BMJ Open

Any qualified provider: a qualitative case study of one community NHS Trust's response

Jackie Walumbe,[1] Deborah Swinglehurst,[1] Sara Shaw[2]

[1]Centre for Primary Care and Public Health, Queen Mary University of London, London, UK
[2]Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford, UK

Correspondence to
Jackie Walumbe;
jackie.walumbe@nhs.net

ABSTRACT

Objective: To examine how those managing and providing community-based musculoskeletal (MSK) services have experienced recent policy allowing patients to choose any provider that meets certain quality standards from the National Health Service (NHS), private or voluntary sector.

Design: Intrinsic case study combining qualitative analysis of interviews and field notes.

Setting: An NHS Community Trust (the main providers of community health services in the NHS) in England, 2013–2014.

Participants: NHS Community Trust employees involved in delivering MSK services, including clinical staff and managerial staff in senior and mid-range positions.

Findings: Managers (n=4) and clinicians (n=4) working within MSK services understood and experienced the Any Qualified Provider (AQP) policy as involving: (1) a perceived trade-off between quality and cost in its implementation; (2) deskilling of MSK clinicians and erosion of professional values; and (3) a shift away from interprofessional collaboration and dialogue. These ways of making sense of AQP policy were associated with dissatisfaction with market-based health reforms.

Conclusions: AQP policy is poorly understood. Clinicians and managers perceive AQP as synonymous with competition and privatisation. From the perspective of clinicians providing MSK services, AQP, and related health policy reforms, tend, paradoxically, to drive down quality standards, supporting reconfiguration of services in which the complex, holistic nature of specialised MSK care may become marginalised by policy concerns about efficiency and cost. Our analysis indicates that the potential of AQP policy to increase quality of care is, at best, equivocal, and that any consideration of how AQP impacts on practice can only be understood by reference to a wider range of health policy reforms.

Strengths and limitations of this study

- Extends previous literature on Any Qualified Provider policy which has been limited to surveys and commentary.
- Adopts a detailed case-study approach exploring how policy unfolds 'on the ground', which shows this is contingent on how actors understand and interpret policy, with unanticipated consequences.
- Linguistic analysis of clinicians' and managers' narrative accounts generates insights that conventional qualitative methodology cannot reach.
- Prioritises depth of analysis over breadth, increasing richness of understanding, but limiting generalisability of findings.

achieving a more patient-centred health service. It is assumed that the operation of patient 'choice' underpinned by the principles of a competitive market will drive up the quality of care. One way of expanding patient choice has been to facilitate new entrants to healthcare provision; there have also been changes to the ownership, governance and accountability arrangements of existing publicly owned providers.[1] In England, recent policy on 'Any Qualified Provider' (AQP) was intended to diversify healthcare provision by allowing patients to choose any provider—National Health Service (NHS, publicly funded), private or voluntary sector—that meets agreed quality standards and prices if their general practitioner agrees a referral is necessary.[2] Key features of AQP arrangements are outlined in box 1 (interested readers can read more detail in ref. 2). Commissioners set the price for the service and competition arises from patients choosing from a range of qualified providers. It is assumed that the quality of service will drive the market, rather than concerns about cost. This contrasts with alternative contracting arrangements (eg, competitive tendering) in which a contract to provide services is awarded to the

INTRODUCTION

Across Europe, there has been a trend towards increasing the choice of healthcare provider available to individual patients as one means of empowering patients and

Box 1 Key features of Any Qualified Provider (AQP) arrangements

▶ Providers (who can be National Health Service (NHS), private, third sector or social enterprise providers), qualify for AQP by meeting stipulated 'quality' criteria, and register as a provider within the scheme
▶ Commissioners (Clinical Commissioning Groups—CCGs— which are clinically led NHS organisations of which all General Practitioners are members) set local care pathways and referral protocols for the range of services open to AQP
▶ Commissioners set the price for the service
▶ Providers enter into 'zero-based' contracts with the Commissioners, offering to provide the contracted service but with no guaranteed income. Income depends entirely on how much activity they attract
▶ Referring clinicians having decided a referral is necessary offer patients a choice of qualified providers
▶ Competition among providers is based on the quality of the service (and not its cost)

successful bidder, and competition on price is an explicit feature of the bidding process.

This paper examines the impact of AQP policy on providers in the NHS in England. It addresses a gap in the literature concerning the effect of encouraging new entrants into the NHS.[3] AQP was a cornerstone of a programme of reforms set out by the previous Coalition Government in 2010 which sought to increase choice for the provision of NHS services.[4][5] Commentators suggested that commissioners were receptive to AQP in principle, but there were concerns over how it would be implemented, the capacity of smaller providers to respond, and potential fragmentation of services.[6–8] To our knowledge, limited research has examined the impact of AQP. We report findings from a single case study of an inner city NHS Community Trust, examining how clinicians and managers have understood, experienced and responded to AQP. These findings are relevant to all health systems that seek to increase quality and efficiency of care by introducing competition, with special relevance to those engaged in healthcare policy reform in the NHS in England.[4][9]

