

<b>Title:</b> Response to consultation 'Liberating the NHS: No decision about me, without me' IA No: 2042  <b>Lead department or agency:</b> Department of Health  <b>Other departments or agencies:</b>	<b>Impact Assessment (IA)</b>		
	Date: 25/09/2012		
	Stage: Final		
	Source of intervention: Domestic		
	Type of measure: Other		

**Summary: Intervention and Options** **RPC Opinion: RPC Opinion Status**

Cost of Preferred (or more likely) Option				
Total Net Present Value	Business Net Present Value	Net cost to business per year (EANCB on 2009 prices)	In scope of One-In, Measure qualifies as One-Out?	
£0m	£0m	£0m	No	NA

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

Evidence finds some NHS patients are not as involved in decisions about their care as they should be. It also shows the NHS could do better in responding to the patients it treats and does not have a genuine patient-centred approach. This prevents resources from being allocated to services and care that patients want to use and therefore creates suboptimal outcomes in terms of patient satisfaction. The Government is best placed to increase patients' involvement in decisions about their care because it sets the regulatory, contractual and financial framework within which NHS services are delivered.

**What are the policy objectives and the intended effects?**

The policy objective is to give patients more say in decisions about the care and treatment they receive, increasing convenience and ensuring they get the services they want. Allowing patients to choose from whom, when and where they receive services will drive quality improvements: first by making services more aligned with patient preferences; and second by a knock on effect of better outcomes as a result of the improved responsiveness.

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

Option 1: Do Nothing. Policies in place for patients to choose some of the services they receive will continue: a) choice of any clinically appropriate provider when referred for first consultant-led outpatient appointment, b) choice of locally provided community services under the any qualified provider framework, and c) choice of named consultant-led team within providers.  
 Option 2: 'No decision about me, without me' for the majority of NHS funded services. Implement a model of shared decision-making to give patients more involvement in decision about their care in four areas: in primary care; before a diagnostic test; at referral to secondary care; and after a referral (i.e. post-diagnosis). Priority areas for this proposal are non consultant-led diagnostic test provider, maternity services and mental health services. Option 2 is the preferred option.

**Will the policy be reviewed? It will be reviewed. If applicable, set review date: 10/2017**

Does implementation go beyond minimum EU requirements?			N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	Micro No	< 20 No	Small No	Medium No	Large No
What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? (Million tonnes CO <sub>2</sub> equivalent)	Traded: 0		Non-traded: 0		

*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) that the benefits justify the costs.*

Signed by the responsible Minister:

 Date: 5th Dec. 2012

## Summary: Analysis & Evidence

## Policy Option 2

**Description:** Implement model of shared decision-making and policies intended to increase patient involvement

### FULL ECONOMIC ASSESSMENT

Price Base Year 2012	PV Base Year 2012	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low:	High:	Best Estimate:
<b>COSTS (£m)</b>		<b>Total Transition</b> (Constant Price) Years	<b>Average Annual</b> (excl. Transition) (Constant Price)		<b>Total Cost</b> (Present Value)
Low					
High					
Best Estimate		<£10,000			<£10,000
<p><b>Description and scale of key monetised costs by 'main affected groups'</b></p> <p>New providers under the expanded choice offer may face costs in preparing for Choose and Book. Costs will depend on the needs of each new provider and how many providers take up the model. Other mechanisms currently in place, or are introduced as part of the Health and Social Care Act (2012) will be used to implement the policy and can be done at zero cost.</p>					
<p><b>Other key non-monetised costs by 'main affected groups'</b></p> <p>Expanding choice in mental health may cause an increase in demand for mental health services, which may increase costs. Depending on scope, ensuring compliance between Choose and Book and other IT systems may impose a cost. There is an opportunity cost from training forgone from emphasising patient involvement in education of health professionals. Failing to exploit this training may result in an increase in consultation times.</p>					
<b>BENEFITS (£m)</b>		<b>Total Transition</b> (Constant Price) Years	<b>Average Annual</b> (excl. Transition) (Constant Price)		<b>Total Benefit</b> (Present Value)
Low					
High					
Best Estimate		Unquantified	Unquantified		Unquantified
<p><b>Description and scale of key monetised benefits by 'main affected groups'</b></p> <p>Detailed analysis of how patients' referrals might change, and the improved health outcomes as a result, is not feasible. The impact of the proposals will depend to a great extent on how much intrinsic value patients place on shared decision-making and how far they experience better outcomes as a result of exercising expanded choice. This is inevitably uncertain.</p>					
<p><b>Other key non-monetised benefits by 'main affected groups'</b></p> <p>Most benefits fall on patients: greater convenience from selecting a greater number of providers; intrinsic value of more say and involvement in their treatment; improved health outcomes and greater quality of care; and greater adherence to treatment. More say and involvement will bring improved efficiency of provision and a more efficient allocation of resources, leading to potential cost savings.</p>					
<b>Key assumptions/sensitivities/risks</b>					<b>Discount rate (%)</b>
The biggest risk is the attitude and behaviour of patients and healthcare professionals in embracing shared decision-making. An unwillingness to support expanded choice could see overall costs increase or the benefits not being fully realised.					3.5

### BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: 0	Benefits: 0	Net: 0	No	NA

## Evidence Base (for summary sheets)

### Introduction

1. This final stage impact assessment accompanies the policy document “Response to consultation ‘Liberating the NHS: No decision about me, without me’”. It is informed by responses to the consultation *Liberating the NHS: No decision about me, without me – Further consultation on proposals to secure shared decision-making*<sup>1</sup>, which ran from May to August 2012.
2. As the response to this consultation shows, many respondents were supportive of the notion of making “no decision about me, without me” a reality. There was also broad support for the additional areas where we propose expanding choice further. Some responses had reservations about the practical implementation of the policies, which we take into account in this impact assessment. This impact assessment also includes additional information and progress with other government policies that have come to light over the latest consultation period.

### What is the problem under consideration?

#### Characterise the underlying problem

3. The way the NHS is configured and the way services are commissioned means that patients are not as involved in decisions about their care as they could be. The choices patients have over their care and treatment are often limited. Patients must accept what is offered whether or not the service is convenient or the patient is happy with the quality.
4. There is overwhelming evidence to show that patients want choice. A British Attitudes Survey<sup>2</sup> found 95% of people feel that they should have choice over the hospital they attend and the kind of treatment they receive. The King’s Fund found<sup>3</sup> 75% of respondents said that choice of hospital was either ‘very important’ or ‘important’ to them. More recently a Department of Health commissioned survey<sup>4</sup> of 5,000 people in England, conducted in October 2011 found:
  - 81% of respondents want more choice over where they are treated;
  - 79% of respondents want more choice of how they are treated; and
  - 75% of respondents wanted a choice of hospital consultant in charge of their care
5. Comparisons with other countries suggest outcomes in some areas of healthcare across the NHS are not as good as they could be, for example measures of amenable mortality<sup>5</sup>. A recent report by the Care Quality Commission on Dignity and Nutrition for Older People<sup>6</sup> suggests that non-clinical aspects of care could also be delivered better. Other reports have shown that the NHS score relatively poorly on being responsive to the patients it serves and lacks a genuine patient-centred approach where patients are often expected to fit in around services<sup>7, 8</sup>.
6. One reason why outcomes are not as good as they could be is that services are not as responsive as they could be to patient preferences. For example:
  - patients are not always fully informed about their condition and treatment options;
  - there are limited opportunities for patients to choose, with the support of their GP, the best provider for their care and treatment; and
  - there are institutional and individual attitudes and behaviours that do not put patients at the centre of care.

