

discussion paper

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NHS Partners Network
Primary Care Trust Network

Any Qualified Provider

Key points

- The concept of Any Qualified Provider is not new, it has already been used in elective care.
- Any Qualified Provider policy proposes to widen application of the concept in order to improve quality and give choice to patients across more NHS services.
- The challenge is how to balance increasing choice with providing continuity and integration of care.
- This paper explains how this can be achieved by using the right levers (competition and choice) to achieve the right outcome.

This paper looks at the introduction of the Any Qualified Provider (AQP) policy and debates the different models under which AQP may operate. As a policy that aims to take into account patients' values and needs, the NHS Confederation envisages that AQP will operate under three models:

- competition in the market
- competition for the market
- a combination of the two.

We also recognise that there are some circumstances (for example, natural monopolies such as A&E departments) where it would not be appropriate to use competition. However, this discussion paper focuses on the services where some form of competition between providers would be appropriate.

The paper sets out how these approaches could work and considers when each approach might be most appropriate. We plan to test these ideas at a workshop with input from different types of providers together with current and future commissioners.

Introduction

Over the last five years, the NHS in England has increasingly emphasised the role of competition and choice as drivers to improve quality and innovation. The new government remains supportive of these policy levers, and the amended Health and Social Care Bill now before Parliament will

establish a clear framework for the National Commissioning Board and Monitor to determine the extent of competition exclusively on quality and outcomes rather than price.

The intention is for a mixed provider market to help ensure that patients have access to the services that provide the best quality and

overall value. Central to this is the plan gradually to extend AQP beyond elective care, where it already largely applies, to most other parts of the NHS. This could potentially facilitate new providers entering the market, subject to the existence of a national or local tariff and to the licensing requirements imposed by Monitor, the Care Quality Commission (CQC) and local commissioners. The three models outlined in this paper are the NHS Confederation's initial view of how extending AQP could lead to a more patient-centred service and improved outcomes.

Background to AQP

AQP allows patients to choose, where appropriate, from a range of qualified providers who are licensed to provide safe care and treatment, and select the one that best meets their needs.

AQP, as a model, is not new. It has been in place for routine elective care since April 2008 – known as 'free choice' and managed by a national-level contract for each provider on the Extended Choice Network (ECN). The rationale for extending it is:

- it gives patients the right to choose to be treated in the place that is most appropriate to their needs
- it drives quality up and provides levers for the best quality providers to grow
- it encourages innovation by making it easier for new providers to offer services.

One of the key features of the 'free choice' (ECN) agreements is that

they have been based on national accreditation combined with local (indicative, not binding) activity planning. The simplicity of these arrangements is one of the main strengths of the approach and is something that providers are very anxious to retain under the new AQP regime.

Building on the positive results of 'free choice', the Government's Health White Paper sets out plans to extend AQP to more NHS services over time.

Qualification of providers

Before providers can compete to offer a service, they need to be accredited. This is to ensure that they meet the quality standards and the appropriate pricing. A potential provider would therefore be accredited/licensed to provide a particular service or services. A provider is qualified under AQP on confirmation that they:

- are registered with the CQC (and Monitor from 2013) where required
- agree to the tariff that the commissioner is willing to pay (or national tariff where applicable)
- receive no guarantees of volume or payment
- can demonstrate a track record of delivery of the service (or pass due diligence if new to the market)
- agree to the terms and conditions of the standard NHS contract, incorporating any local commissioner quality requirements or service specifications

- sign up to managing potential conflicts of interest explicitly and transparently, ensuring patients are aware of their right to choose and options (especially if a GP practice).

Patients can choose from amongst all the providers who have met these requirements.

Providers will still need to register with local commissioners, but this will be mainly for the purpose of confirming adherence to local requirements. Commissioners cannot refuse to accept qualified providers unless providers:

- reject the price offered
- refuse to agree to any reasonable additional local standards (which will need to be justified by objectively identified local differences and needs) or to comply with pathways and referral thresholds
- fail quality standards.

Operation of AQP

The AQP model is intended to lead to an increasing focus on choice and competition as the drivers of a well functioning, patient-centred NHS that delivers effective and efficient services. The NHS Confederation supports the idea of extending choice and competition and recognises that an AQP approach has much to recommend it as long as it is designed and implemented intelligently. 'Free choice' seems to have been operating well and so it is worth extending. However, the new system also needs to recognise that patients have varying needs and that optimal models will be different for different services.

