

Title: Choice of Named Consultant-Led Team Lead department or agency: Department of Health Other departments or agencies:	Impact Assessment (IA)
	IA No: 2010
	Date: 11 th October 2011
	Stage: Final
	Source of Intervention: Domestic
	Type of measure: Other

Summary: Intervention and Options

What is the problem under consideration? Why is government intervention necessary?

Comparison with other countries suggest NHS outcomes in some areas of healthcare are not as good as they could be, for example rates of amenable mortality, mortality rates of respiratory diseases, acute complication of diabetes and incidence of MRSA infection rates. The NHS also scores relatively poorly on being responsive to the patients it serves and lacks a genuinely patient-centred approach where patients are often expected to fit in around services. We also know from the evidence that patients want and increasingly expect greater choice and control over their health care. Organisation with an acceptable level of performance for the organisation as a whole has less incentive to raise the performance of any relatively poorer performing teams. As hospitals report performance at an organisation level, the hospital management may not be aware of problems at a more disaggregated level

What are the policy objectives and the intended effects?

The policy objectives are:

- Improve outcomes from health interventions;
- Improve responsiveness of services to patient preferences;
- Increase patient choice and control; and
- Improve resource allocation between consultant-led teams

The intended effects are

- Providers will be more responsive to patients in the way they design their services; and
- More money will flow to more popular services

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 1: Do nothing

Option 2: Implement new requirements of choice of named consultant-led team policy on commissioners and providers under the Standard NHS Contract for Acute Services as set out in contractual guidance

NB: Further policy options relating to the broader set of commitments to extend patient choice will be considered in future impact assessments

Will the policy be reviewed? It will be reviewed. If applicable, set review date: 6/2016

What is the basis for this review? PIR. If applicable, set sunset clause date: NA/

Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	Yes
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SELECT SIGNATORY Sign-off For final proposal stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister:

..... *M. ...* Date: 3rd October 2011

Summary: Analysis and Evidence

Policy Option 2

Description: Implement new requirements of choice of named consultant-led team policy under Standard NHS Contracts for Acute Services as set out in contractual guidance

Price Base Year 2011	PV Base Year 2011	Time Period Years 5	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate: 50.0

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	Optional	60.2
High	Optional	Optional	71.4
Best Estimate	0.4	14.3	71.4

Description and scale of key monetised costs by 'main affected groups'

The identified economic cost areas that have been monetised include: GP consultation time (estimated to be up to £1.8 million p.a.); NHS funded patient transport to out of area providers (up to £885k p.a.); and changes and maintenance of profiles on NHS Choices (up to £650k p.a.). The policy is modelled over a 5 year period. These financial costs are adjusted for opportunity cost of health gains foregone by multiplying by 2.4 to give the figure in the box above.

Other key non-monetised costs by 'main affected groups'

Other cost areas that are not monetised are information costs, costs arising from patients receiving care from providers located in more expensive parts of the country, costs to patients in terms of time taken to research their choice and their private transport.

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	Optional	121.4
High	Optional	Optional	121.4
Best Estimate		24.3	121.4

Description and scale of key monetised benefits by 'main affected groups'

Monetised benefits include: short term improvements to quality (£22.7 million); and efficiency (£2.4 millions).

Other key non-monetised benefits by 'main affected groups'

Non-monetised benefits include the longer term benefits of efficiency gains resulting from improved investment decisions over time

Key assumptions/sensitivities/risks

Discount rate (%) 3.5

The key benefits reported here are based on one academic study and therefore there is a risk that these are under or over stated. Thus the figures reported in this impact assessment should be treated as indicative. The risks to the success of the proposals are whether or not patients and clinicians engage with the choice offer. The modelling of the costs is sensitive to the assumptions on time taken by patients and clinicians to discuss choice options and to the distance patients will travel if they choose a named consultant-led team located at a hospital that is further away than their "local" hospital.

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure qualifies as
Costs: £650k	Benefits:	Net:	No	NA

Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?		England			
From what date will the policy be implemented?		July 2011			
Which organisation(s) will enforce the policy?		Department of Health			
What is the annual change in enforcement cost (£m)?		No			
Does enforcement comply with Hampton principles?		Yes			
Does implementation go beyond minimum EU requirements?		N/A			
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)		Traded: N/A		Non-traded: N/A	
Does the proposal have an impact on competition?		Yes			
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?		Costs: N/A		Benefits: N/A	
Distribution of annual cost (%) by organisation size (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	No	No	No	No	No

Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
Statutory equality duties¹ Statutory Equality Duties Impact Test guidance	Yes	EIA
Economic impacts		
Competition Competition Assessment Impact Test guidance	Yes	21
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	Yes	21
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	11
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	Yes	22
Sustainable development Sustainable Development Impact Test guidance	No	

¹ Public bodies including Whitehall departments are required to consider the impact of their policies and measures on race, disability and gender. It is intended to extend this consideration requirement under the Equality Act 2010 to cover age, sexual orientation, religion or belief and gender reassignment from April 2011 (to Great Britain only). The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Evidence Base (for summary sheets) – Notes

References

Include the links to relevant legislation and publications, such as public impact assessments of earlier stages (e.g. Consultation, Final, Enactment) and those of the matching IN or OUTs measures.

No.	Legislation or publication
1	Government response to implementing choice of Any Qualified Provider and choice of named consultant-led team and accompanying http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_125442
2	Liberating the NHS: Greater Choice and Control http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_119651
3	Equity and Excellence: Liberating the NHS http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
4	Health and Social Care Bill 2001 http://www.publications.parliament.uk/pa/cm201011/cmbills/132/11132.pdf

One in One out (OiOo)

The proposals for choice of named consultant-led team do not require primary or secondary legislation. The lever for bringing about choice is guidance issued by the Department of Health to commissioners (statutory bodies). Any obligations on providers (public sector, private sector or civil society organisations) are terms and conditions of contractual agreements to provide NHS funded services. By virtue of applying to the public sector or being contractual obligations the proposals for increased patient choice are out of scope of the one-in-one-out process

Obligations fall on the public sector

The guidance for choice of named consultant led team and the impact assessment falls on the NHS commissioners (the public sector) and covers NHS funded activity under the standard NHS contract for Acute Services

Evidence Base

The evidence base provides information to support the findings in the summary pages. **Annual profile of monetised costs and benefits** include discounted values (at 3.5% and 1.5% for life years saved). Presented costs reflect opportunity costs of health gains foregone. The financial costs of year 0 are £160k transition costs and £5.7m annual recurring costs, giving economic costs of £0.160 * 2.4 = £0.4m and £6.4m * 2.4 = £15.3m

Annual profile of monetised costs and benefits* - (£m) constant prices

	Y ₀	Y ₁	Y ₂	Y ₃	Y ₄	Y ₅	Y ₆	Y ₇	Y ₈	Y ₉
Transition costs	£0.4 m	£0	£0	£0	£0					
Annual recurring cost	£15.3m	£14.8m	£14.3m	£13.8m	£13.3m					
Total annual costs	£15.7m	£14.8m	£14.3m	£13.8m	£13.3m					
Transition benefits	£0	£0	£0	£0	£0					
Annual recurring benefits	£25.1m	£24.7m	£24.3m	£23.8m	£23.5m					
Total annual benefits	£25.1m	£24.7m	£24.3m	£23.8m	£23.5m					

* For non-monetised benefits please see summary pages and main evidence base section

Evidence Base (for summary sheets)

Introduction

1. This impact assessment covers the Department of Health policy to deliver on the White Paper, *Equity and Excellence: Liberating the NHS*^a commitment to extend choice policy to choice of named consultant-led team. It discusses the impacts that result from implementing the policy as set out in the document *Government response to implementing choice of Any Qualified Provider and choice of named consultant-led team* and accompanying guidance to *Choice of named consultant-led team*, following the consultation *Liberating the NHS: Greater Choice and Control*^b which took place between 18th October 2010 and 14th January 2011. The consultation asked for views on how to implement a number of different choice commitments to give patients and service users greater choice and control. The Government has decided to publish its response to the choice of named consultant-led team element and issue contractual guidance to implement this commitment in July 2011 after the Listening Exercise. Subsequent Impact Assessments will be published on a timeline to match the implementation of the other choice commitments.
2. 617 unique responses were received from a wide range of stakeholders including patients and members of the public, clinicians, voluntary organisations, patient representative groups, carer organisations, local authorities, local involvement networks (LINKs), NHS organisations and staff, independent providers, pharmacists, academics, professional bodies and Royal Colleges, think tanks and trade unions. We would like to thank everyone for taking the time to respond.
3. Around 25% of respondents answered the question on implementation of named consultant-led team (approximately 154 unique responses). Of those, some 66% were generally in agreement with the proposed approach to implementing choice of named consultant-led team, with the Royal College of GPs noting that *"We broadly agree that these are steps in the right direction"*, and Berkshire Local Pharmaceutical Committee stating that *"Yes without these measures the system will not work"*.
4. Approximately 20% of respondents disagreed with the proposals. For example, 2020 Think Tank said *"we believe that choice of named consultant-led team is not necessary and makes the variety of choices too complicated"*. Coventry LINK noted that some of the individuals they had spoken to *"said that they did not think that choosing a consultant team was necessary and said they would prefer all consultants to be of sufficiently high standards"*.
5. The remaining 14% were either unsure or did not specify whether or not they were in agreement but offered comments. Further details can be found in the Government response^c.