<sup>1</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_134218.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134218.pdf)

<sup>2</sup> British Social Attitudes survey (2009), Natcen, <http://www.natcen.ac.uk/study/british-social-attitudes-25th-report/>

<sup>3</sup> 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)

<sup>4</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_131611.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131611.pdf) (Page 26)

<sup>5</sup> [http://www.oecd-](http://www.oecd-ilibrary.org/docserver/download/fulltext/5kgj35f9f8s2.pdf?expires=1343208545&id=id&accname=guest&checksum=ADB33C697FDB4A2559821F87422E8542)

[ilibrary.org/docserver/download/fulltext/5kgj35f9f8s2.pdf?expires=1343208545&id=id&accname=guest&checksum=ADB33C697FDB4A2559821F87422E8542](http://www.oecd-ilibrary.org/docserver/download/fulltext/5kgj35f9f8s2.pdf?expires=1343208545&id=id&accname=guest&checksum=ADB33C697FDB4A2559821F87422E8542)

<sup>6</sup> Care Quality Commission, Dignity and Nutrition: Inspection Programme (2011)

<sup>7</sup> The Tallinn Charter, Health Systems for Health and Wealth Draft Charter World Health Organisation (2008)

<sup>8</sup> Is the NHS becoming more patient centred? Trends from the national surveys of patients in England 2002-2007 Picker Institute 2007

7. Where services are not responsive to patient preferences, there is potential for a misallocation of scarce healthcare resources leading to suboptimal outcomes.

## Rationale for government intervention

8. The NHS is a public service funded through general taxation. Government is best placed to introduce more say in decisions about care and treatment because it determines the policy, regulatory and contractual framework within which healthcare services are delivered.
9. There is some evidence to suggest that shared decision-making exists in the NHS already:
- The GP Patient Survey (2010/11) found 71% of respondents rated their doctor as “Very Good” or “Good” on involving them in decisions about their care. The equivalent proportion for the rating of practice nurses was 59%<sup>9</sup>.
  - The CQC Inpatient Survey from 2011 found only 52% of respondents were ‘definitely’ involved as much as they wanted to be in decisions about their care and treatment<sup>10</sup>.
10. This represents good progress in making “no decision about me, without me” a reality for all. However, to embed patient involvement further will require intervention from government through its regulatory and contractual frameworks.

## Delivering public services through markets

11. The policies which this impact assessment accompanies are compatible with the National Audit Office document “*Delivering public services through markets: principles for achieving value for money*”, published in June 2012<sup>11</sup>. This document sets out ten principles for obtaining value for money from public services markets. These principles are designed to ensure a healthy competitive market, where providers can enter, expand and exit easily. The principles indicate the need for users to participate actively in the market, with informed choices, and to ensure that the market is delivering the objectives of the policy. The implementation of the policy which this impact assessment accompanies will follow the main principles outlined in the National Audit Office document.

## Summarise and put into context the analytical narrative.

### Evidence that supports choice

12. This section sets out the evidence that demonstrates expansion of choice policy can lead to better outcomes. It also discusses the academic studies that investigated the effects of the reforms that introduced choice of provider for elective acute services from April 2006.
13. There is a rich body of academic literature that has investigated the overall relationship between market structure and outcomes, productivity and innovation. In general, any market (not just health) that is plural and provides more choice to service users tends to be more productive and innovative than those that are monopolies. Some of the most frequently cited studies are:
- Nickell (1996)<sup>12</sup> finds that firms which face more competition have significantly greater productivity growth than those facing muted competition.
  - Ahn (2002)<sup>13</sup> reviews a large number of studies on the link between competition and innovation and concludes that competition encourages innovation activities and has a significant impact on long term productivity;

<sup>9</sup> [http://www.gp-patient.co.uk/results/download/y5q4/y5q4\\_SHA\\_weighted.xls](http://www.gp-patient.co.uk/results/download/y5q4/y5q4_SHA_weighted.xls)

<sup>10</sup> [http://www.cqc.org.uk/sites/default/files/media/documents/ip11\\_national\\_summary\\_final.pdf](http://www.cqc.org.uk/sites/default/files/media/documents/ip11_national_summary_final.pdf)

<sup>11</sup> [http://www.nao.org.uk/publications/1213/delivering\\_public\\_services.aspx](http://www.nao.org.uk/publications/1213/delivering_public_services.aspx)

<sup>12</sup> Nickell, S. Competition and Corporate Performance. Journal of Political Economy, 1996. Volume 104

<sup>13</sup> Ahn, S. (2002). Competition, innovation and productivity growth: a review of theory and evidence, Economics Department Working Papers No 37, OECD

- The Office of Fair Trading (OFT) commissioned a study<sup>14</sup> by Frontier Economics on choice and competition in public services. They concluded that “supply side flexibility around entry, exit and expansion is critical”.
  - The Office of Health Economics (OHE) (2012)<sup>15</sup> has undertaken an intensive review of the use of competition in health services. It concluded that “... evidence both from the UK and internationally suggests that quality based competition with prices fixed by a regulator can be beneficial, producing higher quality care at the same cost on average and, importantly, not leading to increased inequity in access to care.”
14. These studies suggest that the right approach to competition on the supply side of any sector of the economy can help deliver efficient services. This includes:
- productive efficiency in the short run – ensuring providers are getting the most out of the resources invested in the services they deliver;
  - allocative efficiency – ensuring services get the right balance to match service user needs and preferences; and
  - dynamic efficiency – ensuring the providers deliver innovation and productivity gains over time.
15. Looking at healthcare markets in more detail, there is a paucity of research that directly examines choice in healthcare markets in the UK, This is mainly because the degree to which choice has been available in healthcare has been limited. However, a number of studies have looked at the impact of earlier reforms to introduce patient choice in elective care in England:
- Cooper et al (2010a<sup>16</sup>, 2010b<sup>17</sup>) found that following the introduction of choice in 2006 “... that in markets with fixed-prices, hospital competition can improve patient outcomes.”;
  - Bloom et al (2010)<sup>18</sup> also used the introduction of choice in 2006 to investigate the impact of competition on management and outcomes. They conclude that “... our measure of management quality was robustly associated with better hospital outcomes...[and]... more hospital competition appears to cause improved hospital outcomes.”
  - Gaynor et al (2012)<sup>19</sup> uses the introduction of choice in 2006 to investigate the impact of fixed price competition. Their findings corroborated those of Cooper, and conclude “...that competition can be an important mechanism for enhancing the quality of care patients receive, even in a set up where hospitals are not profit maximisers.”
16. In summary, there is evidence that plurality of supply in service provision can lead to more efficient delivery of goods and services in the wider economy. There is an emerging evidence base to support the assertion that fixed price competition as introduced to some areas of the NHS (elective care) has had positive effects in terms of both efficiency and outcomes for patients.

### Evidence that supports shared decision-making

17. This section briefly summarises evidence supporting the desire for shared decision-making. Coulter and Collins (2011) define shared decision-making as “a process in which clinicians and patients work together to clarify treatment, management or self-management support goals, sharing information about options and preferred outcomes with the aim of reaching mutual agreement on the best course of action<sup>20</sup>.” Two ways of achieving shared decision-making are through patient decision aids and through training/education for medical professionals.
18. A Cochrane Review of patient decision aids was published by Stacey et al (2012) which analysed available literature on the effectiveness of decision aids for people facing treatment or screening

<sup>14</sup> Choice and Competition in Public Services: A Guide for Policy Makers. March 2010

<sup>15</sup> <http://www.ohe.org/publications/article/report-of-the-ohe-commission-on-competition-in-the-nhs-108.cfm> (see page 6 para4)

<sup>16</sup> 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

<sup>17</sup> 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

<sup>18</sup> 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

<sup>19</sup> Gaynor, M., Moreno-Serra, R. and Propper, C. (2012) Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service

<sup>20</sup> For references of all papers in this section, see Bibliography in Annex B.

decisions. The evidence found decision aids were effective in improving participation in treatment, communication between clinician and patient, and improved patients' knowledge of treatment options.

