NHS

Liberating the NHS:

Greater choice and control

Government response:
Extending patient choice of provider
(Any qualified provider)

DH Department of Health

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Executive Summary

1. The White Paper, *Equity and excellence: Liberating the NHS*,[1] sets out the Government's vision of patients and the public being at the heart of an NHS where patients, service users, carers and families have far more influence and choice in the system, and the NHS is more responsive to their needs and wishes.

2. We envisage there being a presumption of greater choice and control over care in the vast majority of NHS-funded services. Greater choice and control will include a choice of any qualified healthcare provider – previously referred to as "any willing provider" in the consultation document - wherever relevant.

3. In *Liberating the NHS: Greater choice and control; A consultation on proposals*,[2] the Department of Health sought the views of patients, the wider public, healthcare professionals and the NHS about how we take forward these proposals. We wanted to know what sorts of choices you want to make, when you want to make them, what information and support you need to make the right choices for you, and how we make this happen.

4. This document sets out the Department's response for the questions associated with the extension of choice to any qualified provider.[3] It is being published now alongside guidance to support NHS development and testing in 2011/12, with phased implementation for a small range of appropriate community and mental health services in 2012/13. A fuller response covering all of the remaining issues and questions in the consultation document will follow later this year.

5. 617 unique responses to the consultation were received. The number of responses to individual questions is indicated in the text that follows. On choice of any qualified provider, the majority of respondents who answered the specific questions suggested that:

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[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

[2] http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_119651?PageOperation=email

[3] At the time of publication of the consultation document, this was referred to as "any willing provider". However, although the meaning of "any willing provider" and "any qualified provider" is the same, the terminology has since changed to reflect the rigorous qualification process providers will be expected to meet before they can provide NHS services. The new terminology was used by the Secretary of State in a speech at a social enterprise conference on 30 March 2011. The term "any qualified provider" will be used in this document except where referring to direct quotes from previously published documents or from responses to the consultation.

- Community services should be a priority for implementing the approach;
- Providers must meet service quality requirements when they are providing NHS care to patients;
- Providers should meet consistent criteria, but the approach should be proportionate to enable smaller providers from the charitable and voluntary sector to provide;
- The majority of respondents were in favour of a provider directory, although some issues were raised around management and updating of the directory.

6. The issues raised in, and the responses to, the consultation, together with the subsequent NHS Listening Exercise[4] have been taken into account in drafting the guidance published alongside this response, and the accompanying impact assessments.

[4] http://www.dh.gov.uk/en/MediaCentre/DH_125865

1. Introduction

1.1 This document is the Department of Health's response for one of the commitments for which it sought views in the public consultation, *Liberating the NHS: Greater choice and control* which ran from 18 October 2010 to 14 January 2011: implementing choice of any willing provider. It is being published now alongside guidance for providers to allow for NHS development and testing in 2011/12, with phased implementation for a small range of appropriate community and mental health services in 2012/13. This is in line with recommendations following the NHS Listening Exercise.[5]

1.2 A fuller response covering all the remaining commitments upon which we consulted, and taking into account the outcome of the NHS Listening Exercise, is being prepared for publication later this year. More detail on next steps is in chapter 4 of this document.

Why focus on choice and control?

1.3 The White Paper, *Equity and excellence: Liberating the NHS* sets out the Government's vision of patients and the public being at the heart of the NHS – where patients, service users, families and carers have far more influence and choice, a NHS that is more responsive to their needs and wishes. The proposals are in line with the NHS constitution right *"You have the right to make choices about your NHS care, and information to support these choices."*[6]

1.4 The White Paper set out a number of specific choice commitments around extending choice of provider and treatment in planned hospital care and in maternity, mental health, end of life care and long term conditions. More specifically, it stated that *"The Government will create a presumption that all patients will have choice and control over their care and treatment, and choice of any willing provider wherever relevant…We expect choice of treatment and provider to become the reality for patients in the vast majority of NHS-funded services by no later than 2013/14."*

[5] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443

[6] http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/nhs-constitution-interactive-version-march-2010.pdf

1.5 The subsequent NHS Listening Exercise announced by the Government on 6th April 2011 allowed for further engagement specifically around "choice and competition". The NHS Future Forum's report, published following the NHS Listening Exercise, said that choice can help support better quality and more integration between health and social care. The Forum reported that whilst it had heard genuine concerns about the disruption of joined-up services and profiteering, it had also heard how competition can drive up quality and how more charities and social enterprises are keen to play a greater role in providing health services. Any qualified provider is an innovative approach which could allow smaller local organisations to offer services that truly reflect their communities' needs and ensure patients have a greater choice of provider.

1.6 In response to the NHS Future Forum's report, the Government stated that, *"We will maintain our commitment to extending patients' choice of "Any Qualified Provider", but we will do this in a much more phased way, and will delay starting until April 2012."*[7] Choice of any qualified provider will be limited to services covered by national or local tariff pricing, to ensure competition is based on quality. We will focus on the services where patients say they want more choice, for example starting with selected community services. This approach reflects the concerns and issues raised, not only through the listening exercise, but also in response to the *Liberating the NHS: Greater choice and control* consultation.

1.7 In the following chapters, we will set out:

- Details of the consultation process, engagement activities undertaken during consultation and an overview of the responses received;
- The questions we asked on choice of any qualified provider, a summary of the responses we received and the issues raised, and our response;
- Our plans for responding to the remainder of the questions in the choice consultation and opportunities for further comment.

