, and being able to be robust, and to be able to look at life and say, this is a really sad, awful time, but I’m going to get through it, and I’m learning something. I often hear, “I’m having a huge amount of pain at the moment in my life, but I’m alive”: we almost welcome that this is a bad few months – “I’m going through a process of change here”. The NHS doesn’t like it that this is hard to measure – you measure it, it’ll be target-driven. There’s a kind of implicit idea of what human experience should be. Human experience is very awkward and doesn’t comply.

**B6 Tariff, risk and workflow**

The combination of tariff, zero value contract, and uncertain workflow was too much for some providers. This provider felt that the new framework had far-reaching and potentially harmful consequences:

A move to AQP occurred at the end of a block contract with one commissioner, and it was therefore possible to reduce overheads. Another contract elsewhere was about half way through and the service was tied in to costs (such as a lease on a city centre base) making it impossible to reduce overhead costs. In both services, the income uncertainty made it financially unwise to recruit to vacancies and as a result the waiting times increased. While the model could support a reconfiguration and appropriate skill mix to meet patient needs and choice, the financial uncertainty made this impossible, again with detrimental effects on patient care. The inadequate tariff also results in restricted patient choice of venue, therapists etc. The tariff is also inadequate to support overhead costs and clinical time to deliver NICE guidelines and best practice. Overall AQP and the inadequate tariff has destabilised the health community, introduced perverse incentives, pushed down quality, increased waiting times, staff turnover and staff sickness. All of these have an impact on quality of services.

This provider felt that the new market had her organisation on a knife-edge for similar reasons:

*It may be that we do withdraw if we don’t get enough referrals. Because when we were first up and running in November, we had enough referrals but they seem to have dropped off. And obviously, if we don’t get sufficient referrals we can’t have staff waiting around and expecting to be paid - so we haven’t withdrawn at this stage but we may well have to, but we’ll just see how things go really. We do know other providers who have withdrawn and also some who didn’t even know they had got the accreditation. I’m not sure how well placed smaller organisations are, to deliver this work. It has a significant impact the smaller you are because of the resources that are needed to deliver it on such a small tariff.*

One interviewee had made the decision much earlier, and decided not to go ahead:

*AQP is not a suitable model for a small inter-regional enterprise. The impact on us would have been unacceptable. The AQP framework cannot allow for flexibility of provision if you are excluding many services who cannot compete.*

This commissioner talked about new stresses for providers appearing in the system:

*The cost to the provider, providing all this individual validating information on a monthly basis, I’ve heard from other areas that some of their contracts go bust, waiting for the money, data sharing information problems, now some Caldicott Guidance has come out that they can’t share patient identification data, which they need for validating invoices. The*
whole system’s vulnerable. Extra costs are hidden, it all looks good on paper, when you work it out at cost per person but that’s not the real cost.

This commissioner talked about an additional burden of contract monitoring:

From three contracts we’ve now got 11 or 12. Quarterly meetings, how many is that – 44 meetings a year – that’s four a month involving me, the contracting department, somebody from the clinical commissioning group, in terms of time and cost of contract monitoring that’s going to be.... (sigh)

**B7 Adopting NHS IT systems**

A related area of concern was the difficulty and cost of requirements to adapt and link up to NHS IT systems. There was anger about disproportionate demands, inefficiency and cost:

N3 [IT connection] is a chaotic nightmare. Two years of persisting with a dysfunctional system designed for big NHS trusts. No one seems to know what they are doing or how to successfully achieve this. Our own outcome measures have already been successfully used for many years by the service and work well.

This perception of disorganisation and wasteful expense was common, and several expressed reluctance to meet the demands. This provider believed that there might be some flexibility over IT provision, in a response that reflects a significant, and perhaps risky, lack of clarity in communication between commissioner and provider:

Certain requirements are not fulfilled yet, which would almost put us off; but I spoke to somebody in another organisation who had been through the process, and she said you just have to say you are willing to do those things. For example, we would not be able to invest any infrastructure costs in terms of special, secure internet links, or email – it’s a big outlay, that would put us off, so we just said, well, we’re not doing this. It would be grossly unfair, as a voluntary sector organisation, we just don’t have a fair bit of money lying around to invest in that kind of thing. If I got a big bill in for, say £1,500 of outlay, I would withdraw from the contract. I can’t justify to my trustees putting so much money into a project, and the other thing is, because AQP is paid by attendance, so far we haven’t had one client come to the X branch, I think we’ve had two referrals, but unless I know that I’ve got a guaranteed income stream, it’s very hard for me to argue for that expenditure.

We are working on the special N3 connection. We have found information systems like IAPTus and CORE-NET to be highly costly. We have not yet bought them – we have been informed from an outside colleague that it is £30k for IAPTus; I hope they’re joking. It’s difficult with zero hour contracts. We have developed an interim homegrown management system – it’s taken three weeks, it’s a modified version of MS excel. It doesn’t do everything like provide scores of graphs or any niceties like that but it does what is needed in the contract.

I think we’re going to have to get our data into the main partnership hub, somehow. But I don’t think they’ve worked out quite how that’s going to happen.

Due to requirement to use Choose and Book for booking of appointments, the commissioners are currently moving over to NHS IT. The cost of this for new equipment, transfer of data etc. is approximately £300,000. We have to employ a data analyst and rely on Trust informatics to provide the breadth and detail required in reporting.
Only two interviewees reported a satisfactory approach to the IT requirements of becoming an AQP, although they both reported significant, though manageable, investment. This provider gave credit to her commissioner:

It was free across the board, all the AQP providers in fact. So it was only really staff time but there was no initial outlay for us connecting to the IT systems. We didn’t have to pay anything up front, obviously we invested lots in terms of staff time, which does cost the organisation but it was free for connection. In terms of the resources needed to run an Outcome Measurement IT system, we’ve had to increase our capacity, so we’ve had to employ our administrator on additional hours to meet needs.

We pay a user fee of £80 per person that uses IAPTus. In addition we have used training for staff via IAPTus IT Support, with us covering the cost of workers being out of office for two days each time. Our IT officer has spent significant time with workers in community venues addressing a range of connectivity issues to support the need for remote work. We have purchased a number of laptops and 3G connection for workers to enable effective remote working. With IAPTus, we have sufficient resources in terms of hardware availability, with support provided for us around technical issues.

This commissioner recognised the difficulties faced by non-NHS providers:

It was a prerequisite of AQP that they had to be able to list themselves on Choose & Book, which meant links to the NHS N3 network, and if you a private provider you don’t have access to that. The NHS do, so we had to quickly work with the other non-NHS providers to put in other solutions. A lot of them had to purchase connections through the PCT, to access our N3 connection. That was a bit of a pain, and for some quite difficult. They were all aware of it from the tender process, but they relied heavily on the PCT. They couldn’t have done it themselves.

Another commissioner felt that the N3 connection constituted a disproportionate demand for small provider organisations:

The N3 connection - oh the cost of that and time! It takes ages to get an N3 connection plus the IT governance procedure. I was involved in that from the provider side, I couldn’t believe what a complex thing it would be to get some information off a memory stick from here to here. It’s almost Kafkaesque, what you imagine a communist bureaucracy to be to get something that should be simple up and running. The connection is in their contract, but I’m not being too hard at the moment on enforcing that; it’s fine if you are a partnership trust or an existing huge provider, but if you’re a little one trying to develop a service, I think it’s discriminatory to apply the same rules to them. So I’m going to be hauled over the coals; as I know that CCGs will go, “So you’re not providing that – we’re taking away your contract”. I can see that kind of mentality.

**B8 Distortion of provision: an outcome-driven, competitive service with cost pressures**

As we have seen, distortion of provision against providers' better judgement is a recurring theme in the interviews. Distortions already described include:

- tariff and PbR as a factor in the decision to take patients on, and the type of treatment to offer (B4, B5 above)
- destabilisation and deterioration in service (B4, B6)
- destabilisation of provider organisations affecting their viability (B4, B6)
- the impact of a conveyor-belt service and resultant pressures (B5)
• financial incentives to misuse measurement scales within therapy to improve measured outcomes – measurement scales that were not designed or validated as a payment method (B5, and C below).

The relationship of tariff to greater administrative burden associated with the IAPT model was referred to by several interviewees, as we will see at greater length in the section below on administration of outcome measures:

*Inputting of outcome measures takes time for therapists and impacts on their overall availability for face-to-face time.*

This provider was very forthright in describing ways in which the new regime affected decision-making in ways that worried her:

*I don't feel I'm able to work in the ethical way I've been used to, because we're under time constraints, with 20 days between the patient opting in and us offering them a first session, and the tender is for up to eight sessions: I find myself making a decision very early on to maybe offer somebody just six, rather than giving them the opportunity of the full eight, aware that I've got people waiting, that I've got to offer an appointment to the next person because I'm running out of time. I think that impacts on the quality of time I'm giving to a particular client. It's hurrying somebody through in order to see the next person.*

This provider had improvised in response to rigidities in the service:

*I myself have signed up to deliver on AQP, and I'll do an eight-week piece of work, but what do you do when someone comes in who's presented for example with depression and problem eating? That's not resolved in eight weeks. They are involved by week five, but then if it is related to child sex abuse, for example, as has happened several times in my career, if that happens on week five or six, how do you sufficiently process and tie that off, to be done by week eight? I don't think it's possible. The best you can hope for in that situation is that we have good signposting, and I'll be brutally frank, if I see a person on AQP who's presented to me in that way, I'll get them closed down enough to discharge them from AQP, and refer them to our main counselling service, which would give them two years' restorative work. I don't think the AQP framework lends itself to restorative work.*

A commissioner encapsulated the ethical traps entailed in Payment by Results:

*There's an onus for providers to demonstrate some form of recovery. The pitfalls are that recovery might not be real, and then it might be just to get the payment, to put pressure on the client to say that they're well when they're not. Then the patient is at risk: please say you're well or I won't get paid. I can see people doing that. You want to please the therapist.*

Another provider brought up a different aspect of what was commonly seen as a mechanistic regime which caused difficulty in his practice:

*There is an issue of time slotteding. With physical illness, the NHS send you a letter through the post and say you have been booked in there for then. That doesn't work for psychological therapies, they can't exactly say "This is your appointment: Be there!", when many can't be there: needs are specific. Also, it's much easier for people to get time off work for physical conditions but not many people like admitting they need to get off because they have a psychological therapy session.*

This is perhaps a factor in considering the very high dropout rate in IAPT.

The issue of perverse incentives is discussed in Chapter Five.
B9 Working with groups

Although development of psycho-educational groups is recommended by NICE, and commended in the Talking Therapies: A Four-Year Plan of Action (DH, 2011b) there were varying accounts from providers of the feasibility of these. The ability of such groups to increase capacity and thus reduce waiting lists, and to present in such a way as to reach communities that had not traditionally taken up, or been able to take up, psychological therapies, was mentioned favourably. This commissioner was in no doubt that it was a significantly positive direction:

It’s possibly been influenced by the model our Level 1 provider brought to the service, but it’s not only them who are providing the psycho-education groups. There’s a large diversity, and I think the groups have enabled more people to be seen and quite frequently their needs are being addressed without needing to go to one-to-one. I think it’s quite a cultural shift for some of the providers, but it’s also enabled there to be a wider geographical spread of availability so more people can access them. I don’t know if it’s the case in operation, but certainly in the design originally the idea was that when we talk about groups, to the public, it’s never a group, it’s a course. Its de-medicalised, so you go in, in the same way you go on a course to learn about bicycle maintenance, you go on a course to learn about wellbeing and stress management and coping skills, and it’s not group therapy where we all sit around and say, “Hello my name is Andrew and I’m an alcoholic”, it’s not that sort of approach …. So that de-medicalising, normalising of the issues is seen to be a strength and a positive, which gets more people in to attend and also to stay with it till the end.

Several providers mentioned obstacles:

The service specification said it allowed for flexibility in the form of provision, e.g. group work. I’m not sure that it does. Tariff wise, that definitely is a problem. I think organising groups and setting them up is far more complex and requires far more administration than is catered for. I had a go at running groups as well, and I couldn’t see how on earth you could make it financially viable.

We felt as an agency we weren’t in a position to run groups because of the resources that are required to run them and also how many clients or patients have to fill a group in order for us to run one, so we felt that we had to be very choosy in what we were offering as an AQP.

But there was clear variation in the extent to which working with groups had been prominent in service specifications, or promoted by commissioners:

Didn’t clock groups. It didn’t come up very high on our radar. We really have approached it on a one to one basis. If groups were high up in the criteria, fair enough, but it wasn’t something we designed into our project. Flexibility was not designed into AQP.

This respondent had a sense of the future potential of such provision among other forms of diversification:

We would like to expand the specification to include groups, particularly bereavement groups, and telephone counselling, but we’d also like to maybe think about couples, and also adolescents, we’ve certainly got one counsellor who’s very experienced at working with that group. We took on a group of five counsellors who’d been employed to run a psychological therapy service. They offered all of that, and they could manage waiting lists very effectively, because they were always able to offer something immediately, and that’s particularly missing now.
B10 Empowering patients and carers, improving their outcomes and experience: understanding and responding to a whole community

It follows from the aim to use AQP to empower patients and carers, and to improve their outcomes and experience, that service specifications should seek to widen the reach of services to include those who have traditionally not had their needs recognised or met. To this end, respondents were asked whether they thought that the qualification process sought to assess whether providers had knowledge of conditions and needs specific to their local area.

