**Reform Group**

**5 September 2011**

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| **Title:** | Any Qualified Provider (AQP) – update |
| **Agenda item:**  | 8 |
| **Action requested:** | For noting and comment. |
| **Timing** | DH guidance published on 19 July requires PCT clusters to notify their SHA by 31 October 2011 of their three priorities for implementing AQP by September 2012. |
| **Executive Summary:** | An update on progress towards, and plans for, identifying each cluster’s priorities for implementing patient choice of AQP across three service lines between April and September 2012. This includes some generic emerging themes, opportunities and risks identified to date as well as early indications of which services may be considered local priorities.  |
| **Summary of recommendations** | The Reform Group to note progress and provide any comment on the work planned to implement AQP in London. |
| **Fit with NHSL strategy:** | The Department of Health requires SHAs to oversee the development of patient choice of AQP by PCT clusters. |
| **Reference to related / other documents:** | Department of Health guidance published 19 July 2011 |
| **Date paper completed:** | 30 August 2011 |
| **Other forums that have considered this paper:** | Cluster CEOs’ meeting 30 August 2011 (since updated to reflect its discussions)The subject of this paper has been considered by Strategy & Innovation PLG on 19 July and Reform Group 1 August. |

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| **For EMT/ SSG reports,****Date paper seen by SMT/ PDG** | n/a | **Equality Impact Assessment complete?** | No | **Risk assessment undertaken?** | No | **Legal advice received?** | No |

**Any Qualified Provider (AQP) update**

1. **Introduction**

1.1 This paper provides an update on progress towards, and plans for, identifying each cluster’s priorities for implementing patient choice of AQP across three service lines between April and September 2012. This work also considers what opportunities and risks there may be in implementing across more than one cluster or pan-London.

1.2 The Reform Group is invited to note and comment on the contents of the paper outlining the process for deciding which services should be implemented for AQP in 2012.

**2. Background**

2.1 On 19 July, the Department of Health (DH) published guidance setting out:

* By October 2011, PCT clusters are expected to identify three or more community or mental health services in which to implement patient choice of Any Qualified Provider in 2012/13, based on the priorities of pathfinders, and having engaged with local patients, local authorities and professionals. Their selection of these services should be based on patients’ priorities for improving quality of, and access to, NHS services.
* Between April and September 2012, PCT clusters should implement patient choice of Any Qualified Provider in those services agreed locally.

2.2 Anticipated benefits of offering choice of AQP include:

* Giving patients the right to choose how they access treatment in a manner most appropriate to their needs
* Driving up quality and providing levers for the best quality providers to grow; and
* Encouraging innovation.

2.3 The DH has identified a list of services that could benefit from additional choice, improved quality and challenge to existing providers:

* Musculo-skeletal (MSK) services for back and neck pain
* Adult hearing 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)
* Podiatry services
* Venous leg ulcer and wound healing
* Primary Care Psychological Therapies (adults)

2.4 Volunteer PCT clusters across the country are being supported to develop implementation packs[[1]](#footnote-1) – including service specifications, contract currencies and tariffs – which will be available to all clusters by November 2011. It should be noted that these packs are not intended to be mandated approaches for implementation (e.g. these will not be national tariffs), rather as useful suites of products for local adaptation. NW London PCT Cluster is developing the pack for MSK, and ELC PCT Cluster is supporting the national work for children’s wheelchairs.

2.5 All PCT clusters are to begin implementing choice of AQP for three of these services in April 2012 and for all eight in 2013. The DH is content for PCT clusters to consider alternative services that are locally determined to benefit from extended choice; however these will not be supported by the tools and learning from the implementation packs.

2.6 The DH guidance sets out that:

 “*SHAs…will oversee the development of patient choice of Any Qualified Provider by PCT clusters and clinical commissioning groups.*

 *Specifically, SHAs should coordinate the work of PCT clusters in their region to engage patients, professionals and providers. SHAs must also assess of the suitability of alternative services to those on the national list where proposed by PCT clusters.”*

**3. London’s approach**

3.1 Following discussion at the Strategy and Innovation PLG on 19 July and subsequent Cluster CEO meeting, the NHS in London has been exploring whether there are benefits to implementing AQP over a larger geography than cluster-level.

3.2 For example, the provider and commissioner landscape might mean that a joint approach between more than one cluster would make more sense than each one procuring three separate AQP service lines. This approach could pool expertise and resources and take best advantage of the pan-London provider market.

3.3 The Cluster CEOs agreed that further benefit / risk assessment and planning work was needed before the decisions could be taken as to which services should become subject to AQP and whether a ‘multi-cluster’ approach would be best.