The specifics of implementing AQP will have to vary to reflect this and the different characteristics of different services and care pathways.

The NHS Confederation envisages that there will be three different models under which AQP may operate:

- **Model 1: competition in the market** – this is the most straightforward model, where

patients directly choose where and by whom they want to be treated (see Figure 1 below)

- **Model 2: competition for the market** – this model would address circumstances where commissioners need to tender for a more complex service (see Figure 3, page 5)
- **Model 3: a combination of the above** – this model would see commissioners tendering, but instead of granting the contract

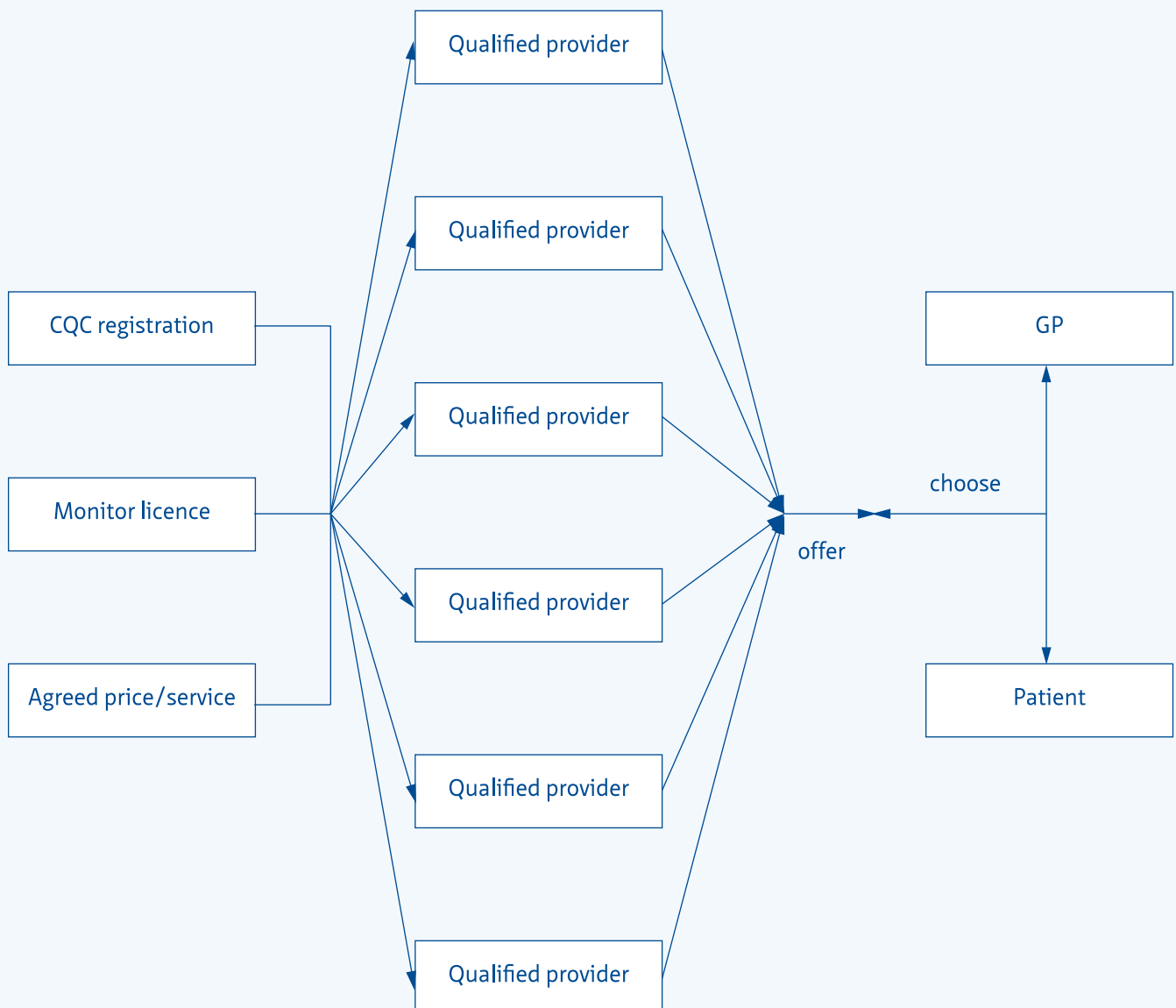
to one provider they might decide to have more than one provider and/or still offer some choices to the patient within a pathway (see Figure 4, page 7).