A. What is the problem under consideration? Summary of analytical narrative.

6. Comparison with other countries suggest NHS outcomes in some areas of healthcare are not as good as they could be, for example rates of amenable mortalityⁱ, mortality rates of respiratory diseasesⁱⁱ, acute complication of diabetesⁱⁱⁱ and incidence of MRSA infection rates^{iv}. The NHS also scores relatively poorly on being responsive to the patients it serves and lacks a genuinely patient-centred approach where patients are often expected to fit in around services^{vi}. We also know from the evidence that patients want and increasingly expect greater choice and control over their health care.
7. Part of the reason, for outcomes not being as good as they could be, is that the provider of services are not as accountable to patients as they could be. Patients are referred to the organisation that provides the services, e.g. the Foundation Trust or independent sector treatment centre and not to the specific consultant-led team that will treat them. The performance of an organisation as a whole could mask a significant variation in performance across the teams within that organisation.

^a http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf

^b http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_119651

^c http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_125442

8. Consequently an organisation with an acceptable level of performance for the organisation as a whole has less incentive to raise the performance of the relatively poorer performing teams than it would if the organisation as a whole was performing poorly. The problem may go deeper. As hospitals report performance at an organisation level the hospital management may not be aware of performance issues at a more disaggregated level.
9. This leads to a related problem. By masking the relatively poor performance of certain teams within an organisation, resources continue to be allocated to teams on the basis of criteria other than the outcomes achieved. So a lack of patient choice of named consultant-led team means resources are not allocated to the named consultant-led team in line with patient preferences and this contributes to, and perpetuates, a relatively less efficient allocation of resources for acute care.

Rationale for Government Intervention

10. The proposed choice reform give patients more control over the healthcare they receive which is something survey evidence^{vii} suggests patients value in itself. In addition, the reforms will enable patient preferences to be signalled more clearly such that resources can be allocated to consultant-led teams more closely to those preferences. Greater choice and control by patients over the named consultant-led team to which they are referred, can influence the resource allocations in their local area. With money following the patient, the quality of the care provided by named consultant-led teams that patients choose will become more apparent to parent provider organisations.
11. A similar signal about patient preferences through choice of named consultant-led team will be available to commissioners. They can use this when making strategic decisions about priorities and the allocation of resources to providers.
12. Government is best placed to introduce the proposed amendment to the allocation mechanism because it funds the framework under which NHS healthcare is provided to patients and can influence the design of contracts between commissioners and providers. It can also influence, to an extent, the attitudes and behaviours of healthcare professionals and patients and ensure choice is implemented equally across England.
13. Through the proposals to extend choice, set out in the White Paper, the Government aims to create a presumption of choice over care and any treatment across the majority of NHS-funded services. Specific commitments cover a range of choice offers including: choice of any willing provider^d; choice about maternity services; choice about mental health services; choice about diagnostic testing; choice after a diagnostic test; choice as part of personalised care planning; choice about end of life care as well as choice of named consultant-led team discussed here. Therefore the impacts discussed in this document need to be viewed in the wider context of the presumption that everyone should have more choice and control over their care and treatment.
14. This proposed reform builds upon, and strengthens, the choice policy introduced to date. Patient choice has been introduced incrementally in specific areas of the NHS since 2004. The proposals in the consultation document *Liberating the NHS: Greater choice and control* (2010) are designed to change radically the impact of patient choices on resource allocations, to move accountability in the NHS closer to those who deliver the service and to increase the level of control patients have over their care. The introduction of choice of named consultant-led team forms part of these wider proposals.
15. Local decisions about how money is spent makes a big difference to the types of services available to local communities. Choice of named consultant-led team, combined with Payment by Results where money follows patients will allow patient preferences as indicated by their choice of named consultant-led team to influence local services. This will have the following effects: firstly providers will be more responsive to patients in the way they design the services; and secondly, more money will flow to more popular services giving these services a financial incentive to improve and expand.

B. What are the policy objectives and the intended effects?

16. The policy objectives are:
 - Improve outcomes from health interventions

^d 'Any willing provider' has been replaced with 'any qualified provider' as a more accurate reflection of Government policy.

- Improve responsiveness to patient preferences;
 - Increase patient choice and control; and
 - Improve resource allocation between consultant-led teams
17. The intended effects are
- Providers will be more responsive to patients in the way they design their services;
 - More money will flow to more popular services; and
 - Patients will be more satisfied with the services they receive.
18. At present patients only have a choice at the point of referral over which provider they can go to for their first consultant-led outpatient appointment. If a patient would like to see a specific named consultant-led team, either because they have had treatment with them previously or because of their reputation, the referral system makes it difficult for him or her to do so. The proposed change makes it possible for all patients.

C. What are the underlying causes of the problem (its aetiology)?

19. The policy proposal considered in this Impact Assessment is to extend choice over acute services from the existing choice of provider to choice of named consultant-led team. A discussion of the evidence that supports the wider policy of patient choice can be found in Annex C.
20. For choice of a named consultant-led team to function smoothly, there are a number of practical issues to be addressed:
- Ensuring the appropriate functionality of support systems, e.g. choose and book, is in place
 - Attitudes of healthcare professionals and patients should be supportive of the policy and its objectives; and
 - There should be information available at named consultant-led team level;

Functionality of support systems (Choose and Book and NHS Choices)

21. Choose and Book already supports choice of named consultant-led team provided that services are listed against a specific consultant. Choose and Book can be searched for appointment availability against a specific named consultant-led team where the consultant name is known in advance. Therefore Choose and Book should not be a barrier to the introduction of the choice over named consultant-led team. However the functionality of the system is limited and any further modifications to the system, e.g. to show multiple consultant-led teams simultaneously to support a search of available options, would be more complicated and could not be achieved to a time scale concurrent with implementation of the policy commitment.
22. NHS choices also needed to be updated to reflect the change to the choice offer. Some of the information on NHS Choices originates from the same database as choose and book, so that will need to be updated only once. NHS Choices has introduced the ability for providers to upload profiles for each named consultant-led team.

Attitudes and Behaviours

23. GPs have an important role to play in assisting patients to understand information about the options patients have about their care. Both GPs and patients will need to engage with patient choice for the policy to be fully effective.

Patients

24. A criticism, levelled at choice in general by some commentators, is that patients do not want it^{viii} and that they simply want good quality services at their local hospital. The demand for good quality local services is one with which no-one would argue. Choice is not about replacing local services but a mechanism by which high quality services can be delivered for all. There is evidence that patients are comfortable with, want and value greater choice. A number of surveys^{ix, x, xi} conducted since 2004 have found that approximately two thirds of patients would like a choice of hospital. By 2009, the British Social Attitude Survey^{xii} reports 95% wanting a choice of hospital.

25. The system at present allows patients a choice of provider. The King's Fund^{xiii} found that 21-29% of patients go to providers that are not their local hospital and that 5-8 percentage points of that was through patients actively choosing an alternative provider. Non-NHS hospitals are able to offer services through the extended choice network (ECN)^e. It was established in April 2007. From data collected by the Department of Health we can see that by January 2011, monthly activity had risen to 16,775 procedures at a value of £34million. This confirms that when offered an alternative, some patients will choose to go elsewhere.
26. Awareness of the opportunity to choose has also arisen. The Patient Choice Survey^{xiv}, conducted from May 2006 to Feb 2010, shows the proportion of patients saying that they are aware of choice rose from approximately 30% to 50%. The proportion of patients saying they were offered choice also rose by a similar amount. This gives encouragement that patients are more enthusiastic about opportunities to exercise choice over services than critics suggest and that as patient choice is embedded and expanded to more areas, take up will increase.

General Practitioner

27. The attitudes of GPs are also important. They act as the 'gatekeeper' to secondary acute care and make the decision about clinical appropriateness at the point of referral. Patient choice is not about replacing this role, but about involving the patient more in the decision-making process. If GPs are hostile to the idea of choice, take up of the opportunity could be limited. In its 2010 report, the King's Fund^f interviewed GPs and hospital providers about what they thought about choice. They summarised their findings thus:

In general, the majority of those we spoke to among GPs and providers were positive or ambivalent about choice. Many felt that patient choice had existed within the NHS prior to the recent policy focus, and therefore, choice was really nothing new. A small number of interviewees felt that the policy had focussed the minds of GPs and providers on what really matters to patients.

28. This suggests GPs are not against patient choice in principle. The take up figures of 50% suggest however, that GPs may be reluctant to turn their acceptance into action within the GP consultation or at least in such a way that patients recall a "choice conversation". This might be a result of a perceived time pressure associated with offering patient choice, i.e. a belief that to offer choice effectively costs time that they do not have. For example one GP told the King's Fund^g
- 'If you have to refer that patient and have to create a choose and book letter... you have to explain their choice... then you have to explain the process... and it takes... at least 15 minutes'*
29. The Kings Fund suggests that it is problems with the Choose and Book system^h that has influenced GP views on choice more generally. One of the problems discussed is that the system does not allow referrals to a named consultant.
30. In summary, the evidence around attitudes towards patient choice appears to be broadly positive and ambivalent at worst. The change from choice of provider at point of referral to choice of named consultant-led team is relatively small and should cause few additional problems in terms of the way people view the policy. Indeed as the inability to refer to a named consultant was a criticism by GPs, the change proposed here may improve attitudes towards patient choice.

Information

31. Choice is at its most powerful to shape services if those choices are fully informed because the matching of patient preferences to healthcare services will be more closely aligned. At present, the NHS generates large amounts of information in some areas and smaller amounts in others, while insufficient data is collected and reported on outcomes. The level of that data is typically at provider organisation level. For decisions on choice of named consultant-led team to be better informed, information will need to be collected and published at that level. NHS Choices is being updated to publish whatever data are currently available at named consultant-led team level. The Government recognises the need to do more and has a specific programme to develop a new information strategy. A consultation Information Revolution (2010)ⁱ was also conducted from October 2010 –

^e Department of Health programme allowing non-NHS providers to register and list their services for NHS funded activity

^f *Patient Choice* p38, King's Fund (2010)

^g *Ibid* p42,

^h *Ibid* p45

ⁱ http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_120080

January 2011. Questions seeking views on the requirements to support patient choice formed part of that consultation.