3.4 Therefore, a ‘problem-solving group’ (the Group) was convened to take the discussion forward and make recommendations to cluster CEOs on how best to meet the DH’s requirements. The Group has been considering the following items:

* Risk assessment of the eight nationally listed AQP services for suitability for AQP on a cluster, ‘multi-cluster’ or London-wide basis;
* Exploration of benefits of procuring AQP services for roll-out between April and September 2012 on a cluster, multi-cluster or pan-London basis;
* Which three services should be included in this first wave for each cluster (whether alone or with ‘partner’ clusters);
* Which clusters might lead on each element including procurement arrangements, if implementing across more than one cluster; and
* How best to engage with stakeholders on a joint approach.

The Group has representatives from all clusters, NHS London and a London provider of community services to advise on provider issues.

**4. Progress**

4.1 The Group has had weekly teleconferences throughout August, which are planned to continue through to October.

4.2 All clusters agreed to undertake a ‘stocktake’ of each of the eight service lines proposed by the DH as suitable for AQP. Broadly, this involved examining the quality of current service provision and the method by which services are currently commissioned. This is intended to provide an initial high-level view on local priorities of each service line by cluster, their feasibility for early AQP implementation in 2012 and any issues that will need to be addressed before all eight are rolled out in April 2013. They would also consider whether any alternative service lines, representing specific local priorities, might be suitable for an AQP approach. The results of this ‘stocktake’ will inform wider engagement during September as described in the following section.

4.3 The DH requires every cluster to have implemented AQP for 3 services, not necessarily across the whole of the cluster, and for every locality to have implemented at least one AQP service, ensuring there are “no AQP free zones”. Where there are intransigent issues in particular areas, this does not preclude other parts of the PCT cluster from implementing AQP for that service.

4.4 On this basis, there are early indications that AQP could be implemented in certain service lines over a geography greater than cluster-level. However, there are no clear service lines that all PCT clusters consider suitable for AQP. Some clusters have given early indications that Community Adult Hearing, MSK and Children’s Wheelchair services could be potential candidates for AQP. Consideration will be given as to how to implement these services on a collaborative cluster basis to ensure there is a sufficiently robust provider market, benefits of economies of scale are captured and to avoid a ‘postcode lottery’.

4.5 In addition to some agreement on AQP suitable services, there are a number of emerging themes including:

*Contractual / legal issues* – a number of these services are provided within block contracts with community providers or are subject to terms and conditions agreed in Business Transfer Agreements that were negotiated as part of the Transforming Community Services agenda. DH is planning to issue some guidance regarding variation / termination of contracts and informal discussions have indicated this should not be an issue of itself. Therefore, clusters have focussed on whether services could benefit from AQP, in terms of quality and access, and will consider contractual issues only as necessary. For example, contractual issues with FTs, or where services have been competitively tendered outside the NHS with guaranteed volumes, will be identified and considered for suitability for early AQP.

*Fragmenting care pathways* – some concerns have been raised that applying AQP to some of the identified services risk fragmenting pathways. For example, podiatry services often form part the diabetes pathway. However, there are opportunities for implementing AQP to discrete parts of the service identified or to discrete populations, for example podiatry for adults without complications, rather than all services under the heading. Therefore, while pathways should be maintained where appropriate, this should not mean all elements of the service should be excluded from AQP.

*Destabilising existing providers* –consideration should be given to, and dialogue held with, current providers to identify the financial risk to them of potentially removing part of their contract. Detailed analysis will need to be undertaken, however, the services are likely to be fairly small in terms of value; and the current provider could be designated as an AQP for the service, if it met the quality and other standards. Any impact should be reflected in commissioning intentions and provider plans for 2012/13.

*Identifying ‘local’ priorities* – the DH guidance has been widely distributed with the clear message that priorities for AQP should be identified locally. This could create a tension in agreeing the priorities at a cluster-level, as per the guidance, let alone over a larger geography. The benefits of implementation at scale – in terms of making best use of scare resource and stimulating an attractive provider marker – will need to be balanced with local prioritisation. Additionally, consideration should be given to the ‘implementation packs’ that are currently being developed for each of the services identified by DH. Should it be decided to implement AQP for a different service, then the work to implement would need to be resourced, possibly from scratch, locally.

*Meaningful engagement* – early dialogue with some stakeholders has raised concerns that engagement in short timescales, may not be perceived as meaningful. In light of the expectation that all eight services will be open to AQP by 2013/14, some have suggested stakeholder engagement would be better focussed on developing the service specifications, setting expectations of providers, etc, rather than on identifying priorities for implementation. However, clusters, with their pathfinders, are all planning to undertake some engagement as described in the following section.