1.8 Guidance, an Impact Assessment and Equality Analysis on the proposals to implement choice of any qualified provider are being published alongside this response document.

[7] 'Government Response to the Future Forum Report', DH, 20 June 2011.

2. Consultation process

2.1 In implementing the proposals for extending choice, the Department of Health undertook to consult widely. The consultation on *Liberating the NHS: Greater choice and control* ran for thirteen weeks from 18 October 2010 until 14 January 2011, following Cabinet Office protocol for consultations.

2.2 The consultation document set out how the choice commitments should be implemented and sought the views of patients, the wider public, healthcare professionals and the NHS about how this might be achieved and any issues that needed to be addressed in order to do so. The consultation document asked 54 questions covering:

- Our proposals on the specific choice commitments to extend choice of provider and treatment in planned hospital care and, more specifically, in maternity, mental health, end of life care and long term conditions;
- What can be done to achieve the necessary culture change and make shared decision making the norm;
- The information, support and infrastructure that would need to be in place to achieve the vision of informed, empowered patients making choices over the things that matter to them;
- How we can ensure that the choices people make are safe and sustainable, and that people can exercise choices that do not cause problems for them or the NHS.

2.3 Given the huge scope of the content, we did not expect every respondent to answer all 54 questions, and indeed that is reflected in the responses.

2.4 The consultation document was available on the Department of Health's website and responses could be returned online, by email or by post. To ensure that as wide an audience as possible was involved, summaries of the consultation document were made available in various accessible formats, including easy-read, alternative language and large print. A presentation summarising the proposals and the consultations questions, and a guide to running a consultation event were also produced for larger organisations to use when engaging with their members.

2.5 During the consultation period, a number of engagement events and activities were undertaken around the country to promote the consultation document and encourage people to put forward their views:

- Key messages about the consultation were inserted into events where appropriate and relevant;
- Strategic Health Authorities (SHAs) conducted varying degrees of local engagement;
- Presentations were made at regional events run by organisations with an interest (eg the Race Equality Foundation and the Mental Health Providers Forum).

2.6 Many of these activities and events were undertaken jointly with colleagues working on the concurrent consultation, *Liberating the NHS: An Information Revolution.*[8]

Consultation responses

2.7 617 unique responses[9] were received from a wide range of stakeholders including patients and members of the public, clinicians, voluntary organisations, patient representative groups, carer organisations, local authorities, local involvement networks (LINKs), NHS organisations and staff, independent providers, pharmacists, academics, professional bodies and Royal Colleges, think tanks and trade unions (see Annex A for list). We would like to thank everyone for taking the time to respond.

2.8 The next chapter covers what we heard and what we propose in relation to any qualified provider. A fuller response covering the remaining issues and commitments - and which will likewise take into account the outcome of the NHS Listening Exercise - will be published later this year. More detail on next steps is in chapter 4 of this document.

[8] http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_120080

[9] The total number of responses received was 834, but 219 of these were on one of three templates from individuals or their carers with ME/Chronic Fatigue Syndrome. Two of the three templates were identical; the third differed very slightly. For our calculations, we therefore subtracted 219 from the total number of responses, and added two to represent the slightly different templates.

3. Choosing from any qualified provider

The Government commitment[10]

"The Government will create a presumption that all patients will have choice and control over their care and treatment, and choice of any willing provider wherever relevant (it will not be appropriate for all services – for example, emergency ambulance admissions to A&E)."

3.1 When people need healthcare they should be able to choose from any organisation in England that offers a service that is clinically appropriate for them, meets the service quality requirements set out in contracts and by the Care Quality Commission (CQC), and can deliver services within NHS prices. This will apply to all healthcare providers of NHS-funded services, including independent and voluntary sector providers.

3.2 Currently, people can choose their healthcare provider when they are referred for their first hospital outpatient appointment (usually called 'Free Choice'). We will begin to extend this beyond elective care (planned hospital referrals) and to most healthcare services such as those taking place in the community.

What we asked

3.3 We asked (question 2) "Which healthcare services should be our priorities for introducing choice of any willing provider?"

What we heard

3.4 Approximately 55% of respondents answered this question (342 unique responses). Of these, around half identified services that could be provided in a community setting, such as services for people with long term conditions, where "*individuals and their carers have often developed considerable experience and expertise in determining the services they want and where they want to receive them"* (Social Enterprise Coalition). Other community

[10] Equity and excellence: Liberating the NHS. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

services identified by respondents included rehabilitation, end of life care and musculoskeletal services.

3.5 Age UK said *"there are a number of low-level services that…are vital for many older people to maintain independence and manage their overall health. The 'any willing provider' model could be expanded relatively easily in some of these areas…*[including] *foot care and podiatry, falls prevention* [and others]. *As with other areas of care, GPs will still need to support people to join-up services, coordinate their care and enable self-management wherever possible."*

3.6 Around a third of those who answered this question identified elective care services as a priority for introducing choice of any qualified provider, for example *"elective surgery including specialties such as plastics and orthopaedic surgery, ENT, medicine, elements of obstetrics, gynaecology"* (Foundation Trust Network). Other areas suggested by respondents included clinical support services such as diagnostic imaging, public health services such as smoking cessation and weight management, as well as pharmacy and primary care services, such as GP out of hours services.

3.7 Other respondents (around 14%) identified mental health services, including IAPT (Improving Access to Psychological Therapies) and CAMHS (Child and Adolescent Mental Health Services, *"IAPT services would be a good starting point for introducing choice of any willing provider"* (Centre for Mental Health).