32. Information produced by providers of NHS funded services is just one stream that patients use. User feedback and unofficial channels are others. Again the Information Revolution consultation, sought views on how patient feedback could best be used. Unofficial channels of information include past experience, reputation, experience of family and friends and other networks. These channels have the potential to influence strongly the view on which consultant-led team provides the best treatment.
33. There are dangers associated with information disseminated through networks. First it may not always be accurate. Views expressed within a network may be ill conceived or based on a misunderstanding. This could lead patients to make ill-informed decisions that are no better than uninformed decisions. Second, not all members of the public will have the same access to networks. This could lead to inequalities if the better connected can make better-informed decisions.
34. However, the final and most valuable source of information is, and is likely to remain, the General Practitioner (GP). The expansion of choice in general, including choice of named consultant-led team, is not designed to replace the GP as principle advisor to the patient. GPs will have a key role in supporting patients and helping them understand which option is best for them.

D. What policy options have been considered?

Option 1. Do nothing

35. The do nothing option means that choice at the point of referral will continue as now. Evidence from the *national Patient Choice survey* suggests that 50% of patients recall being offered choice and 50% do not. Patients will have free choice of acute services as stated in the NHS directions. This covers most specialties with the exception of some specific exclusions for referrals to mental health services, cancer and maternity. Admissions for emergencies through A&E and other urgent care are also excluded.
36. Patients will continue to receive the benefits of choice between providers including the convenience of picking an appointment slot for service by provider in the GP surgery; and providers will continue to have the incentive to improve services in order to attract more patients and revenue.
37. Not all patients will be able to choose a named consultant-led team for their treatment. This means that the level of accountability will normally remain at the provider level. The degree of pressure acting on individual teams will remain subdued so the incentive to improve services will also remain lower than if the proposal is introduced. Resources will continue to be allocated in a similar pattern to now, with no signal being provided about which named consultant-led teams patients prefer.

Derivation of Policy Options

38. The development of policy options considered for implementing the commitment to extend patient choice to include the choice of named consultant-led team was constrained by the existing systems and limitations to the functionality of Choose and Book and NHS Choices and the time available to consider alternatives. Given these constraints and the limited change to the choice offer that extension to named consultant-led team affords, option 2 was a logical proposition. In future years policies on Choose and Book and the information revolution are set to evolve. However, the commitment to implement the extension of choice and to review the infrastructure are not concurrent. Therefore, the requirements for choice will be considered as information technology and the information revolution are taken forward.

Option 2: Implement choice of a named consultant-led team

39. Patients who want to should be able to be referred to a particular named consultant-led team for their 1st consultant-led outpatient appointment. This will be part of the choice discussion between referrer and patient on where and when the patient wants to be treated. A referrer may also suggest going to a particular named consultant-led team where it is clinically appropriate e.g. when the patient has seen a consultant previously for a specific condition which is re-presenting. Of course, many people will have no preference about the consultant-led team they see. In that case, they should be referred to the generic service of their choice.

40. To make sure that all choices are safe and appropriate, the chosen consultant-led team must offer a health service that is clinically appropriate for the person making the choice. It will be for the healthcare professional making the referral to decide what is clinically appropriate. Providers are required to accept all clinically appropriate referrals. It is for the provider to assess whether the referral information provided meets their acceptance criteria.
41. The main lever for the Department of Health in implementing this choice offer are the Choice Guidance^j and NHS standard contracts^k. The NHS standard contracts are used to commission NHS funded services from all types of providers (NHS Trusts, Foundation Trusts, independent sector providers or civil society organisations). The contracts include standard terms, which cannot be amended and which record agreements reached by commissioners and providers relating to the services commissioned and associated quality and performance requirements. Some of the quality and performance requirements are nationally set and others may be agreed locally.
42. There are currently four core standard contracts (acute hospital service, mental health and learning disability services, community services and ambulance services). The contracts set out a general requirement for commissioners and providers and for 2011/12 include an explicit obligation relating to choice, which requires providers to comply with choice guidance including both current guidance and future guidance issued by DH (or the NHS Commissioning Board).
43. The Choice Guidance has the following implications for commissioners:
- The need to work with providers to ensure patients can be referred to a named consultant-led team of their choice;
 - The need to make referrers aware that providers should be listing services on Choose and Book by named consultant-led team and that referrers should refer to a named consultant-led team where the patient requests it and it is deemed clinically appropriate;
 - The need to ensure referrers have the tools and information to enable patients to make an informed choice of provider and named consultant-led team.
44. The Choice Guidance places the following requirements on providers of NHS services from April 2011:
- Accept all clinically appropriate referrals to a named consultant-led team however received;
 - List all relevant consultant-led services on Choose and Book in a way that allows users to book appointments with named consultant-led teams or by specialty clinic;
 - Publish information about their services that people can use to make their choice
45. Choice of named consultant-led team applies to referrals made to a 1st outpatient appointment with a consultant-led team i.e. where free choice of provider of NHS care applies. As set out in the Primary Care Trusts(Choice of Secondary Care Provider) Directions 2009 there are a number of services and people excluded. These would also apply to choice of named consultant-led team. These exclusions will be reviewed and amended as appropriate as the choice commitments in the White Paper 'Equity and Excellence: Liberating the NHS' are implemented
- Services currently excluded:-
- Accident and emergency services
 - Cancer services or services provided at rapid access chest pain clinics which are subject to the 2 week maximum waiting time
 - Maternity services
 - Mental health services
 - Any other services where it is necessary to provide urgent care
46. However where a service is excluded providers do still have discretion to list services by named consultant-led team if they wish to and where this is the case referrers are able to use their discretion to offer choice of named consultant-led team.

^j http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/Choice/DH_125411

^k http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091451

47. The principle mechanisms for delivering choice to patients and to communicate information to patients is through the appointment with GPs at the point of referral. The General Medical Council Guidance *Good medical practice – duties of a doctor*^l includes a duty to work in partnership with patients, respecting the right to reach decisions with the doctor about their treatment and care.

E. Impacts, Costs and Benefits of Option 2

48. The National Patient Choice Survey shows that approximately 50% of people at the point of referral are offered a choice of hospital and 50% are not. This is supported by research from the King's Fund^m. It shows that, of those offered choice, 68% choose to go to the local hospital and 29% choose a hospital further away. Evidence also suggests that 8% more of those offered a choice decide to attend a hospital other than their local hospital than those not offered a choice. We have no evidence on how these referral patterns will change as a result of expanding the choice offer from choice of provider to choice of named consultant-led team.

49. The benefits and costs calculations presented below are estimated around a central scenario which assumes that the change to the choice offer will increase people's willingness to engage with choice. For many this will simply mean specifying the named consultant-led team within the provider they would have chosen anyway. For some it may mean that they choose to travel further now that they can get an appointment with a particular named consultant-led team. Others who would have chosen to go elsewhere under "free choice" of provider may revert to their local provider, however on balance one would expect the group deciding to travel further to be bigger than the group of 'reverters'.

50. For modelling purposes, we assume that the number of people offered a choice stays the same, but of those that are offered a choice, the referral patterns change so that 10% more people choose to go to a named consultant-led team at a hospital further away. For those not offered a choice the referral patterns are unchanged. This means, of those offered, the proportion choosing to travel to a hospital further away rises from 29% to 32%. In turn this means following the introduction of choice of named consultant-led team, 11% more of those offered a choice decide to travel to a hospital further away than their local than those not offered a choice (the previous figure was 8%)ⁿ. There is a lack of detailed evidence to indicate the impact on take up rates from this choice commitment which has influenced our assumptions for the central scenario. Alternative scenarios can be found in paragraphs 90-97. Although we have modelled the take up rate staying at 50%, it is expected that the cumulative effect of extending the choices people are able to make would result in more people being offered choice. We will look at the potential benefits and costs from increased take up of choice in the impact assessment on the commitment to extend choice of provider significantly.

Benefits

51. As the coordinating document for the Impact Assessments that accompanied the Health and Social Care Bill 2011^o made clear, the benefits from choice are linked to the reforms proposed in the Bill and it is difficult to attribute quantified amounts of benefits to individual policies. This is because it would be artificial to separate out individual policies from the suite of reforms as the evidence is not robust enough to support a disaggregating of the benefits. The quantified figures given below offer a guide only to the likely scale of benefits.

52. The main means by which the extension of patient choice, including choice of consultant-led team, contributes to benefits include:

- Improved quality of care and health outcomes for patients and service users;
- Cost savings from more efficient provision by providers;
- More efficient allocation of resources to named consultant-led teams; and
- Intrinsic value of greater choice and control to patients and service users

^l http://www.gmc-uk.org/guidance/good_medical_practice.asp

^m *Patient Choice* p60 King's Fund (2010)

ⁿ Of those not offered choice 21% of referrals are not to the local hospital. Therefore those actively choosing to travel to a non-local hospital is 8% (29% - 21%). With choice of named consultant-led team, the assumption that 32%, of those offered a choice, are now referred to non-local hospitals means the percentage actively choosing rises to 11% (32% - 21%)

^o see para 37, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123635.pdf

Table of monetised benefits

Benefit	Annual	Total over 5 years*
Improved quality (reduced mortality)	£22.7 million	£110.2 million
Improved quality (other outcomes)	Not known	-
Improved efficiency (reduced length of stay)	£2.4 millions	£11.2 million
Improved efficiency (other efficiencies)	Not known	-
Intrinsic value of choice and control	Not known	-
Total costed	£25.1 millions	£121.4 million

*the benefits have been added over 5 years. Improved quality from reduced mortality has been discounted at 1.5%. Improved efficiency from shorter lengths of stay have been discounted at 3.5%

Details of the individual benefits follow below

Improved health outcomes

53. A paper by Gaynor et al (2010)^{xv} looks at the effects on health outcomes as a result of the expansion of patient choice in 2006. They used mortality rates (both AMI mortality and all-cause in-hospital mortality) as the measure of quality. They found that the policy change did have a statistically significant impact on mortality rates. They estimated that the policy change led to a change in mortality rates that equates to 3,353 life years saved at a value of £227 million. If 10% more people choose to go to alternative providers, by linear extrapolation this could lead to a benefit of £22.7 million per year.
54. The authors point out that this covers only one area of quality. Hospitals undertake many interventions for admissions where risk of death is low. For these, other measures of quality would be more appropriate, e.g. quality of life, but for which no suitable measured variable was available. If one could measure quality of life for other areas of health interventions, it is likely that the value of the health gain would be higher than the £227 million that the authors estimate.
55. As well as the expansion of choice, the paper considers the impact on lives saved from the change in market concentration of hospital provision between 2003 and 2007. A fall in market concentration (measured as a HHI^p calculation) means that a hospital acts less like a local monopoly provider. They find that “a hospital in a lower HHI market would have 3.1% fewer deaths per year... this translates into 54,771 more lives saved, with a monetary value of... £3.7 billion.”
56. They also note that they could find no change in either operating expenditure or operating expenditure per admission following policy implementation, so the life year gains were achieved at no cost to the taxpayer.