*Supply and demand* – in such a short timescales, detailed market analysis has not yet been undertaken across London. The Group will explore undertaking such a market analysis. There is also a risk that by increasing the numbers of providers of services that demand may be stimulated. This will need to be mitigated in the development of service specifications, referral thresholds, etc.

**5. Planned next steps**

5.1 As required by DH, clusters will engage with their pathfinders, local authorities, emerging Health and Wellbeing Boards, LINks / Healthwatch pathfinders, and other stakeholders to gather views on local priorities for AQP implementation.

5.2 The engagement will be informed by the ‘stocktake’ and a set of communications materials has been developed, which can be adapted locally.

5.3 Considering the short timescales, the teleconference of Directors of Communications on 18 August proposed writing to each stakeholder group with the information and inviting comment by the end of September. Other existing routes to engagement (e.g. meetings that are already planned) will also be exploited if possible and appropriate.

5.4 The DH guidance sets out that PCT clusters / commissioning groups (pathfinders) should agree their three priorities, using feedback from the September engagement, for 2012 implementation of AQP and notify their SHA by 31 October. The Group will develop high-level implementation plans for clusters through September / October to ensure deliverability prior to decision-making. It also could support implementation beyond October if this is considered helpful.

5.6 Each cluster has its own governance structure and arrangements with pathfinders to reach decisions. The Cluster CEOs’ meeting on 30 August agreed that a pan-London implementation of AQP may not meet local priorities although there is potential for some collaboration. Therefore, it is proposed that decision-making should be done through existing cluster governance arrangements. It should be noted though that the DH guidance sets out that SHAs’ should assess of the suitability of alternative services to those on the national list where proposed by PCT clusters.

5.7 On 28 July 2011, the Cooperation and Competition Panel published a report in its review of the operation of Any Willing Provider for the provision of routine elective care. It is understood that there may be actions required to be taken by PCT clusters, which DH will advise on in due course. This may have some impact on the AQP work. NHS London will liaise with DH and will share intelligence on this with clusters.

**6. Conclusion**

6.1 The work to identify priorities for implementation of AQP in line with DH guidance is underway. Clusters have identified a number of opportunities and risks for each of the eight services proposed by DH and other services.

6.2 Broader stakeholder engagement will be undertaken by clusters through September, which will inform decision-making by PCT clusters in October and shared with NHS London by 31 October.

6.3 The Reform Group is invited to note and make comment on the work to date and planned.

**Annex A – outline of expectations of development of implementation packs**

**The task**

Drawing on published guidance and identified exemplars, DH are asking the **Volunteer Clusters** to prepare and test an implementation pack which could be used by the wider NHS, to include:

* Key Performance Indicators for the service delivery
* a generic clinical and quality outcome based Service Specification, including key outcome measures
* a Currency Model transferable across the NHS
* engagement with patients and patient representative to give guidance to the NHS on what specific information patients need to make an informed choice of qualified provider in the service area
* consideration of any additional qualification criteria,
* review and ‘dry-run’ testing of the DH “standard” qualification questionnaire and identify any amendments to support the particular service

And in return, the **Department of Health** will:

* work with the identified volunteer clusters to support and where appropriate, co produce the products working in partnership with relevant national patient representative and healthcare professional organisations
* provide funding to assist with the preparation of the products
* provide access to subject matter experts (eg clinical, policy, procurement)
* share exemplar products and information from engagement work undertaken in the development of the policy and selection of the list of potential services for priority implementation
* Provide strategic testing of the pack in terms of upcoming policies and direction, eg use of local datasets vs national direction of travel
* Provide access to experience and lessons learned (for example regarding Market engagement for that service)
* provide programme governance, such as regular workshops and teleconference calls for Lead Clusters, co-ordination across Leads and other relevant organisations and support communication with key stakeholders

**Current SHA leads for implementation packs**

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| **Service** | **Lead** | **Buddy** |
|  |  |  |
| **MSK** | London | SC |
| **Adult Hearing Services** | NE | WM, SC |
| **Continence Services** | NW | tbc |
| **Diagnostic tests** | SW  | Y&H, NE, EM |
| **Wheelchair Services** | EoE | SW, London |
| **Podiatry Services** | EM | SEC |
| **Venus Leg ulcer & wound healing** | SEC | tbc |
| **Primary Care Psychological Therapies** | WM | SW |

1. DH guidance for the development of implementation packs is at appendix A, including expected deliverables, time lines and regions leading on their development [↑](#footnote-ref-1)