Any Qualified Provider: your questions answered

These answers cover a range of questions about the detail of Any Qualified Provider on integrated care, competition and procurement, liability cover, information for patients, currency and tariff, workforce education and training, Choose and Book, contracts, transaction costs, quality assurance, and demand management.

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1. How will AQP deliver integrated care?
Integration is very important for our vision of the NHS. The Department will work with its NHS partners to extend the AQP model so that it can also be used to commission more integrated packages of care. GPs will retain their current role in helping patients navigate the system, including advising patients around continuity of care. If there are continuity of care or integration issues, GP commissioners will be able to address these with providers directly. Where the AQP model is used, providers will have a contractual obligation to co-operate so that patient care is safe, transfers are co-ordinated properly, and patient experience is good.

In other cases, particularly where continuity is very important or where patients require integrated health and social care support, it may be more appropriate to use a tendering approach to identify a single provider, or small number of providers; or to offer the patient a personal health budget for greater choice and control. One tendering model is to appoint a lead contractor who takes overall responsibility for providing integrated care, but involves other providers in delivering different elements of that care whilst offering patients appropriate choice at identified parts of the pathway. The Department is not looking to impose a 'one size fits all' approach. All providers will be required to work within local referral pathways and protocols, as part of the local health system.

Monitor, the healthcare regulator, will also have a new duty to support the integration of services, whether that’s between primary and secondary care, mental and physical care or health and social care.

2. Will AQP mean that commissioners need to competitively tender all contracts?

The Government’s response to the NHS Future Forum stated that the Secretary of State’s mandate to the NHS Commissioning Board will set clear expectations about offering patients choice: a ‘choice mandate’.

While a range of services will be subject to patient choice of any qualified provider, this will not be appropriate for all services. For example, we would not expect to offer patient choice of AQP of A&E and critical care.

When a service comes under AQP, commissioners will not need to competitively tender for contracts.

Tendering would remain an option for commissioners where significant change is required to existing provider markets. For example, by tendering for longer-term contracts for specific patient groups with complex needs, commissioners may find this an effective approach to driving transformation and sharing the demand risk more effectively with providers.

3. Can GP practices provide services under AQP?

Yes, where they are qualified. The Health and Social Care Bill provides for safeguards to manage potential conflicts of interest where GP practices wish to provide services
that are commissioned by clinical commissioning groups. Work is underway to develop appropriate safeguards building on existing good practice. GPs should ensure that their practice in referring patients is in line with the relevant section of the GMC’s Good Medical Practice on managing conflicts of interest.

4. Will services currently commissioned through locally enhanced services be procured through AQP?

Enhanced services are part of GP contract arrangements. Subject to the Health and Social Care Bill, the NHS Commissioning Board will in future be responsible for the commissioning of primary care services through the GP contract and will need to decide on the most appropriate arrangements for the future of local enhanced services.

5. How will AQP ensure that commissioners work collaboratively with established local providers to improve services?

One of the key aims of the healthcare reforms is to promote greater collaboration and dialogue between GP clinicians and clinicians in provider organisations. Commissioners will need to ensure that service specifications do not give an unfair advantage to established providers. However, this does not preclude working with a range of local clinicians to design better and more integrated pathways of care. As per existing Department of Health procurement guidance, we expect commissioners to continue to work with a range of providers and practitioners to develop innovative and deliverable service models, which contribute towards the delivery of Quality, Innovation, Productivity and Prevention.

6. How will NHS commissioners be supported to procure services to enable patient choice of provider?

The Government wants to ensure that emerging clinical commissioning groups have access to high-quality and responsive commissioning support that will enable them to carry out their functions effectively and deliver the best outcomes for their patients.

There are already a number of highly skilled NHS staff and other organisations that support NHS commissioners in procuring services to meet patients’ needs. In the future there are likely to be a greater range of NHS, independent and third sector providers – including local authorities – that will offer valuable support to commissioning groups to help improve the quality of these commissioning and procurement processes.