Improved efficiency of provision

57. In the same paper, Gaynor and Propper, discuss the benefits in terms of reduced length of stay. They estimated the value of the reduced lengths of stay to be £24 million as a direct result of introducing the policy and, similarly to the life years gained, the value of shorter stays for a hospital in a lower HHI market is £0.4 billion. Again, these data do not cover all hospital activity and only give a partial picture. Using a similar linear extrapolation for the 10% more people choosing an alternative provider as explained in paragraph 49, for our central scenario, the benefit is valued at £2.4 million per annum (i.e. 10% of the £24 million from reduced length of stay).
58. The efficiencies listed above are short-term efficiencies. In terms of the discussion in Annex C about the evidence on the impacts of choice and competition more widely, these are the efficiencies a provider can make from better use of existing resources or greater focus on the efficient use of these resources that arise from competitive pressure. However, a provider can also achieve long term ‘dynamic’ gains over time by making the right investment decisions that allocate resources in the most productive areas. In healthcare, this would mean investing in the services that patients want and value most. Patient choice, including choice of named consultant-led team, feeds into

^p Herfindahl Hirschman Index = $\sum_i^N s_i^2$; where s_i is the market share of the firm, in the market

these decisions by providing signals to providers (and commissioners) about precisely which services patients most value. For example, in the case of choice of named consultant-led team, the choices that patients make provide signals through rising referrals to specific popular named consultant-led teams. An astute provider will take note of persistent high (and low) referrals to a named team as a signal of good (poor) performance and where they should be considering investing and disinvesting.

Intrinsic value of choice / control

59. The evidence around the intrinsic value of choice of healthcare, which is set out in paragraph 20, cites a number of surveys that have repeatedly shown a positive attitude by patients to the principle of choice. This is corroborated in the report by the King’s Fund in 2010. The executive summary notes that “even if relatively few patients chose to attend a non local provider, our evidence shows that they valued having the ability to choose. We therefore conclude that given its intrinsic value, the NHS should continue to offer patients a choice of hospital.” However, no research appears to have been carried out on quantifying this intrinsic value. Therefore we have not quantified the value here but these additional benefits that will make any assessment of benefits to costs more favourable.

Costs

60. The table shows a summary of the quantified costs and the main areas where sufficient data are not available to provide quantified figures. Details and a discussion follow under the relevant sub-sections.

Summary table of monetised costs

Cost	Annual	Total over 5 years
GP consultation time	£1.8 million	£8.4 million
Patient time	-	-
PCT management time for contract updates	Low <£1 million	£4.7 million
Provider time for NHS Choice profiles	£0.650 million	£3 millions
Friction costs to providers	Not quantified	-
Information costs	Not known	-
Transport (NHS)	£0.885 million	£4.2 millions
Transport (Patient)	£2.027 millions	£9.47 millions
Patients choosing high cost areas	Low	-
Total cost	£5.4 million - £6.4 million	£25.1 million - £29.8 millions*

*Total are summed over a 5 year period and discounted at 3.5%. The low end of the range excludes PCT management time because it is unclear whether these will materialise. Table excludes one off cost of £160k to update NHS Choices

The figures in the table above are financial cost at 2011 constant prices. The economic cost can be calculated by adjusting for opportunity cost to give a total of £71.4 million (£29.8m * 2.4). This is the figure reported in the summary pages at the beginning of this document.

GP consultation time

61. A review of the evidence does not provide any clear indication whether or not the average length of a GP appointment will rise as a consequence of the extension of choice to named consultant-led team or not. In its response to *Liberating the NHS: Greater Choice and Control*, The Royal College of General Practitioners does raise a general concern that it will put more pressure on GPs time. But this was the only respondent in this area to questions 40 & 54 of the consultation which asked whether respondents agreed with the proposed approach to implementing choice of named consultant-led team and what the main risks were respectively.

62. Anecdotal comments by GPs, from the King's Fund report 2010^q, also raise concerns about additional time it takes to offer choice and use Choose and Book. The quotes given range from 'a few seconds' to 'at least 15 minutes'. The comments refer to choice in general and not choice of named consultant-led team in particular. Other anecdotal evidence from GP experts suggest that choice of named consultant-led team should only lead to a small increase in consultation time.
63. Below we suggest examples of how a referral discussion might develop. Once the GP has made a decision that a referral to secondary care is required, he or she may ask the patient about whether they have a preference about where they go. If the patient responds 'no' the GP should normally refer the patient to a generic clinic. The extension of choice to encompass choice of named consultant-led team will have no impact on the discussion.
64. If the patient responds 'yes' then the GP will arrange an appointment at the preferred provider, either through Choose and Book or by letter. At this point the GP could ask whether the patient has a preferred consultant-led team. If they do, the GP will book an appointment with the stated team, if available, and if no preference is stated then an appointment with a generic clinic would be booked.
65. Only if the patient responds with 'what are my options?' would a discussion ensue. This discussion is as likely to have occurred under the previous choice policy of choice of provider as under the proposal for choice of named consultant-led team. Therefore the primary implication is likely to be a time pressure, if the conversation about the options takes longer.
66. Anecdotal evidence is that the extra time should be short. It is possible in some instances where a patient has a clear idea of their preferred consultant-led team that the consultation time could be shorter. For some instances the view of the GP is that the time to explain the option of named consultant-led team to a patient could only take an extra 30 seconds. For others, it could take longer, but unlikely to take longer than 2 minutes and this should be considered as an upper bound and not representative of the likely impact on GP consultation time.
67. Therefore for the purpose of modelling we make the following assumptions
- Assumptions
- Extending the choice option to include named consultant-led team does not increase the proportion of patients
 - 50% of patients continue to be offered choice
 - 10% of those ask for their options for choice of named consultant-led team to be explained
 - of those 1/3 require 30 seconds extra, 1/3 require 1 minute extra and 1/3 require 2 minutes extra to have choice of named consultant-led team explained
- NB: Policies to encourage greater take-up of choice offer will be covered separately in other impact assessments to follow during 2011.
68. The assumption of 10% asking for choice to be explained is based on the advice from a GP about the proportion of patients who are likely to require a detailed explanation. We expect that most patients say they would like to go to their local provider or if they wish to go elsewhere have already made up their mind. Therefore it seems reasonable that only a small amount enter into a conversation with the GP about the choice options.

Table of estimated costs from a rise in GP consultation time

	Nationally
Total number of eligible referrals	11,000,000
Total offered choice	1,500,000
Total requiring explanation of named consultant-led team	550,000
Extra time	1/3 @ 30 seconds 1.3 @ 1 minute 1/3 @ 2 minutes
Total cost	£1,800,000*

* estimated at £166 per hour of contact time

^q Patient Choice p41-42

69. £1.8 million is the estimated economic cost resulting from increased GP consultation time under the assumptions set out above. In reality this only equates to approximately 1.5 minutes per week per GP. It is likely that a GP could experience this as a time pressure, but would substitute non-contact time for time spent with patients to compensate. This should mean it is not felt as a resource cost on primary care. The risk section discusses other scenarios where choice of named consultant-led team impacts on a GP's time in different ways. To be clear, the costs presented here are illustrative and based on some assumptions considered reasonable. But there is no clear evidence on what the impact of having a choice of named consultant-led team will be on GP consultation times.

Patient Time

70. In the example of a GP appointment in paragraphs 58-62, we suggest that some patients may have already decided prior to seeing their GP which consultant-led team they would like to be referred to. If they undertook any research or information gathering to reach that decision it will have taken their time which carries an opportunity cost. We have no evidence on either the average time a patient might take or the distribution of different approaches to researching choices among patients. Patients have a choice whether they seek out information about different named consultant-led teams and we assume that patients will only research their choices where they perceive there to be an intrinsic benefit from choosing and being involved in decision making. Because of these uncertainties, we have not attempted to monetise this potential cost.

Management costs

71. For choice of named consultant-led team to operate effectively, commissioners will have to amend contracts with providers so that providers organise their services to support this expanded choice offer. Commissioners amend contracts annually. The inclusion of any necessary obligations in the contract to ensure choice of named consultant-led team is offered (bearing in mind that choice of providers is already a contractual obligation) should result in a negligible extra cost and so has not been calculated in this Impact Assessment.
72. Choose and Book needs to be updated to add the named consultant to services listed on the system. It already has the functionality, and changes have been carried out under the existing contract. For providers, potential costs may be incurred to list their services by named consultant-led team on the Choose and Book directory and elsewhere. However, providers regularly amend their listings at present and by January 2011 42% of services had at least one provider listed on the system. Therefore the anticipated additional cost is expected to be small and has not been calculated here.
73. NHS Choices uses information about provider services from the Choose and Book database. In addition NHS Choices has been updated to provide named consultant-led profiles at a one off cost of £160k. Providers are also likely to experience an administrative cost to upload the details of the profiles. Listings data from Choose and Book indicates that there are 36,000 teams that provide first outpatient appointments. After one adjusts for the services that are test codes or not directly bookable at the point of referral the number of consultant teams drops to 25,700. Assuming it takes one hour administration time^r on average to upload a profile the cost would be approximately £650,000. For recurring maintenance and updates, the annual cost should be similar.