The introduction of market mechanisms in healthcare is not new.[10] In the NHS, a small proportion of services has always been provided by independent organisations.[3] However, NHS spending on private providers has increased dramatically as the introduction of competition has become more systematic; it was less than 1% in the late 1990s.[11] The NHS spent £5.6 billion on non-NHS providers in 2006/2007, which rose to £8.7 billion in 2011/2012.[12] It is difficult to provide a precise figure for current NHS spend on the private sector, but reports from the King's Fund and Nuffield Trust (both quoting Department of Health accounts) suggests that almost 9% of NHS budget is directed to non-NHS providers, and that close to one-third of NHS spending on community health services is now with non-NHS

providers.[13][14] Specific examples of NHS spending on private provision include: a nationally led procurement process which resulted in the appointment of Independent Sector Treatment Centres providing high-volume, low-risk elective surgery to NHS patients (2000);[15] a concordat between government and private providers allowed local negotiations with private providers for a range of services (typically elective surgery and primary care) (2001);[16] and since 2006, patients have been able to choose the time, date and place of their first outpatient appointment to secondary care via NHS Choose and Book.[17] Current policy declares an ongoing commitment to increasing the proportion of NHS budget spent on alternative providers. One key assumption that continues to drive this change is that managers and owners external to the public sector are more willing and able to innovate, confront and manage difficult issues, increasing efficiency, quality and productivity.[9][18–20] Such assumptions, and the evidence to support them, have been widely contested.[3][15][21–26]

METHODS

This study emerged from the experience of the lead author (JW) working as a specialist physiotherapist within an NHS Community Trust in England, while taking a postgraduate degree in global health (2012–2014). This provided a unique opportunity for a researcher-practitioner to study how AQP is understood and experienced and shaped by those working within musculoskeletal (MSK) services (one of eight service areas initially open to AQP—see box 2). An autoethnographic approach was used. In autoethnography, the researcher 'is deeply self-identified as a member' (ref. 27, p.374) of the social world which is under investigation. This was combined with in-depth interviews with managers and clinicians working within the Trust.

Approach

Our study is theoretically grounded in interpretive policy analysis.[27–29] This approach recognises that the policy process is emergent and takes place in a social environment of shared language and practice, in which actors interpret and construct AQP policy through interpretation and dialogue—a process that surfaces differences in values and interests and is open to multiple interpretations.[27][29][30] This interpretive approach contrasts with more traditional rational-instrumental approaches to policy analyses, which tend to assume that the implementation of policy is a linear process, the success of which can be examined objectively from a value-free stance, external to the environment in which a policy is enacted 'on the ground'.[27–29][31] Our methodological approach was linguistic ethnography, which is used 'to study language use in a range of social settings' (ref. 32, p.515). This combines linguistics and ethnography, bringing together different sources of data to understand how social and communicative processes

Box 2   Development of policy on 'Any Qualified Provider' (AQP)

July 2010—Coalition Government sets out a programme of reforms including extension of a mixed provider market to help ensure that patients have access to the services that provide best quality and value. Central to this was the plan to gradually extend AQP (then known as 'any willing provider') beyond elective care, where it is already largely applied, to most other parts of the NHS.

October 2011—Commissioners mandated to identify three or more community or mental health services from an initial list of eight for local AQP implementation (Adult Hearing, Diagnostic services closer to home, Venous Leg Ulcers, Podiatry, Primary Care Psychological Therapies for Adults, Community Continence, Wheelchair Services, musculoskeletal (MSK) services).

April 2012—Commissioners roll out AQP on selected community and mental health services with a transitional year to test the implementation process.

April 2013—Clinical commissioning groups (CCGs) take over responsibility for managing AQP implementation with decision-making on a local rather than national level.

March 2014 onwards—The decision to extend choice of providers, establish services as AQP, and ensure qualification of providers rests entirely with commissioners. All services are to be posted by commissioners on a 'contracts finder' website. In accordance with the European Public Contracts Directive, all public sector contracts above £111, 676 must be published in the Official Journal of the European Union.

Box 3   Overview of 'City Centre' National Health Service (NHS) Community Trust

City Centre NHS Community Trust is an inner city community healthcare organisation in the south of England. Established in 2009 following a merger of four organisations, its remit is to deliver a range of community healthcare services, including musculoskeletal (MSK) services, to a local population of around one million people.

At the time of the study, local MSK services had already been subject to competition, with a range of services being commissioned and delivered by different providers, each with different contracts and patient pathways. City Centre NHS Community Trust provides MSK services for one part of the local area. Other areas are served by a private (for-profit) provider and a public-private partnership.

MSK services are commissioned from City Centre via a rolling service agreement which is reviewed annually as part of a larger block contract for community services. There is, therefore, no specific formal contract in place for MSK services. At the time of the study local commissioners were encouraging City Centre managers to streamline services, increase capacity and deliver cost effectiveness. There were indications that future competitive tendering for MSK services was anticipated.

operate in different settings.[32] We were interested in how the managers and clinicians in our sample framed and represented AQP, and what values and experiences they drew on in their representations. Attention to social context alongside analysis of language provided a robust means for understanding the role that interpretation and dialogue played in shaping experiences of AQP.

