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Briefing note

Any Willing Provider – A CSP member briefing

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INTRODUCTION

The 'Any Willing Provider' (AWP) approach being adopted for NHS-funded services in England has the potential to change beyond recognition the professional working arrangements and employment conditions of CSP members.

This briefing has been produced by the CSP to share with members:

- What we know at this point about the any willing provider (AWP) approach and how it might impact on members
- The actions we have been taking in response
- The steps we suggest that you, as CSP members, now need to take

As more information on AWP emerges - the Department of Health (DH) still have many details to work out – we will update this member briefing.

AWP EXPLAINED

AWP is not new. It has been operating for acute elective services in England for several years. Already changes in NHS provision mean that many CSP members are employed by non-NHS organisations which provide NHS services. What **is** new is the intention of the Coalition Government to extend AWP so that it includes most NHS-funded services by 2013/14. Also new is the loss of the underpinning 'NHS the preferred provider' policy, which was dropped by the incoming Government very soon after taking power.

The roll out of AWP will start with certain community services, such as musculoskeletal services, from this autumn.

Initial guidance to commissioners and providers is due to be issued by DH at the end of March, to allow approximately six months for planning at local level.

Essentially, AWP is a way of commissioning NHS services that enables patients to choose any provider that meets the necessary quality standards and price. At the time of writing the details of how these will be assessed are not yet known. The price will be in the form of a national tariff or be set by commissioners locally. Providers can be drawn from the NHS itself, the voluntary sector, the private sector (including independent hospitals), or from a GP practice. Once they have satisfied the agreed assurance tests providers will be put on a local list and patients will be able to choose who to go to from this list once it has been agreed with their GP that their condition warrants it.

Any provider can make a pitch to provide a given NHS service. If they pass the assurance process, they will enter into a formal contract with the relevant commissioner(s) **but there will be no guaranteed volume of work or income.** This is the key difference between

AWP and competitive tendering. The outcome of the latter is a contract to provide a service exclusively for a given number of years, for a guaranteed price.

Contrary to some of the misleading information circulating at the moment, AWP will apply equally to all current providers including social enterprise companies which are already up and running. Once AWP is introduced locally, existing social enterprise contracts will be transferred onto an AWP basis **regardless of what may have been agreed at the start of the contract term.**

The decision whether to go down the AWP route or the competitive tendering route will be down to local commissioners i.e. PCTs at the moment, GP consortia in the future. The guidance to be issued by DH is likely to suggest that AWP (at least initially) should be used for relatively simple 'episodic' types of care, with competitive tendering used for services where the choice of provider is less appropriate such as emergency care - or to provide complex, integrated packages of care such as those for frail, older people with multiple needs. From the CSP's discussions to date with DH, it would seem that almost all of physiotherapy outpatient services are regarded as potentially coming under the category of 'episodic' care.

In addition to deciding which services are to be subject to AWP and the prices to be applied, commissioners will also need to draw up their own local referral pathways and thresholds for different types of care, including 'red flag' protocols where appropriate. Providing they adhere to these local arrangements, providers will be paid the agreed rate for each patient session. If, in the view of the clinician, a patient needs treatment over and above the set threshold, it is likely that the patient would have to be referred back to the GP for a decision on whether or not this can be funded.

Should an existing provider of a service fail to win enough work under AWP and have to reduce its services as a result, any staff displaced would almost certainly not be protected by the TUPE Regulations. The reason for this is that the Regulations are designed to protect workers' jobs and conditions in the event of the service in which they work being transferred to another employer. In the case of AWP, there will be no 'transfer of undertakings' to trigger the protection of the Regulations - a provider will have simply lost some of its work by patients deciding to go elsewhere. Staff displaced as a result would need to be redeployed or made redundant.

"One of the major concerns is the role that the NHS' economic regulator, Monitor, will be given to ensure that any willing providers, including NHS and voluntary organisations, and commercial companies, are able to compete to provide all NHS services" Joint letter to the Times newspaper signed by the BMA, RCN, Unison, Unite, RCM and CSP, 17th January 2011

WHY IS AWP BEING EXTENDED IN THIS WAY?

The Coalition regard AWP as a key mechanism for injecting more patient choice and more competition into the delivery of state-funded health services. The rationale is that under the AWP model of commissioning if a provider is giving a good service, they will get more referrals and therefore more income. By contrast those not providing a good service – or who cannot operate effectively under the local set price - will see their income fall and will either have to improve and/or change how they operate or be eventually put out of business. This, the Government believes, will be an incentive for providers to develop innovative, patient-orientated, cost-effective services.