Friction costs

74. The term friction costs is used here to mean costs incurred by providers when actual output and therefore capacity utilisation is different to planned output owing to changes in referral patterns. One of the purposes of expanding choice of acute elective services from provider to named consultant-led team is to allow patients to move to a service that best fits their needs and preferences. This may lead to changes in referral patterns which could potentially incur costs to providers and patients.
75. We do not have evidence that tells us precisely what the demand for specific named consultant-led teams is, so we do not know what the change in referral patterns might be. The evidence on the impact on referral patterns from the current choice offer, as reported by the Kings Fund, is that between 21% (for those not offered choice) and 29% of patients (for those offered choice) are referred to non-local hospitals. The Kings fund infer that the difference between these figures, 8% of patients, appear to be actively switching provider as a result of the choice offer. For our central

^r estimated at £25 per hour

scenario, we assume that the proportion of patients who are offered choice and go to non-local hospitals rises from 29% to 32%, i.e. a 10% rise.

76. A provider might incur a cost if they cannot instantaneously balance resources to demand and that during the balancing process either some resources within a team are underused (for the teams experiencing reduced demand) or the provider must pay staff overtime (for the teams experiencing increased demand). These “friction costs” are incurred in the short to medium term. In the long run, we assume that the provider can better match its resources to the altered patient flows.
77. Referral patterns could change in one of two main ways. First, overall demand within a provider may stay the same, but there is a shift in referrals between named teams. If a provider has to move resources to match the demand this may create a friction cost. Second, being able to secure an appointment with a named consultant-led team may make a choice of provider more hard-edged and meaningful and induce a patient to switch provider, when making an appointment at referral. This may lead to some providers needing to increase capacity to meet demand and others to disinvest as they face a reduced demand. If there is a lag in investment decisions, then some providers may need to pay overtime to staff while others have resources being under utilised. Both outcomes would be examples of “friction cost”.
78. In reality, a provider does not need to respond immediately to changes in demand. Waiting lists and waiting times act as a buffer to the need to change capacity and throughput of patients treated. Most acute services for routine elective care have waiting times. If a consultant-led team experiences a rise in referrals and the team continues to treat patients at the same rate of throughput, then the number of people on the waiting list and the average waiting time from referral to appointment will go up. Similarly, a team that experiences a fall in referrals will notice a fall in the size of their waiting lists and a reduction in average waiting times. Waiting times act as a buffer giving the provider time to react to any changes in demand before capacity needs to alter, or before any friction costs are incurred.
79. If the average waiting time is a motivation for people choosing different consultant-led teams and providers, then the rise and fall of the length of waiting times described should lead to moderation in referral patterns and acts as an automatic stabiliser, i.e. popular teams with rising waiting times will lose some of their attraction so the volume of demand in the next period should fall back. Similarly, less popular teams will now have shorter waiting times so some of their appeal will return. Over a number of periods, we would expect the provider to face a new equilibrium of waiting times and referral volumes. Note however that the providers in organisations that have had teams with falling demand and rising demand do not necessarily have to adjust or ‘flex’ capacity. It depends on the scale of the changes in referral rates and the size of the existing stock of “waiters”. Equally, this does not weaken the incentive under choice to providers to improve services. The fluctuations in referral rates deliver a signal to providers of patient preferences. Waiting times give providers more time to react to the changes and mitigate against friction costs.
80. If the mismatch between referral rates and throughput persists, the respective providers will have to make a decision about investment requirements. But, owing to the flexibility afforded by waiting lists providers have time to make those decisions. In the short term, providers can continue to operate at original throughput rates, minimising the need for overtime or under utilisation and so there will only be a small effect on costs.
81. Although the rise and fall of waiting times does not impose a financial cost on patients, it does impose an economic cost (e.g. anxiety, lost earnings) on them as a result of having to wait longer to see the more popular consultant-led teams. However, so long as patients have a choice of alternative named consultant-led teams then whether they choose to wait is their prerogative. If waiting times increase too much then some patients will switch to providers with lower waiting times, performing a natural correction.
82. Providers will face a management cost if referral patterns change so sharply that they need to take decisions to change capacity or throughput. This would occur, for example, where referrals changed so much that waiting lists fell, or were falling towards, to zero or waiting lists became too large and it was difficult for the provider to meet the maximum waiting times commitment. Prior to that, management would have had the opportunity to move existing resources between teams or to use shared resources differently. Only in extreme cases and over the long run would investment decisions be needed. Providers will continue to need to balance capacity with demand as they do now. No evidence is available to quantify the impact on capacity from the proposed change in the choice offer.

Information costs

83. As discussed in the underlying problem section, for patients and GPs to make the optimal decision at the point of referral, they need adequate information. Information about different services is not currently available routinely at the level of named consultant-led team. To provide this information could cost money, although how much, or on whom they would fall, is unclear. The Government response to the consultation *Liberating the NHS: An Information Revolution* will be published later in the year and will be accompanied by a corresponding impact assessment.
84. The costs to one off changes to Choose and Book and NHS Choices to support named consultant-led team are included in the infrastructure costs discussed above. Formal information and performance data about named consultant-led teams, such as that captured routinely by the Hospital Episodes Statistics (HES) dataset, is only one area of information. Patients can also find out about different teams through past experience, friends and family or by asking their GP. Therefore the success of expanding choice to choice of named consultant-led team is not contingent on developing the full range of performance data.

Transport (NHS)

85. One of the areas that was expected to drive cost pressures when free choice was introduced in 2006 was the cost of providing transport to patients eligible to either the Patient Transport Service (PTS) or Health Transport Cost Scheme (HTCS). Reference cost data suggests that PTS carried 4.1 million patient journeys at a cost of £133 million in 2009/10 and HTCS reimbursed patients for 755,376 journeys at a cost of £8.4 million. Only a small fraction of this cost is a result of choice policy. It can be calculated as the extra journey made to non-local hospitals by those patients who make a choice about the hospital to which they are referred. The estimated extra cost of the proportion of patients exercising choice to travel further as a result of the extended choice offer, i.e. a rise from 29% to 32% of those patients making a choice and that the journey distance increases by 50% is shown below:

Scheme	Cost
Patient Transport Scheme	£833,000
Health Transport Cost Scheme	£52,000
Total	£885,000

This estimate is an upper bound as some of the patients choose to see a different named consultant-led team at the same provider. Therefore there will be no additional travel.

Transport (patients)

86. Many patients when attending an outpatient appointment will travel there by private car or public transport, rather than by NHS funded transport. A calculation by the Department of Health has estimated the potential extra km travelled by patients exercising choice. This was based on the assumption that for every appointment attended at an out of area hospital the patient would have to travel an extra 48 km (30miles) than if they attend their local hospital. Thus, if 5% of patients exercised choice, then an extra 77,243,00 km would be travelled. In our scenario, we assume that, of those choosing, an extra 3% of patients travel further. So for all patients that is 1.5%. A linear extrapolation would give an extra 23,173,000 km travelled. As with NHS funded travel this is likely to be an upper bound on the extra distance travelled as again patients may choose to see a different consultant-led team at the same provider. Industry estimates of the average cost per mile for car journeys of about £0.20 (or £0.13/km)^s. The marginal cost will be lower, considering petrol only, the figure falls to £0.14 /mile (or £0.087 /km) Applying this gives a cost to patients of the extra distance travelled to hospitals of between £2,027,000 and £2,897,000.

Patients choosing high cost areas

87. It is possible that some patients living in PCTs within easy travel of London may choose named consultant-led teams at institutions with celebrated reputations in central London. Even if services are covered by tariff the cost to the PCT will rise, compared to local provision, owing to the market force factor (MFF). However these concerns appear exaggerated. The table below shows the MFF for provider Trusts in Berkshire and Central London.

^s AA www.theaa.com

Provider Trust	MFF
Royal Berkshire NHS Foundation Trust	1.156132
Imperial College Healthcare NHS Trust	1.250434
University College London NHS Foundation Trust	1.32737

88. The difference in the MFF index means that national tariff treatments cost 8% higher at hospitals in the Imperial College Trust and 14% at University College London. In line with the central projection of those choosing to travel further to non-local hospitals rising from 29% to 32%. The impact on the budget of the PCT would be 0.3% (assuming equal distribution of patients between Imperial and UCHL).
89. One must also remember that patients may also choose to receive treatment from providers with a lower MFF. For example, it is likely that for some Berkshire patients, Oxford Radcliffe would be a potential provider worthy of consideration. That has an MFF score of 1.108470 which means that costs are approximately 4% less than at the Royal Berkshire. Patients from a Berkshire PCT choosing to go here would reduce the pressure on the budget.

Risks

90. This section considers two alternative scenarios to the benefit and cost section above. In alternative scenario 1, the level of patient engagement in choice stays the same, but the time taken to reach the decision about named consultant-led team is longer than for choice of provider. In alternative scenario 2, patients are inspired by the increased offer of choice and engage more fully lifting the participation level.

