

KEY VERBATIM EXCERPTS FROM:

Mental Health's Market Experiment: Commissioning Psychological Therapies through Any Qualified Provider

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Preface (p. i)

The Health and Social Care Act (2012a) radically altered the organization 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 utilized. 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 and 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.

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Introduction

This research project examines the impact of the introduction of a market system for the provision of psychological therapies in primary care. ...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. (p. ii)

1.2 Emerging Context – Key Terms (p. 1)

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 and 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 and Fry, 2012). This report uses the term in its commonly understood meaning, 'payment related to successful outcomes'.

1.5 Limitations of the Research (p. 3)

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 characterized as 'practice-based evidence', described by Guy et al. (2011) as complementary to the quantitative, and dominant, Randomized Control Trial-based approach to evidence. A United Kingdom Council for Psychotherapy (UKCP) report (Ryan and Morgan, 2004, cited in Thomas, Stephenson and 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.

1.7 Background: Research Literature (p. 4) Prevalence and Trends

In the UK, mental disorders account for the largest single burden of disease (22.8 per cent), as measured by disability-adjusted life-years, and this figure is an under-estimate since it does not include several mental disorders, such as generalized anxiety disorder (which affects 4.7 per cent of adults), phobias (2.6 per cent of adults), antisocial or borderline personality disorders (0.7 per cent), or pervasive development disorder/autism (1 per cent) (McManus et al., 2009, quoted in Campion, Bhugra, Bailey and 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 (p. 5)

A recent article in *The Lancet* (Campion et al., 2013) summarizes 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 and 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 2008–9. 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 per cent) of employees were anxious about unfair treatment at work. Just over half of all employees (52 per cent) 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 organizational change in recent years. An important factor offsetting fear at work was the degree of participation allowed to employees with respect to organizational decisions (Gallie, Felstead, Green and 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 and Fry, 2012) and increasing trends of antidepressants and antipsychotic use over the last decade (Ilyas and 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), emphasizes 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).

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 and 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 (Piachaud, Bennett, Nazroo and Popay, 2009; Grady, 2009).

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 per cent recovery rate for IAPT by emphasizing 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 per cent of whom are 'moving to recovery' under IAPT (Griffiths and 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 and Steen, 2013b).

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 and 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.

[p. 27]

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 inimical 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 destabilizing 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 standardization for commissioners; but also of perverse outcomes:

We know we've got a standardization 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. [p. 28]

[p. 56]

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)
- destabilization and some deterioration in service (B4, B6)
- destabilization of provider organizations 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 organizations. 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).

5.14 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).

5.15 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).

5.16 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 organizations 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).

5.17 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).

5.18 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).

5.19 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).

5.110 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 wellbeing during a course of treatment, with an incentive to declare the patient recovered on the basis of one outcome measurement (Chapter Three, Part C).

5.111 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 jeopardized 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
- organizations provided single-level services and held on to 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 organizations 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 recognized the need to understand local conditions, and that this was consequently recognized 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. Need needs to be monitored 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). [p. 59]

5.1.18 Charities which had become companies limited by guarantee were the most successful organization type in securing AQP contracts, comprising 43 per cent 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 per cent 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 organizational change, particularly for small organizations (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).

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 organized 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.

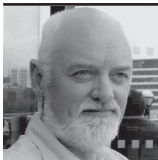
8. There should be evaluation of the impact of IAPT, PbR and AQP on the employment status of therapists, their remuneration, the skills range of the therapy workforce and its appropriateness and adequacy to meet patient need, with a view to creating a work-force best able to achieve good therapy outcomes, in the light of the findings of this study (see 5.1.6 above). [p. 71]

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 organizational change, particularly for small organizations;
- to the widespread concern about whether AQP is a viable model for small organizations, 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 organizations 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 organized by the Centre for Psychological Therapies in Primary Care in 2014, with a follow-up publication. ⑤



Steve Griffiths was lead author of two research papers and a report on introducing a market in psychological therapies in primary care, *Mental Health's Market Experiment*, working at Chester's

Centre for Psychological Therapy in Primary Care (2014). As freelance researcher, Steve wrote area profiles of poverty and health inequality, and reports for the Joseph Rowntree Foundation developing approaches to housing-related support for vulnerable people, including consultancy on the Supporting People programme for three government departments. He has written critical papers on the impact of welfare reform on the well-being of people with long-term illnesses and disabilities (Compass), has published six collections of poetry, and is a Fellow of the Welsh Academy.



Joan Foster is an Honorary Senior Lecturer, Centre for Psychological Therapies in Primary Care, University of Chester. A trained counsellor, MBACP (Snr. Accred.) and supervisor, she is immediate

past chair of Counsellors and Psychotherapists in Primary Care (CPC), which she co-founded in 1998. She was inaugural chair of the Psychotherapeutic Counselling Section of the UKCP, founded in 2005, and Chief Executive of Chichester Counselling Services from 2007 to 2009. Joan was a past chair of PRIMHE (Primary Care Mental Health Education), and has also worked as a consultant within the NHS. She has long experience of working as a primary care counsellor and a supervisor of primary care counsellors.



Scott Steen is in the process of analysing the impact of current legislation in psychological therapy in primary care. He has been part of a number of projects, which have sought to provide a richer

context in which the provision of psychological therapies operate. Presently he is seeking to evaluate and understand the impact of healthcare modelling for both service-user and staff experiences, with a particular focus on the Improving Access to Psychological Therapies (IAPT) programmes. Scott has been involved with a number of extracurricular activities related to counselling and psychotherapy. He hopes to pursue a balanced career between research and psychotherapy. Scott finds the research-clinical gap extremely interesting: especially with reference to human psychology. As a result this is where his main focal point of research and career aspirations lie.



Professor Patrick Pietroni DSc (Hon), FRCP, FRCGP, MFPH: a trained Jungian analyst and formerly Dean of General Practice at London University, Professor Pietroni formerly led an internal consultancy

unit funded by the Department of Health, and headed the Primary Care and Community Health Department, University of Westminster, established by him in 1993. He has published *The Greening of Medicine* and many academic papers. He founded and was editor of the *Journal of Inter-professional Care*, and has lectured in many countries. Professor Pietroni is currently Director of the Centre for Psychological Therapies in Primary Care, University of Chester, and Public Health Lead, Mental Health and Well-being, Shropshire.

Notes and references

NOTES

- 1 Centre for Psychological Therapies in Primary Care, Faculty of Health and Social Care, University of Chester
- 2 This summary is published with the kind permission of Professor Patrick Pietroni and his colleagues. The full version of this report can be accessed at: <http://www.ruthwilliams.org.uk/Pietroni%20Mental%20Health's%20Market%20Experiment.pdf>

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