Study design and data collection

We undertook an intrinsic case study[33] of one NHS Community Trust's experience of AQP (box 3). We deliberately focused on a small sample, as our concern was less about making generalisable claims and more about enabling a sound understanding of phenomena by detailed exploration of practices. Given that the study emerged out of JW's experience of working with the Trust (anonymised as 'City Centre'), we began by negotiating access to the Trust as a research site. We gave assurances about confidentiality, agreeing that we would not reveal the identity of the organisation and assuring anonymity for individuals (participant descriptions are, therefore, necessarily sketchy).

To give our case study of AQP policy a concrete focus, we honed in on MSK services partly because this was the area in which JW was working as a specialist physiotherapist (so providing insights into the everyday work of the service) and partly because this was one of eight services that commissioners were initially allowed to submit for AQP at its outset (box 2). The nature of MSK service

provision was not the main focus of our work; our primary focus was on how providers experience and talk about AQP. However, focusing on a concrete area of service delivery provided a tangible 'peg' for our interview participants, and this was more meaningful than asking about AQP in the abstract.

Data collection began with autoethnographic field notes recorded by JW, reflecting on her work within MSK services at City Centre, and providing a sense of the 'lived' reality of the workplace.[34] JW then undertook narrative interviews with a purposive maximum variation sample of eight City Centre employees involved in managing (n=4) and providing (n=4) MSK services, ensuring a spread of clinical and managerial perspectives, senior-range and mid-range positions (able to reflect on different aspects of strategy), and a historical perspective of recent changes (all had worked within City Centre for 2–10 years). In-depth interviews (informed by a topic guide, but tailored according to the role and responses of the interviewee) were conducted to gather accounts of participants' experiences of AQP. Participants were encouraged to extend their narratives through non-directive follow-on prompts (eg, 'Can you tell me a bit more about that?') our interest being in particular accounts of experience rather than on gathering responses to a set of predetermined questions. Interviewees described their past and current roles before recounting their experience of AQP in the context of delivering MSK services (box 4 gives examples of some questions asked of a senior manager but, as is usual with narrative interviews, each interview differed in its emphasis and was very much shaped by the interviewee). A narrative approach proved helpful in

Box 4 Example questions from the topic guide used in interviews

► Thinking back to July 2010, when the White Paper (Equity and excellence: liberating the National Health Service (NHS)) came out, can you tell me a bit about what your job involved around that time?
► In 2012, there were some major changes made to the law about how the NHS is organised and delivered in England. Would you tell me about your understanding of these changes to the health service?
► Has this change/the Act had an impact on musculoskeletal (MSK) services that you are aware of?
► [Can you tell me a bit more about that?]
► Remaining with the Health and Social Care Act, are you aware of any specific government policies that have emerged from the Act and that may affect MSK services?
► Could you explain a little bit about who is commissioning MSK services within the *borough*?
► [How does this (commissioning) actually work in practice?]
► To your knowledge, has the AQP policy been implemented in [name of organisation]?

enabling interviewees to recount and make sense of their own experience of AQP and interaction with wider organisational and policy contexts.

Analysis

In recognition of the role of dialogue in constructing the experience of AQP, we (JW, DS and SS) combined narrative analysis[35] and theme-oriented discourse analysis.[36] The former structured our analytic approach (gaining familiarity with the data, finding patterns and themes, searching for explanations and writing up).[35] The latter guided our interpretation of themes and analysis of the additional 'work' that words were doing beyond their face value, with a particular focus on how language constructs professional practice.[36] This approach allowed us to focus on the detail of dialogue and understand how the *meaning* of AQP is negotiated by interviewees. The analysis was informed by JW's ethnographic understanding of the local institutional circumstances in which interviews were conducted, and wider discourses concerning AQP distilled from academic and grey literature. All authors took part in data analysis. A distinctive feature of this research is JW's dual role as researcher-practitioner (JW was known to some of the participants). While offering the advantage of 'access' and a local understanding of working practices, an important part of the research process was attention to reflexivity and the role of DS and SS as 'critical friends', encouraging JW to pay explicit attention to the trade-off between objectivity/distance and immersion/access and offering alternative interpretive perspectives for discussion. Transcription included all the words spoken by interviewee and interviewer, with attention to significant hesitations, exclamations of emotion (eg, laughter) and long pauses. Our analysis is based on

83 pages of transcribed text (almost 50 000 words) resulting from just under 4 h of audio recorded interview data. We present quotes from our data to illustrate findings and, as is usual in linguistic ethnography, we focus in detail on the language that was used by interviewees to make sense of their experiences.

FINDINGS

The most striking finding that emerged across our data was the uncertainty expressed by participants regarding what AQP policy is and how it is operationalised. This uncertainty was expressed at all levels of the organisation, including clinical, management and executive staff. It extended to fundamental issues, for example, whether or not AQP was in existence before the Health and Social Care Act,[5] how AQP related to competitive tendering, and even whether or not 'City Centre' was involved in an AQP contracting arrangement. Take the following example from a clinician working in MSK services describing what AQP involves:

So my understanding of that is that services within the NHS can go out to tender and any qualified provider can kind of bid for that service. So I guess the commissioning groups can set out what they are interested in having for that service and then people will bid and say, you know, they can do it for this much money or that much money and this is the services that they can provide and, I guess, get picked according to what the commissioners feel are their kind of priorities…I've an image of them all sat in a room talking—having a meeting and deciding, well, you know, Do we want this? Do we want that? You know that's my image but I don't really know.

