Any Qualified Provider
Where are we now?

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Thursday 26th January 2012
BAA AQP Workshop
Content

• Context
  - What is AQP?
  - What is required in 2012?

• Where we are now:
  - Selection of hearing services
  - Implementation pack
  - Qualification
  - Quality Assurance

• What next?
Evidence shows that giving patients greater control can improve the quality of care, and value for money.

The NHS Future Forum supported the concept of patient choice of Any Qualified Provider.

Not about forcing people to make a choice if they would rather a health professional made it on their behalf. It is about ensuring the system supports people’s choices where they want to exercise them.

Services will remain free at the point of use, based on clinical need keeping true to the principles and values enshrined in the NHS Constitution.

Providers from all sectors, including NHS trusts, voluntary organisations, social enterprises and the independent sector will continue to have a role in providing NHS services.
What is AQP?

• When a service is opened up to choice of ‘any qualified provider’, patients can choose from a range of providers all of whom meet NHS standards and price.

• Prices paid to providers will be determined in advance by the NHS. This could be a national tariff where it applies, or a locally agreed price. There is NO competition on price.

• Patients will choose based on quality and individual preferences and money will follow patients’ choices.

• Providers must pass a standard qualification process to ensure they meet the appropriate quality standards.

• There is NO volume guarantee for providers.
Operational Guidance to NHS
(Jul 2011) ‘Extending Patient Choice of Provider’

• At least 3 services to be selected by Nov 2011
• Could choose from 8 priority areas identified following engagement with patients & professionals as areas where extending patient choice of provider is achievable and can deliver real and significant benefits:
  – Musculoskeletal services
  – Routine adult hearing services
  – Continence services (adults & children)
  – Direct access diagnostic tests
  – Wheelchair services
  – Podiatry services
  – Venous leg ulcer and wound healing
  – Primary care psychological therapies (adults)

• Not restricted to these 8 areas - could select local priorities
• Implementation packs available from Nov 2011
• Implement AQP between April – Sept 2012
Where are we now – local selection of AQP priorities?

At least 26 PCT clusters (over 90 PCTs) have chosen adult hearing services as a priority for AQP implementation in 2012/13.
AQP services offered
by number of PCTs 2012/13

- Adult Hearing
- Psychological Therapies
- Wheelchair Services
- Diagnostics
- Podiatry
- Continence
- MSK
- Venous Leg Ulcer and Wound Healing
- Other

Declared but not operational
Operational
Where are we now – Implementation packs?

• Volunteer PCT clusters developed an implementation pack for each of the 8 priority areas

• Lead Cluster for adult hearing implementation pack was NHS Tees with support from a buddy cluster (NHS Berkshire) and a wider national reference group.

• BAA had a seat on the reference group.
AQP Implementation Packs – Do Once and Share….

The main contents of the implementation pack are:

• Section 1 : Service Specification

• Section 2: Currency & supporting explanations

• Section 3: Recommendations on patient information to support informed choices

• Section 4: Recommendations on additional assurance criteria and questions
AQP selected for service based on patient engagement

Advert placed on S2H including service spec and price

Implementation pack resource drawn down

Provider responds to advert by completing Qualification questionnaire

Questionnaire assessed and provider qualified if:
- Agrees price
- Agrees std contract terms
- Demonstrably meets service specification
- Meets regulatory and quality requirements

Service commences

Central directory of providers populated

The qualification questionnaire is made up of 8 sections.
6 Sections are generic and could be “automated” / undertaken at scale
About half of the form requires dedicated service spec resource e.g. commissioning, clinical and procurement to review.
The final section (section 8) can only be signed off by local commissioner

Routine information checked

Service specific elements assessed

Locally specific elements confirmed by local commissioner

Contract award

Service commences

Eg CQC licence, regulatory & qualifications

Eg service specific and quality questions

More details on roles and responsibilities to follow

Eg referral protocols and local price
Where are we now - QA? (1)

- AQP is likely to lead to an increase in adult hearing services moving out of hospital
- More providers in the community and a possible increase in provision of services on the high street
- Quality assurance will be key.
- IQIPS accreditation programme is being accelerated to ensure providers seeking AQP status can be accredited in a timely fashion.
Where are we now - QA? (2)

Assurance recommendations in implementation pack:

Providers need to:

• have submitted an application for IQIPS accreditation by 31 March 2012

• have completed the IQIPS Self Assessment & Improvement Tool for adult hearing services by 30 June 2012

• be IQIPS adult hearing service accredited no later than 30 September 2012

• AQP qualification will be conditional on achieving accreditation by 30 September 2012 and any provider that is not accredited by this date will be removed from the AQP national qualification register.

• Any new provider seeking AQP status from 30 September 2012 onwards will need to be accredited.
What next?

• From April 2012 - expect commissioners to begin offering choice of provider in their selected services.