There was wide variation in providers' responses, though they generally believed that this should be a priority. Several thought their commissioners had comprehensively recognised the need to understand local conditions, and that this was consequently recognised in the nature and breadth of provision:

Yes – the service specification encouraged us to explore and think about these, culture, language, ethnicity, context, surrounding.

For sure. Reflected in the range of providers and area.

Others thought this was a failure on the part of the specification:

The specification was very much based on the national template without variation from inner city to rural localities, from very deprived to privileged areas.

We are in an area of high deprivation which was not taken in to consideration or reflected in the service spec and tariff.

There was a degree of suspicion about lip service being paid:

They did ask about the locality, and about equality issues. But there’s a question of what they made of the answers. There was a limited, traditional approach, not much innovation.

In X, there’s a massive BME [Black and Minority Ethnic] community. There are huge numbers of people from Asian and East European backgrounds. That was not recognised. We had to point it out the second time round [after rejection] as the reason we have gender specific services to ensure equality of access. So we have women who would love an IT class, or to have counselling, or have a support session, and couldn’t have it unless they were in our building – because their husbands wouldn’t allow them to enter a mixed gender site. This wasn’t accounted for. I couldn’t see the equality duty. I could see the standard “tick the box” type. “Do you have an equal opportunities policy”, that to me is lip service. “Is equal opportunities embedded within your organisation”, is the more relevant point, and it’s harder to tease out and assess.... There wasn’t room for us to point that out.

However, this commissioner had a strong engagement with both equity of access and with wider determinants of mental health in his area, and saw commissioning in this sense as a continuing, developmental process:

Last month I did a report of patients’ GP practice origins, so not where the referrals were but the geographical areas of registered GP practices for people that have entered the service. And it was really positive that the most deprived localities are accessing the service. Another indicator of that is that we have had providers requesting to do specialist courses in relation to race hate crime, Level Two psycho-educational courses, and also courses
specifically for Somali women. So the fact that providers are being innovative and saying right, OK, we want to put these courses on, and the courses are running, populated by the people from the appropriate area - I think it’s a real positive. We have two providers giving low intensity psycho-social support, with a high level of demand predominantly in the areas of deprivation. We’ve got employment interventions as well, we’ve got X commissioned separately, but under the therapist wellbeing services umbrella, so it’s not under AQP. They are linking with Level 1, and all of the AQP are aware of the availability of that service. It is employment support, so job retention as well as for people who are un-employed, and it divides the unemployed into the long-term and the recently unemployed. There’s various different levels, there’s different issues with different populations.

In this commissioner’s view, the diversity of providers brought geographical diversity which in turn led to improved access, both in urban and rural areas.

**B11 Changes in provider culture**

As we have already seen, AQP represents a significant cultural change to the working environment of psychological therapists. This section gathers together some reflections on the nature of that change. A common feature of these was a sense of loss.

One of these changes was the disruption of longstanding working relationships which were seen as a strength, described here in its effect on counselling set in a GP Practice:

*In terms of patient needs and patient choice, having been based in a surgery for 20 years, the GP knows me, he speaks to the patient, and says, we have a counsellor here who will contact you. It all ran very seamlessly. Judging from what a lot of the GPs have commented, now they don’t know counsellors who work for other providers, so they don’t know their work. Maybe the locality may be more convenient for some patients in that they live nearby, but in our experience patients prefer being seen in a surgery rather than in somebody’s home, or wherever they happen to have their office, so I personally don’t think that the framework, although it allows for flexibility, is necessarily in the patient’s best interest. The other crucial point is that in the surgery you’re on hand and the GP will very often talk to us about whether to refer somebody and if they need to be seen quite quickly, and I might be able to say to the patient, are you happy if I talk to the doctor about this, and therefore I’ll be able to talk to the GP within five minutes, and they will always make time to talk, to any of the counsellors, because there’s a mutual respect. Patient needs are best met in that way."

Loss of continuity had some unintended consequences that need to be considered:

*The other big thing that changed for us is that we provided placements for trainee counsellors, who need a minimum of 100 hours of counselling experience. We brought them in to work towards accreditation so that was very useful both for waiting lists, and also for dealing with conflict of interest. After the tender they were not included on the placements, everybody had to be BACP accredited, so we lost that extra facility, and as a group of counsellors we had all done supervision training in order to supervise those placement counsellors. We had got qualified, and now we’re no longer doing it."

This interviewee spoke about the impact of competition on her own sense of identity as a therapist:

*The other ethical issue for me is the personal rivalry that it’s created, and the competition with other local providers. I find myself not exactly touting for work, but being very protective, and concerned that if we don’t get the work, why haven’t we. That may be a good thing, competition, but it’s another pressure, I just haven’t been used to a feeling of*
rivalry, or even being mindful that there are other providers around. That’s been very negative.

However, this commissioner saw competition as a positive force:

Very much. I think it may manifest itself at the provider forum. I think it may manifest itself in some of the more brave providers being more innovative and trying to outdo one another in what they can provide. With that have come innovations of the different psycho-educational groups that are being developed to meet the needs of the population more appropriately. I wouldn’t say competition is a bad thing. It stops providers being complacent.

Another commissioner acknowledged that this meant a shift in employment patterns:

The new provider only takes on the people that they need. So some of those are blossoming and the existing bigger providers are struggling because their working model, they’re employing staff on paid contracts with holidays – da-da-da-da-da – it’s lovely for the staff - but it’s very difficult to run an AQP model like that. So, you need to have a bank of therapists who are qualified, the hours that they will work and would step in and do it, and I could see if I was a therapist who wanted to do a mixed economy of some private work, some NHS work, that would be excellent. Because it would enable me to have some private clients and at least a core income of a bit to keep you ticking over.

**B12 Patient choice**

We take patient choice in the context of AQP to mean a choice between providers in a market structure leading to improvement in the patient experience. Concern was expressed in the interviews that the market structure itself restricted choice “if you are excluding many services who cannot compete”. Another remarked, explaining her view that there was no patient choice:

The tariffs forced us in to rejecting those unlikely to fit in to a recovery model.

On the whole, provider interviewees inclined to the view that AQP did not extend patient choice, and in a number of ways restricted it, although several positive statements below about AQP suggest that expanded provision has given more patients access to a service, if not a choice between providers. That might also have been achieved by simply expanding provision, not necessarily through AQP.

One provider questioned how genuine the offer of choice was:

Does AQP extend patient choice? Well it said so, but I’m not sure that it does. Because I don’t think patients necessarily know how to choose. At Level 1, I’m not convinced that the people doing the triage on the phone would be necessarily helping people to arrive at the right service. On the other hand if they were getting most of them right, most of the time, then that’s probably a good job. I had the idea that there would be choice, but I’m getting the sense that that isn’t what is actually happening. People are being channelled to do one thing or another, rather than actually having the choice that they expected to have. If you’re a purchaser and you don’t really know what you’re purchasing then you’ll go by what your shop assistant wants to sell to you.

One provider replied in the affirmative, defining a simple choice that is likely to resonate with many patients:
Yes, certainly, there is choice now with my service: clients have a choice between us and long NHS waiting lists.

This, however, begs questions about whether AQP is the only, or most effective, route to reducing waiting lists – or that which serves patients' needs best. This commissioner was in no doubt:

Absolutely, AQP improves patient choice. They can choose both, to a degree, the clinical indicator, the intervention that they want, or type of intervention, and also who the provider is, the day of the week, the geographical location, that's the key thing. The time of the day. The gender of the therapist.

However, another commissioner felt there were cultural resistances to choice:

For one thing, you have providers keeping hold of patients. Another issue we are anecdotally aware of is that some GPs have preferred providers. If historically they've sent all their patients to one provider, they continue to do so, unless told otherwise. That's something that is quite hard to break down.

For patient choice to occur there needs to be more than one local provider. This is clearly not the case where there is only one overall provider, as in one case; or where there are sole individual providers on a locality basis, as in other cases. As one commissioner put it:

There is competition, but because of the geography of the area, and where the organisations are based, this is restricted. So you've got for example, A are B Locality's provider of choice, so they seem to mop up a lot of the B referrals, C swallow up most of D Locality's referrals, E mop up most of F Locality's referrals. Of the rest, two have a market share across the whole area. And then the other provider, which is new, are starting mopping up where they can, trying to increase their business. But then when certain GPs only send to their provider of choice, because that's all they've known......

A distinction also needs to be made between urban and rural areas. The former have the potential to offer easier access to an increased number of providers. In large rural areas, distance is a limiting factor.

Another commissioner was concerned about the perverse incentives described above reducing patient choice:

Is it a real choice? It's given them a choice of places to try, but if all those providers become risk averse, that's a choice for those that would get well with a minimum of support – it's not a choice for those that would require NICE guidance 20 sessions. So – choice is a subjective thing isn't it? So, it's great, I've got four people to choose from, none of which would accept me – that's not a choice.

B13 Point of entry, self-referral and patient choice

One service has a single point of entry at Level 1; another a dominant Foundation Trust which is in practice a referral agency and a provider. This entails two risks:

- that access will be controlled in a way that restricts choice. In this scenario, the patient will be told which service they are going to be referred to, will then be assessed (by phone), and be seen at either Step 2 or Step 3.
• that unnecessary and wasteful stepped progression to Step 3 will occur when it is clear that Step 3 is what the patient needs, with providers prolonging the patient’s stay at an inappropriate lower level for financial reasons.

In the first case, confidence in system management is key, and could prove challenging for commissioners. One was struggling with a Foundation Trust (FT):

*The big FT appears to be mopping up a lot of referrals, and one of the issues that we have is that they have access to a lot of patients with mental health conditions and they keep hold of them, and refer them into their AQP service. The specification demands that they should be offering choice, even to those patients, and this does obviously then affect other providers, who are saying they’re not getting their fair share. I think the patients that the FT do refer on to other services are the really complex and potentially problematic ones that aren’t going to be your quick win, these are going to be 20+ sessions who are going to cost them. It probably costs the provider more than they are going to get back. It’s really difficult to prove as well, because as long as the patient has been seen by somebody, she or he is not necessarily going to complain about that, and it’s hard to pick it up."

Information systems and oversight by the commissioner are evidently crucial here, as well as the design of the assessment and referral system, as another commissioner indicated from a different perspective:

*One of the issues we have run into is the whole system management relationship: who manages the system, who gives the AQPs the information. The expectation at the beginning of the process was that the Level 1 provider would be providing that input to the AQPs: however that isn’t a role that they are happy or willing at this point in time to undertake. So that role has been passed back to the commissioners, to manage the system. But also the Level 1 contractor is a provider of Levels 2 and 3 activity; and that could be deemed a conflict of interest. It feels at this moment that it would be more appropriate that the commissioners take that role whilst the confidence of the AQPs is established. There is a fear amongst the AQPs that they’re not going to get work, the Level 1 provider will see all the people that they want at Level 2 and Level 3, and the AQPs will get the more complex people.*

If the aim is to have a choice of providers, a functioning model must entail the patient being told that, and helped to make an informed choice. The patient should also be offered choice of gender of therapist, and asked if issues such as sexual orientation, faith or race are important.

Equally, if choice is provided at Step 2 or Step 3, the patient will need clear information as to the implications of possible choices. This is not straightforward, in reality, it means offering active support for informed choice, otherwise patient choice may not be meaningful. One commissioner reports that it is a significant issue that patients do not understand what IAPT is, or what a choice between IAPT and Primary Care Counselling means.

In the second scenario (second bullet-point above), particularly where self-referral is allowed, there needs to be commissioner monitoring and correct assessment procedures in place so that the system cannot be abused by providers manipulating this progression. Perverse financial incentives may create pressures to do so, as illustrated in the providers’ interviews.

The commissioner using a single point of entry was aware of this issue:

*[The Level 1 provider] Attempts to use the least intervention first, which means they prefer people not to go straight to Level 2 or 3, which is something we’re working through with them at the moment. It needs to be done on a case by case basis, to understand that some*
people absolutely would benefit from going on the short course; it depends on their previous history. As a default position it’s helpful to do the least intervention first - but we don’t want to make people jump through hoops unnecessarily - how it gets interpreted obviously needs to be varied… we’re working through how best to approach that.

In both these risks, there is an issue of GP engagement and related provider accountability (professional accountability, rather than data-based outcome management). If there is a single point of entry, with patients potentially disappearing into an IAPT Service, there will be less GP contact with the providers and it may be more difficult to ensure that an appropriate referral is made: it leaves a heavy onus on the Level 1 provider, but also a need for lines of communication with the GP. The patient experience is likely to be better with an engaged GP who can facilitate the choice. This is a wider issue not confined to AQP areas. One interviewee referred to the loss of relationship with GPs brought about by a multiple provider market (see B12 above).

**B14 Positives of AQP**

Several of the interviews identified no redeeming qualities in AQP. Three exceptions were organisations that had respectively withdrawn, were considering doing so, and had been disqualified.

It gave us a framework in which to really pull our act together. It forced us to attend to clinical governance, to various other procedures in our organisation, internally. So that was really useful. I’m really pleased and proud that we achieved accreditation so that’s been something that ratifies that we’re a strong, valid organisation. It took a lot of administration and it’s just really disappointing that I couldn’t work out a way to provide a service within the public sector [because of the tariffs]. Quite disappointed for the organisation. I mean it’s all very well providing a service for people who have got more money.

It’s been positive. It made us come up with new plans. And we have also recognised that it’s not healthy to be just chasing money, to try to set up services you don’t really want to do. It’s been a lesson for us. If you think it’s wrong to give people scales of assessment after every session, then you shouldn’t do it – we learned that from this process.