To further inform local discussions and decision about how best to support local NHS commissioners, the Department is currently undertaking a business review that will help PCT clusters – and other sectors – to understand their existing capacity, capability and development needs in order to meet the requirements of emerging groups.

7. Will all providers who sign up to a contract with the NHS be able to get NHS liability cover?
An indemnity arrangement has been put in place to cover the clinical negligence risks associated with NHS commissioned elective activity undertaken by independent sector providers when the Extended Choice Network (ECN) / Free Choice Network (FCN) contracts expire at the end of June 2011, replaced by standard contracts for acute services let to independent sector providers which meet the relevant criteria.

While it is currently the intention that this arrangement is only to apply in certain limited circumstances, the Department is considering how the arrangement may be made available on other standard contracts for NHS activity (including AQP), and how providers may register their interest in joining the scheme, but this will only ever be with the express approval of the commissioner’s SHA and the Department.

8. What support will patients have under AQP to make choices about providers?

Commissioners and the NHS Commissioning Board will have a duty to promote choice. It will be for commissioners to ensure that their patients are aware of the choices available to them. Informed choice is highly dependent on the relevance, quality and accessibility of information about the type and quality of available services. We recognise that information to support choice will require significant investment over coming years, together with increasing patient and public awareness of the choices available.

9. Will there be restrictions on advertising and promotions by providers of NHS-funded services?

Restrictions exist already in the promotion code for NHS services. Providers are required to comply with its provisions under the terms of the standard NHS contracts.

10. Can providers negotiate better prices with commissioners?

Not individually. The price is the same for all providers with that commissioner. Before running an AQP opportunity, commissioners must have engaged the market and determined the appropriate service specification, pathway, referral protocols, outcomes and of course, where the service is not covered by national tariffs, a price.

Developing the price outside of national tariff is the responsibility of the commissioner. They may choose to select a currency model or price already in existence, or they may work with a group of providers and commissioners to work out what an appropriate price is. This is the opportunity for the providers to influence the price. However, a commissioner needs to bear in mind that setting the price too high or too low will have consequences on how much choice, innovation and cost savings can be brought to bear.

11. How often is the price set?

Where the service is not yet covered by national tariffs, the price set by the commissioner is fixed for the period defined by the commissioner. However, the
contracts should allow prices to be amended each year. Otherwise this would be a material change and require a new AQP opportunity to be advertised in Supply2Health.

Where the service is covered by national prices, the duration of the specified price will be determined by Monitor and the NHS Commissioning Board in the national tariff document.

12. What impact will the AQP policy have on the planning and commissioning of education and training?

The consultation ‘Liberating the NHS: Developing the Healthcare Workforce’ proposes a number of duties on all healthcare providers to consult on workforce plans, provide data on current and future workforce needs, and to co-operate on planning and the provision of education and training. These duties are necessary to provide assurance that decisions are not being made in isolation and to ensure sufficient investment is being made for the medium to long term.

Our proposals are that all healthcare providers work together in provider-led networks to strategically manage and co-ordinate the planning and commissioning of education and training. All providers of NHS-funded services, including providers in the independent and voluntary sectors, will be expected to participate. Therefore, whether a provider is commissioned via patient choice of AQP or not, our proposals are that the obligation regarding education and training is the same.

This new approach should provide real opportunities so that all providers of NHS funded healthcare services:

- have the right incentives to secure skills, invest in training and innovate to improve the quality of services they provide
- have the capability and incentives to align service and financial planning and workforce planning
- have greater flexibility to respond to the strategic commissioning intentions of the NHS Commissioning Board and clinical commissioning groups.

13. Will all providers have to be Choose and Book compliant?

Yes. They will be required to be compliant with Choose and Book or work towards compliance if they are not. The Department is aware that smaller providers may have difficulty with this and is looking at how they can be supported to achieve this.

14. The current NHS standard community contract is seen by small independent and third sector organisations as a barrier to providing services to the NHS. Will there be a revised, simpler contract for AQP?