3.8 Many respondents emphasised the need for appropriate safeguards to ensure all provision is safe and evidence based. A number of respondents pointed out that there is not yet an agreed national standard price for mental health services and so they are still reliant on local cost information. Some also felt that mental health services would need to be reconfigured to facilitate choice.

3.9 Respondents were largely supportive in suggesting services in which an any qualified provider approach could be implemented. Some respondents opposed the principle of this approach. Most common reasons given for opposition were that it would increase costs and destabilise services. Some respondents said that it would not be appropriate to all types of care e.g. *"Complex services such as those for trauma or cancer need a co-ordinated approach across providers"* (Kings Fund).

3.10 Other respondents took a more positive view of the principle generally provided some consideration was given to potential wider impacts. The Patients Association said that, *"the majority of [the people they asked] believed that competition between providers had potential to improve services."*

Our response

3.11 We are content that the majority of responses indicated community services would be a good starting point for extending choice of any qualified provider beyond elective care. In line with the responses to this consultation and the Government's response to the NHS Future Forum report,[11] *"we will focus on the services where patients say they want more choice, for example starting with selected community services."* Extending patient choice of any qualified provider to community services will include some of the areas suggested in responses to this question such as podiatry, musculoskeletal services, other therapy services and hearing services. In parallel with this consultation, Department of Health officials have been engaging widely on these proposals. Guidance published alongside this document on *Extending Patient Choice of Provider (Any Qualified Provider)* sets out how we are engaging with national groups representing patients, users and carers to ensure that implementation focuses on what is most important to them.

3.12 The Government also committed to introducing choice of provider for diagnostic testing, and the consultation document asked about extending choice of where people go for their diagnostic tests or measurements, or to have samples taken. The responses to this specific issue will be covered in the Government's fuller response later this year and we will also bear in mind relevant points brought up under question 2.

3.13 Most people are already entitled to choose any qualified provider when they are referred to a hospital.[12] We are encouraged by the continuing increase in the use of the Extended Choice Network, which has supported choice of provider in elective care.[13] Usage has grown from 2,078 procedures and £4.5million per month in April 2008 to 17,145 procedures and £34.5 million per month in May 2011, which suggests that when offered a choice many people will exercise it. We have committed to *"increase the current offer of choice of provider significantly"* so that everyone is given the opportunity to choose.

3.14 As detailed in the Government's response to the NHS Future Forum report, we recognise that choice of any qualified provider may not be appropriate to all types of care -*"There will be some services, such as A&E and critical care, where Any Qualified Provider will never be practicable or in patients'*

[11] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127444

[12] The existing right to choose a provider when referred for a first outpatient appointment to a consultant-led team.

[13] The ECN consists of independent sector providers which offer services to NHS patients at NHS standards and costs.

interests." Also, there may be particular challenges in some services around maintaining clinical accountability (such as in administering chemotherapy at home), ensuring that services remain joined up and avoiding unnecessary admissions to hospital (for example in end of life care). Although these difficulties do not necessarily rule out an any qualified provider approach, we may need to think about different ways of achieving it.

3.15 In terms of issues of market stability, choice of any qualified provider will allow patients to choose from a range of providers who are qualified to provide good quality care and treatment – selecting the one that best meets their needs. It allows innovative and responsive services to grow, benefiting patients and providers alike. This will lead to changes in the services offered, but providers will only be adversely affected if they carry on providing services that patients do not want to use. The recently published Open Public Services White Paper announced that the Cabinet Office and HM Treasury would work closely with departments to develop continuity regimes across public services, as an integral part of their modernisation programmes. This work acknowledges the role for external bodies, independent of government, with powers to ensure proper financial management and robustness and to intervene to ensure continuity of service. In the NHS, it would be the role of Monitor, as set out in proposals in the Health and Social Care Bill (2010), to support commissioners to ensure the continuity of healthcare services.

3.16 We note the responses about challenges to ensuring joined-up services. However, we do not agree that choice of any qualified provider should make it more difficult to deliver that. We want to work with the NHS and professional and patient groups so that choice of any qualified provider can also be used to provide more joined-up packages of care. GPs will keep their current role in helping patients navigate the system and clinical commissioning groups would be able to address any issues with providers.

3.17 Providers will have a contractual duty to co-operate so that patient care is safe, transfers are co-ordinated properly, and patient experience does not suffer. That said, we recognise that the any qualified provider approach is not the only way to promote choice, and for some highly complex services, a tendering approach may be more appropriate. In these cases, we have made it clear that tendering will be on the basis of quality, not price.

What we asked

3.18 We asked (question 41): "Do you agree with the proposed approach to establishing a provider's fitness to provide NHS services? What other criteria would you suggest?"[14]

What we heard

3.19 Around 31% of respondents answered this question (approximately 190 unique responses). Of those, some 57% agreed with the proposed approach. Some also suggested additional criteria to ensure that patients receive a quality service. Regional Voices recommended an *"explicit commitment to equality and reducing health inequalities."* The RCN suggested that providers should *"undertake to work alongside other providers and share…prescribed information…to enable patients [to make] choices."* South East Coast Specialised Commissioning Group said, *"A suggested additional criteria would be agreement to participate in and report to national benchmarking audits."*

3.20 The National Lesbian, Gay, Bisexual and Transgender Partnership urged that specialist services such as theirs *"need to be offered support in meeting the requirements needed to become a willing provider"* if they are to continue to meet the needs of minority groups.