It might change later on, but right now I can say overall it’s been positive for our organisation in terms of being able to extend and to be able to offer more women in X a service (but we’re considering withdrawal due to a fall-off in referrals, and the zero-value contract, vs. the need to invest in resources).

Another provider had a message of hedged optimism:

AQP has allowed us to develop our psychological therapies work to provide a range of services in this area. However this was and continues to be a risky area of service provision due to the lack of certainty around demand. We have been able to increase access for patients to talking therapies, offering a wider range of time and locational availability and reducing previous waiting times for these. We have also provided new, targeted interventions for people previously unable to access therapies (e.g. our joint work with Support Against Racist Incidents for victims of race crime broadening access for BME communities)

On the other hand, this interviewee finds his organisation in a transformed position, having been placed in an unexpected position in the local market:

We’re a small volunteer organisation, and our number of full-time staff, and particularly our turnover, have grown, which we attribute to AQP. I consider AQP allowed enough flexibility. The AQP process came in when the original criteria of IAPT changed. It allowed for self-
referral, and counselling as a tool (as opposed to just CBT), and longer periods of involvement. And the introduction of Step 3+ made availability of services more encompassing. If it had stayed the way it was I would have considered it to be far less attractive; too rigid. It has certainly enhanced patient choice: clients have a choice between us and long NHS waiting lists. Also, the service specification encouraged us to explore and think about local needs and conditions, culture, language, ethnicity, context, surrounding. The range of interventions identified in the service specification encouraged a wide enough range of providers. On balance, I’m aware of a number of smaller organisations that applied. Commissioners are now providing choice between smaller and larger organisations. AQP has taken me by surprise. We have increased clients massively; we’re now doing 50+ assessments and 90 sessions a week. This is a massive expansion – it’s now representing 50% of income. The negative is that it is slightly overwhelming in demand. There are two providers in the area, the NHS with an eight month waiting list, and us. Before applying I was hoping to be a “little provider in a big pond”. We now seem to be becoming a sole provider. We want to respond to the need but are slightly nervous about growing too big too fast. We also recognise that other services we offer may suffer as we focus more of our efforts in AQP due to the influx. The benefit for patients is wonderful – waiting lists are the biggest benefit. They are now dealing with this service and in some respects we might be seen as providing a higher commitment to care, and of higher quality. Other benefits for example are in doing personal assessments. We are aware that many others do this over the telephone. We hope to keep at what we are doing.

Another provider also emphasised the change in the IAPT offer as a welcome change:

I think it’s fantastic that the area is offering IAPT+, and actually are open to other therapeutic models being offered which meet patients’ needs, and they’ve obviously listened, and conducted consultation around patient needs and best practice and patient choice.

One commissioner thought there had been a major positive shift, which had been obscured early on by inherited difficulties, but was now there to be built on, particularly in terms of equity and access:

It’s still better than it was [in spite of losing a major provider due to the tariff] by a long, long way, with the relentless pursuit of getting better and better, a significant improvement to where we were 12 months ago. But, it’s still not sufficient… so for the first couple of months we were still dealing with quite extensive waiting lists from the previous providers, and it’s been since January that we’ve been able to look with our existing AQP’s at what really is coming through and to see if that does fit with the modelling that was done. I think it’s a really important point that the backlog we inherited was much bigger than we anticipated. All the previous modelling assumed almost a blank canvas, but the backlog was significant, I mean thousands of people. So from day one there was that level of demand that we had to absorb within the new system as well. It wasn’t the fault of the model or the system or the new providers. I think it could be interpreted as a level of success because where we have got the people waiting, where the greatest demand is, is for low-intensity CBT, whereas the previous picture was the demand being much higher for Level 3 interventions. So, actually, that could be seen as a positive, that we’ve got more people who are getting the lower intensity and they’re not moving up to the higher intensity in the stepped-care model so they’re having their needs met there, and that is where the key demand is.

There were examples of creative initiatives which a commissioner believed had been enabled by AQP, answering specific needs:

We’ve got two really good examples of improvements as a result of AQP: particularly for long term conditions and people with terminal diagnosis, people with life limiting conditions, we have two specialist providers who are AQPs and can see people to expertly manage
those situations for them, so I think that that has made a huge difference. And with long-term conditions, we are now working with the providers because we have the data from IAPTus. Our Level 1 provider is a pathfinder for long-term conditions management, and we are asking them to transfer resources here, based on the fact that we have had a large number of people through the service, particularly living with shortness of breath and living with diabetes A.

**B15 The Commissioner’s role: overview, values, future**

In their interviews, commissioners took stock of the changes to date, and contemplated the future.

Building providers’ confidence to build their service model has to be based on actual evidence and not just on semantics or previous modelling, so that’s ongoing work. It’s around supporting, being there in the commissioning role, okay it’s more of an operational role, but to actually build the confidence in the AQPs to increase their capacity so they do gain more market share without behaving in an anti-competitive manner. Explicitly the risk is on the provider, and the brave who will invest have a far greater chance of becoming more viable and mopping up the market share, the timid won’t. I think it goes right back to the question of why the decision was made to introduce the market to this pathway. It wasn’t our decision. But once the decision is made, it’s almost, “live by the sword, die by the sword”. It is to a great extent a market driven service. So now let’s make it the best we possibly can for the people of X, and make it work to the best of our ability within the framework.

This commissioner had a vision for development of the market, as a route to transparency and accountability:

I’ve always had the aspiration that we would be able to develop like a TripAdvisor type network, where service users themselves would report, out in the public domain: “I went to see provider X and it was great, you know I went to provider Y, and it was a waste of time”, for that to be a driver, rather than the financial. Because that would naturally then mean that more people would go to provider X. They would get more business and market share and I think that implies Payment by Results. They’d get more business because they deliver what people want.

This commissioner summed up what he saw as a highly positive process:

**How does the AQP regime compare?** Far more people being seen for broadly the same financial envelope, far shorter waiting time. More people getting more interventions in a shorter time scale.

Other people may have a different view about this, but I think it is good thing that people are not in years and years of therapy. That people have short term interventions that are focused, they can come back for more if they need it, but a short term focus on coping with today’s issues so to enable them to get on with their life, now I think that’s a good thing, but not all therapists would agree with that.

Another commissioner was more focused on recovery from service failures:

In terms of improvement, it couldn’t get any worse to be honest, so we’ve planned and budgeted to spend an amount of money that will hit our national targets. Last year, because of the way we structured the tariff, providers weren’t able to expand their workforce, because they were being quite cautious themselves. So we didn’t actually see a significant improvement last year. Over the course of the next few months we should hopefully see a
significant improvement against the national targets. And if we do, that’s what we would deem a success. It’s definitely going to be more efficient in terms of value for money, because we as a PCT never hit any of the performance standards, missed them quite dramatically. Paid for in full, in a block amount, there was a lot of wasted money in the previous regime. We only pay for what we use now, so if we don’t hit our targets we haven’t overpaid.

This hope for improvement hinged noticeably on the question of waiting lists, and therefore volume:

A will get a lot of B locality’s referrals. But if for example they’ve got big waiting list pressures, you’d hope that a GP would notice that and start sending patients to a competitor who has no waiting list. And similarly that would drive provider A to drive their waiting list down. To improve quality, that’s the idea behind it. The question of competition through AQP improving the experience of patients is about waiting lists. They have dropped, because it’s a pay-as-you-go service, providers only get paid when patients are going through the books so it’s in their interest not to hold waiting lists, to get patients through. Because it’s outcome-focused as well, it’s sort of focusing their mind to do all they can to make as many patients as they can recover. And have a measurable recovery, so again that’s all around improving the experience for the patient.

Another commissioner reflected on similar shifts in the market due to competition:

I think sometimes the bigger providers bid from outside the area without a clear plan of how they were going to implement it. I think they just wanted the contract. So I come here as a commissioner, and think, great, I’ve got all these providers. But how many are actually seeing people? Several big national providers have not pulled their finger out on the ground. The belief by the people here previously was that they would be brilliant, they would pick up where the demand was slack, where the waiting lists were. But I’m having to have contract meetings with one or two big providers to say to them – do you want this contract or not? Because if you do, I want to see some activity on the ground. But one of the positives is that some of the smaller providers that did get the contract have really run with it. That’s the nice side of AQP, that some of the small charities that were thinking, “We don’t know if we can do this”, one of them has now got two trainee CBT therapists, they weren’t providing any therapist services before, and they are well respected by the GPs, they are doing good work, some psycho-educational stuff, they are employing therapists, not on contracts but paid per session. Getting the flexibility, they haven’t got huge bills, which actually some of the previous providers are at a disadvantage because they’ve just got their set staff.

These shifts were having a particular impact on waiting lists, which appears to be a recurrent indicator in the minds of commissioners who have opted for AQP:

Providers have a geographical focus, but the contract says they can work anywhere in the county. It’s becoming more apparent how helpful to us that is as commissioners, because when some of the big providers have been expected to come in and cover but haven’t, some of the other bigger providers are already beginning to work in that area, just ringing up the GPs and the GPs are going “Great, we’ve got a waiting list, come and work for us”. So that is a bonus – the providers can now follow the work rather than us chasing them to get the waiting list down. So market forces are actually helping us with waiting lists. You don’t have waiting lists because if there is a gap, somebody will get in there and work it.

This commissioner thought that counter-productive administrative burdens for small organisations demanded radical re-thinking:
I think the point of AQP from the Government is to diversify the market, and I think there’s more that can be done to encourage micro-providers, individual practitioners who want to provide this service, not linked to any organisation and providing they meet the criteria, in terms of qualifications and delivering NICE guidance therapies, whatever it is, I think it would be easy to do on a personal budget with, a user-held card. You go where you like with it and if it was a truly diversified market, the individual therapist would have a little swipe machine, the client would have a pre-loaded card, number of sessions or value on it. They’d come in, say “I like you as a therapist, see me at a time that is convenient to me – here’s my card”. I swipe it – it flags up an invoice immediately. It can monitor how many people I’ve seen. With a button they can monitor whether the clients are attending, whether they are recovering, you could do all that, without the need for an IT N3 connection, because it exists already – we have an organisation that does this with personal budgets for people on social care packages. So the system is there. The thing that gets in the way is the N3 connection - Information Governance. Because you can’t do it as an individual. It says “What do your Board do for Information Governance?” You think – I’m one person – I govern myself, I’m quite competent, I sign up to a Code of Practice which says I will not store information disproportionately in a secure place. But they’ll never pass it.

This commissioner had a vision for a different configuration of information that matched a changed pattern of provision:

So I think the future could be much more Community Interest Companies, a group of local therapists just working together having a shared Outlook diary so that they give the client the password, code, internet password that gives them access to their own therapist’s diary, they have a number they put in the diary, I know what the number relates to and that they are going to come and see me soon. If you could do something around that, you’ve got a Choose and Book system – very cheaply.

Commissioners were asked about how they saw the future for commissioning mental health services:

A lot of what we try and offer isn’t strictly speaking, pure IAPT, it is other wider interventions. I’d like to see in the future greater contributions from social care, local authority, to a lot of things that we are currently funding. We should do the psychological components of that and the health component, but there’s the wider social and community element that should be funded from elsewhere: there’s lots of groups, for example like walking groups, cycling groups, gym membership, bibliotherapies and book reading and all the rest of it, all good viable positive alternatives to medication, that we should be promoting. Public health and health & wellbeing boards are generally hosted now by the local authority. So should the NHS be paying for these services?

This response engages with the wider mental health and wellbeing agenda, and the new framework of Health and Wellbeing Boards. However, the defensive conclusion about cost to the NHS can be turned around to embrace common objectives and interests, and shared and cost-effective commissioning.

This commissioner was concerned about the highest end of need, and the low level:

One of the things that has gone is the service for people needing longer than 20 sessions. I think that they will be potentially the big losers - and those with low level needs. It could work either end. It’s meant to be an early intervention model, but we will have people who are not ill enough – sorry your score’s only nine, but that’s only today – they won’t get seen. I am going out to GPs and saying what work are you doing for Step 1 of this triangle, early intervention – how many people do you tell about “Living Life to the Full”, “Mood Juice” or any of those things, especially younger people, do you give them the books scheme list, or
the do-it-yourself books? So how much are you doing as a GP for people’s mental health, before you think about sending them off for screening? There’s a lot that you can do, to help people make their own recovery. If patients try, their confidence will grow, because they’ve got themselves well - and also it means the service isn’t cluttered up with those that could have got themselves well, so what I would do with the protected learning time with GPs is to get some case studies together and say where would you send this person?

The encouragement of self-help can be interpreted by some defenders of the NHS as an abandonment of patients. However, consideration of these last two extracts together suggests a link to integration of the vision of wider wellbeing with the care pathway into one commissioning continuum, supporting objectives shared by both CCGs and local authorities (with Health and Wellbeing Boards as a bridge), using strong evidence for the positive impact of vibrant community activity on mental health, and the impact of community empowerment, and the extension of the care pathway into an active community which nurtures healthy activity, on health inequalities.