In this paper we discuss in more detail how these three models would operate.

Model 1: competition in the market

The first model is the one that is

Figure 1. Competition in the market



being referred to as competition in the market. This is a simple application of the AQP model:

- patients are offered choice at the point of referral
- the patient chooses from AQPs
- providers compete on quality so as to become the most attractive provider for patients.

This model gives more direct power to patients. Commissioners will still be able to add some local requirements but these should be proportionate, and commissioners should be able to have a clear and objective justification for such requirements.

This commissioning model is driven by choice: with certain (but tightly restricted) limitations, patients will be given the right to choose amongst AQPs. It is patient

choice and GP referral that trigger activity and payments to providers.

Commissioner considerations

Whilst the system appears simple from a provider and a patient point of view, it does raise important issues for commissioners. How to ensure that the new system does not lead to unplanned increases in costs is one such issue. This will require effective clinical referral protocols and treatment thresholds. Careful consideration also needs to be given to both ‘currency’ for services and to the need for local pricing where national pricing does not exist. Experience from the current Payment by Results policy operated by the Department of Health shows that these are technically challenging tasks. It is likely to be advisable for commissioners to collaborate rather than try to

address these at an individual primary care trust (PCT) or commissioning group level.

Clarity will be needed as to where different responsibilities sit, potentially as shown in Figure 2.

It is important to be clear what might constitute ‘proportionate’ local standards. It could prove extremely burdensome to providers (particularly those covering more than one area) if local commissioners develop very variable or very complex local standards. This should be avoided unless there are sound objective grounds and evidence that this would either:

- raise standards
- ensure that specific needs of the local population are met.

Provider considerations

Competition in the market opens the market to all qualified providers. This can be attractive for many providers: it allows players to enter the market and allows providers to flourish if they are patient-centred and provide good quality care. Equally, unresponsive or lower quality providers are likely to see reductions in workload and therefore income.

However, the model requires a change of culture which will be challenging for some. The lack of volume guarantees gives providers no reassurance about the level of activity they will get. This implies a very different culture to the one in which some organisations are used to operating, and these providers will have to adapt to the new

Figure 2. Potential division of responsibilities under competition in the market

National/central	CQC registration, Monitor licence, other professional regulation/registration assessed and checked/verified
	Corporate-level questions (for example, corporate governance, licences, tax, director responsibilities, insurances etc)
	National standard contract terms and conditions set
	National policies (for example, equality and diversity, information governance and IM&T requirements) set
	General clinical governance checked/assured
Locally	CQUIN
	Prices (where not covered by national tariff)
	Referral protocols
	Contract management
	Proportionate additional local standards

system rapidly. Otherwise, some providers who offer perfectly good quality services risk failing because of not being able to respond to the new market conditions.

Patient considerations

Information for patients to enable choice is key. Information on outcomes in some services, such as community services, is still not fully developed and sometimes inconsistent. This can make it difficult for patients to make a decision.

Patients will also need support in making such decisions. In

most cases, this support is likely to come from a professional, such as a GP, who may have a conflict of interest. It is important to acknowledge and address possible conflicts of interest to ensure probity and maintain trust between patients and healthcare professionals.

Other considerations

- This model is more suitable for products at a micro level, hence it is seen as episodic.
- Relationships are important here. However, there is a natural limit to the number of relationships a GP can sustain.