The Department has recently published the standard NHS contracts for acute hospitals, mental health, community and ambulance services and supporting guidance 2011-12
(effective from 1 April 2011). The NHS standard contracts are used by PCTs when commissioning NHS funded care. They provide a level playing field for all provider types.

During 2011/12 the contracts will be fundamentally reviewed as part of the NHS reforms agenda. The aim of the review is to improve the structure, layout and where possible to simplify the contract wording. The development of the contracts involves engagement with stakeholders, commissioners and policy officials.

15. Once a provider is qualified on the national directory, do they still require a signed contract directly with each commissioner?

Providers remain accountable to local commissioners for services delivered to local populations. A provider must confirm that it is able to meet local specifications set by the commissioner, which can include different specifications to other similar services. If the provider cannot meet those specifications, it will not be awarded a contract with that commissioner.

Commissioners must be mindful that they should not set local specifications that would be deemed anti-competitive. Additional requirements must be based on national guidance or best practice. It is not acceptable for commissioners to use disproportionate additional local requirements as a way to exclude potential providers.

16. Can commissioners limit the number of providers?

No. AQP is intended to increase choice for patients. Limiting numbers of providers means limiting choice for patients, so this is not aligned with the policy intention.

17. Can commissioners put a cap on the contracted activity that goes to any particular provider?

No. Where services are subject to patient choice, the commissioner cannot set the maximum levels of work a provider can be referred. As part of the discussions with providers, commissioners can set indicative activity plans for planning purposes. Where a provider is popular with patients, the indicative assumptions made for planning purposes are adjusted.

18. Can patients choose a provider service from outside the Primary Care Trust Cluster/ CCG area?

Choice of any qualified provider does not yet offer free choice in the same way as under consultant led services. Yes, if the provider has a contract with that commissioner (i.e. if the provider has qualified as AQP and registered for payment with that commissioner).

No, if the provider is not registered with the commissioner for payment. In essence, there must be a formal relationship between the commissioner and provider for patients to be referred there.
19. Will the introduction of AQP increase the costs of performance monitoring and payments processes due the greater number of providers?

Compared to competitive tendering, AQP reduces the bureaucracy of pre-qualification questionnaires. Once provider’s basic details are checked, commissioners do not need to repeat the same checks repeatedly. This saves time for commissioners to focus on monitoring the quality of services.

20. How will AQP assure patient safety, service quality and appropriate professional registration?

Patient safety is paramount. Our approach to introducing AQP would put patient safety and service quality first, sustaining current standards and support continuous quality improvement.

Providers would have to be registered with CQC and licensed by Monitor (from 2013) where necessary, or meet equivalent assurance requirements. Other registering bodies would be applicable for services not covered by CQC registration. This will be identified by the body leading the qualification process for a given service.

All providers would have to meet NHS quality requirements, appropriate professional standards, and the requirement of NHS standard contracts where applicable.

21. How will demand and cost be managed through the AQP processes, and how can the NHS be assured that this will not undermine delivery of QIPP gains?

Where a service is to be contracted via the AQP route, it is necessary to establish a clear referral protocol and thresholds. This means that a set of criteria is developed, outside of which providers will return referrals to the referring clinician. In the event that patients are treated outside of these criteria, they should not be paid.

Suggested criteria and protocols will be part of the implementation packs developed with lead clusters. However, local commissioners may wish to consider using modified criteria, for example if they wished to promote the use of a community-based intervention via AQP as part of a strategy to manage acute demand.

Supply side constraints such as ‘treatment caps’, fixed numbers of providers being qualified, and minimum waits are contrary to government policy. Commissioners attempting to impose these constraints risk referral to the NHS Cooperation and Competition Panel.

22. How will AQP contribute towards improvements in service quality and productivity?

We expect choice of provider to drive up quality, reduce costs and enable innovation to support the delivery of QIPP. Commissioners control both contracts and prices and will challenge providers to deliver services of the highest quality.
Extending choice of AQP provides a vehicle to improve access, address gaps and inequalities and improve quality of services where patients have identified variable quality in the past.