This clinician does not profess any expertise about AQP policy, indeed his talk is hesitant ('my understanding'; 'I guess'; 'kind of'), and conveys only a vague understanding of a process that includes tenders, bids and prioritisation by commissioners according to 'value for money'. Commissioners are constructed as the decision-makers here, and the clinician is absent and distant from the process ('I've an image of them all sat in a room talking') sure only of his uncertainty of how the process is actually conducted ('that's my image but I don't really know').

Managers in our case study expressed a similar sense of distance from, and uncertainty about, the AQP process. Take the following example from a senior executive:

The provisions for any qualified provider which were confirmed, I think they existed prior to the Act actually, but were confirmed, they were confirmed in the Act …So it's a little bit hazy what is the AQP, what is different about a provider being procured under AQP compared to the traditional procurement routes, the traditional tendering routes?

This interviewee expresses uncertainty about what AQP policy is ('I think, 'it's a little bit hazy'). One of the core assumptions underpinning the AQP policy is that it

would raise overall quality of care by supporting competition and offering choice of alternative 'qualified' (ie, approved) providers to patients, whose choice would be informed primarily by the quality of service. The contracting arrangement does not involve any competition on price; providers are paid a fixed tariff for their services by those commissioning care (ie, the Clinical Commissioning Group). However, this interviewee references the presumed similarity to traditional tendering options ('what is different about…AQP compared to the traditional procurement routes'). Throughout our interviews, AQP was regularly conflated with other types of contracting arrangements, particularly competitive tendering, and was presented as being synonymous with competition and privatisation.

Interviews were ostensibly about AQP. However, all interviewees seized the opportunity to express dissatisfaction with wider healthcare reforms, and their impact on working practice. Their talk focused on the increasing role for the market in healthcare, the rise of privatisation, competition and 'choice', and the consequences for their professional practices. The language they used indexed a range of Taylorist commitments such as efficiency, productivity and standardisation of care.[37] Several participants used the opportunity of discussing AQP policy to convey an acute sense that their ideological commitment to a publicly funded health service was under increasing threat.

It is against this backdrop of uncertainty about AQP policy and dissatisfaction with healthcare reforms over a number of years that our subsequent findings need to be interpreted. Our intention at the outset of the research was to examine understanding of AQP, and recent changes in working practices. However, given participants' own emphasis on a wider range of reforms, our findings reference changes that go back much further. We present three related themes which capture how AQP was understood, experienced and responded to by those working within MSK services: (1) a perceived trade-off between quality and cost in the implementation of AQP, (2) deskilling and erosion of professional identity; and (3) a shift away from interprofessional collaboration. We illustrate our analysis with data extracts in which interviewees gave accounts of their own working experience.

Perceived trade-off between quality and cost in the implementation of AQP

At the centre of AQP lies an assumption that the cost of a service is fixed by commissioners on a zero contract with providers encouraged to focus on *increasing* quality. Information about quality is then publicised to patients to inform their act of 'choosing' and allow them to maximise their utility.[18] Failure to attract patients this way will result in a forced exit of providers from the AQP marketplace leaving only higher quality providers. The Government and Department of Health have been emphatic that under AQP it is *quality not cost* that will drive this competition.[2 4 38]

All interviewees identified cost as a predominant feature of the market for MSK services, emphasising the ways in which clinicians and managers needed to reshape services so that they could be offered at lower cost. Paradoxically, interviewees talked about the tendency for this to lead to a driving *down* of care standards. Take the following example of one senior executive who challenged any suggestion that cost was not a central concern in AQP:

> It's always a factor. It's always a factor, that's rubbish. That's not a true reading of the policy, every tender that is 'let' has two ends of a score, one around price. It has to be because at the end of the day it's public money and in every tender there is a consideration as to price, you have to compete on price and it will be against the law not to compete on price.

This senior executive uses repetition ('It's always a factor. It's always a factor') as a way of highlighting how 'money' and 'price' are central to the tendering process. He emphasises this further by diverting from a formal to informal register of talk ('that's rubbish', 'let'—an informal contracting term meaning 'awarded'), and then directly challenges policy by saying that to suggest cost is not a central concern is an inaccurate interpretation of AQP policy ('that's not a true reading'). He stresses it is imperative to compete on price ('in *every* tender, there is a consideration as to price', 'you *have to* compete on price'), and how ignoring this 'will be against the law'. This view was shared by managers and clinicians within our study.

The emphasis on 'being cheap' in order to attract commissioners was a concern expressed by all interviewees. Managers described MSK services as an integral part of 'City Centre', a large community trust with its own internal bureaucratic processes which, they felt, placed restrictions on how competitive the MSK service could be. Take the following example from one senior manager as he reflects on the potential consequences of AQP for the future of the MSK service:

> I think in all likelihood, it's likely to go to a private provider who has lower running, managerial costs and better administrative support.

and then:

> We're hidebound by the terms and conditions of NHS employees which means that all our services are more expensive. Our overheads are much higher because we will always, we have a responsibility to, for pensions, we have responsibility for holiday pay, contracts, redundancy, you know all those things add that extra element.

