

# Understanding the reforms... Choice and any qualified provider

April 2013



## 1. Introduction

Patient choice has been a priority for successive governments since the 1970s. The last Labour Government focused on enabling patients to choose where to receive treatment, creating an entitlement for patients who required referral to a specialist to choose from four or five providers. From 2008 that choice was extended to any eligible NHS or independent sector provider in , known as 'free choice'. The Coalition Government has maintained this emphasis, increasing the numbers of patients being offered choice and extending the focus beyond choice of provider. Like the previous Government, the Coalition sees patient choice not only as a way to improve the patient experience but also as a lever for competition. In theory, patients choose the best services, encouraging poorer quality services to improve in order to compete for patients and funding, thereby driving up standards across the NHS. Competition and choice are now, therefore, inextricably linked.

For a more detailed exploration of the history patient choice, please see [Appendix A](#).

## 2. Any qualified provider

Any qualified provider (AQP) means 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.

The introduction of AQP began in April 2012, treating 2012-13 as a transitional year. A limited set of community and mental health services covered by national or local tariff pricing were identified as the initial priority areas in which to apply AQP. PCTs were, however, able to choose services not included in the priority list if consultation showed them to be of a higher local priority.

By September 2012, PCT clusters had implemented patient choice of AQP for their chosen services. The Department of Health (DH) has since confirmed that 600 providers have passed through the qualification process. By February 2013 there were 132 unique providers delivering services under approximately 490 contracts, with another 56 contracts already signed. The mix of providers qualifying for AQP is different to that which was expected by the DH, with significantly more small and medium enterprises (SME) and FTs, and fewer large corporate firms. The AQP resource centre features a [national directory of providers](#), which shows the organisations that have been granted AQP status in each area and the services they have been approved to provide.

From 2013-14 it will be for local commissioners to decide in which services, if any, they want to introduce choice of AQP, reflecting local needs, the quality of existing services and patients' views. Procurement regulations for commissioners, laid before Parliament in February 2013, sought to confirm that local commissioners will have the flexibility to decide whether and how to extend choice in their area, including via AQP.

## 2.1 Initial priority areas for AQP

On the whole, the application of AQP to date reflects the priority areas identified by the DH in 2011. [Operational guidance on AQP for providers and commissioners](#) set out eight priority areas for AQP implementation. These were:

- Musculo-skeletal services for back and neck pain;
- Adult hearing aid services in the community;
- Continence services (adults and children);
- Diagnostic tests closer to home such as some types of imaging, cardiac and respiratory investigations to support primary assessment of presenting symptoms;
- Wheelchair services (children) (subsequently removed from the priority list and transferred to the NHS Commissioning Board);
- Podiatry services;
- Venous leg ulcer and wound healing; and
- Primary care psychological therapies (adults).

A map on the [AQP Resource Centre website](#) shows that some PCTs have chosen other services including lymphoedema, dermatology and ADHD and autism spectrum services.

## 2.2 Pricing

One of the stated principles of AQP is that competition is based on quality, not price. Providers are paid a fixed price for a service which is either the national tariff or, where it is not covered by the national tariff, the price set by local commissioners. All providers in the area are paid the same price. Therefore, before AQP can be implemented, commissioners need to identify the price that should be paid for a specific AQP service in their area. The DH has published [high level guidance](#) for commissioners on setting prices for AQP services.

## 2.3 Qualification of providers

In order to be put on the AQP list, providers have to qualify and register to provide services via an assurance process that is designed to test their fitness to offer NHS-funded services. The governing principle of qualification is that providers should qualify if they:

- Are registered with CQC and licensed by Monitor where required, or meet equivalent assurance requirements;
- Will meet the Terms and Conditions of the [NHS Standard Contract](#) which includes a requirement to have regard to the NHS Constitution, relevant guidance and law;
- Accept NHS prices;

- Can provide assurances that they are capable of delivering the agreed service requirements and comply with referral protocols; and
- Reach agreement with local commissioners on supporting schedules to the standard contract including any local referral thresholds or patient protocols.<sup>1</sup>

There are four stages of qualification to become an AQP:

- Stage 0 – commissioners determine which services are appropriate for AQP. The offer is made available on Supply2Health and prospective providers apply using the standard qualification questionnaire.
- Stage 1 – the compliance team checks the applying providers' organisation, regulation, IT, financial, commercial and legal details.
- Stage 2 – Qualification Centres of Excellence (QCEs) or local commissioners deal with any outstanding issues from the compliance check and undertake a service delivery assessment. This includes checking that appropriate integrated care pathways have been described and details of clinical governance leads, processes and reporting.
- Stage 3 – the local commissioning body undertakes final checks before declaring a provider qualified or not qualified. Successful applicants are listed in the National Directory of Qualified Providers.
- Stage 4 – Successful providers are offered a contract with a start date and begin to mobilise.