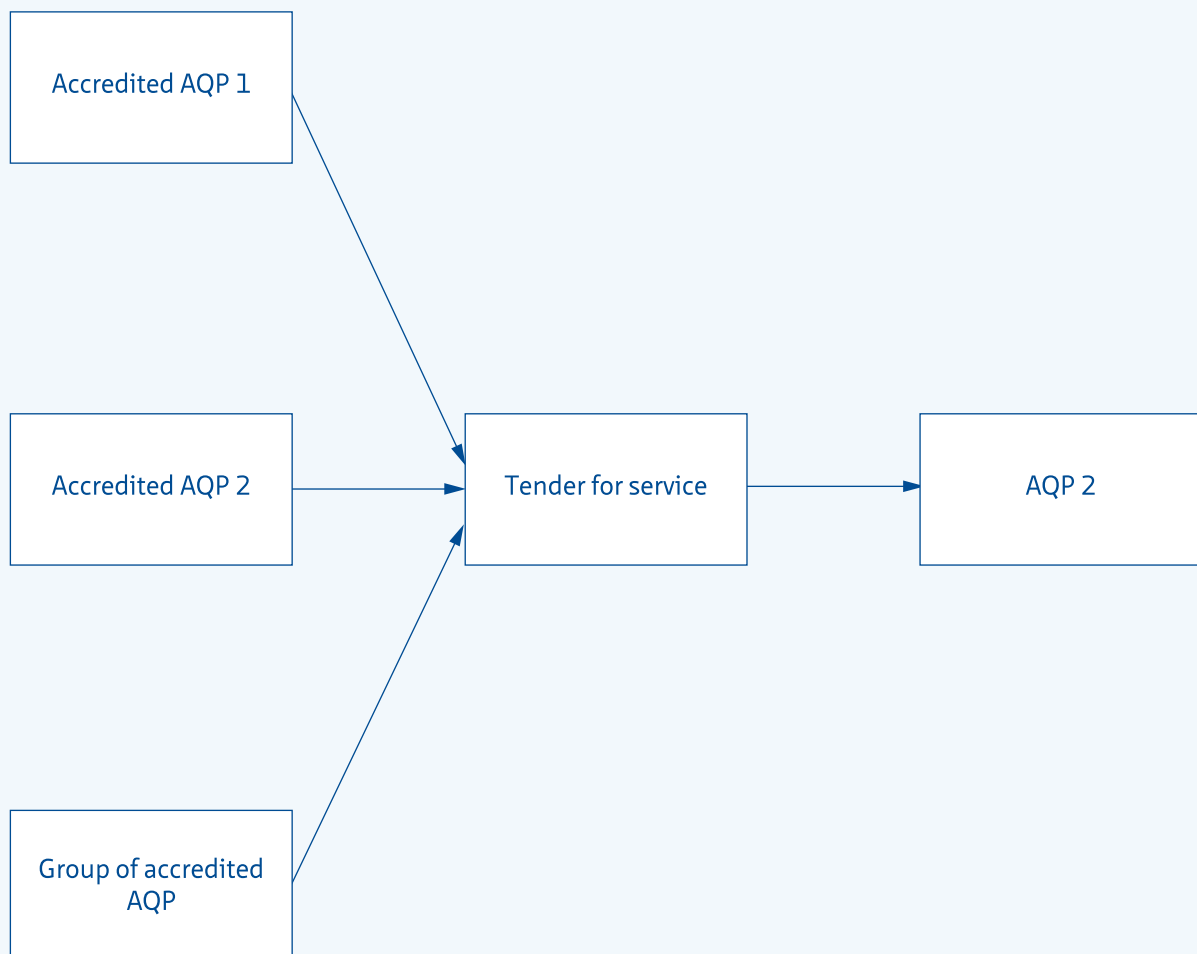
- Navigation is critical.
- This model needs resilience, scope and scale.
- Coordination is a key principle.

Model 2: competition for the market

It is clear that competition in the market can be applied relatively easily for simple episodic treatment of a one-off nature in which the process of care consists of assessment – referral – treatment – discharge.

However, there are other more complex services in which this

Figure 3. Competition for the market



approach is unlikely to be in the interests of either patients or taxpayers. In these circumstances an alternative approach – competition **for** the market – is more likely to be appropriate.

The characteristics of competition for the market are:

- an output or outcome-based service specification developed by local commissioners
- competitive tendering using standard procurement processes, open to any willing and qualified provider or consortium of providers
- award of a contract to the chosen provider to deliver the services for an agreed contract period and price. This could potentially involve a lead provider who could sub-contract to other providers.

Commissioner considerations

Commissioners will need to consider carefully how best to set service specifications for such services. Given there is a significant element of price competition in this model, it will be important to get this right. There are dangers that over-specific service contracts could stifle innovation by providers. However, under-specified services may also not deliver what is required. A move towards output or outcome-based specification is attractive but may be technically difficult, particularly given the shortage of agreed quality measures for many areas of community and primary care. The NHS Commissioning Board could helpfully develop exemplar service specifications for these

sorts of complex services for local commissioners.

Unlike the in the market scenario, choice of individual provider is no longer the driver in this case; this model uses competition ‘for’ the market between willing and qualified providers at the point of commissioning instead.

Provider considerations

The main difficulty that this model may pose for providers is that it makes it more difficult than the previous model to allow new entrants into the market. Since providers would be getting a contract for a certain period of time, new entrants would have to wait until that contract comes to an end before being able to compete for the service.