19. Studies looking at interventions to improve communication skills among clinicians can also support shared decision-making. Evidence from Clark (2000; 2008) found training for physicians improved doctors' communication with patients, to the extent that patients felt more comfortable managing their condition at home. Studies involving communication with pharmacists found improvements in health outcomes and greater adherence to medication<sup>21</sup>.
20. In summary, research on the use of decision aids and training for clinicians suggest that shared decision-making improves satisfaction and adherence to treatment for patients. These improvements will change the way that clinicians engage with patients and how patients respond to treatment. Annex B of this impact assessment contains more evidence for choice and the effectiveness of shared decision making.

## What are the policy objectives and the intended effects?

21. The policy objective is to give patients more say in decisions about the care and treatment they receive, increasing convenience and ensuring they get the services they want. Allowing patients to choose from whom, when and where they receive services should also drive quality improvements: first by increasing the responsiveness of service providers to patient preferences; and second by a knock on effect of better outcomes as a result of the improved responsiveness.
22. Another policy objective is to expand the choice offer that's currently available. The presumption of 'no decision about me, without me' will become the norm for more areas of care and to cover the treatments a patient receives, not just the hospital that provides the service.

## What are the underlying causes of the problem?

### Attitudes and behaviours

23. In order to enable the patient to share in decisions about their care, both patients and professionals must have bought into the idea of the patient being involved in decisions about their care and where 'no decision about me, without me' is the norm. Since the NHS was established, relationships between healthcare professionals and patients have developed which promote the professional as the decision maker and the patient as the passive recipient of care. This relationship is not universal; many clinicians and others seek to involve the patient in decisions and many patients seek to influence the direction of their care. Therefore it is crucial that the expanded choice policy and introduction of shared decision-making model aims to rectify this imbalance systematically.
24. With patient choice being concentrated on certain areas at present, the attitudes of GPs, among healthcare professionals, have been most important to delivery of current choice policy so far. If GPs are hostile to the idea of choice, then this could explain why the proportion of patients reporting being offered choice in the Patient Choice survey plateaued at 49%<sup>22</sup>. In its 2010 report, the King's Fund<sup>23</sup> 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 mattered to patients.'*

<sup>21</sup> See Annex B for a full list of studies.

<sup>22</sup> Dixon, S., (2010) Report on the National Patient Choice Survey- February 2010, Department of Health

<sup>23</sup> 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)

25. This suggests that healthcare professionals are not against choice in principle. The take up figure of 49% suggests, however, that some GPs may be reluctant to turn their acceptance into action within the consultation room – at least in such a way that patients recall a “choice conversation”. This might be the 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 <sup>24</sup>:

*‘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 time... ..at least 15 minutes.’*

26. Overall, the evidence about attitudes is broadly positive, or ambivalent at worst. The proposed changes to increase patient involvement throughout the healthcare system and to embed it into the decision making process could face initial problems as behaviours will have to change. However, the evidence suggests there is little cause for long term concern.

### **Past perceptions of choice infrastructure**

27. Patients must know what options they are able to choose from if the notion of ‘no decision about me, without me’ is to work. Choice of provider at the point of referral is supported by and exercised through the Choose and Book system. This is an electronic referral and booking system that lists the appointment slots available to patients for any given service and allows patients (or their healthcare professional) to choose between them.
28. Evidence suggests<sup>25</sup> that initially, in some cases, the system proved difficult to use. Since then, the user interface has been improved. Some concerns about the Choose and Book system may stem from the way in which it has been implemented locally, the way in which it is used or from past perceptions of the Choose and Book infrastructure. The King’s Fund suggests that it is past problems with the Choose and Book system<sup>26</sup> that has influenced GP views on choice more generally. This perception needs to change so that referrers and patients can use the Choose and Book system with ease and confidence, and fully embed the expanded choice policy.

### **Offer of choice**

29. A lack of available options may have restricted the ability of patients to make meaningful choices to date. But evidence from the Department of Health’s commissioned research (see paragraph 4) suggests any problems of matching healthcare to patient needs is not caused by patients’ unwillingness to embrace choice. Therefore, when choice is expanded to other areas of care patients will be willing to make choices as they become familiar with what is on offer.
30. The Patient Choice Survey<sup>27</sup> commissioned by DH suggests that the awareness level of choice by patients rose steadily but slowly (reaching 54% in Feb 2010). From Spring 2008, the proportion of patients recalling being offered choice stabilised at 50%. This could be a supply side blockage as much as a lack of demand side push from patients.
31. Patients will have to regain their voice and be more demanding about the quality of care they receive and hold providers to account. Healthcare professionals will need to facilitate patients’ involvement in decisions about their healthcare and support patients seeking reassurance about those decisions. As a result, better decisions will be made and the quality of care and outcomes would be improved.

### **Provision of Information**

32. Choice is at its most powerful to shape services if those choices are fully informed because the matching of patient preferences and needs to healthcare services will be more closely aligned.

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<sup>24</sup> Ibid p42

<sup>25</sup> Ibid

<sup>26</sup> Ibid, p45

<sup>27</sup> Dixon, S., (2010) *Report on the national Patient Choice Survey- February 2010*, Department of Health

Evidence from the King's Fund<sup>28</sup> suggests that patients make limited use of the data available to them at present to make decisions about their care.

33. Responses to the most recent consultation highlighted the provision of information as a key concern for respondents. The Government recognises the need to do more. The document, *The power of information: putting all of us in control of the health and care information we need*<sup>29</sup> outlines the Government's plan to improve information to support patient choice. The Government is also committed to publishing more information about outcomes through the NHS Outcomes Framework<sup>30</sup>, and will use the Framework to hold the NHS to account.
34. Information must be accessible if it is to have a positive effect on decisions. The Government currently funds NHS Choices, a website for disseminating information to patients. The Government has also consulted<sup>31</sup> on whether other organisations alongside NHS Choices may also be well placed to deliver information to patients, for example patient representative organisations or private sector firms.
35. Other streams of information can be of value to patients, for instance user feedback, word of mouth advice based on past experience, provider reputations and information from the voluntary sector. The majority of information patients do use is provided by GPs. Some NHS and Foundation Trusts already encourage feedback from patients to help shape services. The Care Quality Commission conducts surveys on patient experience and satisfaction<sup>32</sup>. Voluntary and third sector organisations also provide information about particular conditions and treatment options.

## What policy options have been considered?

### The Do Nothing Option (Option 1)

36. Under the do nothing option policies in place to support patients to make choices about the services they receive in some parts of the NHS will remain in force:
  - Since April 2008, patients can choose from any clinically appropriate provider in England when referred for their first consultant-led outpatient appointment. In April 2009 this was included as a legal right in the NHS Constitution. Patients can choose their provider of Acute Care Services in England as delivered under the NHS Standard Acute Contract.
  - Directions to Primary Care Trusts (PCTs) under the NHS Act 2006 impose legal duties on PCTs to make arrangements to ensure that patients are able to choose any clinically appropriate provider when referred for their first consultant-led outpatient appointment. The Directions provide information to help patients choose and to prepare quarterly reports on choice related complaints.
  - Patients also have choice of locally provided community services under the any qualified provider policy, from April 2012. The coverage of community and mental health services under the any qualified provider commissioning model is expected to increase over time.
  - Since April 2012, the choice offer was expanded at the point of referral to allow choice of the named consultant-led team within providers. This increases the accountability of the service provider to patients.
  - Additional choice options may be available locally.
37. Other government policies will continue to be implemented under the do nothing option. The Information Strategy and the NHS Outcomes Framework will continue to place outcomes at the heart of NHS care, underpinned with improved information to give patients greater knowledge about the care they receive. All these policies enable patients to express their preferences regarding their NHS treatment but only within the particular areas where choice has been granted.

<sup>28</sup> 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)

<sup>29</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_134181](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_134181)

<sup>30</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_131700](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131700)

<sup>31</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_120598.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_120598.pdf)

<sup>32</sup> <http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys>

## Derivation of preferred option (Option 2)

38. The policy options for implementing the additional proposals were influenced by:
- the existing policies on choice and patient involvement;
  - the way in which other choice policies are being implemented; and
  - the existing infrastructure to support patient involvement to make choices (for example, NHS Choices and Choose and Book)
39. Option 2 was designed to build upon the current policy and systems to extend patient involvement.
40. The policy document which this impact assessment accompanies reflects the principles that patients should have more say in decisions about their care and treatment. It does not prescribe the operational details through which the policy proposals will be implemented. Some elements of implementation will be for local commissioners and individual patients to determine. Implementation of other elements will be through nationwide instruments such as the Mandate for the NHS Commissioning Board and the NHS Constitution.

