

Liberating the NHS:

Greater choice and control

Choice of named consultant-led team
Equality Analysis

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1. Introduction

- 1.1. The White Paper, *Equity and Excellence: Liberating the NHS*, set out the Government's vision of an NHS that puts patients and the public first - an NHS where patients, service users, families and carers have far more say and choice in the system and, as a result, an NHS that is more responsive to their needs and wishes.
- 1.2. *Liberating the NHS* stated that "We expect choice of treatment and provider to become the reality for patients in the vast majority of NHS-funded services by no later than 2013/14." It also set out a number of specific choice commitments around extending choice of provider and treatment in planned hospital care and, more specifically, in maternity, mental health, end of life care and long term conditions. Among the commitments was one to introduce choice of named consultant-led team for elective care by 2011, where clinically appropriate.
- 1.3. The choice consultation document, *Liberating the NHS: Greater Choice and Control*, set out more information about how we intend to make the vision in the White Paper a reality: how we aim to give people greater choice and control over their healthcare, supported by a new culture of shared decision-making and an information revolution that will give people the information they need to make effective choices.
- 1.4. The feedback from stakeholders received during the public consultation on *Liberating the NHS: Greater Choice and Control* is being used to shape detailed proposals for each of the choice commitments. These proposals will be laid out in the response to the consultation for each of the commitments.
- 1.5. This Equality Analysis accompanies the consultation response for choice of named consultant-led team, the choice of named consultant-led team contractual guidance and the related Impact Assessment (IA). This Equality Analysis focuses on the equality impact of this specific choice commitment.

Choice of Named Consultant-led Team

- 1.6. ***"Introduce choice of named consultant-led team by April 2011 where clinically appropriate. We will look at ways of ensuring that Choose and Book usage is maximised, and we intend to amend the appropriate standard acute contract to ensure that providers list named consultants on Choose and Book"***.

- 1.7. We want everyone who needs to see a consultant to be able to make an appointment with a particular team headed by a named consultant. The chosen consultant-led team must offer a health service that is clinically appropriate; 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 clinical acceptance criteria.
- 1.8. *Liberating the NHS: Greater Choice and control* looks at how Choose and Book (CAB) - the electronic referrals and booking system – can help people to choose their named consultant-led team. The success of choice in this area depends on the accessibility of information about named consultant-led teams and how easy the CAB system is for all groups.

Relevance to Equality and Diversity

- 1.9. Undertaking Equality Analysis is intended to improve the quality of services by ensuring public bodies systematically consider the actual or potential impacts of this policy on certain communities or population groups. Organisations are required to take action to mitigate or eliminate any potential negative impacts and to maximise the positive impacts or opportunities for promoting equality.
- 1.10. The purpose of this Equality Analysis is to consider the potential impact of the proposals to give patients the opportunity to choose a named consultant-led team. Impacts are assessed with respect to the following protected characteristics: age, disability, gender, race, religion or belief, sexual orientation, gender reassignment, socio-economic group and pregnancy and maternity.
- 1.11. The screening phase demonstrated that a full Equality Analysis was necessary in order to support the extension of choice as proposed in *Liberating the NHS: Greater Choice and Control*. There is no evidence to suggest that the roll out of choice policy to date has created any specific inequalities – but there is potential that under certain circumstances and without due care and attention, specific proposals to extend choice and control could have an impact on equality issues.
- 1.12. There is a possibility that choice of named consultant-led team could have both a positive and an adverse effect on equality for some groups. For example, some patients may wish to see a named female consultant-led team for cultural or religious reasons. This does not mean that they will necessarily be seen by a female healthcare professional, as it depends on which member of

the team they are seen by. However, if that named consultant-led team is popular, the effect could be that this group may have to wait longer to be seen. Similarly, it is possible that providers may have recruited a consultant with particular skills to meet the specific needs of a local population, only to find that they are attracting other patients, and therefore leaving the needs of the local population unattended. Feedback from providers who are already accepting referrals to named consultant led teams for first outpatient appointments shows that they have not experienced a significant problem with capacity management. However, to ensure that this situation does not arise, providers will, as now, have to proactively manage capacity - this is covered in the contractual guidance to providers and commissioners regarding choice of a named consultant led team.

- 1.13. The Equality Impact Assessment for 'Choose and Book' (2009) acknowledges that vulnerable people and those with a disability may be disadvantaged when accessing CAB. There are a number of steps in place to mitigate this, which should also ensure the expansion of choice does not encounter these issues. For example, the CAB website provides information on where to access support; there is a dedicated telephone service to support people with hearing impairments, and a translation and interpretation service; in some areas, public access to online information and how to book via CAB is supported by librarians trained on CAB.

Consultation with stakeholders

- 1.14. In formulating these commitments, we have held and attended a number of engagement events, which has helped us to take into account the views and needs of a wide range of stakeholders. A formal 13-week consultation on *Liberating the NHS: Greater Choice and Control* ran from 18/10/10 to 14/01/11, the feedback from which has been used to shape the proposals laid out in the response to the consultation.
- 1.15. An initial Equality Impact Assessment (EqIA) accompanied *Liberating the NHS: Greater Choice and Control*. This Equality Analysis is designed to update the initial EqIA, taking into consideration the consultation responses from stakeholders and focusing on those that relate to choice of named consultant-led team.

- 1.16. Overall, 25%¹ of respondents answered the question on choice of named consultant-led team (question 40). Of these, 66% were broadly in favour and 20% were against the proposals. A range of issues were raised, however few of these related directly to the impact on equality.
- 1.17. Age UK raised the concern that consultants will become more conscious of their perceived success rate, which may make them less likely to treat complex cases. This could impact unfairly on those such as the elderly and the disabled who tend to have more complex cases. The guidance on implementing choice of named consultant-led team states that providers are required to accept all clinically appropriate referrals, in line with the NHS standard contract for acute hospital services². This should ensure that the risk of refusing cases is mitigated; however commissioners and referrers must still be aware of this risk.
- 1.18. The Patients' Association highlighted that in order to make an informed choice of named consultant-led team a wide range of information is necessary, including long-term outcomes, ease of access and patient experience. Those with access to better information may therefore be able to make better choices, which may have a consequential impact on equality. This issue of access to information is explored more fully in the *Importance of accessible information* section.