There are five QCEs that cover the eight priority service areas. They are designed to support local commissioners in assessing provider applications, including making sure commissioners and clinicians assess applications fairly and consistently, in line with best practice and regulations.

## 2.4 Evaluation

The DH will be carrying out a three stage evaluation of AQP. The first stage will look at the lead up to April 2012, the creation of implementation packs, clinical and staff involvement and how decisions were made. The second stage will provide a qualitative evaluation of existing schemes and will include site visits and staff feedback events. The third stage will be an academic evaluation of how well the policy is working and its impact on quality, the market, workforce, training and education. This is due to report no earlier than 2014.

## 3. Further extension of patient choice

The Government is committed to increasing patient choice in other ways, alongside the extension of AQP. Most fundamentally, under the Health and Social Care Act, clinical commissioning groups, NHS England and Monitor must all act with a view to enabling patients to make choices about their healthcare and the health services provided to them. This enshrines the duty to promote patient choice in legislation, ensuring that it is a priority throughout the new health service architecture.

### 3.1 Referral to a named consultant-led team

Since April 2012, patients should have been given choice of named consultant-led team for their first outpatient appointment in secondary care. Patients should also

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<sup>1</sup> Department of Health. *Operational Guidance to the NHS: Extending patient choice of provider*. 2011.

be given choice of specific professionally-led team when referred to a mental health service. [Implementation guidance on choice of named consultant-led team](#) has been published, which sets out the requirements providers are obliged to meet, including:

- Accept all patients who are referred to a named consultant-led team as long as the referral is clinically appropriate;
- List all named consultant-led teams against all the relevant consultant-led services on Choose and Book in a way that allows users to book appointments with named consultant-led teams as well as generic services; and
- Publish information about services to enable patients to make informed choices.

Previously, patients could only be referred to a named consultant-led team if it was clinically necessary, for example, if the consultant was one of a very few specialists dealing with the patient's condition.

### **3.2 Maternity services**

Choice has been extended in maternity services so pregnant women have the option of going to their GP for a referral to a midwifery service or going directly to the midwifery service without a referral. Pregnant women can also expect to choose to receive ante-natal care from a midwife-only service or from a team of maternity health professionals including midwives and obstetricians.

### **3.3 Diagnostic tests**

Patients should be given a choice of diagnostic test provider when referred by their GP for a range of more common diagnostic tests. This will not include when tests are required as part of admitted inpatient care or when tests are needed urgently.

### **3.4 Personal health budgets**

The concept of personal budgets for health was introduced in 2008. The Labour Government hoped that giving patients greater control over how money was spent on their care would help to ensure they got the services they needed and had more positive experiences. It was also hoped that personal health budgets would encourage successful services to grow and others to adapt to meet individuals' needs.<sup>2</sup>

A three year pilot programme was started in 2009, offering patients a choice of three different types of personal budget:

- A notional budget held by the commissioner;
- A real budget managed on the individual's behalf by a third party; and
- A cash payment to the individual (direct payment).

Evaluation of the pilots was completed in summer 2012 and found that the quality of life for people with a budget had improved, with some seeing a drop in attendance at hospital. The benefits of having a personal health budget were felt more strongly by people with the highest health needs. As a result, personal health budgets will be initially targeted at people receiving NHS Continuing Care – by April 2014, up to 56,000 people on the NHS Continuing Healthcare scheme will have the right to ask for a personal health budget. Clinicians will also be able to offer budgets to others who may benefit.

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<sup>2</sup> Department of Health. *Personal health budgets: first steps*. 2009.