This commissioner proposed two alternative visions of provision which he thought addressed some of the weaknesses of AQP and the perverse incentives of PbR – and then wondered whether they could be combined effectively:

*If I had a magic wand I would go back to a well performance-managed, cost by volume contract. Providers by area. You can let the provider be in charge of averaging out the number of sessions – it’s their job to manage the average number of sessions, not ours, actually be client led, up to a maximum of sessions per person. I would always commission organisations that delivered Steps 2 and 3 and 3+, I wouldn’t have one provider doing Step 2 and one doing step 3 – I’ve seen them do that – because a lot of them hang on to people at Step 2 because they’re getting paid, suddenly everybody’s all step 2 or all step 3 – fighting amongst themselves – “you’re not giving them to me”. I just think that’s bad commissioning. A straight line of accountability within one provider for supervision, case management, step up, outcomes, is simpler to commission. It’s fair on providers – so that would be my vision for it. Whether I am allowed to do that, I very much doubt.*

*Or alternatively, I would go completely the other way – have a real open market model, but be personal budget-led. In fact you could have a mixed economy. You could have a small number of providers doing a cost by volume contract, and a few independent small providers almost like a buffer to take up surplus when there are waiting lists. You could say to the other providers – when you’re waiting list is ‘x’ you have to give them to the others. So you never have a waiting list because the providers know, it gives them an incentive to keep the waiting list down, but there’s a waiting list red light waiting to go on – so that the overflow providers are now on line. Make providers actually employ these people for an overflow market, so they have bank staff that they have to set up – they are private people who want to do bank work.*

His final conclusion on AQP was strongly expressed:

*It’s the curse of my working day – unnecessarily complex and bureaucratic. It doesn’t reduce bureaucracy; it increases it, it’s just hidden. Another problem with AQP and commissioning is that people take stats as facts.*
PART C – WIDER ISSUES ARISING FROM THE IAPT MODEL

Use of outcome measures at every session – impact on the therapeutic process

Along with the tariff question, this evinced the biggest response from interviewees. It is not an issue confined to AQP: use of outcome measures at every session is general across IAPT services.

Responses are given under four headings: use at every session; the administrative impact; the measures themselves; and their use as a payment method.

C1 Use at every session

With a couple of exceptions, interviewees expressed negative views about the use of outcome measurement tools at every session. Concerns raised included intrusion, disruption of therapy, counter-productive diversion, using up limited session time:

Feedback from our service-users, they think it’s excessive. And I have to agree, I think it’s unhelpful at times. Using it for every single session, that’s the overwhelming response. They say, “We don’t have to do this again do we?” Although we explain the purpose, it is excessive. You could get the outcomes without having to complete forms for every single session. When it comes to providing a service for vulnerable people, you have to look at the needs of the patients using the service and the overwhelming feedback is it’s unhelpful.

Practitioners complete data collection at the start of each session. This can take up to 15 minutes in exceptional circumstances, out of an already brief session (35-45 minutes for Step 2, one-to-one). Some patients can struggle with an exercise that requires them to list how poorly they are doing and this can result in increased low mood. Others find this an intrusive process and may say that they feel overly measured. With Step 2 interventions potentially only being delivered across six consecutive weeks and focusing on specific issues patients can feel they are being asked to record the same information each week with little progress being evidenced.

In terms of the therapeutic process, session by session, I think they should be treated with sensitivity. There’s a danger of scores dropping rapidly – “naked” scores are not the whole answer. There are large increases and decreases throughout. I feel they need to be taken with some form of discretion and consideration. They can have an impact on the client concerned – seeing their scores may make them descend further into depression, from fear of failure. I accept them as a payment system.

Use at each session is a bad idea. It’s better to do pre and post-treatment, see how people are at the beginning, and later, a few months and a year later. That’d be much more useful. It’s very intrusive and insensitive, treating people like robots, not recognising that this deals with deep thoughts and feelings and you’re expected to do it in five minutes. You should do it in a very sensitive way. We haven’t used GAD-7 and PHQ-9 previously, we have wanted to distance ourselves from a clinical approach. We use the Warwick / Edinburgh MH and wellbeing scale, which is short, with a positive focus, asking about the future for example.

We are strongly resistant to using these measures at every session. I wouldn’t want anyone doing counselling for this organisation to be doing something like that, because of the way it impacts on the therapeutic process. There is something about the process of recording those figures that impacts on the trust that you’re able to build when you’re in the room. I think clients get it that you do it at the beginning and you do it at the end.
A key problem about this is that recorded outcomes are a trigger for payment. As one interviewee put it:

I can see why they’re doing it, some therapists would work fine with it, and some therapists would find it extremely difficult. And then they’d end up not getting paid and it would be a pain. And not only that, it would intrude on the session time, and that is something I have heard clients complain about. I do know that they are doing that model in IAPTu and it works, and basically what you’ve got to do is leave them in the waiting room and get the client to fill them out then. However, the idea that you’re dependent on that for whether or not you get your fee is a bit problematic, because if the client doesn’t do it for some reason.... I think it’s onerous, on both the client and the therapists and I can’t see that it adds anything to the therapy. Our main problem is getting the final measure completed. Because, quite often, people don’t come for their last session, you know, their therapy is completed and we weren’t aware that the last time we saw them was going to be the last session. That’s been fairly disappointing. I think a lot of the time the therapist, including me, forgets to give them.

However, other respondents did not see a problem:

Outcome measures are already successfully used for many years by the service and work well. We’re well established users of CORE-NET. Its use at each session is fine – it works well and is useful to the process with clients. The administration is built in as we’ve used it for many years. Therapists are used to it. The cost is the licence. The problem with this though is the commissioners jumping around demanding different reports every quarter – this causes major issues. We’ve used all the IAPT measures, and CORE. They are simple and they work fine for clients.

A majority were concerned about use at every session, and saw this as a serious issue. We need to explore further why this works for some and not for others, and whether the disruption described is more prevalent in some types of therapy (or levels) than in others.

C2 The administrative impact

Several respondents spoke of the administrative burden of entering the measures, with varying levels of concern:

All the stuff that we had to enter on to IAPTu, and the administrative overhead of making sure that these things were entered, would have been tricky. It added to our decision not to provide through AQP.

Inputting takes time for therapists and impacts on their overall availability for face-to-face time, particularly when dealing with more complex / risky patients with an increased need to also record additional information. This has resulted in admin staff doing some inputting, particularly in the case for psycho-educational groups where a worker is responsible for inputting up to 10 sets of results. The cost of the admin time is not funded in addition to the session cost, but has required the recruitment of a part time admin worker.

Use of evaluation tools has become a standard procedure for all staff, however it becomes an issue when recruiting agency or temporary staff who then need full IT equipment in order to complete their role. We have implemented alternatives to this which have included admin staff inputting data. This in turn, has cost implications.
In terms of administrative burden, we have session-to-session recording overall, in areas that aren't AQP, keeping a uniform service. This has increased everyone's work a bit, because it has made it more frequent.

Only one respondent said that this was not a problem:

Increased frequency is not an administrative problem. These measures are fairly easy to administer.

C3 The measures themselves

A minority of interviewees expressed satisfaction with the measures themselves:

We previously used GAD-7 and PHQ-9 and found these to be suitable for the clients.

As for the GAD-7 and PHQ-9 measures, for AQP I think they’re fine, in that they specifically measure anxiety and depression, so I think they’re appropriate for specific disorders.

One recognised that some therapeutic use could be made of them, even if she did not:

As for their suitability, do you know what, I haven’t got a clue. I use them because we’re supposed to be gathering the data. Clinically, I don’t use them that much, I have a quick look to see whether somebody is indicating that they’re at risk like very, very, very depressed. But other than that, I don’t really use them. I know other clinicians will actually use them quite a bit, and feed back to the client. So different people use them in different ways.

But there was considerable scepticism in the interviews about over-reliance on the measures – or in some cases, on any measures. This does suggest that reliance on them to trigger payment may be simplistic and mechanistic. This reflection calls into question a key assumption on which IAPT is based:

There is a need for a better evidence base. We use CORE-10. I do have a strong belief that if I take CORE-10 on a Tuesday morning – and then you assess that person’s state of mind, their subjective well-being, say at 9 o’clock on the Thursday night, well, it’s a snapshot in time. We’re always saying, “oh, you’re very good today, you’re functioning so much better and your well-being is better”: what we’re saying to people is, “you’re acceptable to the therapeutic process if you score highly in these charts”, and then, “off you go and fly”, and we have just seen so many times people taking a leap into wellness. We are now in the land of wellness, and before you know it, there’s the crash, and the failure, and the results from that can be very dramatic. It’s that difficulty of trying to apply objective measure to human beings who are ultimately subjective.

Or to put it more simply and colourfully:

It can be very difficult for clients, sometimes it can poke them into a place of resistance in some way, because [the measurement scales are] a bit crude and there’s no dancing into the story or process.

This provider thought that measurement scales were part of the evidence on which judgement might be made, but by no means a final determinant of progress:

We also find with CORE that there’s this discrepancy, a disconnect between CORE figures, and (a) presentation, (b) the therapist’s experience, so we might have a CORE-10 that the
counselling co-ordinator brings to me and says, I don’t get this, CORE-10 says this person is doing really well, but in the room, they were in huge distress, it doesn’t match the presentation. It’s a bit like having a recipe in a cookery book, and the practical of cooking the meal, the recipe’s great, but unless you have an experiential ability to translate what the recipe says, six eggs and flour and butter is not going to be the full story. If you’re a therapist you’re using yourself as a tool, and that is the subjective nature of what we do, if we apply the objective measures of a theoretical model, it’s to what is ultimately a very human process.

There were very specific objections which suggested that a less simplistic approach might need to be developed:

GAD-7 and PHQ-9 do not pick up on all issues, e.g. low self-esteem and social anxiety. Also increasingly within Step 2 we are now expected to see patients with issues such as OCD [Obsessive-Compulsive Disorder] [where previously they would have been stepped up] and again the scales will not meaningfully reflect these.

A commissioner reinforced the point about OCD:

The OCD form gives you an idea whether they’ve got OCD, it’s not a diagnosis. They could just score four on hand washing as a maximum but they could be hand washing 24 hours a day and score nothing on the rest of the form. So technically they haven’t got OCD – I know they have OCD, they know they’ve got OCD, but the form says they haven’t! I tried to explain this to the people when they were setting it up, when I went to the consultation events, and it is even more relevant now I am in the position to try to sort it out. I don’t think they grasped it and I kept saying – I can show you all the outcome measures and how they are used and they won’t give you a whole story on anybody.

The therapeutic effect depends on the measure. Symptom tracking can be intrusive. More acceptable measures are available that can be tailored to specific patient needs. We use CORE and Therapeutic Alliance scale and Goal-based outcome measure. GAD-7 and PHQ-9 are not suitable for low level interventions, nor for online work.

In CBT and PWP [Psychological Wellbeing Practitioner] work it can integrate well enough. In IPT [Interpersonal Psychotherapy] and Counselling it can disrupt the process. We use PHQ-9 and GAD-7 in the IAPT block contract; CORE in primary care counselling, psychology and psychotherapy. PHQ-9 and GAD-7 are fairly suitable.

**C4 Their use as a payment method**

The view that the measurement scales were designed to assist professional judgement, not as a payment method, and that this use is not validated and intrudes on the integrity of the therapeutic process, is also described under ‘Payment by Results’ in Part B above. The commissioner putting that position emphasised the incompleteness of the specific measurement scales used:

I say, what about all those people who are not reflected in the measures? I’ve treated people with Irritable Bowel Syndrome, there is no outcome measure for that, it’s really affecting a lot of people: a lady who couldn’t leave the house, go on holiday with her husband and children, in 30 years, she went across the Sahara on her first holiday and is going up Snowdon with her kids. No outcome measure for that – one of the best pieces of work I ever did. Saves colonoscopies, psychotherapy, years of it – and I know it was followed up because she sent me a letter a year later, saying it was brilliant with a photo of
her and her kids on top of Snowdon. So, what do you do about that – pay providers for ones where there are outcome measures? There’s no official outcome measure for panic attacks.

He described what he saw as an unfair ethical challenge in the combination of outcome measurement with Payment by Results – and a possible solution:

The pitfall for me is that I don’t trust the data that I get. I used to think it brilliant as a therapist. I was very honest with GAD-7 etc., because I was more concerned about being honest than I was about being paid. Once you introduce payment by results, especially if you are only employed on an hourly basis on a PbR rate...... I think what I would have wanted to do was contract in a way that could not be fiddled, rather than put the onus on therapists to have to make an ethical decision about what they do – you’re putting therapists in a difficult ethical position every time you ask them to do that for payment. So my suggestion is to try and review the payment model. My area has gone for a very heavy recovery based payment method. I think that if the therapist knows that they’re going to get paid more or less whether they get well or not, I think that’s a fairer way of doing it. Or, as I know happens in some providers, they take the measures until they go into recovery, and they continue to see them, but don’t do the measures in case they relapse. On balance, I would prefer a cost per volume contract with less providers but much better performance-managed than they have been so that the waiting lists don’t build up. So a commissioning process which supports that, which is allowed to educate providers to deliver the model that the commissioners think works, rather than what they thinks works and is evidence based, if they can’t do that then the contract goes to somebody else – that would be my preferred model as commissioner, not Payment by Results. I’d rather really firmly manage a provider or a group of people than all the choice agenda in the world. Because I think that the people that most need the service might not get it. Because they would be risk averse to it. I don’t know that for definite - but why have we introduced a contract with that element of doubt – we’ve been forced to by Government to do it, that was never in doubt before – people would get seen, if they needed 20 sessions, they got 20 sessions. OK it may not be ideal long-term like some people want, but it was sufficient for the bulk, as some only saw you for four sessions, so the average was about 10. So I want to go back to a model where providers have to see people for an average number of sessions – I could get some complex patients well in about six sessions, others took longer, and the average was about eight/nine.
CHAPTER FOUR

ANALYSIS OF THE FIRST WAVE OF AQP SERVICE SPECIFICATIONS FOR PSYCHOLOGICAL THERAPIES

4.1 Introduction

A profile of issues arising from the Service Specifications of all the PCTs pursuing AQP was created by the Co-ordinator of CPTPC’s Consultancy Unit, who has extensive experience of AQP in practice from the point of view of both provider and commissioner. This section summarises key aspects of her analysis of consistency and variation between the service specifications, and their implications for policy, practice and commissioning. In some cases, attention is drawn to undesirable variations. Recommendations are made in Chapter Five of this report.