¹ 154 unique responses

² See clause 20.2 of the NHS standard contract with acute hospital providers:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124518.pdf

2. Background

Current choice policy

- 2.1 Many people already have choice over their healthcare. For example, most people who are referred by their GP, dentist or optometrist for their first outpatient appointment with a consultant-led team already have the right to choose their healthcare provider.

Do people want choice?

- 2.2 Patient choice is important to a large number of patients. Over 95% of people feel that they should have choice over the hospital they attend and the kind of treatment they receive³. The Free Choice in Elective Care EqIA reported that 76% of patients said they wanted to be involved in decisions about their condition and treatment and wanted to feel they had a choice even if they did not exercise it.
- 2.3 Through the introduction of choice of named consultant-led team we are giving people the opportunity to make more choices about their own healthcare; however we acknowledge that some people may not want to exercise this choice. At engagement events with stakeholders we heard that some people do not want to feel as though they have to make a choice, as this could be a daunting process for some patients. Shared decision making does not mandate patients to make choices; those who wish to delegate their choice of named consultant-led team to their GP can choose to do so.
- 2.4 Recent evidence from The King's Fund (2010), found that 75% of respondents said that choice of hospital was either 'very important' or 'important' to them. See table 1 overleaf:

³ British Social Attitudes survey, Natcen, <http://www.natcen.ac.uk/study/british-social-attitudes-25th-report/findings> (2009)

Table 1

How important to you is being offered a choice of hospital?		Important or very important (% (number))	Somewhat important (% (number))	Of little importance or unimportant (% (number))
All respondents		75 (1,623)	14 (293)	11 (246)
Age group	16-35	68 (154)	20 (45)	12 (27)
	36-50	73 (347)	14 (66)	12 (58)
	51-65	76 (535)	13 (94)	11 (78)
	66-80	79 (473)	11 (65)	11 (64)
	81 and over	73 (114)	15 (23)	12 (19)
Level of education**	No formal qualifications	79 (532)	10 (68)	12 (78)
	Qualifications below degree level	74 (602)	15 (123)	10 (84)
	Degree-level or higher qualifications	67 (209)	18 (57)	15 (45)
Ethnicity**	White background	74 (1,442)	15 (272)	12 (229)
	Mixed/non-white background	85 (144)	8 (13)	7 (12)
Gender**	Male	70 (645)	16 (145)	15 (138)
	Female	79 (978)	12 (148)	9 (108)
Employment status **	In paid work	71 (526)	16 (115)	13 (98)
	Unemployed	78 (59)	12 (9)	11 (8)
	Retired from paid work	76 (627)	13 (103)	12 (96)
	Unable to work because of disability or ill health	83 (160)	10 (20)	7 (13)
	Looking after family, home or dependants	79 (70)	15 (13)	7 (6)
	In full-time education, including government training programmes	55 (11)	40 (8)	5 (1)
	Other	71 (24)	18 (6)	12 (4)

** Difference statistically significant at 1%

Source: King's Fund (2010)

- 2.5 Differences in the importance given to choice by respondents with different levels of education, ethnicity, gender and employment status are statistically significant⁴. Respondents with fewer qualifications rated choice as being more important compared with those with higher levels of qualifications.
- 2.6 Choice may mean something very different to different people. Therefore, the choices that people have over their care should reflect what matters to them. People want to make choices for a number of reasons including receiving healthcare that gives them the best chance of better health outcomes and accessing healthcare in a way that is most convenient for them.⁵
- 2.7 Having greater choice and control may be particularly beneficial for some people, for example mental health service users, because it could help build confidence and aid recovery. 'Our Choices in Mental Health' - a review by the Sainsbury Centre for Mental Health and the King's Fund - found that choice clearly had a central role to play in improving the daily experience of people with mental health problems and supporting them on the road to recovery. There is no evidence to suggest that restricting choice has a corresponding negative impact, or no impact.
- 2.8 Choice policy will be supported by a new culture of shared decision-making: 'no decision about me without me'. Many people are already working together in new

⁴ A. Dixon et al, Patient choice - how patients choose and how providers respond, Kings Fund, [http://www.kingsfund.org.uk/publications/\(2010\)](http://www.kingsfund.org.uk/publications/(2010))

⁵ ibid

ways, which give patients more say. But for many this will mean a significant cultural change. Some people may want to take a less active role in making decisions about their care, either all of the time or in some limited circumstances (for example in a crisis or when they are very ill). An important skill of healthcare professionals should be gauging how much involvement their patient is comfortable with and how they can be supported to make informed decisions. *Liberating the NHS: Greater Choice and Control* provides more detail about how the new culture of shared decision making could become a reality.

Who is exercising choice?

- 2.9 The King’s Fund (2010) analysed survey responses to explore the factors that influence whether patients said they were offered a choice of provider. The results are expressed as the odds ratio that a particular category of patient was offered a choice compared to the comparison group (in brackets). See table 2 below:

Table 2

Variable	(Comparison group) Response category	Odds ratio	Significance	Lower 95% CI	Upper 95% CI	Interpretation
Gender	(Female) Male*	0.79	0.03	0.64	0.97	Men were significantly less likely to be offered a choice than women.
Referral priority	(Routine) Urgent**	0.60	0.00	0.44	0.83	Respondents whose referral was routine were significantly more likely to be offered a choice than those with urgent referrals.
EQ-VAS self-rated health status	(Healthiest quartile) 2nd quartile**	0.72	0.01	0.57	0.91	The healthiest respondents were significantly more likely to be offered a choice than those who rated their health in the 2nd or 3rd quartile.
	3rd quartile**	0.67	0.01	0.50	0.89	
	Unhealthiest quartile	0.59	0.07	0.34	1.04	
Urban/rural	(City/large town/suburbs)					Respondents living in small towns and villages or rural settings were significantly more likely to be offered a choice than those in cities/large towns or suburbs.
	Small town**	1.71	0.00	1.32	2.23	
	Village/rural*	1.42	0.02	1.07	1.89	