Alternative Scenario 1: GP Consultation times rise

91. In this scenario the referral patterns remain broadly unchanged to those laid out for the central scenario in the benefit and cost section above. The main difference in this alternative scenario is that the time to make a decision about choice of named consultant-led team is longer than the time to make a decision about choice of provider. For example, the conversation may take longer because there are more potential options to consider. However, as time is already being used to make the current decision about choice of provider the extra time needed should be small. We assume that this means a GP appointment takes an extra 2 minutes for the relevant consultations.
92. The table below shows the volume of patient appointments per year at GP surgeries, the number of referrals to first outpatient appointments, the number of appointments per day per GP and the average number of referrals that result from them.

Total GP appointments (England)	GP referrals eligible for choice	Average appointments per GP per day	Average referrals per GP per day
190 million	11 million (6%)	35	2

Source: DH Referrals data^t

93. The average length of a GP appointment is 11.7 minutes^u and this includes the time that GPs and patients take to discuss the current choice options. (NB: this is the average time of all GP appointments: some will take longer, some shorter, and over 90% of appointments do not require a referral to secondary care).

Average length of GP appointment	Extra time for choice discussion	Extra time per GP per day
11.7 minutes	2-3 minutes	4-6 minutes

94. This suggests that offering choice of named consultant-led team could put a time pressure on GPs of an average of 4-6 minutes per day if all appointments needing a referral result in an increased

^t http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/HospitalActivityStatistics/DH_077454

^u <http://www.pssru.ac.uk/pdf/uc/uc2010/uc2010.pdf>

choice discussion. However, not all patients who are referred to secondary care exercise choice. In line with the central scenario of 50% being offered choice and 32% of them referred to an alternative hospital the cost pressure on GP time can be valued at £10 million per year in monetary terms^v. However, this cost pressure may not manifest itself in the need for more resources in primary care. The pressure may encourage GP practices to operate more efficiently, by for example GPs substituting the use of their time from some other activity. The economic cost estimate presented here should be treated as an upper bound. It is not clear that this time pressure would actually result in increases in GP working days nor that time would displace other contact activities. Equally, the time pressure could lead to prioritisation of time and transfer of tasks to other staff.

95. The other costs and benefits stay the same. The table below shows a revised summary of the costs

Cost	Annual
GP consultation time	£10 million
Patient time	-
PCT management time for contract updates	Low <£1 million
Provider time for NHS Choice profiles	£0.650 million
Friction costs to providers	Not quantified
Information costs	Not known
Transport (NHS)	£0.885 million
Transport (Patient)	£2.027 millions
Patients choosing high cost areas	Low
Total cost	£14.6 million - £15.6 million

* The low end of the range excludes PCT management time because it is unclear whether these will materialise. Table excludes one off cost of £160k to update NHS Choices

Alternative scenario 2: Full engagement

96. This alternative scenario assumes that all patients at the 11 million GP appointments that lead to a first outpatient referral engage in choice and that the result is that those appointments take on average 2 minutes more. The evidence on which the benefits are based estimates that the value of benefits from policy changes introduced in 2006 is £250 million. If the King's Fund figure of only 8% of patients being actively involved in choice is genuinely representative of the country as a whole, then if 100% of patients actively engage in choice there is considerable potential for substantial benefits. However, the evidence is not robust enough to extrapolate a figure for the value of benefits for the fully engaged scenario because the £250 million value can potentially be attributed to policies other than just choice and it is unlikely that the increase in benefits will be linear.
97. If patients fully engage then following the calculations presented earlier with the amended assumptions, the costs would be higher as follows:

Cost	Annual
GP consultation time	£64 million
Patient time	-
PCT management time for contract updates	Low <£1 million
Provider time for NHS Choice profiles	£0.650 million
Friction costs to providers	Not quantified

^v valuing GP contact time at £166 per hour value = 11million * 50% * 32% * 2min * £166 per hour

Information costs	Not known
Transport (NHS)	£1.806 million
Transport (Patient)	Not quantified
Patients choosing high cost areas	Low
Total cost	£66.9 million - £67.9 million

As one would expect, the cost of GP consultation time and transport both rise as the numbers of patients going to alternative hospitals rise. Costs associated with maintaining the NHS Choices profiles does not change. The impact on friction costs is uncertain, although waiting times will continue to act as a buffer. It is possible that if more patients migrate from poor providers to good providers, then the buffer of waiting lists will rise and fall more quickly. If they become unmanageably long, or reduce to zero before providers can make resource adjustments then they will incur a cost. However, if patients are taking the opportunity to actively switch providers, then the signals to providers will be stronger too.

Summary

98. The central projection for introducing choice of named consultant-led team estimates that the annual value of the quantified benefits could be £25.4 million and the quantified recurrent financial costs should be £6.4 million (£15.3 millions opportunity cost). However, the figures for the benefits are based on a single paper and therefore cannot be considered to be more than an illustration of the scale of likely benefits. More robust evidence would likely indicate higher benefits as it would also include benefits from improved quality of life and improved efficiency from the delivery of services and improved investment decisions over time. Not all areas of costs have been quantified. Information is subject to a policy still under development and will be subject to a separate Impact Assessment. The increase in costs come mainly from an increase in transport services (which falls on patients) if more patients choose to travel further to an alternative hospital and administrative time to update choose and book and provide consultant-led team profiles on NHS Choices.
99. The central scenario assumes that the choice of consultant-led team is a sufficiently small change from the current choice of provider that only a small amount of extra time is needed to make the decision during a GP appointment. An alternative scenario is also modelled that assumes an extra 2 minutes is needed for all patients which equates to an economic cost of up to £10 million per year across primary care. There is no evidence that extra time is needed although the Royal College of General Practitioners did raise the general issue of time pressure on their members in their response to the consultation *Liberating the NHS: Greater Choice and Control*.
100. If this alternative scenario were to play out, it should not create an affordability issue. The economic cost of £10 million seems high as a result of the high cost of GP time. However, it is likely that a GP practice can absorb the small extra call on consultation time by substituting GP time into duties spent seeing patients from other duties.
101. Overall, we consider that the evidence on the impacts of choice of named consultant-led team policy suggests that it is likely to be cost-beneficial. While the evidence is limited there is enough to provide assurance that there are no obvious large cost drivers nor any evidence of significant negative impacts. Therefore we believe that the implementation of choice over named consultant-led team is affordable. On the benefits side, there is limited evidence of benefit of the proposed specific policy. Benefits evidence is hard to disentangle but there is sufficient to suggest that the policy, taken in conjunction with the other choice reforms will be of sufficient high positive impacts to justify its introduction.

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- ⁱ Nolte, E. McKee, C.M., *Measuring the Health of Nations: analysis of mortality amenable to healthcare* BMJ 2003; 327:1129 (2003)
- ⁱⁱ Eurocare-4, www.eurocare.it
- ⁱⁱⁱ OECD, *Health at a Glance 2009* (2009)
- ^{iv} European Antimicrobial Resistance Surveillance System (EARSS) incidence of MRSA per 100,000 patient days (2008)
- ^v The Tallinn Charter, *Health Systems for Health and Wealth Draft Charter* World Health Organisation (2008)
- ^{vi} *Is the NHS becoming more patient centred? Trends from the national surveys of patients in England 2002-2007* Picker Institute (2007)
- ^{vii} British Social Attitudes Survey, NatCen, www.natcen.ac.uk/study/british-social-attitudes-25th-report/findings (2009)
- ^{viii} *The Patient Association's response to "Liberating the NHS: Greater Choice and Control"* The Patient Association (2011)
- ^{ix} Taylor, R., *Implications of offering "Patient Choice" for routine adult surgical referrals*. (2004) Dr Foster Limited, University of Nottingham
- ^x Picker Institute
- ^{xi} Thorlby, R. and Gregory, S., *Free Choice at the point of referral*. London King's Fund (2008)
- ^{xii} British Social Attitudes Survey, NatCen, www.natcen.ac.uk/study/british-social-attitudes-25th-report/findings (2009)
- ^{xiii} Dixon, A., Robertson, R., Appleby, J., Burge, P., Devlin, N., Magee, H., *Patient Choice: How patients choose and how providers respond* The Kings Fund (2010)
- ^{xiv} Dixon, S., *Report on the national patient choice survey – February 2010 England* Department of Health (2010)
- ^{xv} Gaynor, M., Moreno-Serra, R., Propper, C., *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service* The Centre for Market and Public Organisation working paper series no 10/242 (2010)

Annexes

Annex 1 should be used to set out the Post Implementation Review Plan as detailed below. Further annexes may be added where the Specific Impact Tests yield information relevant to an overall understanding of policy options.

Annex A: Post Implementation Review (PIR) Plan

A PIR should be undertaken, usually three to five years after implementation of the policy, but exceptionally a longer period may be more appropriate. If the policy is subject to a sunset clause, the review should be carried out sufficiently early that any renewal or amendment to legislation can be enacted before the expiry date. A PIR should examine the extent to which the implemented regulations have achieved their objectives, assess their costs and benefits and identify whether they are having any unintended consequences. Please set out the PIR Plan as detailed below. If there is no plan to do a PIR please provide reasons below.

<p>Basis of the review: Implementation of choice of named consultant-led team is through new requirements under the standard NHS contract for acute services enacted through the issuing of contractual guidance to commissioners and corresponding contractual agreements between them and providers. Responsibility for patient choice will pass to the NHS commissioning board, subject to Parliamentary processes</p>
<p>Review objective: The review objectives would be to see whether choice of named consultant-led team delivered on: 1. improved outcomes, 2. improved responsiveness of services to patient preferences; and 3. increased patient choice and control.</p>
<p>Review approach and rationale: The prudent to consider whether any review of choice of named consultant led team should be conducted alongside the other choice commitments and reforms from the White Paper <i>Equity and Excellence: Liberating the NHS</i></p>
<p>Baseline: The base line for any assessment will be hard to establish as many policy proposals are being introduced with the same aim of improving health outcomes and efficiency of service provision. Any baseline will need to consider an appropriate counter-factual that controls for other policy developments from the White Paper and Health and Social Care Bill</p>
<p>Success criteria: A large take up rate or big change in referral patterns are not necessary for the policy to be a success as there is considered to be an intrinsic value to patients and service users of having more choice of their care and treatment. The main criteria are improvements to services, health outcomes and patient satisfaction with their care.</p>
<p>Monitoring information arrangements: Monitoring arrangements of choice are through the technical specification to the operating framework. The choose and book system records the referrals through to services listed by named consultant led team</p>
<p>Reasons for not planning a review:</p>

Annex B : Specific Impact Tests

Competition

The OFT has published screening questions to help determine whether a policy is likely to have an impact on competition . These are:

Would the proposal directly limit the number or range of suppliers?