This senior manager is concerned by the threat (presumed to arise as a result of AQP) from private providers who, she assumes, can provide the same services at lower cost. She uses extreme case formulations[39] (eg, 'all our services'; 'all those things'; 'we will always') to

defend her assessment of the situation as one in which she is bound by a set of inescapable constraints ('pensions', 'holiday pay', 'contracts', and so on) that mean it is not a level playing field. These formulations are used in everyday talk as a way of justifying a complaint or mounting a defense. She also uses three part lists[40] ('running [costs], managerial costs and administrative support'; 'holiday pay, contracts, redundancy') to persuade the listener of the key message here: that is, that the NHS is 'hidebound' and unable to respond to AQP because of conventional ways of working. Other interviewees talked similarly about NHS organisations being 'loaded with legacy costs' and non-NHS competitors being 'more nimble and agile' by comparison.

Clinical interviewees were sceptical of the idea that AQP drives quality within MSK services, describing new constraints on clinical practice resulting from concerns about—and cuts to—the costs of providing care. The following extract from a senior clinician suggests a downward shift in the standards of clinical care:

> I feel that the changes have been very cost driven. Changes have been put into place, which aren't necessarily from a clinical or for changes have been put in place that aren't necessarily focused on a clinical reason and more focused on cost reason. Although these two things are meant to be interlinked in reality it feels that a lot of the changes are being cost-driven. And instead of being able to provide a gold standard package of care, we're expected to deliver a bronze standard of care. Although that's not explicitly told or we're not informed explicitly of that, but the restrictions put on our working practice lead to that practically.

He points to two major changes that he has experienced in his own practice (both reiterated twice). First, and mirroring findings above, he points to changes being made on the basis of cost ('very cost driven', 'focused on cost reason'; 'a lot of the changes are being cost-driven') over clinical care ('aren't necessarily from a clinical'; 'aren't necessarily focused on a clinical reason'). Second, and drawing on metaphors of competition, he speaks of a resulting shift from 'gold standard' care to 'bronze standard' care.

This perceived shift in standards of care was reflected in the talk of other clinical interviewees (less so, managers) who expanded on what this meant for MSK services and patients. Clinicians acknowledged the need to 'balance' caseloads and waiting lists with what care it is feasible to provide. However, they talked emotively about how the 'balance is tipping' away from 'good' care towards 'acceptable' care, with services developing in a way that does not allow sufficient understanding of the patient and the 'subjective burden' of MSK problems.

Deskilling and erosion of professional values

Interviewees spoke persuasively about the ways in which their professional values were challenged by recent reforms. Clinicians, in particular, felt that they were

witnessing a devaluing of MSK care as a specialism, with likely detrimental impact on patient care. Take the following example from a senior clinician who suggests that there is a lack of understanding of the 'very complex needs' that patients have and the time and skills needed to understand and address them:

> But this has a big impact especially to our local clientele who often have very complex needs. Half an hour is adequate for basic MSK assessment, but quite frequently, these are not basic MSK assessments that we do here, and it feels there is no understanding of that from higher levels. And although you can do an assessment in half an hour, you miss so much and that impacts on your effectiveness.

This clinician challenges policy discourse about driving up quality ('no understanding…from higher levels') and, instead, explains how the recent requirement to conduct an MSK assessment in half an hour constructs the practitioner as providing a 'basic' or 'adequate' service. This, he argues, is 'not what we do here', and risks developing a service that is, in his view *less* effective ('you miss so much', 'impacts on your effectiveness').

All the clinicians in our sample described how their specialist skills were no longer recognised by a range of actors, including employers and commissioners. This sense of 'de-skilling' was captured in a perceived reframing of MSK work from 'non-traumatic MSK conditions' into 'aches and pains' that then made it a low priority for commissioners.

Managers described an uneasy shift in their own roles from public servants to corporate businesspeople:

> It's a huge difference, it's a completely different job…you make it up as you go along…you know it's the NHS, suddenly we're business modelling and we're marketing. We've had management consultants in to advise on efficiencies and process mapping.

This senior manager captures how their role is now characterised by new technocratic challenges ('business modelling', 'marketing', 'process mapping'), and the arrival of new kinds of professionals from outside ('we've had management consultants in'). This was a shift which neither managers nor clinicians felt equipped to deal with ('completely different job', 'you make it up as you go along'). Some interviewees were sufficiently uneasy about these changes that they said they would consider abandoning their career completely.

There were differences in the values that clinical and non-clinical staff attached to their work in delivering MSK services. Take the following example from JW's autoethnographic account:

> I'm starting to get the sense that non-clinical managers do not fully understand the MSK service provided and

the complexity of the patients we see in specialist clinics…They do not seem to be aware of the issues that could come up if new services did not work in an integrated way with other providers e.g. the acute hospitals, primary care GPs etc. …In today's interview with one of the senior clinicians, it felt like there was a fair bit of frustration about not being supported by the more senior people in the Trust…this mismatch in how the two groups see the service could explain some of the decisions that have been made to make the service more efficient.