** Statistically significant at 1% level

*Statistically significant at 5% level

Source: King's Fund (2010)

- 2.10 The report finds that a patient’s age, their level of education or their ethnicity does not have a significant impact over whether choice was offered. However, men were less likely to be offered a choice than women. Although GPs thought that choice was more applicable in urban centres, patients living in a small town were significantly more likely to be offered a choice than those living in a city, large town or suburb. These results should be looked at in context, for example, people from some BME communities may be more likely to live in towns and cities compared to rurality so may be less likely to be offered choice.

3. Summary of Evidence

- 3.1 Impacts relating specifically to the introduction of a choice of named consultant-led team are likely to be limited and must be viewed in the context of the wider choice offer. We anticipate that the equality issues relevant to choice of named consultant-led team will be broadly similar to those associated with the extension of choice more generally. The section which follows takes a general overview of the positive and negative equality impacts of extending choice, which can be applied to choice of named consultant-led team.

Aims and objectives

- 3.2 The proposals to extend choice aim to give people more choice and control both as a means to an end - leading to improved health outcomes and better satisfaction with the healthcare experience - and as an end in their own right.
- 3.3 Greater choice and control are not only important for the patient or service user. For many patients and service users, their families and carers are partners in their healthcare. Families and carers are often experts about the health needs and care of the person that they support, and we must recognise the important role they have in supporting choice and shared decision-making.
- 3.4 Whenever this Equality Analysis discusses giving people choice, involving them in decisions and making sure they have information and support, it applies equally to adults and children who are patients, service users and carers, their families, and others who represent and support decisions and choices as appropriate.
- 3.5 Whilst the evidence from the Kings Fund Report supports the importance of choice to patients and service users, the same report finds that patients are not always able to exercise that choice because of General Practitioner (GP) misconceptions, language barriers, socio-economic barriers and limited support for those from ethnic minorities, those with disabilities, and those from other marginalised groups. These aspects will be explored in more depth in this analysis, as will the impact on equalities of increasing the offer of choice.

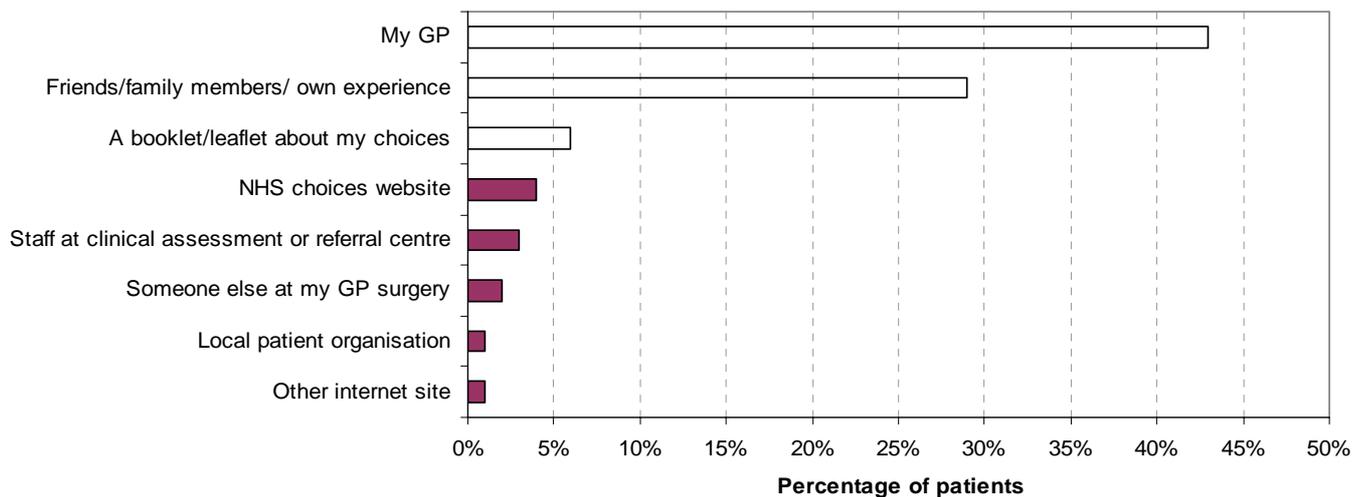
The importance of accessible information

- 3.6 Without reliable, user-friendly and accessible information, it will be more difficult to make meaningful informed choices. The development of supporting information that enables patients to make meaningful choices is likely to be integral to the extension of choice. The White Paper, *Equity and Excellence: Liberating the NHS*

set out the Government's vision of an NHS where patients will have access to the information they want, to make choices about their care.

3.7 Patients currently have a number of sources of information available to them to assist in the choices they already make with respect to their healthcare. Research from the Department of Health's National Patient Choice Survey (2010) shows that the GP is the single most important source of information to help patients choose their hospital, followed by the patient's own experience, or that of their friends and family. Other important sources of information were printed materials and the NHS Choices website (www.nhs.uk). 83% of patients offered choice reported that they had enough information to help them make their choice, however as the choice offer is expanded it is essential that patients continue to have the information necessary to support informed decisions.

Figure 1: Most important source of information used by patients offered choice to choose a hospital



3.8 Through the NHS Constitution, The NHS is committed to offering easily accessible, reliable and relevant information to enable patients to participate fully in their healthcare decisions and to support them in making choices⁶. From April 2011, providers have been required to publish information about their services so that people can use this to make informed choices about their healthcare⁷. However, changes to the information content alone may not be

⁶ Section 2a of the NHS Constitution.