The Service specifications analysed were from:

- Bristol/South Gloucestershire
- Cornwall
- Derby City and County
- Bournemouth and Poole Teaching/Dorset
- Hertfordshire
- Kent (Eastern and Coastal Kent, Medway, West Kent)
- Nottingham City and County
- Surrey
- Tees (Calderdale, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-on-Tees)

The issues that arise have significance for future commissioning in the new NHS structure for both CCGs and providers, through AQP, but also in some cases more widely for CCGs commissioning IAPT services.

4.2 The boundary between child and adult in commissioning services

There was inconsistency between service specifications in how those aged 16-17 are treated. Two PCTs saw clients from the age of 16. One will see 16/17-year-olds if not in full time education. One confines services to “adults”. The rest see clients from the age of 18.

This decision has various implications, which may not be thought through either locally, or by the DH. CCGs need to be aware of them.

The Children’s Act covers children up to the age of 18; therefore services that see children aged 16-18 should ensure that they have all the appropriate procedures and training in place.

This gives 16-18-year-olds in three PCTs the opportunity to be seen by adult services rather than Child and Adolescent Mental Health Services (CAMHS). This could be beneficial in terms of waiting lists and access. There will be a disparity of provision between these PCTs and those who see clients from 18+. There needs to be clear guidance as to the criteria to apply in such a decision, and what the recommended course of action should be in terms of
best practice. This is too important to be left to chance. It is possible that such inconsistency is not confined to those pursuing the AQP option.

The decision by one PCT to provide adult services to 16/17-year-olds not in full-time education may suggest an assumption that young people can access psychological therapies through school or college. If it is a continuing policy, the rationale for this needs to be examined; and if it is based on a misapprehension, it needs to be amended.

Since young people aged up to 18 are covered by the Children’s Act (2004), if they are to be offered what are in effect adult services, this has implications for providers in terms of Disclosure and Barring Service (DBS) (previously known as Criminal Records Bureau (CRB)) checks being required, and ensuring that all staff are fully informed and trained as to how any abuse issues are handled.

For services that are provided only to those aged 18 and over, the referrer has no choice but to refer under-18’s to CAMHS.

Finally, given that there is such a strong emphasis on outcomes achieved in IAPT, if the age parameters are inconsistent, data from different services will not be comparable. This needs to be investigated and regularised.

4.3 Patient Group

There was variation in the patient groups to be seen. Definitions of Care Clusters are given in Box 1.

Four PCTs said that patients would be in Care Clusters 1 - 4. Two of those four said that patients in Care Cluster 5 could possibly be seen. One PCT stated that patients would be in Care Clusters 1 – 3, with the boundary at Care Cluster 4. Three PCTs made no clear definition of the patient group. The PCT that had commissioned a Primary Care Counselling Service as opposed to an IAPT+ service defined suitable patients as having mild to moderate mental health problems.

This means that patients with similar conditions would be seen in primary care in one CCG area, and in secondary care in another: in effect a postcode lottery. This would result in a very different experience and would mean that some patients might receive an over-medicalised treatment in the secondary sector. It has significant implications in terms of both cost and appropriate (and effective) treatment which demand both mindful local commissioning, but perhaps more importantly clear national guidelines as to where patients should be referred. CCGs will need to clearly understand the ramifications of patient group definition in order to make choices that offer the best service to their patients. One temptation may be to refer to the service with the shortest waiting list, a choice clearly illustrated in the providers’ interviews above, where by virtue of NHS waiting lists, one small provider has effectively become sole provider (see Chapter Three, B14).

If this is not thought through and monitored, there is a danger of perverse outcomes. For example, patients may not be ill enough for secondary care, but be too ill for primary care. With payment by results, it will be tempting to keep the “easy” patients in primary care and refer the more “complex” patients to secondary care (see Chapter Three, B12 and 13).

Finally, if there are differences across CCGs as to who is seen in primary care and who is referred to secondary care, comparative outcome data become difficult to analyse meaningfully.
BOX 1 – DEFINITION OF CARE CLUSTERS

From Mental Health Clustering Booklet (2013/14) (DH, 2013b)

CARE CLUSTER 1: Common Mental Health Problems (Low Severity)
Definite but minor problems of depressed mood, anxiety or other disorder but they do not present with any distressing psychotic symptoms.

CARE CLUSTER 2: Common Mental Health Problems (Low Severity with Greater Need)
Definite but minor problems of depressed mood, anxiety or other disorder but they do not present with any distressing psychotic symptoms. They may have already received care associated with cluster 1 and require more specific intervention, or previously been successfully treated at a higher level but are re-presenting with low level symptoms.

CARE CLUSTER 3: Non-Psychotic (Moderate Severity)
Moderate problems involving depressed mood, anxiety or other disorder (not including psychosis).

CARE CLUSTER 4: Non-Psychotic (Severe)
Characterised by severe depression and/or anxiety and/or other increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.

CARE CLUSTER 5: Non-Psychotic Disorders (Very Severe)
Experiencing severe depression and/or anxiety and/or other symptoms. They will not present with distressing hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk for non-accidental self-injury and they may present safeguarding issues and have severe disruption to everyday living.

CARE CLUSTER 6: Non-Psychotic Disorder of Over-Valued Ideas
Moderate to very severe disorders that are difficult to treat. This may include treatment resistant eating disorder, OCD etc. where extreme beliefs are strongly held, some personality disorders and enduring depression.

4.4 Self-referral
Self-referral is a key factor in point of entry and patient choice. Once again, there was wide variation in the specifications:

- One PCT had a Level 1 Service at the front-end of its psychological therapies provision, which was the entry point to the service; they allowed self-referral at Level 1.
- Two PCTs allowed self-referral at Step 2 but required that the GP be informed to validate the referral.
- One PCT allowed self-referral directly to the provider of choice, another to the appointment line service, where the client would be offered a choice of provider.
- One PCT said that it would ensure direct access for people who self-referred. Two PCTs gave no details.
- One PCT allowed self-referral at Steps 2, 3 or 3+, provided the client met the relevant assessment measures.

Self-referral at Steps 2 and 3 raises several of the issues discussed in Chapter Three, B12 and B13 above. It may be argued that such a facility is the only one that truly offers the
patient a meaningful choice; but choice is only meaningful if the patient is well-informed, with good quality support for decision-making.

It is likely that some of these approaches work better for some patients than for others. Evaluation appears to be called for.

### 4.5 The model

This section concerns variation in expectations of providers in terms of the combinations of steps they are required to offer. It should be read in conjunction with Chapter Three, B13, which contains providers' and commissioners' reflections on this and related issues. The service specification analysis found:

- Four PCTs specified an IAPT Step 2 and Step 3 Model, with all providers having to offer both Step 2 and Step 3.
- Four PCTs specified IAPT+ – Steps 2, 3 and 3+. Two of these four said that providers must offer all of the Steps, one of those two stated that the provider had to offer all Steps, but could apply to provide services in all or just one of the identified localities.
- The other two said that providers could offer one or all Steps.
- The model for Primary Care Counselling was for clients who would not benefit from IAPT.

For commissioners, managing multiple providers can be more complex than working with a single provider. This will have time and cost implications (see Chapter Three, B6). It also means greater risk from zero-value contracts: the more steps offered by a provider, the greater the investment and the greater the risk, particularly for smaller organisations. In the context of the findings of Chapter Three, it adds to the sense that managing a genuine market in psychological therapy is expensive, with high overheads and high risk.

### 4.6 Access to Treatment Requirements

These were broadly similar, with the majority of PCTs requiring one to three working days from receipt of referral to decision to treat. Assessment could be carried out either by phone or face-to-face. Three PCTs required assessment within ten days, Step 2 treatment to start within 10 days and Step 3 treatment to start within 28 days. One PCT required Step 2 treatment to start within 10 days of receipt of referral and Step 3 within 28 days. Two PCTs required 1 – 3 working days from referral to decision to treat and all treatments to start within 28 days. One PCT gave no details.

Being seen quickly is important for patients. However, as we have seen in the provider interviews, meeting these requirements can be challenging for small providers, given the need to have staff on hand, in spite of the constraints of a zero value contract. Erratic flow of work with these performance standards but limited resources can put pressure on therapists which may have undesirable consequences (i.e. pushing patients through) – again illustrated in the interviews (see Chapter Three, B8).

### 4.7 Did Not Attend (DNA)

Again, there was wide variation in the specifications:

- Two PCTs did not pay for DNAs.
- One PCT would pay for one DNA in six sessions and two DNAs in 12 – 15 sessions.
- One PCT did not mention DNAs,
The others stated that if patients refused or did not attend two reasonable appointments for assessment, they would be discharged back to the GP, except for one allowing three DNAs at that stage.

As in other areas of specification, there is no guidance on this for commissioners.

Where the therapist is not paid for DNAs, there may be a temptation to pressurise the patient to attend. As reported in the provider interviews, this can create untoward tensions, which can compromise the therapeutic process. Informal estimates suggest that about 25% of appointments are DNAs, higher where organisations have a complex case mix. With high dropout rates, low tariffs and unpaid administrative burdens in this market structure, this is one of the significant factors in the viability of AQP services, with an incentive to limit provision of therapy for “difficult” patients, as several interviewees suggested.

4.8 Rejecting Referrals

The Service Specifications did not all address this:

- Three PCTs made no mention of the requirements if a provider rejected a referral.
- Three PCTs required that a referral be made the same day to Step 4 (Secondary Mental Health Services).
- Three PCTs made different provision for information flow to the referrer, with letters to be sent respectively within two working days, 24 hours and 72 hours.
- One PCT required the provider to contact the referrer and discuss reasons for non-acceptance, and to give recommendations for a more appropriate treatment pathway.

There are a number of problems with this variation, and if they are replicated more widely in IAPT provision, they suggest a lack of grasp of patients’ referral pathways, with unacceptable consequences. This is not a trivial issue because of the scale of dropout from IAPT (Griffiths & Steen, 2013a). Formal rejection may be a small part of this problem; there are many ways of “losing” a patient, and the importance of those not completing treatment (and there are issues of definition there) cannot be overemphasised. How commissioners address rejection of referral is symptomatic.

It may be that only in the last bullet-point is an acceptable level of enquiry and accountability provided for. It is concerning that several commissioning bodies viewed this as a matter for referral to secondary care. There may be a wide range of reasons for rejection in the context of wider fallout of patients from the pathway, and there is no evidence that they are exclusively concerned with higher level needs. We have seen evidence in the interviews that the outcome-focused financial regime, with a quick turnaround required, is leading to cherry-picking. If the logic of the IAPT regime tends to this, it is unlikely to be an isolated phenomenon.

4.9 Pricing Tariffs

There were widely differing tariffs across the PCTs, not only in amount but also in payment structure. The PCT offering a primary care counselling service paid one hourly rate. Two PCTs had three tariffs, a further two had six tariffs, one had eight tariffs, one had 12 tariffs, one had 14 tariffs and one had 28 tariffs.

Here are figures obtained from the nine groupings of PCTs opting for AQP, for a set of key tariff categories. These should be read in parallel to the qualitative material above from our provider interviews.


**TABLE 3**

<table>
<thead>
<tr>
<th>Category of tariff</th>
<th>No. of PCTs</th>
<th>Lowest tariff</th>
<th>Highest tariff</th>
<th>Highest / lowest ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment course only</td>
<td>2</td>
<td>367.29</td>
<td>673.00</td>
<td>1.8</td>
</tr>
<tr>
<td>For “moving to recovery” Step 2 treatment</td>
<td>4</td>
<td>167.00</td>
<td>366.00</td>
<td>2.2</td>
</tr>
<tr>
<td>For “moving to recovery” Step 3 treatment</td>
<td>4</td>
<td>525.00</td>
<td>650.00</td>
<td>1.2</td>
</tr>
<tr>
<td>For “moving to recovery” Step 3+ treatment</td>
<td>2</td>
<td>621.92</td>
<td>934.96</td>
<td>1.5</td>
</tr>
<tr>
<td>Assessment only</td>
<td>8</td>
<td>30.00</td>
<td>59.93</td>
<td>2.0</td>
</tr>
<tr>
<td>Access within 28 days</td>
<td>2</td>
<td>20.00</td>
<td>37.00</td>
<td>1.9</td>
</tr>
<tr>
<td>Performance element for “moving to recovery” at Step 2</td>
<td>3</td>
<td>42.00</td>
<td>60.00</td>
<td>1.4</td>
</tr>
<tr>
<td>Performance element for “moving to recovery” at Step 3</td>
<td>3</td>
<td>50.00</td>
<td>150.00</td>
<td>3.0</td>
</tr>
</tbody>
</table>

For clinical improvement at Step 2 or 3, one PCT pays £100.