The proposals will not directly limit the number or range of providers. Any provider who meets the existing contractual requirements under the standard NHS contract for acute services will also be able to offer services by named consultant-led team.

Would the proposal indirectly limit the number or range of suppliers?

For providers to be able to offer NHS funded services they must meet the requirement of the standard NHS contract for acute services. The changes to offer services by named consultant-led team is not expected to increase burdens on providers that would result in the number or range of suppliers being limited

Would the proposal limit the ability of suppliers to compete?

The proposals are not expected to limit the ability of providers to compete. Patient choice indirectly encourages all providers to compete more and for those who offer the services patients want, to flourish.

Small Firms

Part of the policy proposal is for providers to place a profile of named consultant-led teams on NHS Choices. Uploading information and maintaining the profiles will be optional. Therefore, there is no reason to expect any disproportional impact on small firms

Environmental and sustainability impacts

As mentioned in the main evidence base of the IA, the extension of choice has the potential to increase the distances travelled by patients if they choose to be referred to a non-local hospital. For patients using their own transport this was calculated to be an extra 23,173,000 kms. For patients using NHS funded transport the extra distance is 8,150,000 kms. This gives the following emission levels

Extra Distance travelled	31,323,000 km
CO2	5679 tonnes
NOx	15 tonnes
Particulates	0.8 tonnes

This is based on the following tonnes per km

CO2	181.6×10^{-6} tonnes/km
	0.47×10^{-6} tonnes/km
	0.03×10^{-6} tonnes/km

Human Rights

There is no reason to expect any significant impact on human rights

Justice System Impacts

There is no reason to expect any significant impact on the justice system

Rural proofing

Choice of named consultant-led team could potentially have a differential impact on those living in rural areas. People living in rural areas may have different priorities and therefore different considerations when making a choice of consultant-led team than those living in urban or suburban areas, and may face greater difficulties in exercising choice.

In remote rural areas journey times are typically longer, public transport options are relatively poorer and alternative travel options are limited or expensive¹. Only 54.9% of rural households have a hospital located within 8km from their home, compared to 96.7% of urban households². Although households in rural areas are more likely to have cars available to them, for some people, restricted access to transport or the time and cost associated with travelling will act as a barrier to choice; therefore the benefits of choice of named consultant-led team may not be fully exploited in rural areas.

While 19.1% of the population in England live in rural areas, only 11.1% of hospitals are located in these areas³. This relative under-provision of hospital services in rural areas can be explained by a lack of a critical mass of population, which limits the potential to exploit economies of scale and therefore makes healthcare services relatively more expensive. Services are therefore more likely to be located in areas with greater population density, where average costs can be minimised.

Despite the barriers to choice that exist in rural areas, research from the King's Fund (2010) found that respondents living in small towns and villages or in rural settings were significantly more likely to be aware of choice, to be offered a choice and to choose a non-local hospital than those in cities, large towns or suburbs.

This Impact Assessment covers the choice commitment to extend choice in acute elective care to choice of named consultant-led team. This gives patients the opportunity to make a sharper choice within existing providers. Access to information in rural areas about choices in healthcare is an issue, whether that is from libraries, directly from healthcare providers or by computer via internet connections. However, it is unlikely that expanding the choice offer to named consultant-led team will have a disproportionately positive or negative effect on people living in rural areas because the consultant-led teams will be within existing providers.

Specific impact tests for rural issues will be carried out for other choice commitments where appropriate.

¹ Commission for Rural Communities, Rural Proofing Toolkit

² Commission for Rural Communities, State of the Countryside 2010

³ Commission for Rural Communities (2010) "State of the Countryside 2010". <http://ruralcommunities.gov.uk/files/sotc/sotc2010.pdf>

Annex C: Evidence to support Patient Choice

The theory

- C1. Economic theory attests that a perfectly competitive market will allocate resources efficiently. However, like many others, healthcare markets are not perfectly competitive. They display a number of market failures. The demand for healthcare is derived demand based on clinical opinion and unpredictable nature of illness. Patients therefore rely on the doctor's advice about which intervention is appropriate and when it is needed. In addition, outcomes from interventions are uncertain, making it difficult to know whether favourable outcomes are a result of the efforts of the doctor or from chance.
- C2. The NHS was established through a Government intervention, in response to a perceived market failure and in order to provide healthcare for all. The commissioner and provider functions were integrated in an attempt to minimise incentives for supplier induced demand. Responsibility for allocating resources within a fixed budget fell to clinicians and health authorities. Patients requiring treatment first visited their General Practitioner (GP) who would refer them on to secondary care on the basis of need. This gives the GP a dual role; advisor to patients and a 'gatekeeper', who rations resources on behalf of taxpayers. Initially this worked reasonably well with the UK having a good standard of healthcare for a relatively moderate budget as a proportion of GDP compared to other countries.¹
- C3. However, the NHS has proved to be slow to change as health services evolved, the range of services grew, treatments became more complex and expectations have risen. Two shortcomings of the system have been its lack of responsiveness to patient preferences, resulting in poor patient experience, and poor ability to allocate resources to where they are most needed, resulting in lower survival rates compared to other countries.
- C4. Successive governments have looked to introduce elements of the market into healthcare. The aim was to allocate resources better and improve patient experience. The reforms have included competition between providers and the ability of patients to choose between them coupled with a payments regime that allows resources to follow the patient.
- C5. An important part of these reforms is greater patient choice and control over services. This can drive up the average quality of services and deliver better outcomes through a number of mechanisms:
- a) Competition through choice of provider leads to changes in patient flows which improve the average quality of care;
 - b) Competition through choice of provider that creates a genuine threat of patient moves and therefore lost business, and revenue, (contestability) provides sharp incentives to providers to improve the quality of the services they provide;
 - c) Greater patient empowerment, including shared decision making and choice of treatment, affords a better match of patient preferences with treatment characteristics which may lead to better outcomes and is considered a benefit in its own right; and
 - d) Individualised patient centred services can reduce health inequalities and promote equality of access
- C6. The following paragraphs discuss the merits of each of these in turn and gives a summary of the supporting evidence.

¹ http://www.oecd.org/document/30/0,3343,en_2649_34631_12968734_1_1_1_37407,00.html

Patient choice of provider (Competition)

- C7. The most simple aspect of patient choice is that patients are not constrained to go only to a local hospital for treatment, but can elect to go to an alternative. The monopoly of provision is removed from hospitals which can lead to improvements in the average level of quality in a number of ways:
- 1) patients move from poor performing providers to better ones, changing the distribution of patients receiving better care and consequently the average quality of care received by the median patient. This does not necessarily change the performance levels of individual hospitals in the short term;
 - 2) poor performing hospitals lose patients. This acts as a signal of relatively poorer performance, the hospital may close, or reduce capacity, in the medium term again changing the distribution of care received across patients; alternatively
 - 3) poor performing hospitals lose patients and management respond by improving performance in the medium term and consequently the hospital attracts patients back.
- C8. The bulk of evidence on competitive health service markets comes from the US and investigates the relationship between competition, prices and capacity (see Dranove and Satterwaite 1992; Hughes and Luft 1991, Joskow 1980). More recent literature looks at the impact of hospital competition on clinical performance (Gaynor 2004; Gowrisankaran and Town 2003; Propper et al 2004) and is moving towards the consensus that higher levels of fixed-priced competition lead to improved clinical performance so long as the reimbursement price is high enough to cover the marginal cost of treatment. Publications using UK NHS data (Cooper et al 2010a, 2010b; Gaynor et al 2010; Bloom et al 2010) support these findings.
- C9. Cooper et al test whether financial incentives led to improvements in quality. They use the January 2006 introduction of choice for patients in England to create a quasi-natural experiment to estimate the impact of fixed-price competition on 30 day in hospital mortality from acute myocardial infarction (AMI). They exploit the fact that the introduction of choice reforms will create sharper financial incentives in markets where choice is feasible and that prior to 2006, in the absence of choice, hospitals had no direct financial incentives to improve performance in order to attract more patients. Their results suggest ‘...that in markets with fixed-prices, hospital competition can improve patient outcomes.’
- C10. Observable quality is the key to improving levels of quality. The competitive incentives, introduced through offering patients a choice of provider, have the potential to lead to a negative effect if patients and commissioners cannot adequately observe the quality of services and if prices are variable. Commissioners will be drawn to cheaper services to stay within fixed annual budgets, which creates an incentive to providers to offer cheaper services potentially at the expense of quality. If patients are unable to distinguish quality levels between alternative providers, they will be unable to choose to avoid poor quality providers. Therefore good quality providers will not be rewarded for higher quality so poor quality could crowd out the good.
- C11. Papers by Popper (2008, 2004) suggest that price competition can lead to lower quality. Both papers use data covering the internal market between 1991 and 1999. It found that competition led to improvement in measurable areas of service (i.e. lower waiting times) but a deterioration in non-measured areas of quality (higher mortality rates).
- C12. This is summarised nicely by Frontier Economics: On balance, the evidence suggests that the outcome for price and quality competition will depend on the preferences of consumers of healthcare services, and the quality of information available to them. The implication is that this form of competition is likely to lead to quality improvement that benefits patients if there are quality-focused and well-informed commissioners. This, in turn requires that there is sufficient robust quality information available. On the other hand if quality is difficult to observe this form of competition carries the risk of creating perverse incentives to lower quality in order to lower costs.