• By September 2012 - patients can expect to be offered a choice of provider in three or more community and mental health services.

• Trade fairs in each region from January 2012

• Joint DH / Hearing Loss & Deafness Alliance AQP Info Day (12 March - London) - BAA received an invite. Aim of event:
  
  - provide a clear understanding of what AQP is and isn't
  - clarity around some of the common questions that arise both in general AQP terms and in the context of hearing services specifically
  - opportunity to learn more about IQIPS
  - attendees then use their own networks to filter accurate and consistent messages down to their stakeholders so that there is a level playing field for all stakeholders
  - there will be handouts to support this info cascade
Conclusion (1)

• A common myth is that AQP is new.

• It is not - Any Willing Provider began in 2008 with the choice of hospitals for elective care.

• AQP is Government policy

• There have been a number of misunderstandings and factual inaccuracies about AQP - you need to ensure you are well informed. Events like this will help – thanks to BAA for organising it.

• AQP is fundamentally about giving patients a choice about services they need.

• Many of the concerns expressed, particularly about those services that have already gone down that route, are actually about the commissioning decisions.

• Poor quality commissioning impacts on services, whether part of AQP or not, which is why we must all understand that influencing commissioning decisions, whoever is making them, is crucial!
Conclusion (2)

- Consider how resistance (or apathy) is viewed by local commissioners: Could it be viewed that if patients are given a choice of services, we are concerned that ours won’t be chosen because it is lacking in some way?

- Patients groups will expect commissioners to ensure services meet/exceed the outcomes and quality requirements in the spec – you need to ensure your service can.

- If you have not already, you need to understand your service in detail; what you offer, what your patients think of it and what changes they would like to see and how much your service costs.

- You need to talk with commissioners about what they want and you need to ensure your service features on NHS Choices and that you are registered with Choose and Book.

- AQP is not without its challenges but it should not be ignored.

- We need to learn from the first year of AQP – AAG being set up – it will provide a useful forum to feedback to DH on experience.
Prof Adrian Davis – Additional Slides
Specification

The specification is largely based on the draft SHA Clinical Leads Audiology Network (CLaN) specification, is in line with national guidance, and has been developed with involvement from the following:

1. British Academy of Audiologists
   British Society of Hearing Aid Audiologists
   Action on Hearing Loss
   Hearing Link
   Chief Scientific Office, DH
   DH Lead Advisor on Audiology
   National Audiology Clinic Lead

8. NHS Tees
9. NHS Durham
10. NHS Berkshire
11. NHS West Midlands
12. NHS South Central
13. NHS Solihull
14. NHS North of England
Hearing assessment, fitting, follow-up and aftercare services should be familiar with the best practice guidance signposted below:

- NHS Core principles
- National Institute for Health and Clinical Excellence Guidance/Quality Standards, when available
- Department of Health: Standards for Better Health
- Clinical protocols specified by British Society of Audiology and British Academy of Audiology
- British Society of Audiology guidelines on minimum training standards for otoscopy and impression taking 12
- British Society of Audiology and British Academy of Audiology guidance on the use of real ear measurement to verify the fitting of digital signal processing hearing aids 12 and 13
- Guidelines on the acoustics of sound field audiometry in clinical Audiological applications.
- Hearing Aid Handbook, Part 512
Published Clinical Guidelines and Best Practice (2)

- British Society of Audiology Pure Tone air and bone conduction threshold audiometry with and without masking and determination of uncomfortable loudness levels
- British Society of Audiology recommended procedure for taking an aural impression
- British Society of Audiology recommended procedure for tympanometry (when undertaken)
- British Academy of Audiology Guidelines for Referral to Audiology of Adults with Hearing Difficulty (2009)
- Recommended standards for pre-hearing aid counselling (Best Practice Standards for Adult Audiology, RNID, 2002)
- Recommended standards for deaf awareness (Best Practice Standards for Adult Audiology, RNID, 2002)
- Guidance on Professional Practice for Hearing Aid Audiologists (British Society of Hearing Aid Audiologists, 2011)
Suggested Minimum Qualifications and Skills of Clinical Staff
- Professional Head of Service

They must have as a minimum the following qualifications and skills (or equivalent):

- BSc Audiology (or equivalent e.g. Hearing Aid Council examination or Foundation Degree in Audiology) level of expertise in audiology, with a Certificate of Audiological Competence (or equivalent)

- Registered with the Health Professions Council (HPC) as a Clinical Scientist in Audiology or registered with the Registration Council for Clinical Physiologists (RCCP) voluntary register as an Audiologist.

- Where the Government’s Modernising Scientific Careers (MSC) programme brings about changes to registration requirements, senior audiologists must be registered accordingly.

- Appropriate training, skills and experience in testing, assessing, prescribing, fitting digital hearing aids and providing aftercare.