## Summary of the options assessed in this IA

41. Option 2 outlines a model in which “no decision about me, without me” is applied to the majority of NHS funded services. The model aims to give patients more say in decisions about their care in four areas:
- In primary care
  - Before a diagnostic test
  - At referral to secondary care
  - After a referral (i.e. once a diagnosis has been made).
42. Priority areas for this proposal are non-consultant led diagnostic test provider, maternity services and mental health services. These areas are examined in more detail in the “Impacts” section.

### A model of shared decision-making

43. 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, where “no decision about me, without me” is the norm. Patients and service users have more choice over their care and treatment across the majority of NHS services by 2013/14 including choice of any qualified provider and choice of treatment.
44. The second round of consultation proposed a model of increased patient involvement in care and treatment decisions all along the patient pathway. Shared decision-making underpins the proposals to deliver more say. Information is also essential to firmly underpin patients’ choices. The Department of Health’s Information Strategy<sup>33</sup> recognises the importance of appropriate, timely and accessible information.
45. The model includes specifically:
- a) Choice of GP practice,
  - b) Use of the any qualified provider commissioning model for community based services,
  - c) Choice of any clinically appropriate provider in England for referrals to a first consultant-led outpatient appointment
  - d) Choice of named consultant led team for referrals to a consultant led first outpatient appointment for acute elective services

<sup>33</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_134181](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_134181)

- e) Choice of diagnostic test provider
- f) Extension of choice of named consultant-led team to secondary care mental health services
- g) Extension of choice to other professional-led team in secondary care mental health services
- h) Choice of place of birth within a maternity network
- i) Choice of treatment and care planning where clinically appropriate.

Some elements of this model are covered by separate impact assessments<sup>34 35 36</sup>, and will not be analysed here.

### Choices in primary care

- 46. In 2010, the Department of Health consulted<sup>37</sup> on proposals to extend choice of registration with a GP practice. 77% of respondents supported the principle that people should be able to register with any GP practice with an open list. Pilots commenced in April 2012 for one year for new arrangements in London, Manchester/Salford and Nottingham where patients can access GP services away from where they live. There will be a full independent evaluation of the pilot, which is expected to conclude in the summer of 2013<sup>38</sup>.
- 47. There are also commitments to increase choice of provider for community services and personalised care planning for people with long-term conditions. The expansion of choice in this area will work through the any qualified provider commissioning approach<sup>39</sup>. This theme will also arise in the long-term conditions strategy.
- 48. Personalised care planning has been giving patients with long-term conditions more say in their care. This includes telehealth and telecare, which are being evaluated through the Whole Systems Demonstrator programme. The workstream on Quality, Innovation, Productivity and Prevention (QIPP) for long-term conditions is looking at ways of reducing the variations in care planning that people receive<sup>40</sup>. As the evaluation of these workstreams has not been completed, we are unable to include the evidence in this impact assessment.

### Choice before diagnosis

- 49. When being referred for a common diagnostic test by a GP, the presumption should be that a patient should be able to choose the provider of those tests as well as where and when they are carried out. This applies to tests provided by primary care in the community, and those offered by secondary care providers as well as direct access tests. The Choose and Book referral and booking system will be the key mechanism to facilitate these choices. The any qualified provider commissioning model already plays a role in delivering this proposal.

### Choice at referral to secondary care

- 50. The policy document which this impact assessment accompanies makes a commitment that users of mental health services should have the same choices available to those using acute elective care unless there are good reasons not to. We set out that mental health service users should be able to choose any named consultant-led team within their secondary care mental health service, mirroring the arrangements in place for other acute service areas.
- 51. Furthermore, the policy proposes service users should also be able to choose teams led by healthcare professionals other than consultants for referrals to secondary mental health services. This recognises the differences between mental health and acute elective care services. However, we acknowledge that choice of provider may not be feasible for secondary mental health services

<sup>34</sup> [http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Consultations/Liveconsultations/DH\\_113437](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Consultations/Liveconsultations/DH_113437)

<sup>35</sup> [http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH\\_125442](http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_125442)

<sup>36</sup> [http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH\\_130425](http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_130425)

<sup>37</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_120284.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_120284.pdf)

<sup>38</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_133410](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133410)

<sup>39</sup> <http://healthandcare.dh.gov.uk/any-qualified-provider-2/>

<sup>40</sup> <http://www.dh.gov.uk/health/2011/12/wsd-headline-findings/>

because of the need to ensure integration with social care. Commissioners would be expected to consider how best to achieve more choice of provider locally taking into account local features of mental health services.

52. We also propose expanding the choices for service users who use Improving Access to Psychological Therapies (IAPT) programme<sup>41</sup> so that choices are available whether IAPT services are provided in primary or secondary care. The extension of choice of provider of community (primary) care based IAPT services was discussed in the any qualified provider guidance<sup>42</sup>. Choice of professional-led team in secondary care for services under IAPT is covered under this impact assessment.

### Choice after a diagnosis

53. A key part of the shared decision making model is ensuring patients' decisions about their treatment, care management and support once a diagnosis has been made are respected. The presumption should be that patients make choices from a set of options that are clinically appropriate and financially affordable. There may be times when providing a choice of treatment is not appropriate, possibly due to the specialised nature of the condition or where urgent treatment is needed. Nevertheless, the patient should still remain involved in decisions about their care as much as possible. Maternity services are one example of where post diagnosis choice is a key area.
54. Personal health budgets are an important element of post diagnosis choice that will allow patients to have more say in decisions about their care. They are currently being piloted in the NHS in England with a final report of their evaluation expected in Autumn 2012.
55. The policy document re-iterates the choices patients have after a diagnosis to go to another provider who can treat them more quickly than their original provider if they have wait longer than 18 weeks for treatment. This right is enshrined in the NHS Constitution and the impact was analysed in a separate impact assessment<sup>43</sup>. Pilots are looking into the optimal mechanism for delivery, with roll-out and implementation scheduled for April 2013.

## Impacts, Costs and Benefits of Option 2

### How is Option 2 is intended to work?

56. Embedding patient involvement and expanding choice will be achieved through a variety of different mechanisms. Almost all of these mechanisms exist in one shape or form currently, so this policy does not intend to create new delivery mechanisms.

### Legal/contractual mechanisms

57. The NHS Constitution currently gives patients the right to "make choices about your NHS care and to information to support these choices."<sup>44</sup> This is an updated pledge from when the NHS Constitution was first published in 2009. Work is ongoing to strengthen the NHS Constitution with the legal basis for these rights set out in the standing rules legislation.
58. The Health and Social Care Act (2012) places a duty on the NHS Commissioning Board and Clinical Commissioning Groups to promote the involvement of patients and carers in decisions about care and treatment.
59. A 'choice framework' will be published to accompany the Mandate to the NHS Commissioning Board which sets expectations for the NHS Commissioning Board and clinical commissioning

<sup>41</sup> <http://www.iapt.nhs.uk>

<sup>42</sup> <http://healthandcare.dh.gov.uk/any-qualified-provider-2/>

<sup>43</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_116510.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_116510.pdf)

<sup>44</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_132958.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132958.pdf)

groups about the choices that patients should be able to make at each stage along a patient's pathway where they will expect choice to be available<sup>45</sup>.

60. The NHS Standard Contract has the ability to place requirements on providers to list eligible services through Choose and Book, or publish all relevant information to allow shared decision-making to take place. The NHS Standard Contract can be used to embed shared decision-making in a formal contract. It will fall to the NHS Commissioning Board to determine whether such a mechanism is appropriate.