On the other hand, providers would have a clearer understanding of the possible income level they can expect, which can make it easier for them to develop their business plans.

Patient considerations

Patients will not be offered choice in the same way as they would under the competition in the market model. However, the reason why certain services would be commissioned under the competition for the market model is precisely because patients would need a high level of care coordination, which would be difficult to provide within the competition in the market model.

Quality of care would not be undermined. Periodic competition, as well as regulation, would continue to safeguard a high quality of care.

Other considerations

- This model works where there is an indivisibility of the pathway.
- Economies of scope along the pathway would make this suitable where, for example, removing one aspect of care makes the rest of the pathway no longer economically viable.
- Given the complexity, there is a need for coordination.
- Linked to this, given the number of parties, there is also a need for accountability.
- There could be price efficiency, particularly where the risk is transferred to the provider from the commissioner.

Model 3: the combined model

In some instances where competition in the market is not appropriate, it may not be necessary to move completely to the model of competition for the market. It is possible to envisage scenarios where commissioner and patients will benefit from secure supplier arrangements (as in competition for the market) but there will still be opportunities in the care pathway for the patient to exercise choice between alternative treatments and alternative providers. However, this will be within the overall management framework established by the prime contractor selected through the initial commissioning and tendering process. The overriding principle will continue to be ensuring seamless, integrated arrangements which deliver what the patient needs.

This third model is a combination of the two models explained above. It will be driven by competition at the outset and tendering stage, but it will still have a level of choice.

Competition will happen in a similar way to that seen under the competition for the market model: commissioners will undertake a competitive tendering process against a service specification and accredited providers will be able to bid for the contract. Choice can be offered in two different ways:

- the commissioner may decide to offer the contract to only one provider. However, this provider will have agreements with other providers and offer choice along the pathway. In this case, one provider will act as the lead contractor. This can make the commissioner/provider relationship easier. However, in order to ensure a

smooth relationship, it should be clarified that responsibilities for 'sub-contractors' will rest with the lead contractor. This poses a question for providers as to how best to manage those relations

- the commissioner may award contracts to more than one provider so that patients can choose between them once the contracts are in place.

This model may be the most complex for commissioners and providers.

Commissioner considerations

For commissioners, it raises questions about how to performance manage providers. Competitive tendering is also a process which requires high management overheads which may be exacerbated with this model.

At the same time, this model offers additional choice for

patients and competition, improving quality and patient experience without moving to full competition in the market.

Provider considerations

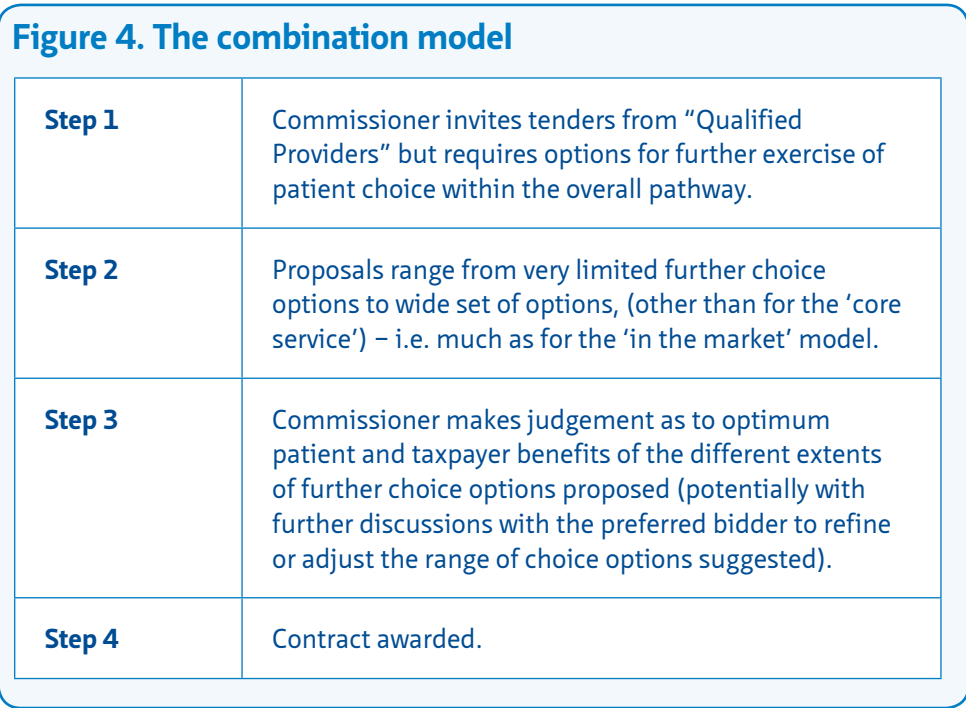
This model offers the possibility for providers to work together in such a way that they can offer a combination of coordinated services to best meet the needs of patients. For most providers, the opportunity to combine their services and offer a bundle of services will be new. It will require some relationship building as well as some new business processes, which can take some time.