3.21 Support for smaller providers was a common theme, with the Chartered Society of Physiotherapists suggesting that *"consideration should be given to making support available to small charities to enable them to continue to tender for NHS contracts without the process becoming too costly or bureaucratic for them to participate,"* and the British Association and College of Occupational Therapists similarly saying, *"The College would generally agree with the approach. However, we would like to see support put in place for small providers. Further consideration is needed to enable new innovative service providers and businesses to enter the market. Without a range of providers there will be no real choice for patients."*

3.22 Around 14% of respondents who answered this question disagreed with the proposed approach for a number of reasons:

- They disagreed with the any qualified provider approach in principle (for reasons similar to those given in the previous section), for example, "*Private*

[14] The proposals in the consultation document covered currencies and standard national NHS pricing of services, joint licensing of providers and, contractual and commissioning issues.

companies or service providers are by very nature run to make profit, severely ill patients may prove less profitable and attract less service providers and therefore choice. Without any democratic input into this process, the field is wide open to abuse" (respondents with ME or their carers), *"The NHS should remain a universal service, free at the point of delivery without any notion of making a profit from the health needs of the population"* (NHS staff member);

- Or, they felt the proposed approach to establishing a provider's fitness to provide NHS services was too prescriptive, for example, *"Healthcare professionals who are already regulated should not have to also be licensed with CQC and the economic regulator…"* (Berkshire Local Pharmaceutical Committee), *"…while this may be appropriate for secondary care providers, we feel very strongly that such a system would be unnecessary and duplicatory in the community optical sector…regulated by the General Optical Council"* (Optical Confederation);

- Or, they felt that the proposed approach did not go far enough, for example, *"As well as meeting financial and quality of care standards, all providers must commit to providing standardised information about the service that they provide. This should include numbers of referrals, waiting times, outcomes, etc"* (anonymous);

- Or they had concerns about the business model, for example, *"Requiring any willing provider to sign an agreement that they will deliver services without any indication of volume or price makes a very unsound business model"* (Berkshire Local Pharmaceutical Committee).

3.23 The remainder of respondents (around 29%) were unsure or commented without specifically answering 'yes' or 'no'. For example, *"The proposed approach is the right one and will ensure that the licensing process is streamlined and efficient and is based on both quality of services and financial due diligence. The licensing process should apply uniformly to all providers regardless of size or sector but the financial due diligence required could perhaps be categorised according to turnover. All accreditation should be done nationally and a central directory of accredited providers developed. This will minimise the administrative burden for both providers and commissioners"* (NHS Midlands), *"Help the Hospices does not agree that the approach should apply uniformly to all providers. A major flaw in the current and the proposed systems is their failure to acknowledge the additional regulatory obligations on providers such as independent charitable hospices", "There was concern about the standards of treatment and care that might be available when looking at a number of different providers but that information would need to be robust and provided in clear, simple and straightforward ways"* (NHS South West).

Our response

3.24 We found responses to this question to be useful both in supporting and challenging our thinking.

3.25 With regard to pricing, as specified in the Government's response to the NHS Future Forum *"Choice of Any Qualified Provider will be limited to services covered by national or local tariff pricing."* Patients choose, and providers compete, on the basis of quality, not price. The Department is working on developing currencies and tariffs for a range of community services and is introducing a standard currency for adult mental health services in 2011/12. Guidance has also been published[15] that emphasises the Department's position of competition on the basis of quality, not price.

3.26 Because national standard prices could take considerable time to develop, we have said that it makes sense for prices to be agreed locally using appropriate national guidance where available. The Department will encourage the NHS to share currencies that work well to avoid duplication. Any procurement process would need to follow existing principles of procurement including transparency, proportionality, non-discrimination and equality of treatment.

3.27 We need to strike the right balance between regulation and maintaining service quality requirements. But patient safety is critical and this is why we have proposed a qualification process to ensure that the safety of patients remains paramount when there is a greater choice of provider.

3.28 We appreciate that lack of volume or income guarantees may be an issue for some providers, but these kind of guarantees open the way for abuse of the system and they can undermine patient choice. Moreover, they do not necessarily ensure a good quality service because, once a contract is awarded, there is no incentive for the provider to improve. Where contracts with volume guarantees do not deliver good outcomes, quality or value for money, an any qualified provider approach is preferable.

3.29 We note that there were comments made by respondents who disagreed in general with the any qualified provider approach. In addition to our response to the previous section, we would emphasise that extending choice to any qualified provider is not privatisation of the NHS. Services will still be free at the point of use, based on need, not ability to pay. Patients will be able to choose who provides their services based on information about the quality and accessibility of those services. Providers from all sectors, including NHS

[15] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124522.pdf

trusts, voluntary organisations, social enterprises and the independent sector will still have a role in providing NHS services.

3.30 On balance, we feel that responses suggest that the proposed approach is sensible. We will give more thought to the additional criteria that have been suggested around equality and information, bearing in mind the proposed duties on commissioners to act with a view to enabling patients to make choices. We will also think about support for smaller providers. Democratic input to commissioning is also strengthened by the proposals underpinned by the Health and Social Care Bill, which we have improved in line with the NHS Future Forum's recommendations; for example, the proposed arrangements for health and wellbeing boards and local HealthWatch. These are being established to increase local democratic legitimacy of NHS commissioning decisions by bringing together local councillors and patient representatives with the key commissioners of NHS, public health and social care services in each local authority area to work in partnership. We will review any further relevant input on this subject in our full response to the consultation.

