As IAPT services have matured, a number of service characteristics have been highlighted to enable the delivery of high quality care and achievement of clinical and other outcomes (e.g. see Gyanì et al., 2011). These characteristics have been set out as a series of standards with a suggested metric to support effective commissioning and delivery of IAPT services (IAPT Programme, 2011).

Currently, the main procurement routes (Commissioning Development Directorate, 2012) for IAPT services are:

1. Competitive tendering process to appoint a specific provider, a specified number of providers or collaboration of providers; or
2. Appoint a specific provider or group of providers without competition (called Single Tender Action); or
3. To open the service delivery to Any Qualified Provider (AQP) and enable patients to choose from these providers.

When a service is commissioned via AQP, patients can choose from a range of providers based on perceived quality and individual preferences. The prices paid to these providers will be determined in advance by the NHS, this could be a national tariff, or a locally agreed price. Providers have no volume guarantees and patients will decide which providers to be referred to. Patients will choose and money will follow patients’ choices, therefore competition will be on quality not price. Commissioners will own the service specification and will confirm if the provider can deliver that specification. This means that the commissioner has a key role to play in the qualification of providers. A national directory of qualified providers and contracts will allow information sharing across the NHS when the regulator or a commissioner terminates or suspends a contract. This could potentially make care safer for patients. Commissioning services via AQP requires a cost per volume payment and pricing system. The Department of Health (DoH) is currently working with 22 IAPT sites to develop an evidence based currency that will support the use of a ‘payment by results’ system in IAPT services while avoiding perverse incentives that could undermine the value of the programme. In theory, AQP should place patient choice at the centre of commissioning and should incentivise high quality care based on a competitive free market model.
Unfortunately, our local experience has shown that there are problems with the process, linked to the limited availability of IAPT qualified clinicians and the whole arena of capacity and demand. Very few organisations applied to join the AQP framework, and out of all the ones that applied, not all have reached the final stage due to contractual issues and an inability to collect and share the minimum dataset with the DoH as is required for IAPT services. I believe this has reduced choice as some agencies that previously provided services are no longer on the framework, although work is being done to rectify this and hopefully they will eventually meet all the contractual requirements. It seems to be mainly third sector/voluntary organisations who have suffered due to the complexity of the AQP requirements and the data collection and submission requirements. It would be a real loss to patient choice and quality if such services are not supported with the process and do not join the market.

I think commissioners were not expecting the small number of applications. There is also a lack of awareness outside of IAPT that services do not have a surplus of suitably qualified and trained staff. With reduced delivery of training and reduced intakes from Universities offering IAPT courses, this is becoming progressively worse. Some of the issues may be geographic however, and areas whose borders touch may have a larger number of potential providers. Within our patch, there are no IAPT services with additional capacity on our borders.

References


Debate this topic:

Statement 1  Commissioners know enough about IAPT to determine the qualifications of potential service providers.

Statement 2  AQP is an appropriate commissioning model for IAPT services.

Statement 3  There is a sufficient supply of qualified therapists to promote competition between different service providers.

Statement 4  AQP services will sacrifice quality of care to maintain financial viability.

Statement 5  Patient care will be better under AQP.
Debate results:

This public debate was launched in March 2015 via an open-access and anonymous survey promoted online, via email to IAPT services linked to the Northern IAPT Practice Research Network and through social networking sites. The survey concluded at the end of May 2015.

Responses to the above statements (Total number of participants = 59)