Patient considerations

The model can open a new approach to care for patients, where they can make choices whilst still being provided with strong coordination of care.

Principles: when to operate under which model

The competition in the market model of AQP appears simple for straightforward episodic treatments, as in elective care, because the choice of a willing and qualified provider from a list essentially only has to be made once. It is harder to envisage for complex care pathways where, in theory at least, multiple choices of qualified providers could be needed along the care pathway. That seems unlikely to be welcomed by anyone, so, as described above, the use of AQP in such scenarios needs further thought. The question is then open as to when and in what circumstances it will be sensible for commissioners to use either the competition for the



market model or the combination model. The immediate response to this question may well be to think in terms of listing different types of service appropriate for the different approaches. However, defining services may be problematic, especially as parts of a service may fall under one category and others under another, and healthcare is likely to see a growing number of 'cross-overs' and new configurations of service in the future. It may therefore be more helpful to identify the characteristics that make a treatment fall under one or another category.

The NHS Confederation would welcome a designation based primarily on patient needs and experience. This means thinking about what will produce better outcomes for the patient. The key factor would be connectivity of patient journey: the more interactions and handovers, the less likely it is to be in the patient's interest to fragment their care or require repeated selection and referral decisions. Where the need for strong coordination of **multiple and complex care needs** is so important that operating under the competition in the market model would worsen patients' outcomes, it would seem right to use the competition for the market approach. Whether this is the competition for the market model or the combination model will need to depend on the judgment of commissioners.

Whilst patient experience is the key defining characteristic, complexity in relation to **price setting** may also need to be taken into account. Again, complexity of care plays a key role here as

this can lead to unpredictable costs of care which would make competition in the market difficult.

Whether **length of time for the treatment** (or series of treatments) is a defining characteristic is arguable. At first sight, services for people with longer term conditions can be complex and not easily connected. But that is not always true if we think about treatments rather than services as a whole. Cost is again an issue when looking at long-term conditions as they become costlier with time. However, this could be addressed if patients did not have to choose a provider for the entire term of their care but instead for either specified treatments with a time limit or if they were able to choose a provider for a period of time only and review their decision after that period of time has lapsed.

Choice

A key objective of the proposed NHS reforms is to embed patient choice across the system, partly because of the potential for choice to drive quality improvements, but more importantly as part of the drive to put patients at the heart of the NHS. It is also an overdue recognition of the fact that healthcare lags behind almost every other sector in its level of consumer choice and information and that this will inevitably change anyway.

The role of choice in the AQP model needs some discussion. At the strategic level, the availability of AQP makes choice a far more telling reality. Patients should, with AQP, be able to choose between a genuinely diverse range

of qualified, quality providers, with different approaches, different treatments and pathways, and different styles, rather than a narrow range of providers with essentially the same culture and the same methods. However, this apparently simple and desirable proposition requires significant elaboration as soon as it is applied at a more practical level. It will be vital in the detailed implementation of AQP to ensure that the availability of choice is not diluted or abandoned because of other considerations.

Choice under the competition in the market model

Individual patients have greatest scope to exercise choice under the competition in the market model. This model applies where informed patients can make choices between multiple providers, usually in a planned way and with support from a GP or other referrer. Where individual patient choice is not possible or appropriate, for example in a natural monopoly scenario or under a designated service model, competition in the market is likewise not appropriate. Emergency services and rare or complex procedures carried out by only a tiny number of specialists in a few locations do not lend themselves to patient-level choice and it is entirely sensible and reasonable to recognise this in commissioning strategies.