This extract points to tensions between those responsible for managing and providing MSK services ('non-clinical managers do not fully understand'; 'a fair bit of frustration', 'mismatch in how the two groups see the service'). The 'two groups' are situated as having different priorities with non-clinical managers' concerns seemingly focused on organisational efficiency ('make the service more efficient', 'do not fully understand the complexity') and 'tayloring'[38] the organisation to the patient rather than, as with clinicians, finding ways to understand and address complex MSK problems ('complexity of the patients'; 'specialist clinics'; 'work in an integrated way').

A shift away from interprofessional collaboration

Clinicians and managers expressed anxiety about the changing nature of interprofessional relationships. Interviewees felt that when patients with non-traumatic MSK problems were understood as having complex medical conditions, they were best served when there was a spirit of collaboration and information-sharing between healthcare providers. However, interviewees described how, in a more competitive environment, different parts of the service were being 'performance-managed' against different metrics, and it was becoming more important to protect the boundaries of one's practice and, (importantly) not to work beyond boundaries. This shift away from highly collaborative towards more protectionist ways of working is clearly revealed in the following example from a clinical manager, selected as illustrative of a range of concerns expressed by participants across our data set:

There's a lot of people trying to protect their roles, and saying 'that's strictly not within the boundaries of what I do' whereas before there would have been a bit more flexibility and things like that. I can't think of the word at the moment—I think there's a lot of competition to maintain certain aspects of decisions within certain departments and then firmly push back on other departments. Because I think a lot of departments obviously are now being scrutinised for performance and things like that, so no one really wants to go out of their way to help and to blur the boundaries anymore because they're going to be questioned as to why they're working outside their scope of work or why they're taking longer than it should do. There's a lot of scrutiny on how well people are performing their roles as defined by their job role, as

well as I think in the past, a lot of people have had additional stresses and pressures and things like that and I think people are pulling back from that and so within the organisation, there's in some ways much less working together and more pushing back on each other to say you know, 'That's not my role. I'm not going to do that anymore'.

This interviewee provides a coherent narrative about competition in healthcare. However, he says he 'can't think of the word', suggesting that there isn't the vocabulary to adequately capture the competitive environment in which he works. He invokes metaphors of space ('boundaries', 'go out of their way', 'outside of scope'), and struggle ('protect', 'push back' 'pulling back'), to paint a picture of an environment in which people work to rule, not 'going out of their way to help', characterised by less flexibility and an unwillingness for any blurring of boundaries. The impression conveyed is that it is precisely this 'blurring' of professional boundaries that has, until now, made the management of patients with complex needs possible. Previously, interprofessional dialogue that negotiated shifting boundaries made the service work and allowed it to be responsive. He also uses reported speech ('that's strictly not within the boundaries of what I do'; 'that's not my role. I'm not going to do that anymore'), to invoke the collective voice of unnamed 'others'. In doing so, he is able to distance himself from this competitive behaviour, while at the same time, passing an evaluative comment on it (as an undesirable change). The speaker points to something that has been lost in this transition towards a more competitive environment: in the words of another senior clinician, the perception was that there is now '[a] reluctance to share, primarily because different organisations now might become competitors to provide the same service'.

DISCUSSION

There has been a steady growth in competition for services within the English NHS over the past 20 years.[41] The Health and Social Care Act 2012 marked a major milestone in the journey for the English NHS from a planned system to a competitive market for the supply of healthcare services, with AQP as a cornerstone. Our findings suggest that extending competition within the NHS via AQP is far from straightforward. There is limited understanding of the policy or its relevance within community settings, and limited commitment to qualifying as a provider within the AQP system (at least for those working in NHS MSK services). Our analysis indicates that the potential of AQP policy to increase quality of care is, at best, equivocal as far as clinicians and managers working in MSK services are concerned. Although policy documents and guidance emphasise the role of AQP in supporting competition based on quality (and not on price),[4][20] we found a troubled vocabulary about quality, and a concern that cost

dominates decisions by providers about how best to organise, deliver and bid for MSK services. Furthermore, managers and clinicians in our study indicated that market-based reforms over the past 20 years—deepened via the Health and Social Care Act[42]—have eroded professional values and reduced the willingness of managers and clinicians to go beyond the organisational, disciplinary and administrative boundaries of 'usual care'. Clinicians, in particular, associate this programme of reforms with commitments to efficiency, standardisation and deskilling that systematically ignore the complexity of MSK problems and allow no space for the 'biographical disruption'[43] entailed by chronic illness, nor the recognition that specialist care for patients with MSK conditions necessarily extends beyond the 'MSK'.

Research on AQP is limited. What little there is has suggested that AQP—at least at the outset of the Coalition Government's reform programme in 2010—was well received by commissioners and emerging or new providers.[7] To our knowledge, no further research has since been undertaken to examine the acceptability and feasibility of AQP to commissioners or providers, nor its impact on patient care. What information there is tends to consist of commentary,[12 44 45] popular articles,[8 46 47] and data repositories.[48 49] This 'information' tends to assume that AQP policy is widely understood and draws on surveys of people, organisations (eg, clinical commissioning groups (CCG), providers) and/or contracts about existing or planned AQP arrangements. Such information clearly has a role in contributing to debate (it highlights limited enthusiasm for AQP nationally, and limited use locally, with no requirements for commissioners to use AQP for services in 2013/2014 or 2014/2015, and only 77 (of 183) CCGs opening up any services to AQP[13 47]). However, it falls short of rigorous academic research.