⁷ The Operating Framework for the NHS in England, Department of Health, December 2010.

enough; the way information is provided, discussed and used as the basis for choice is also important.

- 3.9 Where possible, information should be available in a variety of formats so that all groups can access it, including those with learning disabilities, those with hearing or sight impairments and non-English speaking people. This may include the provision of interpreters so that patients with specific language or communication difficulties can communicate freely with healthcare professionals.
- 3.10 The internet is increasingly being used as a means of providing information, however certain groups may have limited or no access to the internet. The ONS survey of internet access (2010) highlights that internet use is closely linked to socio-economic and demographic factors. Their findings show that gross income and educational qualifications are both significant indicators of internet use. The survey also found that 60% of those aged 65 and over have never used the internet. It is therefore important that, where necessary, information can also be accessed from different sources and in alternative formats. Additionally, there are a number of measures that can be taken to enhance the availability of internet access with communities, such as better use of IT facilities in schools, libraries and Citizens Advice Bureaus.
- 3.11 People may also need support to use information effectively. The White Paper envisages that local HealthWatch organisations will be able to give people the assistance they need to make a decision about their healthcare. Health and adult social care professionals will provide much of the relevant information face-to-face as part of a shared decision-making process. It is clear that the communications skills of clinicians and practitioners will assume an increasingly central part of their practice and professional development.

Supporting healthcare professionals

- 3.12 Research has shown that some GPs may be assuming incorrectly that only young and middle-class people want choice⁸. To support the changing healthcare relationship, *Liberating the NHS: Greater Choice and Control* proposes to:

⁸ A. Dixon et al, Patient choice - how patients choose and how providers respond, Kings Fund, 2010 (<http://www.kingsfund.org.uk/publications/>)

- Give healthcare professionals the right support and advice about what choice means and how it can be used as part of shared decision-making and patient-centred care,
- Consider how education and training can build patient-centred care into healthcare professionals' working practices, and
- Consider whether new obligations should be added to NHS contracts to make sure that healthcare professionals - both clinical and other NHS staff - offer choice.

3.13 To support patients in making choices it is important that healthcare workers also have the skills and training to understand the information requirements of their service users and respond appropriately to them to provide information in a high quality way. The Department of Health's information strategy will provide details on workforce development to support the provision and use of information.

Age

3.14 The population of the UK is ageing. The percentage of the population aged 65 and over increased from 15 percent in 1984 to 16 percent in 2009, an increase of 1.7 million people. The fastest population increase has been in the number of those aged 85 and over. In 1984, there were around 660,000 people in the UK aged 85 and over. Since then the numbers have more than doubled reaching 1.4 million in 2009.⁹

3.15 The 'Free Choice in Elective Care' equality impact assessment suggested that older people experience inequalities when exercising choice. This is because external factors sometimes influence their decisions. For example, older people:

- Are not keen to travel to hospitals further away
- May need help to make decisions
- Like good quality information on the alternative hospitals as they often have a good knowledge of their local hospital
- Are more likely to have a caring role than younger people, making it difficult for them to travel long distances

⁹ Office of National Statistics: <http://www.statistics.gov.uk/cci/nugget.asp?id=949>

- Rely on their own personal experience and the experience of others they know in making decisions about their healthcare
- Are less likely to have access to the internet and prefer written material and often use libraries and local community centres to access health related books

3.16 However, The King's Fund (2010) found that older people, particularly those aged 66-80, were more likely to be aware of choice than younger respondents. Furthermore, it indicated that older respondents, women and those with no formal qualifications, are more likely to rate having a choice as important or very important. However, the perception of several providers interviewed was that choice is more applicable to the young, those from higher socioeconomic groups and those with higher levels of education. This is in accordance with the report on the National Patient Choice Survey¹⁰ which reports that the highest proportion of patients offered choice were 35-54 year olds and 55-64 year olds, whilst there were lower proportions for 16-34 year olds and those aged over 65. It should be recognised that organisations will have to take account of the Equality Act 2010, which will make unjustifiable age discrimination unlawful. This should mitigate any concerns associated with providers' perceptions of who should be offered choice.

3.17 It has previously been suggested that patients who consistently chose their local hospital over other alternatives were more likely to be older, have left formal education and have lower incomes (Burge et al, 2004). However, the more recent evidence from The King's Fund (2010) suggests this has changed, with older and more educated patients more likely to choose a non-local provider. It shows that patients aged 51-65 were more likely than younger patients aged 16-35 to travel to a non-local provider.

3.18 The King's Fund report also found that many GPs did not believe it was possible to ensure all patients had an equal opportunity to exercise choice and that a significant proportion of older patients were happy to entrust the responsibility to them. This has encouraged some GPs to adopt a paternalistic approach, as they saw their role as that of patient advocate. *Liberating the NHS: Greater Choice and Control* proposes an increased focus on the principle of shared decision making. Feedback to the consultation indicated that stakeholders felt this could be brought about through the provision of accessible information for all, engagement with voluntary and community

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http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_117096.pdf

organisations and education and training – both for healthcare professionals and patients.

- 3.19 The response to the consultation from Age UK highlighted that support and advocacy will be key in supporting older people to make choices. Their response stressed that it is essential that there are no barriers to information, particularly with an increasing amount of information being provided via the internet, as over 60% of over 65s have never been online¹¹. To ensure that older people can exercise real choice information must be provided in a wide range of formats which takes this into account (see *Importance of accessible information* section for further details.)
- 3.20 The Joseph Rowntree Foundation, in its consultation response, highlighted that people living in institutional settings including older people in care homes, can often be disempowered in terms of making their own choices. People living in care homes should be given the opportunity to choose a named consultant-led team, however they may face specific barriers to exercising choice e.g. travel or accessibility difficulties.
- 3.21 Children and young people should still be involved in decisions and choices about their healthcare as much as possible, even when they are unable to make decisions and choices by themselves. The level of involvement that they are able to have will depend on their individual circumstances. For example, it will be determined by their ability to understand and interpret information, which may often be in partnership with their parents, family and other representatives as appropriate.