- Relevant experience at a senior managerial level, including experience of team management in adult audiology and evidence of CPD including the provision of patient education related to hearing loss and hearing aids.
Minimum Qualifications and Skills (2)

Suggested Minimum Qualifications and Skills of Clinical Staff, Audiologists.

They must have as a minimum the following qualifications and skills (or equivalent):

- BSc Audiology or Post Graduate Diploma in Audiology or pre 2004, Medical Physics and Physiological Measurement (MPPM) B-TEC and British Association of Audiological technicians (BAAT) parts I & II, with training in Clinical Certificate of Competency.
- Registered with the HPC as a Clinical Scientist in Audiology or a Registered Hearing Aid Dispenser, or with the RCCP voluntary register.
- Where the Government’s MSC programme brings about changes to registration requirements, audiologists must be registered accordingly.
- Evidence of appropriate and recognised training (including CPD) to conduct hearing assessments and rehabilitation, including the provision of patient education related to hearing loss and hearing aids.
- Appropriate training, skills and experience in objective measurements (e.g. REM) of digital signal processing (DSP) hearing aids.
Minimum Qualifications and Skills (3)

Suggested Minimum Qualifications and Skills of Clinical Staff, Registered Hearing Aid Dispensers, Assistant/Associate Audiologists

They must have as a minimum the following qualifications and skills (or equivalent):

- Hearing Aid Council qualification or Foundation Degree in Hearing Aid Audiology
- Registered with the HPC as a Hearing Aid Dispenser

Assistant/Associate Audiologists

- Assistant/associate audiologists must be trained to perform the functions for which they are employed. Such training may be provided by BAA accredited training centres or national training courses for assistant audiologists, or specific topics such as the BSA course in otoscopy and impression taking or audiometry.
- Associate audiologists would be expected to have completed the Foundation Degree in Hearing Aid Audiology (or equivalent).
## Currency and quality thresholds (1)

These guidelines are extracted from the implementation pack

<table>
<thead>
<tr>
<th>Technical Guidance Ref</th>
<th>Quality Requirement</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to assessment time</td>
<td>Assessments to be completed within 16 working days following receipt of referral, unless patient requests otherwise</td>
<td>90%</td>
</tr>
<tr>
<td>Assessment to fitting time</td>
<td>Hearing aids to be fitted within 20 working days following assessment, unless patient requests otherwise</td>
<td>90%</td>
</tr>
<tr>
<td>Fitting to follow-up time</td>
<td>Appointments are offered within 10 weeks from fitting, unless there are clear, documented, clinical reasons to do otherwise, or the patient chooses to wait beyond this period</td>
<td>90%</td>
</tr>
<tr>
<td>Quicker follow-up</td>
<td>Where patients request this, a quicker follow-up is offered within 5 working days</td>
<td>90%</td>
</tr>
<tr>
<td>Objective measurements (e.g. REM)</td>
<td>Patients undergo objective measurement at first fitting where clinically appropriate (exceptions reported in IMP)</td>
<td>95%</td>
</tr>
<tr>
<td>Additional follow-up</td>
<td>Where required, additional face to face follow-ups are offered within 7 working days of non-face to face follow-up</td>
<td>90%</td>
</tr>
<tr>
<td>Aftercare</td>
<td>Aftercare is available (face to face or non-face to face) within 2 working days of patient request</td>
<td>90%</td>
</tr>
</tbody>
</table>
### Currency and quality thresholds (2)

These guidelines are extracted from the implementation pack

<table>
<thead>
<tr>
<th>Technical Guidance Ref</th>
<th>Quality Requirement</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information sharing</td>
<td>Patient records and associated letters/reports completed and sent to GP within 5 working days of hearing assessment/fittingfollow-up</td>
<td>95%</td>
</tr>
<tr>
<td>Service user experience</td>
<td>Standardised patient questionnaire to be issued at discharge points. 95% of responses received from service users sampled should report overall satisfaction with service.</td>
<td>95%</td>
</tr>
<tr>
<td>Peer satisfaction of service</td>
<td>A minimum of one GP satisfaction survey will be designed and sent to all referring GPs. 95% of GPs sampled should report overall satisfaction with service.</td>
<td>95%</td>
</tr>
<tr>
<td>Service improvement</td>
<td>Service user questionnaires and peer satisfaction surveys to capture areas for improvements. 100% of recommendations made and agreed with Commissioners are addressed.</td>
<td>100%</td>
</tr>
</tbody>
</table>
### Currency and quality thresholds (3)