Contestable and transparent markets

- C13. In 1776, Adam Smith warned of the dangers of monopolies, ‘...monopolies... ..is a great enemy of good management.’ While competition wards off complacency in management, a market does not have to have a plural provider base for patient choice of provider to have the desired effect. Incentives and competitive pressure still exist so long as markets are transparent and contestable. Here transparent means that it is possible to observe the level of quality of the provider, and the cost of the service, and contestable means that new providers are free to enter the market. This means that there is a credible threat that should the standards of the existing services fall below what is acceptable then a new provider could enter the market and take business from the incumbent. This credible threat is sufficient to ensure management maintain acceptable levels of quality and efficiency.
- C14. Bloom et al conclude that ‘...our measure of management quality was robustly associated with better hospital outcomes...[and]...more hospital competition appears to cause improved hospital management’. Their paper seeks to test the hypothesis that competition between hospitals can lead to better hospital performance through improved management practices of hospitals by using an instrumental variable model. The degree of competition is measured as the number of other hospitals within a given catchment area, the hospital performance clinical outcomes measure is mortality rates following emergency admissions for acute myocardial infarction (AMI) and surgery. Data on management performance is collected from an 18 question survey. The first stage of their model shows that management practices and hospital performance are positively correlated; the second stage that competition is positively correlated with management quality.
- C15. Like Bloom et al, Gaynor et al also uses the introduction of the 2006 reforms on hospital outcomes. It uses a panel of data for 162 hospitals between 2003 and 2007 and finds that the effect of introducing choice of hospital was to save lives without raising costs. Indeed they go on to state in their concluding remarks ‘...that competition is an important mechanism to enhancing the quality of care patients receive. Monopoly power is directly harmful to patients, in the worst way possible – it substantially increases their risk of death.’
- C16. In both of these studies, the volume of patients that moved from one hospital to another was not large. The viability of the hospitals was not called into question through loss of business. Nevertheless a significant improvement in quality was observed.

Patient Empowerment (Shared Decision Making and Control)

- C17. The following paragraphs discuss how control and choice of treatment can lead to better outcomes and are valued by patients as a benefit in its own right. Patient decision aids are an evidence-based tool to support shared decision making between patient and clinician. They involve patients more in the decisions about their care, increasing their sense of control.
- C18. Patient decision aids are most commonly employed where there is not a single best treatment (‘preference sensitive’ decisions) and where patients need support to help them work out how treatment options fit with their preferences, values, lifestyle and what they are looking for from treatment. Often these are elective surgery options (eg knee replacements or hernia repair) but patient decision aids can also be useful in certain decision points for long-term conditions such as starting insulin treatment or a disease modifying drug for rheumatoid arthritis. At least 500 decision aids exist worldwide. [ref: inc example from Roger Halliday’s note]
- C19. A review of 10 systematic reviews of patient decision aids (O’Connor et al, Cochrane Library 2009) found that they improved patients’ participation, increased their knowledge of treatment options, realigned their expectations, and improved the match between their values and subsequent treatment decisions. It also led to people making decisions about their care and subsequently people being treated quicker. However, most studies suggested little difference in satisfaction with decision making and with health outcomes.

C20. International evidence shows that involving patients in their care and treatment can improve their health outcomes. Bechel et al (2000) found that patient centred care led to improved outcomes when measured by rates of unexpected mortality and rates of complications. Fremont et al looked at whether patient experience of non clinical aspects of care affected health status. They found that patients who received patient-centred care following a myocardial infarction reported higher satisfaction scores for their care and higher health status scores 12 months later than patients in a control group. Kaplan et al (1989) investigated the effects of the patient physician relationship and communication with health outcomes of patients with chronic diseases. They found a positive correlation between improved communication and better outcomes whether objective measures (e.g. blood pressure or blood sugar levels) or subjective measures (survey responses on health status). This evidence shows that shared decision making is applicable in a wide range of health contexts and that clear improvements can be obtained.

Health Inequalities

C21. A full equality impact assessment is published separately alongside this document and the Government's response to the consultation. A summary of some of the evidence is outlined below.

C22. Concern has been raised that choice can widen inequalities because less articulate and vulnerable groups are less likely to exercise choice and that some population sub-groups may find it more difficult to digest performance data (RAND 2006). Also in 2006 the King's Fund found that PCTs felt that equity of choice may be difficult to deliver, particularly for non-English speaking groups.

C23. However, Dixon and Le Grand (2006) hypothesise that choice may narrow inequalities as a greater number of access points will provide patients with a wider range of services and services more adapted to individual need. Instead of better services only being accessed by those who go to great lengths to navigate the system, choice will help to reduce the barriers of access making them accessible to a larger section of the population.

C24. A study by Cookson and Laudicella considered the impacts on inequalities of choice and competition reforms introduced in 2006. They examined socio-economic equity and utilization of hospital services. They found that the reforms had not undermined socio-economic equity in hospital care and, if anything, may have very slightly increased utilisation of elective inpatient care in low income areas. They went on to say that disparities in health care utilisation are relatively impervious to changes in the supply side, brought about by health care reforms, suggesting that inequity is caused by under-lying socio-economic need and care-seeking behaviour, which do not change rapidly over time.

Conclusion

C25. Fixed price competition between providers, facilitated by choice from 2006, has been shown to be particularly effective. Gaynor et al calculated a rough estimate that net benefits from improved mortality and reduced length of stay was £227 million. This evidence appears to suggest that large numbers of patients do not have to move from one provider to another to achieve the results. Improvements appear to result from the threat of patients choosing to go elsewhere coupled with the transparency provided by the availability of information on the quality of performance.

C26. Other evidence gives cause for caution, pointing out that where aspects of quality cannot be measured, there is potential for competition with variable prices to lead to lower quality of those aspects. This emphasises the need to be able to measure the multi dimensional aspects of quality to ensure against unintended consequences and that one aspect of quality is not sacrificed for another.

- C27. Shared decision making and putting patients in control of their care are important elements of choice. A truly patient centred approach to care can improve outcomes and patient experience and individualised services can improve inequalities through improved access to care.
- C28. Choice and transparency can combine to have a positive impact as patients choose the services that best fits their requirements. The choice and control commitments are not proposed in a vacuum, the regulatory framework, subject to parliamentary approval, in the Health and Social Care Bill 2011 sets out proposals designed to boost transparency and accountability. The information revolution, on which the Government consulted in Autumn 2010 is designed to develop the tools necessary to measure outcomes and performance.

Bibliography

- Bloom, N., Propper, C., Seiler, S. and Van Reenan, J. (2010) The Impact of Competition on Management Quality: Evidence from Public Hospitals CMPO WP 10/237
- Cooper, Z., Gibbons, S., Jones, S. and McQuire, A. (2010a) Does Hospital Competition Save Lives? Evidence from The English NHS Patient Choice Reforms, LSE WP 16/2010
- Copper, Z., Gibbons, S., Jones, S. and McQuire, A. (2010b) Does Hospital Competition Improve Efficiency? An Analysis of the Recent Market-Based Reforms to the English NHS CEP discussion paper no.988
- Dixon, A. and LeGrand. J., (2006) 'Is greater patient choice consistent with equity? The case of the English NHS'. *Journal of Health Services Research & Policy*, vol 11, no3, pp 162-6
- Dranove, D and Statterthwaite, M. (1992) Monopolistic Competition When Price and Quality Are Not Perfectly Observable Rnad *Journal of Economics*, 23,247-262
- Gaynor, M., Moreno-Serra, R. and Propper, C. (2010) Death by Market Power: Reform, Competition and Patient Outcomes in the NHS CMPO WP 10/242
- Gaynor, M. (2004) Competition and quality in hospital markets. What do we know? What don't we know? *Economic Publique* 15, 3-40
- Gowrisankaran, G. and Town, R. J. (2003) Competition, Payers, and, Hospital Quality *Health Services Research* 38, 1403-1422
- Hamilton, B. H. and Bramley-Harker, R. E. (1999) The impact of the NHS Reforms on Queues and Surgical Outcomes in England: Evidence from hip fracture Patients *The Economic Journal* 109, 437-462
- Hughes, R. G. and Luft, H. (1991) Service Patterns in Local Hospital Markets: Complementary or Medical Arms Race *Health Service Management Research* 4, 131-139
- Joskow, P (1980) The effects of Competition and Regulation on Hospital Bed Supply and the reservation Quality of the Hospital *Bell Journal of Economics* III, 421-447
- Klein, R. (1999) Markets, Politicians and the NHS *British Medical Journal* 319, 1383-1384
- Le Grand, J. (1999) Competition, Cooperation or Control? Tales from the British National Health Services *Health Affairs* 18, 27-39
- OECD Health Data 2010
- Propper, C., (1996) Market Structure and Prices: The response of Hospitals in the UK National Health Service to Competition *Journal of Public Economics*
- Propper, C., Burgess, S., and Gossage, D. (2008) Competition and Quality: Evidence from the internal Market 1991-1996 *The Economic Journal* 118, 138-170
- Propper, C., Burgess, S., and Green, K. (2004) Does Competition Between Hospitals Improve the Quality of Care? Hospital Death Rates and the NHS Internal Market *Journal of Public Economics*, 88, 1247-1272
- Propper, C., Wilson, D. and Soderlund, N. (1998) The effects of Regulation and Competition in the NHS Internal Market: The case of GP Fundholder Prices *Journal of Health Economics* 17, 645-674
- Soderland, N., CSABA, I., Gray, A., Milne, R. and Raferty, J. (1997) Impact of the NHS Reforms on English hospital productivity: an analysis of the first three years *British Medical Journal* 315, 1126-9