AWP is not explicitly covered in the Health & Social Care Bill presently going through Parliament. However, the Bill has clearly been written with the assumption that AWP will apply and also puts in place the necessary framework for it to work in terms of licensing, pricing, and promoting competition. Under the Bill, both Monitor and the new National Commissioning Board will be required to promote competition and all NHS commissioners will have a duty not to distort competition, for example by favouring their existing NHS service.

If a provider considers that a local commissioner has behaved anti-competitively they will be able to complain to the new Board, or to Monitor, or take legal action against a particular commissioner using European competition legislation. Once an NHS service has been opened up to competition, either through AWP or tendering, the UK loses its right under European law to keep that service as a publicly-run service.

"Extending the any willing provider arrangements would make EU competition law 'bite' in new areas of NHS activity." Anne Crofts, Health Service Journal, 20th January 2011.

"Any Willing Provider makes NHS services subject to EU competition law, so that any GP consortia fondly imagining they can keep using their well-trusted local hospitals will find themselves open to challenge in court if they don't tender everything out." Polly Toynbee, The Guardian, 4th February 2011

POTENTIAL IMPLICATIONS OF AWP

For Services…….

From autumn 2011, physiotherapy outpatient services for musculoskeletal conditions will be opened up to AWP. This means services could be opened up to competition from other providers which could include professionals such as osteopaths, chiropractors and sports and exercise therapists as well as private physiotherapists. They could also include private healthcare and independent hospital companies (domestic or multinational) such as ATOS, Circle, Allied Health, Nuffield, Ramsay and HCA.

Current contracts will fall away and with them, agreed volumes of activity. The resultant financial instability will mean managers will find it difficult to decide the numbers of staff they will require in the future. Depending on the tariff set for a particular patient condition, some

providers might judge that it is not possible to continue to offer a safe, high quality service and may withdraw from 'the market' altogether.

With no guarantees of work combined with acute pressure on budgets, existing NHS providers – who have always provided the bulk of support for students and the newly qualified – will clearly have difficulty in continuing to provide either student placements or junior rotations. Effective workforce planning – a long outstanding problem in healthcare – could become even more problematic with a greater number of providers of NHS-funded services, ranging across the sectors and from very small to very large.

For Quality of Care…

It is hard to see how the sharing of good practice and innovation locally will not be affected in a significantly more advanced competitive market.

Very worryingly the CSP believes that the AWP approach lends itself to the rationing of services to NHS patients, especially at a time of severe economic constraint. The CSP has received examples of AWP already in operation where the number of NHS-funded treatment sessions has been severely restricted. Rationing services, for example to one assessment and one follow-up, irrespective of patient need or clinical judgement, could compromise members' professional ethics and standards as well as lead to worse clinical outcomes. It may also lead to patients paying for extra services where they can afford to, inevitably increasing inequality of care.

For Patients…….

In reality, AWP could mean more confusion and **less choice** for patients.

Many patients report already how confusing and difficult it is to make a meaningful choice when presented with lots of different information and options for elective surgical care. AWP could be more confusing still as the choices offered may include practitioners from professions they have no knowledge or experience of.

Without considerable support and access to information to understand the variety of options available to them and the pros and cons of each option, people with better access to information will be able to educate and inform themselves to a greater degree than other patients – for example those from socially deprived backgrounds or with poor literacy and numeracy skills. So choice could become the privilege of some, but not all.

CSP is extremely concerned that AWP may prevent patients from self-referring to physiotherapy services. It is still not clear at the time of producing this briefing how self referral can operate in the new commissioning environment where the GP is the gatekeeper for all decisions. If self-referral schemes cannot continue, **patients will in practice have less choice and less control over their own health.**

Self-referral has been proven to reduce costs for GPs and reduce time delays for patients as well as giving patients greater choice and control. In recognition of self-referral improving both quality and productivity, NHS Evidence has recently accepted self-referral to physiotherapy for musculoskeletal conditions on its QIPP database. The CSP advocates greater adoption and roll-out of self-referral because it has proved successful in increasing timely access to physiotherapy services, improving outcomes for patients through early intervention and ultimately preventing onward referral to specialists in secondary care.

A greatly expanded plurality of providers could also fragment care for patients, especially those with a long term musculoskeletal condition who require integrated care across the whole pathway. If physiotherapists have to refer back to the GP to ask for permission to continue to treat a patient or to refer them to another professional, this will inevitably lead to delays in patients accessing the right person, at the right time.