However, it is also important to recognise that following emergency procedures or specialist treatment there may well be secondary points at which it does become possible to offer choice to the patients, for example in follow-up care or rehabilitation. This possibility needs to be

Summary of the three models of Any Qualified Provider

	In the market	For the market	Combination
Commissioning driver	<ul style="list-style-type: none"> • Choice 	<ul style="list-style-type: none"> • Competition 	<ul style="list-style-type: none"> • Competition followed by choice
Basics of the operation model	<ul style="list-style-type: none"> • Patients can choose from AQPs • AQPs compete (primarily on quality) 	<ul style="list-style-type: none"> • Providers bid for tenders to run a service 	<ul style="list-style-type: none"> • Providers bid for tenders but patients still have choices after that
Principles to decide what model to apply	<ul style="list-style-type: none"> • Episodic care • Referral – treatment – discharge • Short timescale • No additional choices in the pathway 	<ul style="list-style-type: none"> • Needs coordination • Complex package of care • Short or long time period • Services need volume to guarantee safety 	<ul style="list-style-type: none"> • Providers can offer a bundled service • Longer-term conditions • Opportunities to offer choice along the pathway
Issues for providers	<ul style="list-style-type: none"> • Allows best quality providers to grow • No guarantee about the income level 	<ul style="list-style-type: none"> • Difficulties for new entrants • Better understanding about the income level 	<ul style="list-style-type: none"> • How best to bundle services and coordinate provision with other providers
Issues for commissioners	<ul style="list-style-type: none"> • Difficult to performance manage a large list of providers • Need to improve quality data 	<ul style="list-style-type: none"> • Easier to performance manage • What to do when a provider fails 	<ul style="list-style-type: none"> • Possible difficulties in performance management
Issues for patients	<ul style="list-style-type: none"> • Gives more choices to patients • Drives quality up • Presumes an informed patient 	<ul style="list-style-type: none"> • Competition will safeguard quality • Coordinated care 	<ul style="list-style-type: none"> • Coordinated care with choice • Presumes an informed patient

acknowledged and catered for by identifying what the 'choice points' under different circumstances may be, subject always to clinical considerations.

Choice under the competition for the market model

Choice also exists when providers compete for, rather than in, the market. Here, however, the primary choice points will be the commissioners' choice of main

provider and, potentially, patient choice of treatment type or care package. Again, there may also be secondary choice points – for the initial diagnostics or for the follow-up care such as physiotherapy.

What matters for choice in this model is that:

- it is offered impartially and with a reasonable range of real options
- relevant, valid and sufficient information is available about the alternatives
- the offer is recorded on the patient's record along with the reasons for the eventual choice
- where the patient does not have either the capacity or possibly the wish to exercise choice themselves, the GP – or other key professional/clinical adviser – has to go through and document the process in the same way.

Choice under the combination model

It is in the combination model that the preservation of choice could be most at risk. This is because the model presumes the selection of a provider, who either itself or with the aid of sub-contractors, takes over the care of the patient at the outset of a potentially lengthy and complex care pathway. The opportunities for choice could therefore be restricted to:

- only the provider contracted with as a result of an initial tendering process
- only the sub-contractors tied into that provider as part of the original 'partnership' which has won that contract.

In order to protect choice under this model, a number of safeguards and principles could be adopted. The ideas below are not exhaustive but are certainly both

plausible and indicative of what could be done.

- Commissioners should try to ensure availability of more than one provider of a service or bundle of services – which could themselves be different in composition or in the overall approach to treatment – even if some of the alternatives are 'out of area', so that some genuine choice can be offered at the outset of care. That 'choice' may increasingly need to be about different clinical approaches or alternative pathways rather than simply a choice between qualified providers.
- In doing so, it is recognised that commissioners will not wish, and may not be able, to manage relationships with large numbers of providers, but that doing so is not necessary to achieve the objective. In many instances, the number of providers willing to participate will, in any event, be largely predetermined by the size of the potential market.
- It should be possible for a patient to switch out of the originally chosen provider. But in order to give reasonable stability to the system, there could be merit in stipulating, as in some other healthcare systems, when and how frequently such switching can take place.
- Contracts, which in many instances should be relatively long term, should identify and require designated 'choice points', either in time or in terms of sub-contracted services which would otherwise sit comfortably within the competition for the market model.

- At the choice points, the same principles should apply as in the competition for the market model.

If these or similar proposals are established and adhered to, it should be possible to ensure that within each of the AQP models the central principle of patient choice can be protected and implemented in ways that are realistic but that also make choice a reality.