Disability

- 3.22 Results of the National Patient Choice Survey (2010) indicate that the proportion of patients who are aware that they have a choice of hospital, before visiting their GP, is higher for patients with a long-standing illness or disability. However, the 'Free Choice in Elective Care' (2007) equality impact assessment suggests that disabled people experience difficulties when accessing health services.
- 3.23 A key risk to equality, which may affect this group, relates to transport. Some disabled patients may not have the capacity to travel to a non-local provider, this may be due to mobility problems or restricted access to information; information on travel timetables and routes is often inaccessible, which is

¹¹ Office for National Statistics (2010). 'Internet Access: Households and individuals 2009'

particularly challenging for blind or partially sighted individuals. Issues around transport relate to access to services, but also to choice as choice of provider or named consultant-led team may be restricted by where a patient is able to travel to. The impact that access to transport has on the ability to exercise choice has been reiterated by stakeholders in response to the consultation on *Liberating the NHS: Greater Choice and Control*.

- 3.24 To mitigate these risks, choices offered must be sensitive to any additional needs disabled people may have, and information must be made as accessible as possible so that they can make informed decisions about their healthcare.
- 3.25 The King's Fund (2010) found that some GPs make certain assumptions about choice on behalf of patients with mental health problems. People with learning disabilities, who may be less articulate, are unlikely to exercise choice - as are those from other vulnerable groups. This might mean that they need help to make choices or decisions, or another person might have the legal authority to make decisions on their behalf.
- 3.26 Local HealthWatch organisations will be local consumer champions across health and social care; they will have a role in healthcare complaints advocacy and will signpost people to information to help them make health and social care choices. Local HealthWatch organisations should work closely with voluntary and community organisations to ensure that the views of the community are fully represented.
- 3.27 To enable people to exercise real choice it is imperative that everyone has access to information about their health and what choices they can make, which is reliable and easy to understand. Information must be provided in a range of formats, ensuring that disabilities are taken into account (see the *Importance of accessible information* section for further details).

Ethnicity

- 3.28 The UK is becoming increasingly ethnically diverse. The 2001 Census showed that approximately 12.7% of the population of England and Wales came from a black or minority ethnic (BME) background. Population projections indicate that this percentage increased to 15.7% by 2007 and will increase further to 21.3% by 2016.
- 3.29 The ONS Census Report (2001) found that there are health inequalities between different ethnic groups and between genders. BME communities face a number of barriers when accessing health services which may include: knowledge of the UK healthcare system, which may be a particular problem

for newly arrived immigrants; culture; language; geographical location; health status and family issues. Although choice policy is not designed specifically to tackle these issues, extending choice may encourage and enable different and minority ethnic groups to access the healthcare system by better accommodating their needs and preferences and may therefore have a positive impact on existing inequalities. Conversely, there is also a risk that the expansion of choice could widen the gap between those with the best and worst access to healthcare, exacerbating inequalities.

- 3.30 Romany Gypsies and Irish Travellers are protected as ethnic groupings under the Equality Act 2010 and make up 0.6% of the total UK population. People from gypsy and traveller communities have significantly poorer health than the rest of the population¹². A common problem for the travelling community is access to primary care, as a permanent address is often necessary in order to register at a GP practice. This leads to increased reliance on A&E and walk-in centres, presentation with multiple conditions and poor follow-up care. Although the main issue here is access to healthcare, this could have an impact on the extent to which choice can be exploited by these groups.
- 3.31 The EqIA for 'Free Choice in Elective Care' outlined concerns associated with expanding choice in elective care for different racial or ethnic groups. One issue raised was the extent to which cultural factors could limit people becoming actively involved in decision-making. There was also emphasis on the importance for some BME people in finding a GP who understood their approach to health from a cultural perspective.
- 3.32 The Kings Fund reported (2010) that GPs who work in ethnically diverse areas believe patients whose first language is not English do not receive equal opportunities when it comes to choice. The report found that when a patient's understanding is limited due to language difficulties, some GPs make assumptions on their behalf. However, some GPs did offer practical assistance to non-English speaking patients when booking appointments.
- 3.33 This perception of GPs contrasts with the observations by The King's Fund (2010) based on their survey, which found that the opportunity to choose did not differ by ethnicity. It should be noted that the Kings Fund survey was based on a hypothetical scenario and not on actual data. The National Patient Choice Survey (2010)¹³, on the other hand, reported that the proportion of patients who recall being offered a choice of hospital for their first outpatient

¹² Leeds GATE (Gypsy and Traveller Exchange)
<http://www.grtleeds.co.uk/Health/makingaDifference.html>

¹³
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_117096.pdf

appointment was higher for patients in the white ethnic group than BME patients.

- 3.34 Given that people whose second language is English are more likely to need support for making choices as choice is extended, it remains important that information is made accessible to all groups, including non-English speaking patients. The availability and use of interpretation services will be necessary in order for healthcare professionals to fully engage with patients¹⁴. Healthcare professionals will receive support, advice and education about how best to support these groups to make choices, as it is imperative that assumptions are not made around the type of support individuals would like to receive.
- 3.35 Voluntary and community organisations will be a valuable resource in providing support to those in the community who need help to make choices about their healthcare. Responses to the consultation on *Liberating the NHS: Greater Choice and Control* emphasise the importance of engaging with these organisations to ensure that the views of ethnic minority communities are voiced. Local HealthWatch organisations could support engagement with voluntary and community organisations as well as signposting patients to information to enable them to make choices.