"The Department intends for more integration of services, and more competition – these things are not in conflict" Sir David Nicholson, NHS Chief Executive, 17th February 2011

The Government has argued that because AWP has been in place for patients requiring elective surgery there will be no problem with extending AWP to all community services. The CSP believes that this argument is based on their belief that community care is similar to elective surgery in that it is simple and episodic. Clearly this is not the case with many community services providing specialist care for patients with complex long term conditions. This can include patients with chronic pain due to a longstanding MSK disorder, and patients with long term chronic pulmonary disease with existing co-morbidities. These services frequently cross organisational boundaries and can include health, social and voluntary care providers. To open up such services to AWP would be detrimental to patients.

Effective quality control, that is assuring safe, quality patient care, may be made more difficult with a multiplicity of providers.

Should rationing become a feature of AWP, the patients who will lose out the most will be those who cannot afford to top-up their care by paying to see a private practitioner.

"…any willing provider", the policy that will be weighing ever more heavily on the minds of commissioners over coming years, risked producing a "seething cauldron of competing provider interests". Dr Mark Porter, Chair BMA Consultants and Specialists Committee, quoted in Health Service Journal, 10th March 2011

"*Any willing provider means that anyone can set up shop and steal easy patients: the result will be anarchy. If it means a hospital shuts, I'm at a loss to understand what happens to the 80-year old with a complex broken hip."* Alan Milburn, former Health Secretary, The Guardian, 5th February 2011

For Taxpayers……

It is not easy to see how transaction costs will not increase under AWP – the costs of contracting with more providers, the costs of monitoring contract quality and outcomes for patients, the costs relating to invoice checking and payment, higher HR costs linked to staff 'churn'.

If AWP is implemented in a way that means patients have to keep being referred back to GPs for decisions this will also inevitably lead to increased GP costs.

If an NHS provider loses income under AWP to such an extent that they need to make staff redundant, the taxpayer will pick up the redundancy costs **even in a situation where the need for the work has not diminished, but has simply been picked up by another provider.** What could be seen as a cynical attempt to circumvent the TUPE Regulations, will also therefore represent a cost for the taxpayer.

Ultimately, any increase in administrative costs such as these will have a direct knock-on effect on the money available to treat NHS patients.

For Staff…….

Working in a climate of constant instability and uncertainty will create:

- Less job security as work ebbs and flows
- More use of casual, short-term and/or zero hours and bank contracts
- Reduced employment protection in situations if TUPE does not apply
- Greater pressure on gradings, pay, terms and conditions of employment in order to meet local tariffs
- Less support for training and development as a result of both financial pressures and lower levels of staff continuity
- Even greater difficulties for the newly qualified in finding their first health post
- The distress of being unable to meet patients' needs
- Dissatisfaction and low morale among staff who may choose to leave the NHS.

AWP Case Study, Nottinghamshire

In September 2009, Principia (a practice based commissioning social enterprise covering 16 practices in Nottinghamshire) transferred their community physiotherapy services to an AWP procurement model, with nine private providers and one NHS provider. Using previous referral rates, this model would have been estimated to cost £510,000 per year. However, the annual budget was actually set at £41,000.

After a year, Principia carried out a review which showed that:

- Their budget was overspent; with a predicted year end spend of £555,408.
- Waiting times had decreased.
- No reduction was seen in secondary care referrals. [*However, it should be noted that the AWP model is intended to improve patient choice so the CSP is not clear why secondary care referral data was used as a measure of success*].

As a result, Principia increased the referral threshold, so that now:

- A patient can only be referred to physiotherapy having presented to the GP for the same condition twice, six weeks apart (with only one referral allowed per year for the same condition).
- The service has been rationed to "an assessment, advice and guidance service" with one assessment and one follow-up and the instruction that patients must not leave with "an impression of unfinished treatment".
- Patients are then discharged back to the GP regardless of whether they need ongoing physiotherapy management. The CSP is concerned that this leaves the GP with the only option of referring on to secondary care.
- CSP has been advised anecdotally that Principia has suggested patients could be given the option of continuing with private physiotherapy treatment after the two "assessment, advice and guidance" sessions.