What we asked

3.31 We asked (question 42): "Should this approach apply uniformly to all providers, no matter what size, sector and healthcare services that they provide? For example, should a small charity providing only one healthcare service to a very localised groups of patients be subject to the same degree of rigour as a large acute hospital that delivers a range of services to a regional catchment of patients?"

What we heard

3.32 Around 30% of respondents (some 187 unique responses) answered this question. Of those who did, around half explicitly indicated that they agreed with the suggested approach to introducing the any willing provider policy, for example, *"If there is a system for any willing provider to enter the market there must be clear, effective and rigorous methods for both licensing entrants to ensure basic standards and for monitoring standards of care"* (Academy of Medical Royal Colleges). However, even within this agreement to universal care service requirements, there were many respondents who felt that some degree of proportionality would have to be applied "*The standards of service quality and delivery should apply to all, irrespective of NHS or private; large corporate or small sole practitioners. There should be no unnecessary presumption of organisation size, functionality or service volume requirement*

which would preclude small/sole practitioners" (British Society of Hearing Aid Audiologists).

3.33 Of the remaining respondents, around 25% were either uncertain or ambivalent and the rest (some 27%) disagreed. The majority of these respondents also suggested that the requirements on providers should be proportionate, *"It is essential that the rigour should be proportionate, but the principles should be the same across organisations"* (Social Enterprise Coalition). Nevertheless, these respondents did not necessarily disagree that principles should be uniformly applied, *"The RCN has always suggested a case by case approach be used (see our principles) and would continue to call for this to be taken under this policy. In essence, principles of safety, quality, and sustainability must underpin the choice of provider. This applies whatever the size, sector, or service they provide"* (Royal College of Nursing).

3.34 Some concerns related specifically to ensuring a level playing field between providers, *"There should be an element of proportionality enforced - for example the monitoring and reporting regime for a NHS Foundation Trust of £500 million size should be greater than for a £10m voluntary organisation"* (Terrence Higgins Trust). *"We appreciate the need to provide services to common standards, but any additional burdens should be proportionate so whilst small scale providers must deliver the same quality of service they must not be disadvantaged by inappropriate or onerous bureaucracy"* (Pharmacy Voices).

3.35 Others related to ensuring that a certain element of local discretion in commissioning was allowed for, against the context of national requirements, *"Local circumstances must be taken into account"* (Isles of Scilly LinK). *"[Many felt it] would be disproportionately difficult to manage for precisely those smaller, local providers whom many respondents felt frequently provide the best standard of service and whom we would wish to preserve. Broadly, we would have to argue for a proportionate level of scrutiny, with some leeway for commissioners to exercise their judgement, particularly regarding the local services which they might be expected to know well"* (Royal College of GPs).

3.36 The British Association of Counsellors and Psychotherapists suggested that their professional standards could play a part as a 'kitemark'.

Our response

3.37 We have heard a number of issues being raised about our proposed approach to implementing this policy. These include the need for all providers of NHS

healthcare services to meet NHS quality requirements when they are providing care to patients. We heard that providers should meet consistent criteria, but that the approach should be proportionate to enable smaller providers to contribute. These concerns also relate to the need for the any qualified provider procurement tool to be implemented in a way that supports integration between providers, and to enable commissioners to achieve QIPP (Quality, Innovation, Productivity and Prevention)[16] benefits.

3.38 Alongside this response document, we are issuing initial implementation guidance to commissioners and providers, with a corresponding impact assessment. During 2011/12, we expect to develop and publish service specific guidance for a range of community services.

3.39 As part of our work to develop service specific guidance, we will also consider how nationally consistent service quality specifications can support all providers of NHS care to ensure quality of care for patients. In recognition of the comments received, we have already replaced the term "any willing provider" with "any *qualified* provider". The revised terminology is a more accurate reflection of the qualification process that providers will have to meet before they can provide NHS services.

What we asked

3.40 We asked (question 43): "Do you agree that an "any willing provider" directory should be established to make it easier for commissioners to identify providers that are licensed and have agreed to the NHS standard contract terms and conditions?"

What we heard

3.41 Around 35% of respondents answered this question (some 202 unique responses). The vast majority of these - some 88% - agreed with the establishment of a central directory. BUPA said that, "*The proposal to create a centralised directory is an inherently sensible one that would provide commissioners with the information they need to make accurate choices in the best interests of patients and the NHS."* Regional Voices agreed, "*This would*

[16] The QIPP agenda, included in the NHS White Paper published in 2010, aims to generate efficiency savings within the NHS of up to £20 billion by 2014/15 which will be reinvested into the health system to support the delivery of continued quality improvements. To support clinical teams and NHS organisations with QIPP, a programme of national workstreams has been established, where the potential for large scale savings has been identified.

be a welcome introduction, provided the process was not overly cumbersome."

3.42 The responses from individuals with ME and their carers to this question were split. Most of them explicitly stated that a directory would be a good idea. *"Yes, as long as there is tight control over the licensing of the providers."*

3.43 Members of the public and third sector organisations who responded to this question requested that the directory be made available for patients in the interests of promoting patient voice and equality, for example, *"Yes, as long as this directory and all the information in it is in the public domain. There should be no exemptions on the grounds of commercial confidentiality so the public has a means of assessing the decisions that commissioners make on their behalf"* (member of public). *"The directory should be accessible directly to patients, because the majority of LG B people may not have disclosed their sexual orientation or gender identity. Providers should also be able to state that they offer an LGBT-specific service"* (National Lesbian, Gay, Bisexual and Transgender Partnership).