Managing the system

There are several challenges which will need to be addressed if we are successfully to manage a system based on an AQP approach. Some of these will require changes to the way the current system operates, outlined below.

Commissioner specifications

Commissioners will need to be more explicit about which services they wish to commission and which they do not. This should be published in their commissioning strategies/service specifications and be made available to providers and the public. Commissioners will need to be transparent in their decision-making and be ready to explain their decisions if challenged.

Providers should not provide services which are not specified by the relevant commissioner and should not expect to be paid if they do. While commissioners have a responsibility to manage referrals by clinicians in their area, providers should not regard a referral as permission to treat.

We do not yet know how many

commissioning groups will be formed, but it is likely to be rather higher than the current number of PCTs. If every consortium develops very different service specifications, there is a risk that this would lead to increased transaction costs across the system. This will be particularly challenging for larger providers who operate across several consortia. While it will be for consortia to decide on their local priorities and plans, we would encourage them to collaborate, wherever appropriate, to avoid unnecessary complexity and variation in the system.

Pricing

Monitor will be responsible for developing national tariffs for services, against a framework drawn up by the NHS Commissioning Board. It will be important that this pricing structure incentivises providers and commissioners to put in place high-quality, cost-effective services. The current tariff arrangements do not work well for the management of long-term conditions and unplanned care.

Where there is competition in the market, pricing will need to be sufficiently refined to avoid 'cherry picking'. Where there is competition for the market, there will need to be flexibility for the commissioner to move away from the national tariff where this restricts sensible delivery options. Providers should not have the ability to veto such decisions, although they will need the approval of Monitor.

It is unlikely that all services will

be covered by national tariffs. Therefore, for some services, there will need to be local tariffs in place. These should be clearly published alongside commissioning plans. Providers should only offer treatment to patients where they are willing to provide the service for the locally published price. While individual commissioning groups are free to develop their own local prices, they would be well advised to collaborate as effective price-setting is a technically complex task.

Quality

It is very important for there to be clarity about responsibility for quality in the new system proposed under the Health and Social Care Bill.

Responsibility for assessment of qualification to enter the market should be the responsibility of the CQC as part of its registration system for quality and Monitor in relation to licensing. It is important to be very clear that accountability for this system would sit with Monitor and the CQC rather than local commissioners, to avoid commissioners duplicating effort and 'double jeopardy' and burden for providers, as can happen currently.

Therefore, in the event of a provider failing to comply with minimum quality standards, responsibility would sit with the provider organisation and the CQC rather than the local commissioner. This would require strengthening of the CQC's current approach to registration, which is not fit for purpose, to fulfil this requirement.

Local commissioners do retain responsibility for quality through monitoring of contract compliance, implementation of contractual remedies, where appropriate, and use of CQUIN or equivalent measures to reward quality improvement. Where a commissioner has serious concerns about quality, they would also have a duty to notify the CQC and Monitor of their concerns.

Confederation viewpoint

AQP, as a model, has been in place since April 2008. The rationale for extending it is that it opens up choice for patients, can drive quality up as well as providing levers for the best quality providers to grow, and encourages innovation.

Whilst the idea is very plausible, there are various challenges to overcome. It is important that the Government develops appropriate policies that support the model and allow it to offer the best outcomes for patients. This paper suggests three models that the PCT Network and the NHS Partners Network believe could achieve this objective.

We would encourage the Government to look at these three models, which have been consulted on with our members, and consider whether they could form the base for its AQP policy.

For more information on the issues covered in this paper, contact patricia.suarez@nhsconfed.org

NHS Partners Network

NHS Partners Network (NHSPN) was established in 2005 and incorporated into the NHS Confederation in June 2007. NHSPN is an alliance of independent (commercial and not-for-profit) healthcare providers involved in all aspects of NHS care at primary, secondary or acute level, including diagnostic and specialist treatment centres.

We aim to help independent sector providers become a fully accepted part of a mixed economy NHS that seeks to offer greater patient choice and value for money for patients and taxpayers.

For further details about the work of NHSPN, please visit www.nhsconfed.org/nhspn or email nhspn@nhsconfed.org

Primary Care Trust Network

The PCT Network was established as part of the NHS Confederation to provide a distinct voice for PCTs. We aim to improve the system for the public, patients and staff by raising the profile of the issues affecting PCTs and strengthening the influence of PCT members.

For further details about the work of the PCT Network, please visit www.nhsconfed.org/pctn or email pctnetwork@nhsconfed.org

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