The CSP has a number of concerns about this:

1. Limiting patient care for short term cost savings at the expense of patient need, quality of service and without regard to evidence of best practice is short sighted and is likely to have a negative impact on clinical outcomes.
2. Patients face a minimum seven week delay between first attending the GP and accessing physiotherapy.
3. There is an increased potential for conditions to become chronic and resulting in increased referrals to secondary care. This will incur additional and long term costs. Primary care physiotherapy input is crucial to managing demand further down the musculoskeletal care pathway.
4. Principia's service will lead to inequality across the region and between those who can and cannot afford to pay. Under Trust policy Principia should have conducted an Equity Impact Assessment prior to the changes being implemented.
5. Care has become less convenient and accessible, with an anticipated shift from local community physiotherapy to regional secondary care providers.
6. A number of professional issues for physiotherapy clinicians have arisen, including an inability to meet the continuous professional development requirement of their HPC registration and the duty of care requirements of their Rules of Professional Conduct. These issues will all have an impact on recruitment and retention of skilled NHS staff.

WHAT ACTION IS THE CSP TAKING ON BEHALF OF MEMBERS?

The CSP believes that mainstream NHS services are best delivered by NHS-employed staff and we have major concerns – as detailed above - about the implications of AWP for services, patients and members.

We have therefore been using all opportunities nationally to relay our concerns: through our written submissions to Government; our parliamentary briefings; and in our media work.

We realise however that with the work to introduce AWP already started, we cannot afford not to get engaged. So alongside our lobbying efforts, we have also been taking part in numerous meetings and workshops organised by DH to develop the initial guidance that is due to be launched later in March, as well as the infrastructure to support AWP if and when it starts to be rolled out to community services in the autumn.

This involvement has been led by the CSP Director of Practice & Development and the Director of Employment Relations, making the most of the CSP's combined role of professional body and trade union. We have also secured places at a number of the workshops for members who are clinical specialists, so that their expertise can be used for the benefit of both DH and the profession.

Our objective has been to try to ensure that AWP is introduced in a way that does least damage to patients, members and taxpayers

We will continue to engage with DH beyond the issuing of the initial guidance. Providing members keep us informed of local developments so that we can track what is happening on the ground, we will use this feedback to press for revisions to the DH guidance when it is reviewed later in the year.

We will also be looking between now and the autumn to see how best we can support members to respond to the wider introduction of AWP, building on the CSP work already launched to help managers and clinical leaders cost and adapt their services and develop an effective dialogue with commissioners. The more members can influence commissioning decisions - especially those relating to local referral pathways, thresholds and prices - the greater the potential benefit for patients and members themselves.

Through the CSP stewards' network, the CSP will also support members facing the employment consequences of AWP, working with other health unions as much as possible.

"The CSP believes that collaboration and communication are the best ways to deliver services within the NHS and that competition between healthcare providers is potentially destructive to patient care." CSP evidence to the Health Select Committee Inquiry into Commissioning, 6th October 2010

WHAT CSP MEMBERS NEED TO DO

- Find out more about AWP by visiting the CSP and DH websites – see the links at the end of this briefing
- Add your weight to the concerns about AWP that the CSP has been expressing nationally, for example by writing to your local MP or newspaper – small actions by lot of individual members can have more impact than any amount of lobbying by a national organisation
- Familiarise yourself with the DH guidance when it comes out later in March – we will alert you to its publication through the CSP e-bulletin
- Ask to be informed by your employer of any local planning on AWP affecting the service you work in.
- Start discussing what AWP can mean with your work colleagues and how you are going to respond
- Keep your local CSP steward informed of any developments you hear about. Stewards in turn should keep their CSP Senior Negotiating Officer informed of major developments.
- Identify and make contact with the key local commissioners who you will need to influence
- Local educators and service managers should work together to raise concerns with commissioners and GPs about how effective workforce planning will be undertaken in future.
- Feed information on key local developments back to the CSP via your CSP Regional Network .

LINKS

Chartered Society of Physiotherapy website

CSP response to "Equity and Excellence: Liberating the NHS", 4th October 2010
http://www.csp.org.uk/documents/liberating-nhs

CSP response to "Liberating the NHS: Greater Choice and Control", 7th January 2011
http://www.csp.org.uk/documents/csp-health-white-paper-2010-response-greater-choice-control

CSP briefing for MPs on Health and Social Care Bill, January 2011
http://www.csp.org.uk/press-policy/policy/nhsreforms

LINKS continued over page…

Department of Health websites

"Liberating the NHS: Greater Choice and Control. A consultation on proposals.
http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_119651

"Equity and Excellence: Liberating the NHS", White Paper consultation, July 2010
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

"**Liberating the NHS – managing the transition", letter from Sir David Nicholson, NHS Chief Executive, 17th February 2011**
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_124440

NHS Evidence – QIPP: Musculoskeletal physiotherapy: patient self-referral
http://www.library.nhs.uk//qipp/ViewResource.aspx?resID=406806

Chartered Society of Physiotherapy

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