### **Organisational mechanisms**

61. Local HealthWatch will have two roles:
  - To provide and signpost patients to access information about their local health and care services.
  - use their patient feedback routes to see if patients are having their say and address concerns when patients are not offered opportunities to be involved in their treatment.

### **Existing infrastructure**

62. Choose and Book will be a key interface to allow patients and referrers to see what services are available and how they can be booked. Providers of these services will need to ensure that they list their available services on the Choose and Book system.
63. Patient decision aids provide patients with clear advice on the effectiveness of treatment options and rectify the information imbalance between patient and professional<sup>46</sup>. These are being developed through the QIPP Right Care Workstream.
64. Training opportunities for professionals help to ensure shared decision making takes place as part of their consultation with patients, not just as an additional add-on.
65. The any qualified provider commissioning model will expand choice, in particular through primary and community services and diagnostic testing<sup>47</sup>.
66. The Payment by Results (PbR) framework is currently testing a new tariff for maternity services which is intended to facilitate choice of maternity care for expectant mothers. This should remove the barriers for expectant mothers to choose where they would like to give birth.

### **Existing government policies**

67. The current mechanisms for choice of named consultant led team in elective secondary care will be used for expanding choice in mental health services. These are primarily Choose and Book and the contractual mechanisms discussed above.
68. Pilots on care planning and personal health budgets are a key mechanism for embedding choice after a diagnosis. Tailored, personalised care can lead to improved outcomes for patients.
69. The Information Strategy sets out plans to allow patients to access and use the information that is available to them. The strategy will underpin the choices that patients are able to make about their care and treatment.
70. Choice of GP practice is being piloted and is one way of embedding choice in primary care services. The pilots are being evaluated separately of this impact assessment.

### **Private sector/civil society organisations**

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<sup>45</sup> <http://mandate.dh.gov.uk/2012/07/04/mandate-consultation/>

<sup>46</sup> <http://www.rightcare.nhs.uk/index.php/shared-decision-making/about-the-pdas/>

<sup>47</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_128539.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128539.pdf)

71. Implementation of embedding patient involvement will fall on commissioners and providers of NHS-funded services. The impacts are expected to fall on public sector bodies or on organisations contracted by public sector bodies to deliver services on their behalf (this may include voluntary or third sector organisations, who choose to contract with commissioners to deliver services.) On this basis, the policy falls outside the scope of the One In One Out process.

## Impacts and consequences

72. This section covers generic issues relevant to the model of shared decision-making. It then discusses issues specific to choice of diagnostic test provider, choice in maternity services and choice in mental health services.
73. In general the expected impacts from the model of shared decision-making are that:
- patients will have more say in decisions about who provides their services and when and where they receive them; and
  - patients will be more involved in decision making about the treatment they receive.
74. The consequences of these impacts are that:
- referral patterns of patients, both to and within organisations, have the potential to change as patients exercise choice about from whom they receive care;
  - treatments received by patients will better match their preferences as they are involved in the decisions about their care;
  - in the medium term, the quality of services and patient experience will improve as providers respond to the choices patients make, leading to improved outcomes, convenience and experience for patients which has value in and of itself; and
  - in the medium to longer term, commissioning decisions by commissioning groups and investment decisions by providers will improve as they respond to signals from patient choice and changes in usage patterns.
75. The model of shared decision-making is likely to be implemented in a phased way. This will be true in terms of the engagement with patients as they become more familiar with exercising more choice. It could also be true from the perspective of service providers. Some local commissioners and service providers may embrace more choice sooner than others depending on local decisions.
76. One would not expect greater choice of provider to lead to all patients moving to the 'best' provider in one go. One would expect referral patterns to shift over time and this will provide a signal to providers and commissioners about where investment and disinvestment decisions should be made. Patients will have different ideas about what is best is for them. Consequently, there may be no single 'best' provider for a given service in a given area. There may be many high quality providers meeting different patient needs.
77. A second factor that will determine how the landscape of service providers will develop is the economies of scale for a service in a given geography. Some services require large up front investment in equipment, and therefore may only be efficiently delivered by a relatively small number of providers. Other services, e.g. hearing tests or podiatry services, may be efficiently delivered on a smaller scale and thus the market can accommodate many providers supplying services.

## Diagnostic services

78. The expected impact from expanding choice of provider of diagnostics services is that the patient will have more say in decisions about who provides the diagnostic service they receive, and when and where they receive them.
79. More user involvement in decisions about the provider of non-consultant led diagnostic tests means that there is the potential for referral patterns to change, both to and within organisations, as patients exercise choice. Patient experience should improve as providers respond to the

choices patients make. Principally, this will mean improved convenience over appointment times and innovation in how these services are provided.

80. In the short term, as mentioned above, referral patterns are not expected to change dramatically. This is because the choices available to patients will be constrained by the options available. However, the choices that patients make will send signals to providers about the popularity of their services. In the medium term, providers will have the opportunity to respond to patient preferences. For less popular providers this may be deciding how to improve their service to make them more attractive to patients, or, if this is not possible, making a decision about disinvestment. For more popular providers they may need to consider whether they wish to make more slots available.

## Maternity

81. The impact on the configuration of services of giving women more say in decisions about the place of birth will depend on the choices women make. Local commissioners and providers will need to be responsive to these choices and ensure they have resources in the right places. There is no expectation of a large change in place of birth, but women will have more involvement in those decisions and their care.
82. The Birthplace<sup>48</sup> study (2011) provides evidence for those women with 'low risk' pregnancies about the risks and outcomes associated with different planned places of births – at home, in a mid-wife led unit and in an obstetric unit. The findings will help women make informed choices when planning a birth and can be used by commissioners to plan maternity services at a local level.

## Mental Health

83. In the short term, the expected impact on mental health services is a possible increase in the demand for services. Such an increase would occur only insofar as there are a fixed number of providers available. As before, in the medium and long term patient movements will cause commissioners to think about (dis)investment decisions.
84. A mental health service that is more responsive to patient preferences should improve patient's adherence to treatment (avoiding the need for repeated, costly, treatment) and their satisfaction with the provider. This could also mean that more patients engage with mental health services, once they become aware of the opportunities to choose a service that is more tailored to them.

## What is the scale of impact?

### Overarching impacts for Shared Decision-Making

85. The model of shared decision-making in Option 2 underpins choices in four stages of care and treatment. Securing shared decision-making through these methods means it will have an impact on anyone seeking NHS care in England.
86. The most recent consultation document<sup>49</sup> gives some specific areas where the model of shared decision-making could be applied. Through personalised care planning and the long-term conditions compendium, choices in primary care can have an impact on people with long-term conditions. The Department of Health estimates 15.4 million people in England have a long-term condition<sup>50</sup>.

## Diagnostics

87. The further consultation document indicated work to identify priority diagnostic areas where the extended choice offer will apply. The categories of diagnostic test that are priority areas are:
- a. Endoscopy (Gastroscopy, Colonoscopy, Cytoscopy, Flexible Sigmoidoscopy)

<sup>48</sup> <http://www.bmj.com/content/343/bmj.d7400?tab=full>

<sup>49</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_134218.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134218.pdf)

<sup>50</sup> <http://longtermconditions.dh.gov.uk/about/>

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- b. Imaging (e.g. non-obstetric ultrasound, CT, MRI, DEXA, plain film scans)
- c. Physiology (e.g. Audiology Assessments, Electrocardiogram, Echocardiogram)
- d. Other diagnostic tests (e.g. Genetics and Pathology) are priority areas, but a decision on which tests to include has not been made yet.

88. This impact assessment focuses on the impact of non-consultant led diagnostic tests. Table 1 below gives an estimate of the annual activity for the main priority diagnostic tests covered by the categories above<sup>51</sup>.