3.44 Responses from a variety of respondents gave suggestions on the information that they felt would enhance the directory for various types of user. The British Motor Neurone Disease Association suggested that, *"It should be integrated with other tools, such as the NICE quality standards, map of medicine and commissioning tools…This will allow clinicians, commissioners and patients to see the available options while consulting other resources."*

3.45 The main risk identified around the establishment of the directory was keeping it current. For example, GlaxoSmithKline noted that, *"It will need to be a dynamic and accurate directory which is kept up to date as providers (and the services they offer) change."* Some questions were raised around the mechanism for doing this, "*We question how this will be monitored and kept up to date*" (Royal Pharmaceutical Society).

3.46 Another issue identified by some respondents was finding the right balance between the establishment of a national directory whilst ensuring that the specific needs of local populations are taken into account. For example, Turning Point noted that, "*Commissioners do need to know what is available in their local area yet they themselves should look to engage with their communities, and the providers within them, to understand local need, how it is met and where it is not."* Some respondents suggested that a national directory may not be sufficiently flexible to allow for local variation. "*Local commissioners should also be free to procure from local organisations which meet required standards. We suggest that thought be given to establishing national, regional and local directories"* (East of England SHA).

3.47 Respondents who were not in favour of a directory (around 7%) were generally also against the policy proposals as a whole, *"The BMA does not support the any willing provider policy."*

Our response

3.48 We will take these comments into account in considering further how we develop a central directory of providers. We agree in principle with making the directory available and with ensuring that it is integrated with other relevant tools as far as possible. We note the challenges around ensuring that the directory is adequately maintained and reviewed, but we feel there are mechanisms available for ensuring this is done. We will also consider how the national directory could show which providers are operating locally. More details will be included in the guidance on choice of any qualified provider published alongside this document.

Conclusion

3.49 As the NHS Future Forum concluded, *"There are parts of the system that are offering people choice now, but more needs to be done to deliver real choice."* Any qualified provider is a way of giving people more choice over who they go to for healthcare and where and how they access it. It is a way of commissioning services that reduces the cost and time that would otherwise be involved in undertaking a competitive tender. Any qualified provider ensures that commissioners are able to maximise the potential number of providers from which patients can choose, whereas competitive tendering normally results in the selection of a single provider, or a limited number of providers, to provide a service exclusively. The process for any qualified provider is both quicker and less bureaucratic than a traditional procurement, reducing cost and time on the routine elements of procurement, allowing focus to be given on how providers intend to deliver the service to the benefit of patients. Under any qualified provider, competition is based on quality, not price. Providers are paid a fixed price determined by a national or local tariff.

3.50 While it has been proposed that a range of services would be subject to patient choice of any qualified provider, this would not be appropriate for all services. For example, we would not expect to offer patient choice of any qualified provider to A&E and critical care. Tendering would be an appropriate option for commissioners where significant change is required to existing provider markets to deliver, for example, whole system service transformation.

3.51 We have heard, both through the consultation and the NHS Listening Exercise, that there is a demand for greater choice and control over healthcare. *"We commend the choice 'offerings' set out in the 'Greater choice and control' consultation (including choice of provider, choice of consultant-led team, and choice in maternity, mental health, end of life care and long term conditions). Patients and service users, their carers and families will value such choices and taken them seriously, and we look forward to their further development"* (National Voices). Starting to implement choice of any qualified provider is the beginning of extending choice for all users of NHS services.

4. Next steps

4.1 Guidance, an Impact Assessment and an Equality Analysis on implementing choice of any qualified provider are being published alongside this document.

4.2 Development of policy proposals on the remaining commitments in the consultation document is continuing, informed by the responses to the consultation document as well as to the NHS Listening Exercise, with a view to publishing a full response later this year. Alongside this will be a further Impact Assessment and Equality Analysis. Guidance covering the remaining commitments will also be issued as policy is developed.

4.3 In implementing the proposals for extending choice, the Government undertook to consult widely. Therefore, there will be a further opportunity for organisations and individuals to comment on more detailed proposals when the full report is published. This will be by way of a shorter, second consultation of 8 weeks.

4.4 With regard to further consultation specifically on choice of any qualified provider, this will be ongoing and carried out at a more local level. The guidance issued alongside this response tasks commissioners with engaging locally and seeking views of patients, Health and Wellbeing Boards and clinicians to prioritise which services are procured through any qualified provider. The Department will also be working with commissioners and stakeholders in developing the qualification process to ensure that all providers offer safe, good quality care. We are proposing jointly developing support materials with the NHS, and locally led engagement to respond to views on priorities for choice.