Gender

- 3.36 The King's Fund (2010) has evidence to suggest that whilst men are more aware of the choices available to them, they are less likely to be offered choice than women. This is supported by results from the National Patient Choice Survey (2010)¹⁵. However, there is no evidence to suggest that GPs are actively limiting the offer of choice to men. The explanation put forth by the 'Free Choice in Elective Care', EqIA (2007) is that women are more likely to recall being offered choice. This is further supported by evidence contained within the Choose & Book report (2005) as it found that men were less likely to probe about the choice offer than women, which makes it easier for women to recall the conversation of choice offered.
- 3.37 The patient survey undertaken by The King's Fund (2010) found that men are more likely to know about choice than women. However, when the impact of demography was looked at in conjunction with past experience at the local

¹⁴ For a good practice guide to interpreting see <http://al-hasaniya.org.uk/resources/alhas-interpretguide-eng.pdf>

¹⁵ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_117096.pdf

hospital, it was women, those with no formal qualifications, mixed and non-white respondents and those with a bad past experience of their local hospital who were significantly more likely to rate having choice as important or very important.

- 3.38 The Kings Fund (2010) found no significant differences between different population groups (by age, gender, ethnicity or education) in whether patients were offered a choice, suggesting that the opportunity to choose is reasonably equitable at present. This should remain the same as choice is expanded and healthcare professionals receive support, advice and education about how best to support people to make choices.
- 3.39 Although the evidence shows that there is no gender inequality in who is offered choice, the Woman's Health and Equality Consortium, in response to the consultation, have highlighted some barriers to choice which may be faced by some women:

“Women face particular barriers to exercising choice. These barriers include inequality in power and resources; poverty; gender-based violence; caring responsibilities; confidence and voice; knowledge of rights and a lack of access to appropriate maternity services.”

Choice for women can be promoted by ensuring that women are given a voice in local structures, such as HealthWatch.

Religion or belief

- 3.40 People from different religious groups and communities have specific concerns when choosing a healthcare provider. Healthlink's report (Taking Soundings, 2004), found that Muslim patients and their visitors wanted to be assured that they would have prayer space within the grounds of the hospital, and that members of certain faiths would not use mixed wards under any circumstances. The policy on Delivering Same Sex Accommodation should help to address some of these concerns¹⁶.
- 3.41 It should be recognised that people can delay making a healthcare choice in order to research their preferences in more detail. For example, the NHS Choices website has information about hospitals that members of a certain faith can research to see if prayer space is available. Extending choice is likely

¹⁶ The 2010/11 Operating Framework advocates the elimination of mixed sex accommodation http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107

to have a positive impact upon these groups through a better consideration of their preferences.

Sexual Orientation

- 3.42 We have very little evidence about whether or not lesbian, gay or bi-sexual (LGB) people face discrimination in being offered choice, or in exercising choice. However, there are wider issues about how people access health care that may be particularly relevant to LGB people.
- 3.43 The Sigma report (2005) found that half of respondents had not disclosed their sexuality to their GP, and that of those, 39% had no intention of doing so¹⁷. The report suggested that this was due to anxiety that a GP would not hold the information confidentially, and that the quality of service provision would decline because the GP would be homophobic towards the patient.
- 3.44 Stonewall's report (2005) found that 36% of respondents had not disclosed their sexual orientation to their GP¹⁸. In a second report (2008) they found that half of lesbian and bisexual women reported having had negative experiences in the health sector in the last year, despite it being unlawful to discriminate against lesbian and bisexual women.
- 3.45 There is very limited reliable research on LGB people's healthcare needs and outcomes. This lack of information may be a barrier to making services more inclusive and providing information to people to help them make decisions that are more informed. In response to the consultation on *Liberating the NHS: Greater Choice and Control* the Lesbian and Gay Foundation voiced the opinion that sexual orientation monitoring, along the lines of monitoring for other protected characteristics, would help LGB people make more informed choices.
- 3.46 Consultation responses also suggest that in order for LGB people to have more choice in their healthcare they need access to a range of providers where they feel able to discuss their health issues in relation to their sexuality. Respondents believe that this choice can be increased by provision of specialist providers, especially in areas where LGB people represent a significant proportion of the population, as well as ensuring that generic services are more inclusive.

¹⁷ The Sigma report *It makes me sick: Heterosexism, homophobia and the health of Gay men and Bisexual men.* (2005).

¹⁸ Stonewall Report. *Survey of lesbian health care needs.* (2005)

3.47 Engagement with voluntary and community organisations via local HealthWatch will also be important to help mitigate any risks associated with choice, and help ensure that the needs of this group are being met.

Gender reassignment

3.48 The term ‘trans’ is “a very broad term to include all sorts of trans people. It includes cross dressers, people who wear a mix of clothing, people with dual or no gender identity, and transsexual people. It is also used to define a political and social community which is inclusive of transsexual people, transgender people, cross-dressers (transvestites), and other groups of ‘gender-variant’ people¹⁹.”

3.49 Trans people typically report poor experience with healthcare interactions²⁰

- 17% of trans people reported being refused (non-trans related) healthcare by a doctor or nurse because they did not approve of gender reassignment,
- 29% said being trans adversely affected the way they were treated by healthcare professionals, and
- 21% of GPs did not appear to want to help or refused to help with treatment for gender problems.

3.50 There have been no large-scale surveys focusing on the healthcare needs of trans people, therefore reliable information in this area is limited. When considering the equality impact of this policy on trans people we must consider both the impact on services specific to trans-people, such as gender re-assignment treatment, as well as the impact on wider healthcare needs; transgender people often face barriers to routine healthcare such as breast and prostate screening²¹

3.51 Feedback to the White Paper consultation suggested that trans people report that GPs do not include or engage them by offering choice or in decision-making. The independent scrutiny role that the local HealthWatch will have has the potential to help close the gap in current inequalities. In addition, more

¹⁹ Whittle S, Turner L, and Al-Alami M (2007) *Engendered Penalties: Transgender and Transsexual People’s Experiences of Inequality and Discrimination*. London: The Equalities Review

²⁰ *ibid*

²¹ Mitchell and Howarth (2009) “Trans Research Review” published by the Equalities and Human Rights Commission.

capacity for complaints advocacy and support for choice are likely to benefit transgender people.