**Discussion**

This is a high level of variation, which suggests that tariffs may not be empirically based, particularly in relation to evidence of provider costs. This in turn may have implications for the economic viability of services, as we have seen in one case reported in Chapter Three, where services had to be re-commissioned due to unrealistic tariffs. Regulation may be required to achieve a more stable environment.

If the therapist knows that they will only get paid if the patient stays for six sessions, then the therapist could be tempted to encourage the patient to keep coming, when they did not need to (see examples of perverse incentives and distortions in provision throughout Chapter Three).

The tariff in some areas appears to have been too low and based on 100% attendance, which is not realistic (see 4.7 above). In others it was based on the fees of an individual therapist, with no recognition of the associated service costs (see Chapter Three, B4).

CCGs will need to understand the complexities of running a psychological therapy service. The fees are so low in some cases that some providers will make a loss or collapse (see Chapter Three, B4, B6). Informal discussion with Finance Directors in 2012 showed that understanding of the needs of possible smaller providers was not high in the context of familiarity with large NHS provider Trusts with the capacity to absorb substantial on-costs. The complexity of some tariffs may also be problematic.
CHAPTER FIVE
FINDINGS, DISCUSSION AND RECOMMENDATIONS

5.1 Main findings

5.1.1 In the seven PCT areas or clusters opting to enter the AQP process examined by the research, the number of providers contracted ranged from one to 12 (effectively meaning that some areas initiated AQP but did not implement it) (Chapter Two).

5.1.2 The combination of tariff structure and PbR produces widespread perverse incentives for providers and perverse outcomes for patients (Chapter Three, Part B). Distortions described include:

- tariff and PbR as a factor in the decision to take patients on, and the type of treatment to offer (B4, B5)
- destabilisation and some deterioration in service (B4, B6)
- destabilisation of provider organisations affecting their viability (B4, B6)
- the pressure of mechanistic throughput of patients affecting decision-making and quality (B5)
- financial incentives to misuse measurement scales within therapy to improve measured outcomes and trigger payment – measurement scales that were not designed or validated as a payment method (B5, and Part C).

5.1.3 There is widespread concern about whether AQP is a viable model for small organisations. Providers spoke about the risk of investment in the range of interventions demanded by some service specifications while there was no work guaranteed; about the wisdom of investment in required infrastructure, particularly IT, given the risk involved in zero value contracts; and in a number of cases about unpredictability in the flow of patients. In several cases this combination of circumstances was seen to be unsustainable (Chapter Three, Part B).

5.1.4 Providers interviewed generally thought that the levels of tariff were causing severe strain in AQP areas, affecting the type of work providers undertook, often against their professional judgement. For several of the providers interviewed, this was reason to question the viability of contracts. The frequent exclusion from the tariff of significant and increased administrative costs, non-attendance by patients, holidays, and the cost of inputting weekly outcome measurements, were a major financial challenge for many providers (Chapter Three, Part B).

5.1.5 Zero value contracts came up repeatedly. The volume of patient ‘throughput’ was crucial, with the result that AQP finances only broke even when a threshold of provision was reached. Providers could not be expected to maintain a skilled workforce in the expectation of patients being referred, particularly with unrealistic tariffs. Because there was no reserve workforce given the volatility of the market, high demand in a context of insecure income flow created an incentive to hurry patients through the system. This view was endorsed by a commissioner who spoke of “a sausage machine, getting as many people through the system as you can – with a risk of relapse” (Chapter Three, B4 - B6).

5.1.6 The employment status of therapists had a significant impact on the financial viability of AQP tariffs, with higher costs ascribed to those employing staff under normal working conditions such as holiday pay and a degree of job security, and to
organisations with self-employed, highly skilled and experienced therapists - while those using volunteer or trainee staff were at a competitive advantage. Zero value contracts for providers meant zero value contracts for individual therapists. One commissioner held that new providers were “blossoming” because they were able to keep costs down by not employing staff on secure employment contracts, which were not viable under the AQP model. This had major implications for retention, continuity, and maintaining levels of skills (Chapter Three, B4, B11, B14).

5.1.7 Several interviewees had withdrawn from AQP provision for these reasons, or were considering doing so, and one commissioner reported withdrawal by a major provider. Another acknowledged that tariffs had been set unrealistically low, and when a major provider reported a threat of insolvency, a risk articulated by others, had felt obliged to recommission the entire service, at considerable expense. A third commissioner felt that with its hidden extra costs, the whole system was vulnerable, and reported that the larger number of providers meant greater administrative burdens of contract monitoring (Chapter Three, B4).

5.1.8 The three commissioners interviewed all reported significant reductions in waiting lists for therapy, with some dynamic providers responding to changed demand in terms of type of treatment and to geographical variations in need, and others proving less flexible and successful. This was ascribed both to market forces and to creative and flexible commissioning. Waiting lists at the start had meant a high volume of patients. As they were dealt with, lower volume was creating issues for providers with zero value contracts, and creating some market instability (see above). A key unresolved question is whether competition was a positive factor in these achievements in the context of increased public investment (Chapter Three, B14-15).

5.1.9 Another major concern was the use of outcome measures at every session, a requirement which is general across IAPT services. Concerns raised included the intrusive effect of patients feeling overly measured, disruption of limited session time, disproportionate and unpaid administrative burden, and the perception that some patients can struggle with a weekly exercise that requires them to list how poorly they are doing, which can result in increased low mood (Chapter Three, Part C).

5.1.10 There was considerable scepticism about over-reliance on the measures. Several interviewees thought this raised fundamental questions about the assumptions on which IAPT is based, particularly in terms of measurement being a snapshot in time which might produce quite different results within 24 hours; perverse incentives and unfair ethical pressures created by payment depending on a positive outcome; and non-recognition of fluctuation in well-being during a course of treatment, with an incentive to declare the patient recovered on the basis of one outcome measurement (Chapter Three, Part C).

5.1.11 Several providers and a commissioner raised limitations in the scope of outcome measures used in IAPT, with concern about whether they reflected low self-esteem, social anxiety, panic attacks, and particularly Obsessive-Compulsive Disorder, with narrow scoring not reflecting wider improvements which may be far-reaching, for example in psychological conditions that might be related to physical disorders (Chapter Three, Part C).

5.1.12 Providers and commissioners described how linking outcome measurement to recovery payment created pressure to manipulate the former – and indeed to manipulate patients’ completion of these measurements. For example, payment can be jeopardised at the end of a long treatment by a sudden, temporary dip in outcome measurement, with the result that that treatment becomes unpaid. The result can be,
where there is doubt or difficulty, that the patient is avoided or rejected. It was reported that such pressure was widespread. The point was made that outcome measures were designed to assist clinical judgement, not as a payment structure, which was how they were being used through Payment by Results; and that it is wrong to assume because patients did not return that they were or were not recovered, an assumption integral to IAPT. According to some providers and commissioners, this was leading to selection by providers of those patients most likely to recover: choice of patients rather than patient choice (Chapter Three, C4).

5.1.13 Commissioners identified conflicts of interest where:

- there was a single point of entry to services, where that assessment agency also provided services at Levels 2 and 3, creating a danger that more complex cases would be referred to other agencies, and more profitable, easier, cases, would be retained by the Level 1 agency; and where
- organisations provided single level services and held onto patients when they needed to be stepped up (Chapter Three, B15).

5.1.14 There was widespread anger about disproportionate demands, inefficiency and cost occasioned by requirements to adopt and link up to NHS IT systems, a requirement seen as largely unnecessary and discriminatory towards small organisations with limited resources. Two commissioners interviewed had provided logistical and financial support to enable small providers to meet the requirement (Chapter Three, B7).

5.1.15 One strand of providers’ response to AQP acknowledged that some commissioners had comprehensively recognised the need to understand local conditions, and that this was consequently recognised in the nature and breadth of provision. There was an example of a strong commissioning engagement with both equity of access and with wider determinants of mental health as part of a continuing, developmental process, successfully adapting therapies such as low-intensity psycho-social support to the needs of deprived communities which had high levels of need for mental health services but little knowledge of, or access to, psychological therapies. This is an approach that could be replicated, strengthening agendas to reduce health inequality (Chapter Three, B10).

5.1.16 Evidence in the report suggests that the term ‘patient choice’ can be understood in a number of ways, and that AQP and PbR may have some unintended consequences that are detrimental to patient choice and in turn to patient outcomes, in particular that the payment model led to providers rejecting those unlikely to fit in to a recovery model – a reduction of choice for those patients. On the other hand, the expansion of provision in itself, leading to reductions in waiting lists, created a choice by offering a service where there was previously none. In this context, the absence of a genuine voice of patients in the evolution of psychological therapies in primary care was striking (Chapter Three, B12).

5.1.17 An analysis of AQP service specifications found significant inconsistencies in their scope which will affect patients’ access to appropriate services and create a postcode lottery. This is likely to affect more areas than those that have opted for AQP, since these issues are not specific to the new market arrangement. Monitor need to take action to create a level playing field, and CCGs need to look to their own areas’ service provision. They affect issues such as the age threshold for access by young people to adult psychological therapies, the level of need at which patients only have access to secondary care, and what happens when referrals are rejected (Chapter Four).
5.1.18 Charities which had become companies limited by guarantee were the most successful organisation type in securing AQP contracts, comprising 43% of contractors. Private limited companies were less successful, with only seven out of 30 achieving contracts. Previously existing contractors did well, and made up 42% of AQP contractors – which meant that more than half of the 46 providers contracted were new (Chapter Two).

5.1.19 The overwhelming view of the providers and commissioners interviewed was that the online AQP qualification process was wasteful, bureaucratic, stressful and poorly structured and defined, demanding disproportionate resources and organisational change, particularly for small organisations (Chapter Three, Part A).

5.1.20 Providers’ assessment of the quality of commissioners’ support through the qualification process was extremely mixed, ranging from “awful generally - smoke and mirrors”, to reports of well-structured and thorough consultation and support. Commissioners as well as providers had struggled with unclear definition of requirements. In one case, well-implemented consultative processes had been developed into continuing support and feedback through provider forum meetings, which were praised (Chapter Three, A4).

5.2 Context: three shifting frameworks of policy and payment

In order to assess the relevance of the research findings to the achievement of the policy aims of AQP, it is necessary not only to note those aims, but to set them in the context of continuing change in a related policy narrative which is central to the unfolding story of AQP: PbR.

The vehicle of delivery of psychological therapies in primary care is IAPT, which is pressing on with development of its own outcomes-based payment model based on PbR, even as Monitor sets out new principles for PbR which are highly relevant to the findings of this study.

It is not possible to reach conclusions about AQP in isolation from these related processes of change. A brief summary of where these three evolving frameworks stand is given here. In the following section we examine the relevance of this study’s findings to their development.

5.2.1 The core aims of AQP

The core aim of AQP appears to have been “to enable patients to choose any qualified provider where this will result in better care”. The policy is to introduce “patient choice of Any Qualified Provider for services where there is a strong pull from patients..... We will ensure lessons are learned from each stage of the rollout” (DH, 2011a).

The DH state that this “is intended to empower patients and carers, improve their outcomes and experience, enable service innovation and free up clinicians to drive change and improve practice”.

It was anticipated that providers would be drawn from the voluntary sector, the private sector and the public statutory sector, and that the competition between providers would raise both service quality and efficiency.

As Monitor takes responsibility for the economic regulation of AQP in 2013, a degree of scepticism is emerging which has given rise to some uncertainty about the future of AQP.
The Monitor Chief Executive was reported by the *Health Service Journal* (HSJ) in April 2013 (HSJ, 2013a) as saying, “when creating a situation where you can have choice within a market [there is] a legitimate question about what’s the evidence that [doing so] will improve the quality of the service patients receive”. “There was”, he added, “a potential cost to having multiple providers, and in some settings that might be difficult”. When asked where he thought the gaps were in the current evidence for the benefits of NHS competition, he replied, “I think they’re in particular around things like the benefits of choice and competition within a market. There’s an amount of research – it’s fairly limited. I think the more objective evidence we can find there, the more we can help people, for example, [to determine] in which areas to extend choice.”

This report aims to contribute to understanding of these shortfalls in evidence.

The note of scepticism should not be taken as a signal that AQP will not be expanded. The legislation is still in place. IAPT, for example, is still proceeding on the basis that:

‘*It is a policy direction that AQP will be expanded and thus, it is likely that IAPT services will become increasing commissioned in this way.*’ (IAPT, 2013)

It should be noted that this is happening in a highly fluid environment, a wider context of accelerating competition in the NHS, including wider mental health provision. As a *Health Service Journal* Local Briefing reported in April 2013 (HSJ, 2013b):

> The South East Coast health economy and its bordering areas have become a highly competitive environment for mental health services. Service design and delivery is evolving fast, with potential lessons for the rest of the sector. The region contains three large mental health providers largely corresponding with the boundaries of the three counties that it covers.

> Each of them has been pursuing or is embarking on major programmes of service and structural change, in an effort to modernise their services in line with clinical and policy direction.

> They have also embraced the opportunities presented by the increased competition in the NHS to develop new services – often beyond their own traditional areas – but at the same time are changing or transferring some of their previous services. All three are also having to deal with the challenges of a new commissioning environment, in which they are having to build working relationships with many more local organisations than previously.