Our study is grounded in practice, and is guided by an interpretive approach enabling us to examine the ways in which AQP and related policy is understood and experienced. We deliberately conducted a focused case study to allow us to examine the working practices of managers and clinicians within one NHS service. This clearly places limits on the generalisability of findings. However, analysing how people talk about AQP, and how they use this opportunity to reflect on wider reforms and their own working practices, combined with an autoethnographic account of working within MSK services, has enabled us to get below the surface of 'policy' and begin to understand what AQP policy means 'in practice'. Our work addresses an important gap in the literature concerning how AQP policy is—or perhaps is not—being interpreted and put into practice as originally envisaged by decision-makers.

The vision behind AQP policy is that commissioners strengthen the market and enable the diversification of provision, and providers respond by qualifying as accredited providers and securing zero-sum contracts for NHS work. Our research indicates that this vision is not being translated in practice. The prevailing discourse around AQP policy assumes that commissioners would welcome the opportunity to plan and purchase services in this way, and that public, private and voluntary sector providers would willingly jump through the necessary hoops to secure contracts. But the willingness and ability of those providing NHS MSK services to engage with AQP is questionable. There is a message here for decision-makers, not only about engaging with and supporting providers to convince them of the need for change, but about doing so in a way that recognises that AQP cannot be seen in isolation. AQP is part of a package of 'modernising' reforms that are perceived to 'taylor' the organisation to the patient, but potentially conflicts with other initiatives that encourage new and extended roles (eg, extended scope physiotherapist). There has been a steady drip of policies focused on extending competition among providers, which the MSK clinicians and managers in our study clearly feel has undermined their working practices. There is some evidence that there have been increases in quality.[3 25 41 50] Hence, while clinicians' reservations about quality of care are undoubtedly well placed, there remains at least the possibility that AQP policy might offer a mobilising force for thinking about and doing things differently.

At the time of writing, notice has been served on City Centre's contract for MSK services, and the Trust is working in partnership with other providers to respond to a competitive tendering exercise. AQP arrangements have, therefore, become less relevant. However, the time taken to contribute to the process of 'being competitive' has likely been considerable. As Reynolds and Mckee say: 'substantial legal, financial, and operational expertise is required to compile successful bids that can be delivered without incurring financial losses for the provider…Assembling a bid capable of winning a tender takes weeks of work and a major financial commitment'(ref. [22], p.1083). We do not, however, know the extent of the work involved. Further research is needed

► To systematically follow the AQP trail, understand the kind of contracts that are awarded to whom, for what and why. This is an important project, but one which is likely to encounter significant challenges regarding commercial privacy. At present, there is no easily accessible central source of information about what is contracted and under what contracting arrangements

► To understand what AQP (and related) policy means to patients and the public, and those working across public, private and voluntary organisations, and how they attempt to engage with and put it into practice in ways that do—or perhaps don't—enable a balance to be struck between high-quality care for those with chronic illness, and taylorist concerns with efficiency and productivity.