Table 1: Diagnostic tests under expanded choice offer

Diagnostic category	Speciality/type of procedure		Annual activity**
Endoscopy	Gastroscopy		<b>540,000</b>
	Colonoscopy		<b>375,000</b>
	Cytoscopy		<b>309,000</b>
	Flexible sigmoidoscopy		<b>226,000</b>
Imaging*	Non-obstetric ultrasound		<b>5,669,000</b>
	CT scans		<b>3,705,000</b>
	MRI scans		<b>2,240,000</b>
	DEXA scans		<b>321,000</b>
	Plain films		N/A
Physiological Diagnostics	Audiology	Assessment	<b>1,226,000</b>
	Cardiac Physiology	Electrocardiogram	<b>1,280,000</b>
		Echocardiogram	<b>1,074,000</b>
	Neurophysiology	Electromyography	<b>175,000</b>
		Electroencephalography	112,000
	Ophthalmology	Diabetic retinopathy	2,000,000
		Glaucoma	57,000
	Respiratory and Sleep Physiology	Spirometry	465,000
		Sleep tests	<b>95,000</b>
		Lung volumes	43,000
		Oxygen saturation	41,000
	Urodynamics	Pressures and flows	<b>88,000</b>
	Vascular Physiology	Other vascular tests	360,000
Deep Vein Thrombosis		120,000	
<b>TOTAL</b>			<b>20,521,000</b>
Notes			
* RIS integration is needed first before Imaging can be captured through Choose and Book			
** Annual activity based on DM01 returns July 2011 to June 2012 in bold; other information from work done in 2011 (Jan - Dec)			

<sup>51</sup> Existing choice policy currently covers:

A diagnostic test taking place as part of an inpatient stay is indirectly subject to choice already as a consequence of a progression from the patient's first consultant led outpatient appointment.

A diagnostic test taking place as part of a consultant led outpatient appointment is currently within the scope of existing choice policy.

Diagnostic tests taking place in primary care are part of the any qualified provider framework.

89. These figures include tests that would have been commissioned as part of inpatient stays, consultant-led outpatient appointments and any services commissioned through AQP. Therefore, the number of diagnostic tests that would be part of this expanded choice offer will be a proportion of these estimates. It is not possible to split these figures by the setting in which they took place, however we can be sure that these estimates represent a maximum (upper limit).

## Maternity services

90. The proposal on maternity services could impact on all births taking place in England. Table 2 gives the projected number of births in England until 2015/16<sup>52</sup>. Choice of provider for maternity services may not be appropriate in instances where pregnancies are considered high risk. The Birthplace study found 81% of all births were classified as 'low risk', which is calculated in the last row of Table 2.<sup>53</sup>

*Table 2: Births and Conceptions in England, 2008 – 2015/16 (forecast)*

	2008 <sup>1,2</sup>	2009 <sup>1,2</sup>	2010 <sup>1</sup>	2011/12	2012/13	2013/14	2014/15	2015/16
Births <sup>5</sup>	672,809	671,058	687,007	697,000	698,000	701,000	705,000	710,000
Conceptions	844,900	852,500	872,960	882,563	883,973	886,805	891,993	898,973
Annual growth in births <sup>3,4</sup> (%)		-0.3	2.4	1.1	0.2	0.3	0.6	0.8
Low risk maternities	536,529	535,133	547,851	555,820	556,618	559,010	562,200	566,187

Sources: Office for National Statistics, NHS Information Centre

## Mental Health

91. The number of adults who access secondary care mental health services in England in recent years are shown in Table 3. The vast majority of patients use non-admitted outpatient services. Services may be led by consultants or other healthcare professionals.

*Table 3: Adult Service Users for Secondary Mental Services, England 2004/05 to 2010/11*

Year	Adult Service Users			
	Admitted	Non-Admitted	No care	Total
2004/05	114,435	916,534	101,465	1,132,434
2005/06	111,088	930,374	108,010	1,149,472
2006/07	106,561	936,629	108,070	1,151,260
2007/08	105,719	982,704	102,119	1,190,542
2008/09	102,571	1,026,366	93,428	1,222,365
2009/10	107,765	1,078,091	84,875	1,270,731
2010/11	106,719	1,094,138	86,873	1,287,730

<sup>52</sup> 1 Actual number of live births

2 Actual number of conceptions

3 For 2011/12 have determined birth growth rate on previous year as average growth rate in live births between 1999-2010

4 ONS Mid-2008 based birth projections for 2012/13 to 2015/16

5 Births from 2011/12 onwards assume 79% of conceptions result in a birth (3 year average.)

<sup>53</sup> Some maternities may involve multiple births, so to calculate the total number of maternities we reduce the number of births by 1.6% to account for multiple birth maternity episodes (Source: NHS Maternity Statistics 2010-11, Health and Social Care Information Centre). We assume all multiple birth maternities are high risk, so we apply the 1.6% reduction first before applying the 81% value.

## Costs and Benefits

92. It is important to make clear the costs and benefits from expanded choice and patient involvement are linked to other reforms under the Health and Social Care Act (2012). This means some costs and benefits, mainly around setting up organisations or putting in place the mechanisms that this policy intends to use, have been accounted for in other impact assessments. Where this occurs, we make reference to these impact assessments, summarise the analysis and report cost/benefit estimates here. We do not apply them to the cost and benefit totals in this impact assessment. This impact assessment therefore emphasises the marginal costs and benefits of the policies in the associated policy document.
93. The previous two sections show the impact of this policy will affect anyone seeking NHS treatment. This makes it difficult to model the choices each patient will make and consequently the specific impacts upon particular services are difficult to quantify. Here we discuss the important elements of benefits and costs from the proposed general principles of patient involvement. As a rule if we can demonstrate that the benefits are likely to outweigh costs, as a result of introducing the model of shared decision-making and other choice policies, then this should hold for any individual service, unless there are specific differences or features of that service that should be taken into account.

### Overarching costs and benefits (from the model of Shared Decision Making):

#### Benefits

94. The main benefits from patients having more say in decisions about care and treatment are:
- greater convenience for patients from greater choice of providers;
  - intrinsic value of more say and involvement for patients and service users;
  - improved quality of care and health outcomes for patients and service users;
  - improved health outcomes from adherence to treatment and embedding shared decision making; and
  - potential cost savings or productivity gains from more efficient provision and management of services by providers and a more efficient allocation of resources to services in line with patient preferences.
95. The lack of existing evidence (for reasons presented below) limits the ability to extrapolate reliable monetised values for benefits. This section, therefore, discusses the types of benefits that are expected to arise and their magnitude.

#### *Greater convenience*

96. Greater say over care and treatment allows more convenient appointment times for patients. This means patients may not need to take time off work unnecessarily if appointments can be scheduled for out-of-working hours. Patients may experience greater convenience if they have the opportunity to choose a provider that is closer to their place of work or homes, thus saving on transport costs as well.
97. Developing an estimate of the improved convenience on all patients occurring as a result of this policy is difficult to predict when looking at the health system as a whole. On this basis, we explore estimating this benefit in the context of the three priority areas separately.

#### *Intrinsic value of more say and involvement*

98. The King's Fund Report on Patient Choice (2010) shows that patients value having choice in their care and treatment:

<sup>54</sup> <http://www.ic.nhs.uk/pubs/mhbmhmds11>

*“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.”*

99. No research appears to have been carried out on quantifying this intrinsic value and hence we leave this benefit unquantified. We can be certain, though, that such a benefit will be greater than zero.
100. Evidence from DH's Self-care survey shows that those patients who had greater participation in their care felt more in control<sup>55</sup>. There is also evidence<sup>56</sup> to suggest that having “activated” patients, who participate more in their care through shared decision making, increases treatment adherence and improves outcomes.