### 5.2.2 Payment by results (PbR)

There have been a number of iterations of the PbR policy: perhaps the most comprehensive from the DH was the *Code of Conduct for PbR* (DH, 2013a). Monitor is responsible for designing the payment rules and pricing methodologies which govern the flow of funding from commissioners to providers of NHS care from 2014/15 onwards. In May 2013, it issued a consultation entitled *A discussion paper: how can the NHS payment system do more for patients?* (NHS England & Monitor, 2013), which formulated some challenging principles which are useful for the purpose of this report:
The design of the payment system should aspire to go beyond regulating the flow of funds from the Government to health care providers and focus on promoting value for patients. By value we mean continual improvement in the quality of care, using scarce resources as sustainably as possible. To achieve this overall aim, we suggest the payment system should:

- reimburse providers for delivering specified outcomes for patients rather than particular treatments or inputs;
- promote the long-term, sustainable well-being of the whole person;
- allow for different payment approaches where people’s care needs differ, with room for local flexibility bounded by a clear structure of rules; and
- signal clearly to commissioners and providers the choices available to them that will promote sustainably better outcomes for patients.

Further elaboration of these principles by Monitor will be discussed in the context of this research’s findings in 5.3 below, in particular Monitor’s recognition of inbuilt contradictions that need to be addressed when designing a payment system based on PbR.

### 5.2.3 IAPT, Outcomes and Payment by Results

Also in May 2013, the IAPT Payment by Results Pilot Feasibility Study Final Report was published (IAPT & NHS, 2013). This is described as “a project .... to pilot an outcomes based system of Payment by Results (PbR currency model) for IAPT”. “Currencies” are defined by Monitor as “the units of purchase for what commissioners buy on behalf of patients” (NHS England & Monitor, 2013). The IAPT report gives the following brief rationale for the undertaking:

- It is well established that the introduction of PbR into acute hospital settings has driven up performance and efficiency. The scope of PbR was already being extended to secondary care mental health services.
- It is therefore logical that a system of PbR should be developed for IAPT services and that, if possible, this should be outcomes based. IAPT services are unique in that outcomes data is readily available and thus is a logical first place to start with an outcomes based PbR system.
- The Minister of State for Care Services has said that the flows of money within the NHS need to change to enable mental health to have parity with physical health and introducing PbR will enable this.

Monitor’s discussion paper (NHS England & Monitor, 2013) refers to the IAPT work as a project “already under way to develop outcomes-based payment for psychological therapies”. However, the HSJ reported in September that “a mandatory tariff for mental health was originally planned for this year, but ..... [the] idea has been dogged by concerns over data quality, particularly around the quality of the minimum mental health dataset which would be used to determine funding levels” (HSJ, 2013c). See 5.3.2 below for discussion of parallel data shortcomings in the IAPT project, as reported by the IAPT authors and others, including this study.

### 5.3 Discussion: the findings in context

#### 5.3.1 Sustainability in the provision of psychological therapies: payment systems and instability
Box 2 (below) outlines Monitor’s understanding of risk to sustainability in its discussion paper *How can the NHS payment system do more for patients?* (NHS England & Monitor, 2013).

Its characterisation of risk in poorly designed payment systems is mirrored in the findings of this report concerning:

- the creation of perverse incentives for providers and perverse outcomes for patients (5.1.2 and 5.1.13 above)
- the creation of disproportionate financial risk, particularly:
  - for small organisations (5.1.3)
  - in levels of tariff at ‘less than it costs that provider to deliver good quality care’ (Monitor) (5.1.4)
  - zero value contracts creating instability for providers (5.1.5)
  - disincentives to maintain and develop a skilled workforce (5.1.5, 5.1.6)
  - withdrawal and threatened insolvency of providers (5.1.7)

**BOX 2**

### NHS ENGLAND AND MONITOR: How can the NHS payment system do more for patients? A discussion paper

......the payment system may influence behaviours adversely as well as positively. For example, providers or commissioners may react in unanticipated ways to signals from the payment system, perhaps because the signals are not clear or conflict with other incentives. We recognise that we must take particular care to design the system to encourage positive change.

......The basic function of a payment system for publicly-funded health care is to regulate the flow of funds from the government to health care providers. However, a well-designed payment system, supported by accurate information on the costs and quality of care, can do more. Different payment approaches within a system can, for example:

- drive productivity;
- signal which models for delivering care are the most effective;
- reward quality improvement;
- allow the money to follow the patient,
- allocate financial risk sustainably; and
- ensure that people always have local access to services.

However, international evidence suggests that the payment system cannot do all of these things at once. ......Selecting suitable approaches will involve making trade-offs between competing priorities.......

In developing the payment system to promote value for patients we must be mindful of the allocation and management of risk. If a provider receives from commissioners less than it costs that provider to deliver good quality care, it becomes increasingly at risk financially. But without incentives to manage provider costs and limit commissioner spending, the affordability of NHS funding overall is compromised. In seeking to achieve a sustainable balance, the design of the payment system must reflect that different payment approaches allocate risk differently between providers and commissioners. For example, block grants put providers at risk of having to serve more patients than the grant can pay for, while activity-based funding puts commissioners at risk of paying for unanticipated increases in patient demand.

The payment system needs to allocate risk between providers and commissioners appropriately and sustainably. We must distinguish between risks to individual health economies and risks to the affordability of care in total. To allocate risk appropriately and sustainably, we need to understand the underlying drivers of patient demand and service cost and seek to apportion risk to those best placed to manage it.
A significant associated risk to both overall performance and sustainability for providers is that only 12% of patients referred by GPs under IAPT are “moving to recovery”, and would therefore be eligible for simple Payment by Results (Griffiths & Steen, 2013a). Of patients ending treatment in 2009/10, 21% attended only one session. Just over half did not complete treatment. Reasons for not completing treatment after two or more sessions included “Dropped Out” (18%); Not Suitable (8%); and Declined (7%) (Radhakrishnan et al., 2013). This represents many thousands of patients that providers will have invested significant time in, and for whom PbR would not be appropriate.

The IAPT Payment by Results Pilot Feasibility Study Final Report (IAPT & NHS, 2013) gives some partial recognition of this limitation. It proposes a payment for activity:

*In situations where there is no outcome, due to there being only one set of scores, or no scores, the currency model would not make a payment for the work done. This could be an assessment only, a single combined assessment and treatment session or an assessment without scoring followed by a single treatment session. It was agreed that these cases are paid on an activity-based system, with a flat rate price. It was agreed that guidance should be given to commissioners about what level this price ought to be.*

However, this leaves many weaknesses unaddressed, particularly in regard to the fragility of recovery measurement by snapshot (see below). As the Feasibility Study puts it concisely: “there is no payment for patients admitted and discharged at caseness as there is no recovery and no statistically reliable change”.

**Recommendation 1:**
Extension of a payment by results system for psychological therapies should be suspended pending development of a sustainable form of provision and a payment system that enhances effective provision.

### 5.3.2 The impact on quality, sustainability and recovery of flawed outcome measurement

Payment by Results depends on accurate measurement of outcomes which does not intrude on or distort the therapeutic process. The research findings suggest a series of worrying features of outcome measurement identified by providers and commissioners which appear to extend beyond the impact of AQP, to be more widely associated with PbR and IAPT’s favoured method of outcome measurement. Concerns identified include:

- the use of outcome measurement at every session, impacting on limited session time, disrupting the therapeutic process and with perceived negative impact on mood (5.1.9)
- reliance on snapshot measurement of recovery when mood can fluctuate significantly over 24 hours, and over the course of treatment (5.1.10)
- Payment by Results and zero value contracts creating significant incentives to find the patient recovered, with associated ethical pressures (5.1.10)
- a mechanistic emphasis on recovery which does not acknowledge the fragility of improvement, linked to a payment system that does not allow for relapse (5.1.10)
- over-reliance on snapshot measurement which may be unreliable for the reasons above, and its use as a payment method for which it was not designed (5.1.10, 5.1.12)
- limitations in the scope of outcome measures, with weaknesses in regard to particular conditions and systemic failure to reflect the wider impact of health gains (5.1.11)
• a financial incentive for providers to select those patients most likely to recover and reject others (5.1.12).

See Part C of Chapter Three of this report for the detailed evidence from providers and commissioners.

We have already noted Monitor’s reservations about the case for the benefits of competition in the NHS (5.2.1), and about poor data quality undermining development of the mandatory tariff for mental health (5.2.3 above). In the field of psychological therapies in primary care, this report’s findings point to parallel, and significant, flaws which are integral not only to AQP, but in some crucial respects to IAPT.

Concern about the development of payment systems based on PbR is deepened by close reading of the IAPT Payment by Results Pilot Feasibility Study Final Report (IAPT & NHS, 2013). A series of significant data weaknesses suggests that Monitor should be wary about rushing into a payment system which does not address the issues discussed here. Weaknesses include:

• Only 15% of patients completing “at least one” patient experience questionnaire (used to score on domain of the proposed PbR payment mechanism). Splitting it into two and administering it less frequently, as proposed, is unlikely to be a substitute for seeking to understand the negative impact on patients of the totality of monitoring they are exposed to, as reported in this research.
• Less than half of patients in the study had a first and last clinical score (21% each had PHQ and GAD, and under 1% for others).
• “A reason for the episode ending of ‘Completed treatment’ was taken as a successful outcome. It should be noted that success here means completion of the planned course of treatment, not clinical improvement”.
• “Services will not be penalised directly for poor data completeness. If they maintain it at baseline levels, they will still cover their costs”.
• In the measurement of employment outcomes, another domain in the proposed payment system, ‘The criteria used were….. when the employment status was ‘Unemployed & Seeking Work’, they were counted as unemployed. Students, long term sick or disabled, home makers, those not actively seeking work, voluntary workers and not seeking paid work, retired, not stated and not recorded were all ignored”. The exclusion of the long term sick and those not seeking paid work from measurement of outcomes takes IAPT a long way from the case that brought it significant Government investment (Layard et al., 2007).
• It is striking that the “Equity of Access” outcome domain includes factors such as ethnicity and age, but makes no mention of deprivation, a major factor both in poor mental health and access to psychological therapies (Campion et al., 2013).
• A recommendation that ‘a number of large services who had good data completeness and good data quality be invited to join the pilot to extend the range of services and so enhance the robustness of the analysis that will take place’ risks diminishing sensitivity to small organisations which according to this research are struggling for reasons not confined to AQP, and thus reducing diversity of provision.

In summary, providers and commissioners describe evidence of a range of flaws in outcome measurement which when combined with Payment by Results can distort the practice of therapy, do not measure sustainable recovery, produce perverse incentives for therapists, and encourage cherry-picking. These combine in effect with the use of outcome measurement instruments as payment triggers for which they were not designed, which itself produces perverse incentives; and may be
exacerbated by poor data supporting the planning for extension of Payment by Results.

**Recommendation 2:**
An independent inquiry should be charged with:
- examining, in the context of available evidence, the effects on the therapeutic process of weekly use of outcome measurement;
- identifying factors such as therapeutic approach in combination with type and use of measurement tool that enhance or hinder the therapeutic process; and
- proposing a sustainable and non-intrusive means and frequency of measuring recovery in combination with, or divorced from, as the weight of evidence may suggest, a payment structure which can support effective, diverse and inclusive provision of psychological therapies.

5.3.3 Is competition necessary to improve outcomes and for range and diversity of provision?

All three commissioners interviewed for the research reported significant reductions in waiting lists for therapy, with some dynamic providers responding to changed demand in terms of type of treatment and to geographical variations in need, and others proving less flexible and successful. This was ascribed both to market forces and to creative and flexible commissioning. Waiting lists at the start had meant a high volume of patients. As they were dealt with, a decrease in the number of patients was creating issues for providers with zero value contracts, and creating some market instability. A key question is whether competition was a positive factor in the achievements described, in the context of increased public investment (5.1.8).

Another area of strong performance was in commissioners’ engagement with both equity of access and with wider determinants of mental health, as part of a continuing, developmental process, successfully adapting therapies such as low-intensity psycho-social support to the needs of deprived communities which had high levels of need for mental health services but little knowledge of, or access to, psychological therapies. This is an approach that could be replicated, strengthening agendas to reduce health inequality (5.1.15). This appears to be a strength in commissioning which need not be associated with AQP, and may benefit from an integrated approach rather than a competitive one. There are indications that such an approach is beginning to have some traction in the community mental health field (Supply2Health, 2013).

Broadly, diversity of provision was viewed as a positive by the commissioners interviewed, reflecting diversity of need. However, increasing the number of providers carried the risks of an unstable market, particularly with zero value contracts and no guarantees of work. Furthermore, a more market-based system subject to regulation appeared to carry with it high levels of bureaucracy in terms of the scale of contract monitoring and contract letting: the rigidity and bureaucracy associated with the latter was almost universally condemned. A market where outcomes were measured required ambitious levels of IT system provision for small and large providers alike. This was a disincentive to small providers, and widely seen as disproportionate (5.1.14).

Finally, there remains a lacuna where there should be evidence to support the Department’s claim that “competition between providers (will) raise both service quality and efficiency”. There have been significant achievements in the areas where AQP has been introduced. But this has been at the expense of a range of new inefficiencies.
Recommendation 3:
Further work needs to be done on whether some of the strengths described in this report can be replicated through a more sustainable and integrated system of provision of psychological therapies which avoids the unanticipated risks identified with the introduction and functioning of the new market system.

5.3.4 Is choice a reality and a key factor in better care?

As we have noted, the Department of Health has claimed that AQP will increase patient choice, which is taken to mean a choice between providers in a market structure leading to improvement in the patient experience.