<table>
<thead>
<tr>
<th>Technical Guidance Ref</th>
<th>Quality Requirement</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing Inequalities</td>
<td>Patient questionnaire demonstrates a high satisfaction rate from all protected characteristic groups (PCGs)</td>
<td>95%</td>
</tr>
<tr>
<td>Reducing Barriers</td>
<td>An integrated patient pathway, which facilitates signposting to wider communication/social support services (where appropriate)</td>
<td>100%</td>
</tr>
<tr>
<td>Personalised Care Planning</td>
<td>All patients have an Individual Management Plan</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technical Guidance Ref</th>
<th>Quality Requirement</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased choice and control of when and where treatment is delivered (time and place)</td>
<td>Patient questionnaire to monitor satisfaction with amount of choice and control offered. 95% of service users sampled should report satisfaction with amount of choice and control</td>
<td>95%</td>
</tr>
<tr>
<td>Increased uptake of hearing aids and proportion of patients continuing to wear hearing aids</td>
<td>Percentage of patients still wearing hearing aids at review stage. 90% of patients fitted with a hearing aid should be continuing to wear the aid(s) at review</td>
<td>90%</td>
</tr>
<tr>
<td>Reduced social isolation and consequent mental health</td>
<td>Improvement in GHABP/COSI/IOI-HA outcome measures after hearing aid fitted</td>
<td>90%</td>
</tr>
<tr>
<td>Improved quality of life</td>
<td>Improvement in GHABP/COSI/IOI-HA outcome measures after hearing aid fitted</td>
<td>90%</td>
</tr>
</tbody>
</table>

These guidelines are extracted from the implementation pack http://www.supply2health.nhs.uk/AQPResourceCentre/Documents/111207%20Final%20Adult%20Hearing%20Implementation%20Pack.pdf
Section 2: Currency model and local prices (p21)

The currency model is broadly based on the 2011/12 non-mandatory tariff model, with some additional component inclusions as per the pathway in the specification. A 10% reduction has been applied to the 2011/12 non-mandatory tariffs, as existing providers (locally and elsewhere) are either currently delivering the service to reduced costs from the non-mandatory tariff or have agreed that it is achievable.

The prices in the model are inclusive of CQUIN and 20% of the total value for annual delivered activity will be subject to achievement of the 5 key service outcomes. The 5 key service outcomes will be equally weighted.

Local commissioners will need to determine which goals/indicators to include under CQUIN. Suggestions include moving one or more of the quality requirement indicators into CQUIN e.g. service improvement or using CQUIN to enhance the thresholds of one or more quality requirement indicators e.g. aim for 100%.
SECTION 2 – CURRENCY MODEL AND PRICES

The draft currency model and prices are based on the 2011/12 non-mandatory tariff

B.1 – SCOPE

Part 3 - Activity Planning, Prices and Payment

1.1 Prices and Payment

<table>
<thead>
<tr>
<th>Basis of Contract</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment only</td>
<td>£50</td>
</tr>
<tr>
<td>Assessment, fitting of 1 aid, cost of 1 aid, follow-up, 3 years aftercare and 3rd year review</td>
<td>£301</td>
</tr>
<tr>
<td>Assessment, fitting of 2 aids, cost of 2 aids, follow-up, 3 years aftercare and 3rd year review</td>
<td>£398</td>
</tr>
<tr>
<td>Annual aftercare and review (after 3rd year)</td>
<td>£23</td>
</tr>
</tbody>
</table>

3 Provision of batteries is included within the above tariffs

4 Prices are inclusive of CQUIN

• 20% of the total value for annual delivered activity will be subject to the achievement of the 5 key service outcomes detailed in section 5 of the specification. Each outcome will be weighted equally.

These guidelines are extracted from the implementation pack
• RCP is working with stakeholders to deliver accreditation

• Accreditation central to AQP in adult hearing services

• Guidance is being produced

• CQC
CQC registration is not a requirement for the provision of AQP routine adult hearing services. Complex services and services for children and people with learning disability could be regulated by CQC. For more information please refer to CQC.

We included additional qualification questions around quality assurance and accreditation for adult hearing services. Our recommendation is that a provider needs to:

• have submitted an application for IQIPS accreditation by 31 March 2012 – the relevant website (www.rcplondon.ac.uk/projects/iqips) will be live no later than 31 December 2011
• have completed the IQIPS Self Assessment & Improvement Tool for adult hearing services by 30 June 2012
• be IQIPS adult hearing service accredited no later than 30 September 2012
• AQP qualification will be conditional on achieving accreditation by 30 September 2012 and any provider that is not accredited by this date will be removed from the AQP national qualification register.
• Any new provider seeking AQP status from 30 September 2012 onwards will need to be accredited.
Thank you

• There is time to discuss now

• There is time to discuss after Jay’s presentation

• There is need for you all (NHS & social enterprise & IS) to have a discussion on local specification, whether you are in or out of AQP at the moment

• If you have further queries do contact me or Cheryl
  
  – adriandavis@nhs.net

  – cheryl.cavanagh@dh.gsi.gov.uk