Any Qualified Provider allows patients to choose the service or treatment they feel best suits their needs; an AQP pack was developed to aid implementation of the process.

**In this article...**
- Why patient choice is important in healthcare
- Rationale behind the Any Qualified Provider (AQP) process
- The development of an AQP pack for continence care

**5 key points**
1. **AQP facilitates greater patient choice**
2. **Competition is based on quality, not price**
3. **Commissioners set local pathways, referral protocols and develop the service specification and tariff, which providers must accept**
4. **National packs on implementation are created to help commissioners to commission services through AQPs**
5. **Potential providers must go through an electronic process of qualification before being accepted**

The government is committed to introducing greater choice and personalisation in NHS-funded services. For patients, choice can be about how care is provided or the ability to control personal budgets and self-manage conditions.

Patient choice is being extended to include any qualified provider or appropriate services. The vision is that when patients are referred (usually by their GP) for a particular service, they can choose from a list of qualified providers who meet NHS service quality requirements, prices and normal contractual obligations. This approach is known as Any Qualified Provider (AQP) and is already in place for many routine elective procedures.

The rationale for greater patient choice and control is that it will lead to better care and improved access, outcomes and experience for all. Over 95% of people feel they should have choice over the hospital they attend and the kind of treatment they receive (Park et al, 2009); they also feel that not all providers are the same and, when services vary in quality, patients should not be given care that is second best. Choice enables patients to be treated by the provider best placed to meet their needs.

Providers care are assessed before being listed as qualified so commissioners know that a range of safe, high-quality and affordable providers are available to which they can refer their patients without the cost and effort of competitive tendering.

Four main principles underpin AQP:
- Providers qualify and register to provide services through an assurance process of their fitness to offer NHS-funded services;
- Commissioners set local pathways and referral protocols that providers must accept;
- Referrers offer patients a choice of qualified providers;
- Competition is based on quality, not price – providers are paid a fixed price determined by a national or local tariff.

The Department of Health has identified, through an engagement process, a set of eight potential services for priority implementation (Box 1). These cover areas in which patients and their representative groups identified greater patient choice and control were needed and the quality significantly varied, meaning there was room for improvement. It was also identified that improvements in productivity and value for money could be made, and the areas were seen as being clinically and logistically suitable for extending choice of provider.

Eight primary care trusts were selected to manage projects to produce AQP implementation packs for specific service areas. They were to carry out an engagement exercise with patients and public, write AQP packs. These packs will allow GPs to offer patients a choice of who provides the care they need.
Keywords: Service/Provider/Any Qualified Provider/AQP/Choice

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Producing the AQP pack
Wirral, on behalf of Cheshire, Warrington and Wirral PCT cluster, was asked to produce an implementation pack for a community continence service in 12 weeks. Due to the tight timescale, the team commissioned an external agency to deliver cluster-wide engagement with patients and the public.

The service specification was developed by the project lead and based on:
- Patient and public experience outcomes;
- Prevalence of incontinence;
- Local and National Institute for Health and Care Excellence guidance;
- Existing local continence pathways;
- Developing a service model that encourages integration;
- Referral forms;
- Outcomes and outcome measures.

The project lead also incorporated a cycle of review and revision using feedback from two key stakeholder engagement groups. The first was a local, clinical, email engagement group comprising clinical lead, continence nurses, urologists, consultants in older people’s medicine, gynaecologists and paediatricians who supported the specification’s initial building. This fed into a second national multidisciplinary expert reference group to refine and edit the specification.

To develop meaningful outcomes, the group adopted the WK Kellogg Foundation’s logic model (2004), which supports the outcome-based element of this specification, focusing on the resources through to impact. Outcomes must be measurable and more than just activity.

The project lead took responsibility for writing the specification and used current local community service specifications and a review of current literature to provide up-to-date guidance and best-practice standards. Key stakeholder engagement was vital for success and two groups were formed.

Commissioners must performance manage services in terms of intervention efficacy relative to the client’s outcome and the wider impact for the health economy. Using validated quality-of-life questionnaires and a symptom-profiling questionnaire before and after supports this process; standardising this allows for benchmarking and comparison.

Key outcomes identified were:
- Satisfaction with service quality;
- Number of adults and children cured, treated or for whom symptoms were alleviated in service or post discharge;
- Number of adults and children self-managing at nine months;
- Key impacts over time;
- Reduction in avoidable secondary-care attendance and admission;
- Reduction in urinary tract infections;
- Reduction in unnecessary treatment and inappropriate reliance on urinary/faecal incontinence products.

The finance lead developed the tariff. Current elements of the service cost (current service block) and current activity were identified. A modelling process generated two appointment levels based on complexity, staff banding and time required. The tariffs reflected pathway prices that included a cap (five follow-ups maximum) and top-up incentive to achieve outcomes of cured, treated or symptoms alleviated while within the service or after discharge.

Evaluation
The pack was delivered on time. It would have been valuable to have a finance expert as part of the national reference group, who could have supported better testing of draft currencies/tariffs. Also, more communication between the eight initial pack teams would have improved the exchange of methodologies and experiences, which may have facilitated some of the processes, such as outsourcing the engagement process.

Implementation
In parallel with the production of the packs, an online application process was developed and four Qualification Centres of Excellence (QCEs) established to support the implementation process. Each centre would be responsible for the qualification of two service areas – the North of England is responsible for supporting areas wanting to offer continence through AQP. Once commissioners have decided on the services they want to procure under AQP, they can use the packs and QCEs to progress with the AQP process.

The first stage is to prepare the offer. This includes links to the service specification, how the qualification will be handled including provider resubmissions, questions, window-open time, qualifying criteria, service start date and any specific local

primary assessment of symptoms
- Wheelchair services (adults)
- Podiatry services
- Venous leg ulcer and wound healing
- Primary care psychological therapies (adults)

Source: tinyurl.com/DH-AQP-list

References

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BOX 1 POTENTIAL PRIORITY SERVICES

- Musculoskeletal services for back and neck pain
- Community adult hearing services
- Continence services (adults, children)
- Direct-access diagnostic tests, such as some types of imaging, cardiac and respiratory investigations to support

Number of adults and children cured, treated or symptoms alleviated in service or post discharge;

References

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