Annex A. List of organisations that responded to the consultation

Organisation Name
2020health
AAH Pharmaceuticals Ltd.
Abbot Healthcare Ltd.
Academy of Medical Royal Colleges
Advanced Dynamics
Age Concern
Age UK
Airedale Foundation Trust
Airedale Mums
All Party Parliamentary Group on Skin
Alliance Boots
Arthritis and Musculoskeletal Alliance
Arthritis Care
Arthritis Research UK
Association for Children's Palliative Care (ACT)
Association for Clinical Biochemistry
Association for Clinical Pathologists
Association of British Healthcare Industries
Association of Directors of Adult Social Services and Local Government Group
Association of Paediatric Chartered Physiotherapists
Association of the British Pharmaceutical Industry
Assura Medical
Astellas Pharma Ltd
Asthma UK
Atrial Fibrillation Association
Avon and Wiltshire Mental Health Partnership NHS Trust
Barchester Health Ltd.
Barking & Dagenham Local Authority
Bayer (Women's Health Business Unit)
Bedford Borough Council
Berkshire Local Pharmaceutical Committee
Birmingham Sandwell and Solihull Cardiac and Stroke Network
Blackpool Council
Blackpool Local Involvement Network (LINK)
Bliss
Blue Ribbon for the Awareness of ME
Bolton Local Pharmaceutical Committee
Bowel Cancer UK
Bradford LINK
Breakthrough Breast Cancer
Breakthrough UK
Breast Cancer Care
British Association and College of Occupational Therapists
British Association for Counselling and Psychotherapy
British Association of Dermatologists

British Dental Association
British Diuretic Association
British Geriatric Society
British Heart Foundation
British In Vitro Diagnostics Association
British Liver Trust
British Lung Foundation
British Medical Association
British Nuclear society
British Pregnancy Advisory Service
British Society for Rheumatology
British Society of Hearing Aid Audiologists
British Specialist Nutrition Association
BUPA
Bury Council
Cambridge Weight Plan
Cambridgeshire LINK
Cancer Research UK
Canons Park Residents Association
Capita
Cardiac and Stroke Shadow Board and Stroke Association
Care Quality Commission
Cares Sandwell
Centre for Mental Health
Chartered Society of Physiotherapists
Cheshire and Wirral Partnership NHS Foundation Trust
Cheshire West and Chester Council
Chesterfield Royal Hospital Council of Governors
Chief Scientific Officer
Children Living with Inherited Metabolic Diseases
Citizens Advice Bureau
City University
College of Optometrists
Community Action on Health
Compassion in Dying
Confederation of British Industry
Cornwall LINK
Council for Disabled Children
Coventry LINK
Crossroads/Princess Royal Trust
Darlington Borough Council
Department of Health Long Term Neurological Conditions Delivery Support Team
Derby City PCT
Diabetes UK
Dispensing Doctors Association
Dorset Cancer Network Patient Partnership Panel
Dudley and Walsall Mental Health Partnership NHS Trust
Durham County Council
East Midlands SHA
East of England Heads of Midwifery

East of England SHA
East Sussex LINK
East Sussex Seniors Association
Ehlers-Danlos support group / Hollybank Trust
Elders Voice
English Community Care Association
Epilepsy Action
Epilepsy HERE
Essex County Council
European Medicines Group
Faculty of Pharmaceutical Medicine
Faculty of Public Health
Faculty of Sexual and Reproductive Healthcare (RCOG)
Family Planning Association
Federation of Irish Societies
Fitness Industry Association
Foundation Trust Network
Gateshead Advocacy and Information Network
General Medical Council
Genetic Alliance UK
Greater Manchester Neurological Alliance
GlaxoSmithKline (GSK)
Gloucestershire LINK
Great Yarmouth PCT (Southwold Surgery)
H3Plus Commissioning Consortium
Haemolytic Uraemic Syndrome Help (HUSH)
Hampshire Partnership NHS Foundation Trust
Harbury Trust
Harrogate and District NHS Foundation Trust
Harrow LINK
Hastings PCT
Health Foundation
Health Scrutiny Committee for Lincolnshire
Health Service Ombudsman
Healthcare at Home
Heart of Mersey
Help the Hospices
Herefordshire Council (staff)
Hertfordshire LINK
Hertfordshire Partnership NHS Foundation Trust
Homeless Link
Inclusion North
Independent Healthcare Advisory Services
Independent Mental Health Services Alliance
Information Commissioners Office
Institute of Biomedical Science
Institute of Physics and Engineering in Medicine
Isle of Wight Service User Group
Joint Department of Health National Clinical Directors
Joseph Rowntree Foundation

Kent Good Health Group
Kidney Research UK
Knowsley Council
Lambeth Council
Learning Disability Parliament Project - Dawlish
Learning Disability Parliament Project - Kingsbridge
Learning Disability Parliamentary Project - Devon
Leeds LINK
Leeds, Bradford and Airedale, Calderdale and Kirklees Local Pharmaceutical Committees
Leicestershire LINK
Lifeblood
Lift Council
LighterLife
Lincolnshire PCT
Liverpool Joint Health Unit
Liverpool Mental Health Consortium
London SHA (Pathology clinic - expert panel)
Lundbeck
Macmillan
Marie Curie Cancer Care
Markyate Parish Council
Medical Protection Society
Medical Technologies Group
Medical Women's Federation
Mencap
Mental Health Providers Forum (Engagement Event)
Middlesborough Council
Mid-Yorks NHS Trust
Milton Keynes Wheelchair User Group
MIND
Motor Neurone Disease Association
Multiple Sclerosis Society
Muscular Dystrophy Campaign
Nacro
NAPP Pharmaceuticals
National AIDS Trust
National Association for Collitis and Chrone's Disease
National Association for Patient Participation and Local Patient Participation Groups
National Centre for Independent Living
NCT
National Children's Board
National Clinical Homecare Association
National Infertility Awareness Campaign
National Information Governance Board for Health and Social Care
National Institute for Health Research Collaboration for Applied Health Research Care for Leicestershire, Northampton and Rutland
National Osteoporosis Society
National Physiology Diagnostics Board
National Rheumatoid Arthritis Society
National Specialised Commissioning Team