### *Improved health outcomes from expanding choice*

101. A paper by Gaynor et al (2012)<sup>57</sup> looks at the effects on health outcomes (mortality rates) as a result of the expansion of patient choice in 2006. They found that the policy change did have a statistically significant impact on mortality rates. They estimate the policy led to a change in mortality rates equivalent to 4,791 life years saved at a value of £302 million.
102. The authors point out that mortality rates are only one area of quality. Hospitals undertake many interventions for admissions where the risk of death is low. For these interventions, 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 health interventions, it is likely that the value of the health gain would be higher than the £302 million estimated in the paper. It is important to stress that these are transitory benefits i.e. they only occur once following the introduction of choice policy in 2006.
103. 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 by the HHI<sup>58</sup>) means that a hospital acts less like a local monopoly provider. They find that a hospital in a lower HHI market would have “4.4% fewer deaths per year and 78,318 more lives saved, with a monetary value of... £4.8 billion.” These benefits would annually recurring, that is, compared to the market structure in 2003 the number of life years saved occurs each year.
104. The evidence shows that allowing patients to choose a provider in elective surgery has improved the health outcomes for those patients. A similar effect would be expected for expanding choice into other areas, but it is not clear of what proportion this might be. Hence, the policy will generate improved health outcomes, but these are not quantifiable. Any quantification would find positive benefits in this area.

### *Improved health outcomes from adherence to treatment and embedding patient involvement*

105. Loh et al (see reference 56) investigated shared decision-making in primary care treatment of depression. They found that 60% of the variation in outcome was attributable to patient adherence to treatment and that shared decision-making could improve adherence. They therefore concluded that shared decision-making can lead to improved outcomes.

<sup>55</sup> Department of Health analysis of “Self care survey”, Department of Health/Ipsos-MORI, 2009

<sup>56</sup> Loh et al. “The impact of patient participation on adherence and clinical outcome in primary care of depression”. Patient education and counselling 65(2007) 69-78

<sup>57</sup> Gaynor, M., Moreno-Serra, R., Propper, C., Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service (2012)

<sup>58</sup> The Herfindahl Hirschman Index (HHI) is a measure of market concentration. It is calculated as  $\sum_i^N s_i^2$ ; where  $s_i$  is the market share of the firm<sub>*i*</sub> in the market. A low HHI implies there are more providers in a local area, a high HHI implies the number of providers is low.

106. Krones et al (2008) investigated shared decision-making through decision aids for absolute cardiovascular disease (CVD) risk. They found that patients who received a decision aid were significantly more satisfied with the process and result<sup>59</sup>.
107. In short, the evidence shows patients who are able to participate in their care are more likely to adhere to their treatment and enjoy better health outcomes as a result. However, monetised benefits are not available, even when looking at individual sectors of NHS care.

### *Improved efficiency of provision*

108. There is some evidence to suggest that expanded choice policy can deliver benefits through improved efficiency of provision. A working paper from Gaynor et al (2010) discusses cost savings in terms of reduced length of stay of hospital admissions from introducing patient choice of provider. They estimate the value of the reduced lengths of stay to be £24 million as a direct result of introducing the choice of provider policy. Similar to the life years gained analysis mentioned above, they estimate the value of shorter stays for a hospital in a high market concentration at £0.4 billion. This analysis does not cover all hospital activity and only gives a partial picture. No equivalent research exists on the impact of improved efficiency on the choice policy covered by this IA. The estimates derived by Gaynor et al show these can be substantial, but at present we are not able to quantify this benefit.
109. The efficiencies covered in the paper above are short-term efficiencies, i.e. 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 pressures. 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 or those areas which align most closely with patient preferences. Patients' choices inform these decisions by showing providers (and commissioners) about precisely which services they want to use. This type of efficiency gain is applicable to all areas of the NHS where patients have opportunities to make choices.

### **Costs**

110. As mentioned in the 'Response to consultation' document, the delivery of patient involvement in their care and treatment relies on a number of mechanisms. We describe and analyse the costs of these mechanisms below. Many of them are already in place, so the marginal cost of using them to implement the proposals is low.

### *Costs of using legal mechanisms/levers*

111. The administrative cost of using the legal mechanisms mentioned in the "How is Option 2 intended to work?" section is zero. This is mainly driven by the fact that the majority of legal mechanisms that this policy intends to use are in place already.
112. One such mechanism is the NHS Standard Contract. It will be the responsibility of the NHS Commissioning Board to determine if and how there will be changes to the NHS Standard Contract. For this reason, we do not quantify the costs here.

### *Information to support choice*

113. Information to support choice will be provided through the proposals set out in *The Power of Information: Putting us all in control of the health and care information we need*.
114. The impact assessment that accompanied *The Power of Information* included costs for information provision to assist patients and service users make decisions about their care<sup>60</sup>. The costs of improving the information available to support transparency and choice (Action 14) were estimated at £1.9m over ten years. As these costs have been identified and assigned already, we do not use this figure in our calculations. There are no further costs arising in this category.

<sup>59</sup> Krones et al, (2008) "Absolute Cardiovascular Disease Risk and Shared Decision Making in Primary Care: A Randomised Controlled Trial", *Annals of Family Medicine*, 6(3): 218-227

<sup>60</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_134181](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_134181)

*Choose and Book*

115. Choose and Book will be the primary interface for patients to choose consultants and services in the service areas of diagnostics, mental health and maternity services. Costs could potentially fall on two groups; the Choose and Book service itself, and service providers wanting to add appointments to the system.
116. As the Choose and Book service is operational already, the costs of setting up and maintaining the infrastructure have already been costed. Therefore the impact of this policy on the Choose and Book system come from the marginal costs of new services (and new suppliers of healthcare) being added to the system. As the functionality to host appointments in the system exists already, and the resources within the Choose and Book organisation to accommodate expanded service categories exist already, the marginal cost on the Choose and Book system is zero.
117. Existing service providers face potential costs when putting appointment slots on Choose and Book. These are principally administrative costs. Providers that already provide NHS-funded services and are connected to the patient administration system (PAS) should incur minimal marginal costs. This is because the PAS and Choose And Book system are compatible – in effect automating much of the process. The impact assessment on named consultant-led team assumed that it would take one hour to add a consultant profile onto Choose and Book, valued at £25 per hour. If service providers already add appointment slots onto Choose and Book it can be assumed that valuing the cost of adding more appointment slots at £25 per hour is reasonable. Costs like these are proportional to the additional number of appointment slots added, and hence will be traded off against the benefits of treating more patients.
118. Providers who use the Picture Archive and Communication System (PACS) and the Radiology Information System (RIS) may incur costs as these systems are not currently compatible with Choose and Book. Work will commence in late 2012 to identify the issues and costs associated with making it compatible in the future. As the scope of this work has not been defined, quantifying the cost of making the systems compatible at this point is not appropriate.
119. New providers of NHS-funded services may face an IT hardware cost to connect to the Choose and Book system. For example, they may need a secure IT connection (an N3 connection) to link themselves with the NHS system. Other hardware may be needed to use NHS PAS. Costs incurred from connecting with NHS systems are an inevitable consequence of doing business with the NHS – these costs should not be counted as costs incurred from this policy per se.
120. New providers may also require training to get accustomed to the Choose and Book system. On-line training courses and materials are available for providers to gain a better understanding of the process<sup>61</sup>. Resources are available to new providers online through the Choose and Book website. Work to identify resources needed to support new providers through the Choose and Book process is ongoing, so it would not be appropriate to mention the costs in this impact assessment. Marginal additional costs for new providers putting services and appointment slots on Choose and Book should be minimal as explained above for existing providers. Adding a profile to Choose and Book is assumed to be £25 per hour – adding appointment slots onto the Choose and Book system is assumed to cost a similar amount of money.

*Decision aids*

121. Patient Decision Aids (PDAs) are designed to help patients make difficult decisions about their treatments and medical tests. They are used when there is no clinical evidence to suggest that one treatment is better than another and when patients need help in deciding which option will best match their preferences.
122. There has already been work to develop PDAs in patient care. Between July 2010 and August 2011, NHS Direct were commissioned by East of England Strategic Health Authority to develop eight online patient decision aids (OPDAs). The project had fixed costs of around £1m and annual recurring costs of £175k<sup>62</sup>.
123. The programme to develop 36 further decision aids has been extended at a cost of £1million under the Shared Decision Making Programme hosted by NHS Midlands and East. The programme has

<sup>61</sup> <http://www.chooseandbook.nhs.uk/staff/training>

<sup>62</sup> Source: NHS Direct

already been costed and funds have been allocated. We therefore do not assign them as costs in this impact assessment.