- 3.52 With the expansion of choice, healthcare professionals will receive support, advice and education about how best to support people to make choices. These measures should ensure that healthcare professionals do not exclude people on the grounds of gender identity and gender reassignment from being offered choice, or to exercise choice.
- 3.53 For individuals seeking gender re-assignment therapy the first step in the process is a referral from their GP to a consultant psychiatrist. Mental health services are currently not included in choice of first consultant-led outpatient appointment and therefore choice of consultant-led team currently does not apply. The White Paper set out specific proposals for choice in mental health services; guidance on the commitment of choice in mental health services will be issued in due course.

Socio-economic status

- 3.54 Evidence from The King's Fund (2006) and RAND (2006) found that certain population sub-groups were less likely to exercise choice and digest information. However, Cookson and Laudicella (2010), in their analysis of healthcare reform between 2003 and 2008, found no substantial change in socio-economic equity as a result of expanding choice, and their findings may actually point to some slight improvement.
- 3.55 There are various reasons why people from certain socio-economic groups may find it difficult to exercise choice. The main barriers to choice are outlined below:

Transport difficulties

- 3.56 Some people might want, but are unable, to choose a healthcare provider that they would find it difficult to travel to, due to mobility difficulties, their financial situation or any other reason.
- 3.57 The King's Fund (2010) found that those who would usually travel to a non-local hospital by public transport were significantly less likely to choose a non-local hospital than those who usually travel by car. Dixon and Le Grand (2006) suggest that limited financial help with transport may cause barriers for patients with communication difficulties or those with low literacy skills. This is consistent with Burge et al (2005) who found that where patients had to organise and pay for their own transport the likelihood of choosing a non-local

hospital was reduced, unless waiting times at the alternative hospital were on average, around three months less.

- 3.58 Feedback to the consultation on *Liberating the NHS: Greater Choice and Control* confirmed transport is a factor that affects peoples' choices and therefore must be taken into consideration. Respondents representing many different groups felt that access to transport could act as a significant barrier to choice. Local commissioners should make sure that people who find it difficult to travel are not disadvantaged by their choices.

Socio-economic group

- 3.59 Certain groups, such as the homeless, tend to have poorer health status and more self-reported symptoms of ill health than other people. However, they are less likely to visit health care professionals or alternative medical workers and are unlikely to contact NHS Direct²². People living in deprived communities have historically had access to fewer GP practices and less responsive primary care services. Consultation responses expressed concern that more informed, articulate patients will gain better access to services through choice, leading to an increase in health inequalities.
- 3.60 Research conducted by The Kings Fund (2010) found that highly educated people were just as likely to be offered choice as less educated people, however those who hold a degree were significantly more likely to choose a non-local hospital than those with no formal qualifications. Furthermore, research has also shown that people from social classes A/B are more likely to be aware that information on choices can make a difference to the care you receive and your health (32% versus 19% of people from social class D/E)²³.
- 3.61 The role of GPs is important when it comes to patients exercising choice. The King's Fund (2010) provides evidence to suggest that some GPs think choice is only of interest to those from the educated middle classes. In addition, it found that some GPs make certain assumptions on behalf of their patients with low levels of literacy, whereas the survey found that patients with fewer qualifications rated choice as more important. Furthermore, there is evidence GPs may be screening who they send to independent sector providers.

²² Inclusion health.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114067

²³ Primary Care Tracker Survey, Ipsos Mori, 2010)

Pregnancy and Maternity

- 3.62 Maternity services are currently not included in choice of first consultant-led outpatient appointment and therefore the commitment to choice of named consultant-led team does not currently apply. The White Paper *Equity and Excellence: Liberating the NHS* set out specific choice commitments in the area of maternity services and the response to the consultation, *Liberating the NHS: Greater choice and control* and related guidance on the commitment of choice in maternity services will be published in due course. As this commitment does not cover maternity services we do not envisage that there will be differential impacts on this group relating specifically to choice of named consultant-led team.

Summary of Impacts

4.1 The table below summarises the potential equality impacts associated with choice of named consultant-led team and the actions which can be taken to mitigate risks or promote positive impacts. The impacts and actions outlined below are not exclusive to choice of named consultant-led team, but are associated with the expansion of patient choice more generally. The actions which can be taken specifically around choice of named consultant-led team are limited and therefore must be viewed in a wider context.

Protected Characteristic	Potential Impacts Identified	Actions to mitigate/opportunity to promote
Age	Older people may be less able or willing to exercise choice, which may potentially restrict their access to more appropriate or better care.	The NHS Information Revolution will ensure that comprehensive and accessible data and information will be available to patients, to enable them to make choices about their healthcare. Commissioners and providers can work with Local HealthWatch and third sector advocacy groups to ensure older people are supported to exercise choice.
	Less mobile older patients could find it difficult to travel and choose providers that best meet their needs. This could create an inequality as some patients could access better care because they can travel further.	Commissioners would be responsible for mitigating the potential risk that particular groups receive an unequal quality of service. Patients choosing their healthcare provider can increase the quality of care for all, even if it is not fully exercised by particular groups. There is some evidence that older people are prepared to travel, more so than younger people, to access the services and clinicians they wish to. Monitor will have a duty to protect and promote the interests of patients where appropriate to achieve the best possible outcomes for patients of all ages.
	Older people living in institutions, such as care homes, may face more restrictions in the choices	Older people living in care homes must be given appropriate support to ensure that they are able to make choices. Where possible, engagement with patients' relatives and carers