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In order to encourage the implementation of personal health budgets, the NHS England mandate requires it to ensure the NHS becomes better at involving patients and carers, empowering them to make decisions about their own care and treatment. One of the ways identified to achieve this is to ensure that, by 2015, patients who could benefit will have the option to have a personal health budget.<sup>3</sup>

More detailed information on personal health budgets is available in the BMA's [position paper](#).

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<sup>3</sup> Department of Health. *The mandate: A mandate from the Government to the NHS Commissioning Board April 2013* – March 2015 . 2012.

## Appendix A

### The history of choice

#### *1948-1997*

When the NHS was founded in 1948, choice for patients was limited. Individuals were able to choose their GP, dentist and optician, but choice did not extend any further.

By the 1970s, choice had been seen to work in other sectors, where it drove improvements in quality and efficiency. It was clear that suppliers of goods or services that did not match the quality and cost of the best alternative producers lost users and therefore revenues. It was felt that the same principles could be applied to health services. Furthermore, people were becoming more consumerist. They wanted to exercise choice and were becoming more critical of inadequacies.

In 1972, the NHS underwent its first major reorganisation, one intention being to become more responsive to the needs of its users. Patients started to be seen as consumers in relation to health services and to be given some choice in the treatment they received. This included being able to access treatment privately. This was not yet referred to as 'patient choice'.

The Conservative Government first explicitly promoted the idea of patient choice as part of its internal market reforms of the late 1980s and early 1990s. The key reform was the separation of the provision of and payment for services, which came to be known as the purchaser/provider split. The provider side of the NHS (mainly hospitals) was gradually re-organised into independent trusts while payment for services, or purchasing, remained with district health authorities. Alongside this were reforms aimed at providing patients with more information to facilitate a 'real choice' between GPs, allowing them to change GP "without any hindrance at all",<sup>4</sup> and the introduction of GP fundholding, which devolved budgets to GPs to allow practices and hospitals which attracted the most custom to receive the most money. This was the first instance of patient choice being used as a lever for competition, as GPs and providers competed for patients and the funding that now followed them, under the guise that it would drive quality and efficiency. In practice, under fundholding the choice of hospital lay largely with the GP rather than directly with the patient.

The Patients' Charter was published in 1991 and then revised in 1995. This affirmed the right of every citizen to be referred to a consultant, acceptable to the patient, when the patient's GP felt it necessary. Although the Charter was seen as weak overall, it helped to establish the importance of putting patients at the centre of care.

#### *1997-2010*

Choice was not an immediate priority for the Labour Government when it came to power in 1997. It was not until 2002 that plans were announced to offer patients who were already on waiting lists opportunities to choose alternative providers.

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<sup>4</sup> HM Government *Working for patients* .1989.

It was at this time that patient choice began to be referred to as a value in its own right. Alongside this, the Government changed the system of hospital payment, to support the policy of patient choice. Payment by Results (PbR) introduced a fixed tariff payment per case treated to create, in theory, strong incentives for hospitals to raise income by attracting and treating more patients, via improvements in quality.

Public perception contributed to the development of choice. The 2005 British Social Attitudes survey found that 65 per cent of people wanted to be able to choose their treatment, 63 per cent their hospital and 53 per cent the date and time of their appointment.<sup>5</sup> From January 2006 patient choice was extended across and all specialties. All patients requiring hospital treatment were able to choose from four or five NHS providers, as well as new independent sector treatment centres (ISTCs), for their first outpatient appointment. The electronic appointments system Choose and Book was also introduced allowing hospital appointments to be booked online or by telephone in the GP consulting room. By 2008 patients were offered 'free choice' of any NHS or registered independent sector provider – any willing provider - for routine elective care. PbR was extended to almost all hospital services, and the Government sought to extend it to those provided in the community.

The NHS Constitution was published in 2009 and updated in 2010. It set out that patients have a right to choose a GP practice and a right to make choices about NHS care and access information to support those choices. It also stated that choices available to patients will develop over time, allowing for further rights to be added to the Constitution.

By the time the Labour Government lost power in 2010, the concept of patient choice in the NHS was firmly established. Since the 1980s, it has been seen not only as a way to improve the patient experience but also as a lever for competition. In theory, patients choose the best services, encouraging poorer quality services to improve in order to compete for patients and funding, thereby driving up standards across the NHS. Competition and choice are now, therefore, inextricably linked.

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<sup>5</sup> The King's Fund. (2008) *Free choice at the point of referral*. London.