National Voices
NAVCA
Newcastle City Council
Newcastle Upon Tyne NHS Foundation Trust
Newlife Foundation for Disabled Children
NHS Bournemouth and Poole PCT
NHS Cambridgeshire
NHS Confederation
NHS Connecting for Health
NHS Cornwall and Isles of Scilly
NHS Counter Fraud and Security Management Service
NHS Cumbria Patients Voice Group
NHS Dorset
NHS East Midlands Inclusion Directorate
NHS East of England Competition Panel
NHS Hertfordshire
NHS Hull
NHS Isle of Wight
NHS Leicester City
NHS Lewisham
NHS Lincolnshire PCT
NHS Medway
NHS North of Tyne
NHS Nottingham City
NHS Partner Network
NHS Salford
NHS South Gloucestershire and South Gloucestershire GP Commissioning Consortium
NHS South of Tyne and Wear PCT
NHS South West
NHS Suffolk Community Reference Group
NHS Sustainable Development Unit
NHS Tower Hamlets
NICE
Nightingale
Norfolk & Waveney Local Medical Committee
Norfolk LINK
North Somerset PCT
North Tees and Hartlepool NHS Foundation Trust
North Tyneside Council
North Tyneside LINK
North West London Hospitals NHS Trust
North West SHA
Northamptonshire LINK
Northumberland LINK
Nottingham City LINK
Novartis
Ophthalmology Sector Group
Optical Confederation
Outreach Worker North Staffordshire Users Group
Oxfordshire PCT

Pan-Birmingham Cancer Network
Papworth NHS Foundation Trust
Parkinsons UK
Patient Information Forum
Patient Involvement Group
Pelvic Pain Support Network
Pharma Mar
Pharmaceutical Services Negotiating Committee
Pharmacy Voice
Picker Institute Europe
Plymouth LINK
Pohwer
Poole LINK
PPS Interim Support Limited: 'www.chooseandbookit.co.uk'
Proprietary Association of Great Britain
Prostate Cancer Charity
Queen Elizabeth Hospital Birmingham
Race Equality Foundation
RAISE
Reach
Redcar and Cleveland Borough Council
Regional Action West Midlands
Regional Voices
Rethink
Revolving Doors Charity
Richmond Carers Centre
Richmond Council for Voluntary Services
Right Care Right Here Partnership
Roche Diagnostics
Roche Products Ltd.
Roy Castle Lung Foundation
Royal College of Anaesthetists
Royal College of GPs
Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians
Royal College of Physicians of Scotland
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Speech and Language Therapists
Royal College of Surgeons
Royal College of Surgeons Patient Liaison Group
Royal Liverpool and Broadgreen Hospitals NHS Trust
Royal National Institute of Blind People
Royal National Institute of Deaf People
Royal Pharmaceutical Society
Ryedale LINK

Sandwell Link
Sanofi - Aventis
Senior Council for Devon
SHA Leads for Long Term Conditions
SHA Scientist Network
Sheffield Centre for Independent Living
Sheffield LINK
Shropshire Disability Network
Shropshire LINK
Social Enterprise Coalition
South Central NHS
South East Coast SHA
South East Coast SHA Events
South East Coast SHA Online Survey (public)
South East Coast SHA People's Engagement Development Network.
South East Coast SHA Technical Response
South East Coast SHA Technical Response for Mental Health
South East Coast SHA Voluntary Sector Groups
South East Coast Specialised Commissioning Group
South East Essex Community Healthcare
South Tees Hospital (Staff Responses)
Southampton City Council
Specialised Healthcare Alliance
Specialist Orthopaedic Alliance
Specsavers
St Mungos
Staffordshire, Shropshire & Black Country Newborn and Maternity Network
Standing Commission on Carers
STEPS
Stockton Helps All
Stonewall
Stroke Association
Sunderland City Council
Sunderland Local Pharmaceutical Committee
Surgeon General, Armed Forces
Target Ovarian
Teenage Cancer Trust
Terrence Higgins Trust
The Alzheimer's Society
The Children's Society
The Community Voice
The Hepatitis Trust
The Ileostomy and Internal Pouch Support Group
The Information Standard
The Kidney Alliance
The King's Fund
The Lesbian and Gay Foundation
The National Council for Palliative Care
The National LGBT Partnership
The Patients Association

The Society and College of Radiographers
The Stroke Association
Thyroid Patient Advocacy
Thyroid UK
Tomorrow's People Charity
Tunstall Healthcare
Turning Point
UK Genetic Testing Network
UK Homecare Association
UK National Screening Committee
UK Public Health Association
Unison
University Hospitals Birmingham NHS FT - PPI Group
University Hospitals of Leicester
University of Cambridge Radiology Department
University of Newcastle Upon Tyne
Urology Trade Association
Urology User Group Coalition
User Panel (patient steering group) for the Central London Healthcare GP consortium
Venous Thrombo-Embolism Group
Vision2see
Voluntary Sector North West
Walsall Centre for Independent Living
Waterside Medical Centre
West Midlands Programme for IT
West Oxfordshire District Council
West Sussex PCT
WHICH
Wiltshire User Group
Wolverhampton City PCT
Women’s Health and Equality Consortium
Women's Resource Centre
York People First
Yorkshire and Humber Child and Adolescent Mental Health Services Team
Young Minds

Liberating the NHS: Greater choice and control
Government response: Extending choice of provider (Any qualified provider)
Department of Health

July 2011