	they are offered.	will be necessary to ensure that their preferences are met.
Disability (including carers of disabled people)	Disabled patients may not have the capacity to travel and choose a hospital further away from their home. More mobile patients will be able to travel and choose a better hospital if they are not happy with their local provider. This could create an inequality as some patients could access better care because they can travel further.	Commissioners would be responsible for mitigating the potential risk that particular groups could receive services that are inequitable. Some patients choosing between providers should improve the quality of care in all providers, even if not all patients are equally likely to travel. This should help mitigate the risk of less mobile patients receiving a lower quality of care to those who travel further for treatment.
Ethnicity	Those whose first language is not English can face specific barriers to accessing information that is required to make an informed choice.	Information must be provided in a range of formats that is accessible to all service users. Local HealthWatch organisations could provide help, advice and engage with voluntary and community organisations to ensure that the views of minority communities are heard.
	Certain minority groups, such as Romany gypsies and Irish Travellers face specific barriers to accessing healthcare, which consequently restricts the potential benefits of choice.	Healthcare commissioners and providers should engage with voluntary and community organisations to help improve access and promote choice.
Gender	Evidence suggests that men are less likely to exercise choice, which may potentially restrict their access to more appropriate or better quality care.	Commissioners and providers can work with HealthWatch, voluntary organisations and public sector organisations to ensure that men have the information and support required to exercise choice. NHS Choices could also be used to provide targeted health information for men and other population groups

Sexual Orientation	There is limited research on LGB people’s healthcare needs, which is a barrier to providing information for people to make fully informed choices.	Engagement with voluntary organisations via local HealthWatch could help ensure that the needs of this population are being met.
Gender re-assignment	Trans people report that GPs do not currently engage them by offering choice or in decision-making. The expansion of choice in consultant-led team and greater shared decision making would improve this situation, although there is a risk that GPs could continue to discriminate against trans people.	GPs should receive support and advice on how best to support people to make choices, which should ensure that healthcare professionals do not exclude people from being offered choice on the grounds of gender identity. The role of HealthWatch has the potential to contribute to closing the gap in any existing inequalities.
Socio-economic status	Some people from socio-economically disadvantaged groups may have their choice of named consultant-led team restricted due to lack of access to transport.	Commissioners would be responsible for mitigating the potential risk that particular groups may receive inequitable services.
	Choice for some people may be restricted due to lack of access to healthcare more generally e.g. people living in deprived communities have historically had poorer access to GPs.	Healthcare commissioners and providers should engage with voluntary and community organisations to help improve access and promote choice.

Glossary

Carer	A carer is someone who spends a significant proportion of their life providing unpaid support to family or friends. This could be caring for a relative, partner or friend who is ill, frail, disabled, or has mental health or substance misuse problems.
Choose and Book	An electronic referrals and booking service which allows patients and their GP to choose a date, time and hospital for their appointment and book it online.
Community pharmacies	Community pharmacies were known in the past as chemists. They are situated in high street locations, in neighbourhood centres, in supermarkets and in the heart of most deprived communities.
Consultant	A consultant is defined as a person who has been appointed to a consultant post within a secondary care provider.
Consultant-led team	A named consultant-led team is where a consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.
Elective care	Hospital care which is planned in advance and not in response to an emergency.
End of life care	Care that helps people with advanced, progressive, incurable illnesses to live as well as possible before they die. It enables the needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes managing pain and other symptoms and providing psychological, social, spiritual and practical support.
Long term condition	A disease, illness or other condition that cannot currently be cured but can be controlled with the use of medication and/or other therapies.

	People live with the condition(s) for the rest of their lives.
Protected characteristics	Protected characteristics are those characteristics which are protected under the Equality Act 2010 and associated secondary legislation. They are: Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion or Belief, Sex, Sexual Orientation.
Provider	A person or organisation that provides healthcare services, whether by running a hospital, an independent treatment centre, providing services in the community, or in any other way.
Referral	A healthcare professional transfers a patient's care to a different healthcare professional or provider organisation. For example, a GP refers a patient if he or she asks the patient to go to hospital to speak to a consultant.

References

Burge, P., Devlin, N., Appleby, J., Rohr, C. and Grant, J. (2005), *London Patient Choice Project Evaluation: A Model of Patients' Choices of Hospital from Stated and Revealed Preference Choice Data*, London: Rand Europe/King's Fund/City University

Report on the National Patient Choice Survey – February 2010 England, Department of Health, June 2010.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_116958

White Paper, *Equity and Excellence: Liberating the NHS*, Department of Health, July 2010

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

Liberating the NHS: Greater Choice and Control. a consultation on proposals. Department of Health, October 2010

http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651

An Information Revolution: a consultation on proposals. Department of Health, October 2010 http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120080

Free choice in Elective Care Equality Impact Assessment. Department of Health, 2007.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081093.pdf

Inclusion Health: improving primary care for socially excluded people. Department of Health, 2010.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114067

Dixon, R. Robertson, J. Appleby, P. Burge, N. Devlin, H. Magee (2010). *Patient choice: How patients choose and how providers respond.* The King's Fund, 2010.

C. Dodds, P. Keogh, F. Hickson (2005). *It makes me sick: Heterosexism, homophobia and the health of Gay men and Bisexual men.* Sigma Research, 2005.

Leeds GATE (Gypsy and Traveller Exchange)<http://www.grtleeds.co.uk/Health/index.html>

British Social Attitudes survey (2009). National Centre for Social Research, 2009.
<http://www.natcen.ac.uk/study/british-social-attitudes-25th-report/findings>

“Our Choices in Mental Health” The Sainsbury Centre for Mental Health, July 2006,
http://www.centreformentalhealth.org.uk/pdfs/briefing31_choice_in_mental_health_care.pdf

Office for National Statistics, Statistical Bulletin: Internet Access 2010
<http://www.statistics.gov.uk/pfdir/iahi0810.pdf>

Stonewall Report (2005). *Survey of lesbian health care needs.*

Stonewall (2008) *Prescription for change: Lesbian and bisexual women’s health check 2008*

http://www.stonewall.org.uk/documents/prescription_for_change.pdf

S. Whittle, L. Turner, M. Al-Alami (2007). *Engendered Penalties: Transgender and Transsexual People’s Experiences of Inequality and Discrimination.* The Equalities Review.