REFERENCES

1. Edwards N, Lewis R. Who owns and operates healthcare providers and does it matter? *J R Soc Med* 2008;101:54–8.
2. Department of Health. Operational guidance to the NHS: Extending Patient Choice of Provider. 2011a. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/151850/dh_128462.pdf (accessed 5 Mar 2015).
3. Allen P, Jones L. Diversity of health care providers. In: Mays N, Dixon A, Jones L, eds. *Understanding new labour's market reforms of the English NHS*. London: King's Fund, 2011:16–29.
4. Department of Health. *Equity and excellence: liberating the NHS*. London: DH, 2010.
5. House of Commons. *Health and Social Care Act 2012*. HMSO, 2012.
6. Office of Health Economics Commission. *Report of the Office of Health Economics Commission on Competition in the NHS*. London: OHE, 2012.
7. Jones L, Mays N. Early experiences of any qualified provider. *Br J Healthc Manag* 2013;19:218–25.
8. Soteriou M. Private companies dominate 'any qualified provider' contract bids. *GP Magazine* 8 January 2013.
9. NHS England. *Five year forward view*. London: NHSE, 2014.
10. Flynn R, Williams G, Pickard S. *Markets and networks: contracting in community health services*. Buckingham, UK: Open University Press, 1996.
11. Keen J, Light D, Mays N. *Public-private relations in health care*. London: King's Fund, 2001.
12. Arora S, Charlesworth A, Kelly E, *et al. Public payment and private provision: the changing landscape of healthcare provision in the 2000s*. London: Nuffield Trust, 2013.
13. King's Fund. Is the NHS being privatised? 15 March 2015. http://www.kingsfund.org.uk/projects/verdict/nhs-being-privatised (accessed 25 Jun 2015).
14. Lafond S, Arora S, Charlesworth A, *et al. Into the red? The state of the NHS' finances. An analysis of NHS expenditure between 2010 and 2014*. London, Nuffield Trust, 2014
15. Gabbay J, le May A, Pope C, *et al. Organisational innovation in health services: lessons from the NHS Treatment Centres*. Bristol: Policy Press, 2011.
16. Department of Health. *For the benefit of patients—a concordat with the private and voluntary health care provider sector*. London: Her Majesty's Stationery Office, 2000.
17. Green J, McDowall Z, Potts HW. Does Choose & Book fail to deliver the expected choice to patients? A survey of patients' experience of outpatient appointment booking. *BMC Med Inform Decis Mak* 2008;8:36.
18. Donaldson C, Gerard K. *Economics of health care financing: the visible hand*. 2nd edn. Basingstoke: Palgrave Macmillan, 2005.
19. Stevens S. Reform strategies for the English NHS. *Health Aff (Millwood)* 2004;23:37–44.
20. Department of Health. *Liberating the NHS: Greater choice and control—Government response: Extending choice of Provider (any qualified provider)*. London: DH, 2011.
21. Pollock AM, Price D, Roderick P. Health and Social Care Bill 2011: a legal basis for charging and providing fewer health services to people in England. *BMJ* 2012;344:e1729.
22. Pollock A, Price D, Roderick P, *et al.* A flawed Bill with a hidden purpose. *Lancet* 2012;379:999.
23. Pollock AM, Price D, Roderick P, *et al.* How the Health and Social Care Bill 2011 would end entitlement to comprehensive health care in England. *Lancet* 2012;379:387–9.
24. Reynolds L, McKee M. 'Any qualified provider' in NHS reforms: but who will qualify? *Lancet* 2012;379:1083–4.
25. Allen P. An economic analysis of the limits of market based reforms in the English NHS. *BMC Health Serv Res* 2013; 13(Suppl 1):S1.
26. Dickinson H, Shaw S, Glasby J, *et al.* The limits of market-based reforms. *BMC Health Serv Res* 2013;13(Suppl 1):I1.
27. Anderson L. Analytic Autoethnography. *J Contemp Ethnography* 2006;35:373–95.
28. Yanow D. *How does a policy mean? Interpreting policy and organisational actions*. Washington, DC: Georgetown University Press, 1996.
29. Fischer F. *Reframing public policy: discursive politics and deliberative practices*. Oxford: Oxford University Press, 2003.
30. Hajer M, Wagenaar H. *Deliberative policy analysis: understanding governance in the network society*. Cambridge: Cambridge University Press, 2003.
31. Wagenaar H. Meaning in action. *Interpretation and dialogue in policy analysis*. Armonk, NY: M.E. Sharpe, 2011.
32. Maybin J, Tusting K. *Linguistic Ethnography. In: Simpson J, ed. Handbook of applied linguistics*. London: Routledge, 2011: 515–28.
33. Snell J, Shaw SE, Copland F, eds. *Linguistic ethnography: interdisciplinary explorations*. Basingstoke: Palgrave Macmillan, 2015.
34. Stake R. *The art of case study*. Thousand Oaks, CA: Sage, 1995.
35. Muller JH. Narrative approaches to qualitative research in primary care. In: Crabtree BF, Miller WL, eds. *Doing qualitative research*. Thousand Oaks, CA: Sage, 1999:221–38.
36. Roberts C, Sarangi S. Theme-oriented discourse analysis of medical encounters. *Med Educ* 2005;39:632–40.
37. Pinder R, Petchey R, Shaw S, *et al.* What's in a care pathway? Towards a cultural cartography of the new NHS. *Sociol Health Illn* 2005;27:759–79.
38. Secretary of State for Health. *Government response to the NHS Future Forum report. CM 8113*. London: TSO, 2011.
39. Pomerantz A. Extreme case formulations: a way of legitimizing claims. *Hum Stud* 1986;9:219–29.
40. Jefferson G. List construction as a task and interactional resource. In: Psathas G, ed. *Interactional competence*. Washington DC: University Press of America, 1990:63–92.
41. Mays N, Dixon A, Jones L, eds. *Understanding new labour's market reforms of the English NHS*. London: King's Fund, 2011.
42. Timmins N. *Never again? The story of the Health and Social Care Act 2012*. London: King's Fund/Institute for Government, 2012.
43. Bury M. Chronic illness as biographical disruption. *Sociol Health Ill* 1982;4:167–82.
44. Charlesworth A, Kelly E. *Competition in UK health care: reflections from an expert workshop*. London: Nuffield Trust, 2013.
45. NHS Confederation. *Any qualified provider—discussion paper*. London: NHS Confederation, NHS Partners Network and Primary Care Trust Network, 2011.
46. Campbell D. NHS being 'atomised' by expansion of private sector's role, say doctors. *The Guardian* 6 January 2013.
47. Williams D. CCG interest in 'any qualified provider' scheme dwindles. *Health Service Journal* 11 September 2014.
48. NHS for Sale. http://www.nhsforsale.info/
49. Contracts Finder. https://www.gov.uk/contracts-finder
50. Gaynor M, Moreno-Serra R, Propper C. *Death by market power reform, competition and patient outcomes in The National Health Service*. Working Paper 10/242 CMPO. University of Bristol, 2011.