Concern was expressed in the provider interviews that the market structure itself restricted choice “if you are excluding many services that cannot compete” for the reasons described in this report.

Both providers and a commissioner expressed the view that the payment model led to providers rejecting those unlikely to fit in to a recovery model – a reduction of choice for those patients (Chapter Three, B12).

If the aim is to have a choice of providers, a functioning model must entail active help to ensure informed patient choice. Self-referral, in regimes where this was allowed, gave rise to issues of inappropriate self-referral and increased risk: patients needed to be informed about the alternatives available. Choice without knowledge or understanding of the options was no choice (Chapter Three, B13).

However, it was widely held that the expansion of provision in itself, leading to reductions in waiting lists, created a choice by offering a service where there was previously none. This was an outcome that could be achieved by making services which reflected diversity of need more widely available, not necessarily through AQP (Chapter Three, B12).

One commissioner was in no doubt as to the improvement represented by AQP, which enabled patients to choose, to a degree, the clinical indicator, the intervention they want, who the provider is, the day of the week, the geographical location, the time of the day, and the gender of the therapist.

In its core statement of AQP policy, the Department of Health announced that it would introduce “patient choice of Any Qualified Provider for services where there [was] a strong pull from patients”. There was no evidence of a pull from patients for greater competition in the area of psychological therapy. Indeed, the absence of a patient voice in the evolution of these policies is striking.

Respect for the patient entails listening to the patient. There is evidence that even the voice of providers delivering essential messages from the front line can be lost in the climate of competition. One commissioner emphasised the importance of both a providers’ and a patients’ forum, and there was evidence that at least the former had been very successful (Chapter Three, A4). Its replication should be explored.

In summary, the evidence of this report suggests that the term “patient choice” can be understood in a number of ways, and that AQP and PbR may have some unintended consequences that are detrimental to patient choice and in turn to patient outcomes. In this context, the absence of a genuine voice of patients in the evolution of psychological therapies in primary care is striking. Such a voice may bring
improvement to what has hitherto been a heavily process-driven narrative. Narrative evidence from providers and commissioners is a small but positive start.

**Recommendation 4:**

(i) The relationship between patient choice and the consequences of AQP and PbR should be examined in greater depth, in order to ground future policy in a coherent relationship with patient outcomes;

(ii) a research evidence base should be developed to reflect the experience of patients, in order to inform development of a sustainable policy framework; and

(iii) structures should be created to allow both provider and patient feedback and input, using this to improve accountability and transparency.

5.3.5 Psychological therapies in the wider context of well-being and inequalities

Another commissioner spoke of creating much greater equality of access, with greater flexibility of provision to reflect a wider range of economic and social risk factors in mental health. Another commissioner in the same area questioned whether the NHS should be paying for the full range of positive alternatives to medication that needed to be promoted, such as walking groups, cycling groups, gym membership, and bibliotherapies.

However, a defensive conclusion about cost to the NHS can be turned around to embrace a wider mental health and wellbeing agenda, particularly through the new framework of Health and Wellbeing Boards, with the potential for harnessing common objectives and interests through shared and cost-effective commissioning.

A third commissioner felt that there were casualties of recent changes in policy and practice at the highest and lowest ends of need: the highest end because long treatments were far less likely to be offered, and the lowest because patients with low-level mental health needs did not reach a threshold for psychotherapy. His solution was to take every opportunity to engage GPs in innovative early intervention, and to take opportunities to promote it, arguing for recognition that supported self-help would increase resilience and would mean fewer severe mental health problems.

The encouragement of self-help can be interpreted by some defenders of the NHS as an abandonment of patients. However, consideration of these perspectives together suggests a link to integration of the vision of wider wellbeing with the care pathway into one commissioning continuum, supporting objectives shared by both CCGs and local authorities (with Health and Wellbeing Boards as a bridgehead), using evidence for the positive impact of vibrant community activity on mental health and health inequalities, building extensions of the care pathway into an active community which nurtures healthy activity. See the subsection on Wellbeing in 1.7 of this report for more on this.

Behind such a preventive strategy stands a comprehensive body of evidence that socio-economic inequalities are a major driver of mental ill health, and that strategies to improve wellbeing need to address that population-wide reality (Campion et al, 2013). With mental distress increasing, the only way pressure can be relieved on any system of delivering psychological therapies is to turn down the tap of supply by addressing major causes of mental distress. It is false economy to look at the effectiveness of services without taking account of this context.
**Recommendation 5:**
The commissioning of psychological therapies should be set in the context of integrated strategies to address the wider determinants of mental ill health and reduce the inequalities that lead to poor mental health, adding a sustainable, innovative and inclusive dimension to such a process, as some commissioners have demonstrated can be done.

5.3.6 An alternative model proposed

A number of interviewees had thought deeply about the lessons of the AQP experiment. One of these was the commissioner who was most critical of AQP. He proposed an alternative model of provision (Chapter Three, B15) which he thought addressed weaknesses identified, particularly:

- the perverse incentives and patient outcomes resulting from Payment by Results
- the use of outcome measures as a payment system for which they had not been designed
- resultant unreliable outcome data
- the ethical pressures put on therapists employed on an hourly basis on a Payment by Results basis
- the fragmentation of contracts entailing one provider doing Step 2 and another Step 3, resulting in financial incentives for providers to hold on to patients at one step for longer than necessary
- an unacceptable increase in bureaucracy, both for providers in resource-intensive, unfunded outcome measurement, and for commissioners in expanded contract monitoring.

This can be considered in the context of Monitor’s principles for sustainability (Box 2 above). This interviewee began with the principle that it was right and fair that the therapist should know that s/he was going to be paid for work. A cost per volume contract made more sense than Payment by Results, with fewer providers but much better performance-managed than they had been, so that waiting lists did not build up. Rather than a patient choice agenda with perverse outcomes (see above), he would strongly prefer to manage a provider firmly, with payment based on an average number of sessions that could be varied by the provider according to need and circumstances. Providers would be organised by area. He advocated a straight line of accountability within one provider for supervision, case management, step-up, and outcomes, which he believed would be simpler to commission and fair on providers.

He also proposed additional flexibilities which might entail a group of independent small providers to take up surplus demand where waiting lists exceeded an agreed level. This would risk the threats to organisational viability, with insecure working conditions, described in this report. To counter this, he proposed a reserve workforce of private practitioners prepared to work flexibly.

This vision attempts to answer some of the key issues raised in this research, and may serve as one starting point in considering how to reconfigure a market system subject to severe criticism. It could be combined with insights from elsewhere in this report, particularly the evident success of new approaches in commissioning for previously excluded communities (5.3.3), and integrating this provision with broadly based measures to address the wider determinants of inequalities in mental health and wellbeing (5.3.5).
Finally, it should be noted that this commissioner’s “reserve bank” idea to address growing waiting lists may depend on the existence of a wealth of private practice with spare capacity, which may not be the case in many parts of England.

Recommendation 6:
Further work be done to develop an alternative model of provision which addresses the weaknesses described in this report, perhaps beginning with one interviewee’s vision of a system entailing:

- a cost per volume contract in place of Payment by Results, with fewer providers closely performance-managed so that waiting lists do not build up;
- payment based on an average number of sessions that can be varied by the provider according to need and circumstances;
- providers organised by area;
- a straight line of accountability within one provider for supervision, case management, step-up, and outcomes, simpler to commission and fair on providers;
- flexible arrangements to deal with high demand where waiting lists exceed an agreed level.

Recommendation 7:
To support an alternative model of provision, work should be undertaken:

- to identify a method of performance management of cost per volume contracts which will support the best and most consistent patient outcomes, service sustainability, and cost-effectiveness, learning lessons from practice-based evidence;
- to ensure replication of the evident success of new approaches in commissioning for previously excluded communities, and integrating this provision with broadly based measures to address the wider determinants of inequalities in mental health and well-being.

5.4 Recommendations in full

1. Extension of a Payment by Results system for psychological therapies should be suspended pending development of a sustainable form of provision and a payment system that enhances effective provision.

2. An independent inquiry should be charged with:

- examining, in the context of available evidence, the effects on the therapeutic process of weekly use of outcome measurement;
- identifying factors such as therapeutic approach in combination with type and use of measurement tool that enhance or hinder the therapeutic process; and
- proposing a sustainable and non-intrusive means and frequency of measuring recovery in combination with, or divorced from, as the weight of evidence may suggest, a payment structure which can support effective, diverse and inclusive provision of psychological therapies.

3. Further work needs to be done on whether some of the strengths described in this report can be replicated through a more sustainable and integrated
system of provision of psychological therapies which avoids the unanticipated risks identified with the introduction and functioning of the new market system.

4. (i) The relationship between patient choice and the consequences of AQP and PbR should be examined in greater depth, in order to ground future policy in a coherent relationship with patient outcomes.
   (ii) A research evidence base should be developed to reflect the experience of patients, in order to inform development of a sustainable policy framework.
   (iii) Structures should be created to allow both provider and patient feedback and input, using this to improve accountability and transparency.

5. The commissioning of psychological therapies should be set in the context of integrated strategies to address the wider determinants of mental ill health and reduce the inequalities that lead to poor mental health, adding a sustainable, innovative and inclusive dimension to such a process, as some commissioners have demonstrated can be done.

6. Further work should be done to develop an alternative model of provision which addresses the weaknesses described in the report, perhaps beginning with one interviewee’s vision of a system entailing:
   - a cost per volume contract in place of PbR, with fewer providers closely performance-managed so that waiting lists do not build up;
   - payment based on an average number of sessions that can be varied by the provider according to need and circumstances;
   - providers organised by area;
   - a straight line of accountability within one provider for supervision, case management, step-up, and outcomes, simpler to commission and fair on providers;
   - flexible arrangements to deal with high demand where waiting lists exceed an agreed level.

7. To support an alternative model of provision, work should be undertaken:
   - to identify a method of performance management of cost per volume contracts which will support the best and most consistent patient outcomes, service sustainability, and cost-effectiveness, learning lessons from practice-based evidence;
   - to ensure replication of the evident success of new approaches in commissioning for previously excluded communities, and integrating this provision with broadly based measures to address the wider determinants of inequalities in mental health and wellbeing.

8. There should be evaluation of the impact of IAPT, PbR and AQP on the employment status of therapists, their remuneration, the skills range of the therapy workforce and its appropriateness and adequacy to meet patient need, with a view to creating a workforce best able to achieve good therapy outcomes, in the light of the findings of this study (see 5.1.6 above).
9. Measures need to be taken to address significant inconsistencies in the scope of AQP service specifications found by this research which will affect patients’ access to appropriate services and create a postcode lottery. This is likely to affect more areas than those that have opted for AQP, since these issues are not specific to the new market arrangement (see 5.1.17 above).

10. If AQP is proceeded with, regard needs to be had:

- to the finding widely shared by providers and commissioners that the online AQP qualification process was wasteful, bureaucratic, stressful and poorly structured and defined, demanding disproportionate resources and organisational change, particularly for small organisations;
- to the widespread concern about whether AQP is a viable model for small organisations, particularly regarding the risk of investment in the range of interventions demanded by some service specifications while there was no work guaranteed; about the wisdom of investment in required infrastructure, particularly IT, given the risk involved in zero value contracts; and in a number of cases about unpredictability in the flow of patients;
- to the need to adopt tariff structures that offer a degree of sustainability for providers, particularly concerning remuneration for treating patients who do not move towards recovery, and the risk of large volume unpaid administration by providers;
- to the removal of disproportionate demands, inefficiency and cost occasioned by requirements to adopt and link up to NHS IT systems, a requirement seen as largely unnecessary and discriminatory towards small organisations with limited resources; and the provision of logistical and financial support to enable small providers to meet what should be a reduced requirement.

11. The themes reflected in these recommendations should be explored and developed in a recorded policy seminar to be organised by the Centre for Psychological Therapies in Primary Care in 2014, with a follow-up publication.
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<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>AQP</td>
<td>Any Qualified Provider</td>
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<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
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<tr>
<td>Caldicott Guidance</td>
<td>Independent review of how information about patients is shared across the health and care system</td>
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<td>Child and Adolescent Mental Health Services</td>
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<td>Clinical Commissioning Group</td>
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<td>Choose and Book</td>
<td>National electronic referral service for outpatient appointments</td>
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<td>CORE</td>
<td>Clinical Outcome in Routine Evaluation</td>
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<td>CORE-10</td>
<td>Short version of the CORE-OM, used as a screening tool and outcome measure</td>
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<td>Information Management System</td>
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<td>CORE-NET</td>
<td>Software to collect client reported outcomes</td>
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<td>CORE-OM</td>
<td>Generic measure of psychological distress</td>
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<td>CPTPC</td>
<td>Centre for Psychological Therapies in Primary Care</td>
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<td>Did Not Attend</td>
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<td>Foundation Trust</td>
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<td>GAD-7</td>
<td>Generalised Anxiety Disorder. A brief clinical measure for the assessment of generalised anxiety disorder routinely used in IAPT services</td>
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<td>General Practitioner</td>
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<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<td>IT system connecting many different sites across NHS within England and Scotland</td>
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<td>Abbreviation</td>
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<td>NICE</td>
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<td>Obsessive-Compulsive Disorder</td>
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<td>PHQ-9</td>
<td>Patient Health Questionnaire. PHQ-9 is the nine item mood module of the Patient Health Questionnaire routinely used in IAPT services</td>
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<td>WSAS</td>
<td>Work and Social Adjustment Scale. A simple measure of impairment In functioning</td>
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