### *Local Healthwatch*

124. The costs of Local Healthwatch are set out in the impact assessment that accompanied the Health and Social Care Act (2012). Funding will be the responsibility of Local Authorities. This will include the transfer of existing budgets for NHS Complaints Advocacy, Local Involvement Networks and Patient Advice and Liaison (PALs) Networks. An evaluation<sup>63</sup> of existing services suggest that they cost £19.3 million per year in England. Of that, 75% of the budget supports patients to make choices by providing information and through signposting. Additional funding from a Spending Review settlement will be provided to compensate for the increased demand for choice. Table 4 shows a summary of financial costs of Healthwatch associated with choice.

*Table 4: Summary of financial costs to Healthwatch to support patient choice*

£m	2011/12	2012/13	2013/14	2014/15
Cost of providing support for choice (75% of £19.3m existing spend)	14.5	14.5	14.5	14.5
Additional funding to support choice from Spending Review settlement	0	0.5	1	1.5
Total to support choice	14.5	15	15.5	16

Source: Impact Assessment on Health and Social Care Act (2012), Annex D Healthwatch p102

125. These costs should not be included in the costs of the current proposals as they have been included in the cost of implementing the Health and Social Care Bill. The marginal cost to Healthwatch as a result of the measures covered by this impact assessment is zero, as this responsibility has already been costed and assigned to them.

### *Staff training*

126. Increasing patient involvement in care will involve educating and training healthcare professionals at an early stage about the importance of shared decision-making. Communicating this message would be incorporated within existing training and education programmes, and within the resources that are available presently. On this basis, there are no financial costs associated with staff training arising from this policy.
127. However, incorporating training on patient involvement into existing education programmes does impose an opportunity cost on the training establishment for the training that has been forgone to allow time for training on patient involvement. The magnitude of this opportunity cost depends on the value of the forgone training and would depend on the views of the training provider. Information about how training programmes might be reconfigured following a renewed focus on patient involvement is not available. This prevents us from quantifying the impact of this opportunity cost, other than to recognise that such a cost does exist.

## **Diagnostic Services**

### **Benefits**

128. The two benefits most relevant to patients from having more say in decisions about diagnostic test provider are the intrinsic value to patient from more choice and greater convenience. There is evidence showing that patients do value choice (see paragraph 98) but there is no evidence on monetising this benefit.
129. For illustrative purposes, it may be worth explaining the potential modelling of patient convenience. We can then populate this with some sample statistics (in the absence of other data) to illustrate the potential benefits available. We can consider the increase in convenience for patients from greater choice as a time saving to patients. These estimates use conservative estimates regarding access and cost of time and so the actual magnitude of benefits may be significantly higher.

<sup>63</sup> Evans et al, National Evaluation of Patient Advice and Liaison Services Final Report, (2008)

130. Table 1 on page 15 shows the number of diagnostic tests that could be part of this expanded choice offer, with a total of 20.5 million. As paragraph 89 explains, these represent a maximum number of tests. For the purposes of this example we assume that 50% of these tests could be subject to this expanded choice offer, with the other 50% already covered. This gives a total of 10.3 million tests. We must now make an assumption of how many of these tests could take place at a more convenient provider, and that patients take up the choice offer. For a conservative basis we assume that 1% of the 10.3 million tests will have patients experiencing greater convenience. This gives 103,000 tests. We have valued the time saving to patients from choosing a test at a more convenient time as one hour, which we value at the national minimum wage of £6.19 (October 2012.<sup>64</sup>) This gives an estimate of patient convenience of £635,000. Such benefits would occur each year into the future, that is, it is not a transitory benefit.
131. This estimate is purely indicative. As we are unable to perfectly model how each patient will react to the expanded choice offer, it may be that more than 1% of diagnostic tests will be provided under greater convenience. Equally, the time saving to patients will vary depending on the choices available – one hour may not necessarily be accurate. This example shows the magnitude of potential benefits available under the expanded choice offer. However, this estimate will not be included in the overall cost and benefit totals.

### Costs

132. The main costs arising from expanding choice of non-consultant led first appointment provider of diagnostic test will fall on the Choose and Book System, which will be the key mechanism for implementing the policy. The overall costs falling on the Choose and Book system are described above. To summarise the main points:
- Costs falling on the Choose and Book system itself are zero as the system is already operational.
  - Providers using Choose and Book already will face minimal costs from adding further services and appointment slots on the system (see paragraph 117 ). These costs will be proportional to the amount of services and appointment slots they choose to add.
  - New providers wishing to list their services on Choose and Book for the first time will face costs in terms of infrastructure and training to use the Choose and Book system. As paragraph 120 explains, work to identify resources needed to provide training is ongoing, so it is not possible to quantify the costs falling on new providers. However, providers that choose to become involved in providing NHS services under this expanded choice offer must conclude that the benefits of providing services must outweigh the costs of doing so.

### Maternity

#### Benefits

133. The main benefit to women will be having more say and choice over the service being delivered to them. We do not have evidence that allows us to quantify this benefit but the evidence listed above shows that it is a choice that women want and that this has an intrinsic value.

#### Costs

134. The Birthplace Prospective Cohort Study<sup>65</sup> conducted cost-effectiveness analysis of planned births by birth setting for women and babies at ‘low risk’ of complications prior to onset of labour. Table 5 shows the adjusted mean costs for intrapartum care were:

*Table 5: Adjusted mean costs for intrapartum care per woman (2010 prices)*

Type of ‘low risk’ mother	Adjusted mean costs (2010 prices)		
	Obstetric Unit (OU)	Alongside Midwifery Unit (AMU)	Freestanding Midwifery Unit (FMU)

<sup>64</sup> [http://www.direct.gov.uk/en/Employment/Employees/TheNationalMinimumWage/DG\\_10027201](http://www.direct.gov.uk/en/Employment/Employees/TheNationalMinimumWage/DG_10027201)

<sup>65</sup> <http://www.bmj.com/content/344/bmj.e2292>

## RESTRICTED

First time mothers	All	£2,075	£1,983	£1,913
	Without complicating conditions at start of labour care	£1,940	£1,933	£1,881
Multiparous women	All	£1,142	£991	£969
	Without complicating conditions at start of labour care	£1,077	£978	£954
	Estimated mean costs	£1,559	£1,471	£1,429

135. An overall average for 'low risk' pregnancies is determined as £1,559 in an obstetric unit, compared with £1,471 at an Alongside Midwifery Unit. Therefore, the potential saving to the NHS per woman delivering in an AMU instead of an OU is £87, and £130 between OU and an FMU.
136. Depending on mothers' preferences, this may not result in widespread reconfigurations of maternity services, but the expectation is that the pattern of births will become more sensitive to mothers' preferences. Nevertheless, the cost data shows that the average cost of births in different settings is very similar and that, if women choose to give birth in settings other than obstetric units, then the cost could be slightly lower in the long-run.
137. Proposed changes to the Payment by Results (PbR) structure for maternity services are intended to reduce barriers to choice for mothers. Providers are currently paid by activity for each inpatient spell, scan or hospital visit. This creates an incentive for providers to offer an increasing amount of activity which may deliver little or no marginal benefit for the mother. It also made home births unpopular from a commissioners perspective on the basis of cost.
138. The new payment structure sets one price for antenatal, delivery and postnatal care. This removes the perverse incentives for providers and gives them freedom to tailor their service for mothers without fear of losing income. The maternity pathway payment system has been in shadow form in 2012/13. Following an evaluation, proposed changes are scheduled to come into force in April 2013. As the evaluation of the shadow year has not been completed yet, we cannot mention any cost or benefit impacts in this impact assessment.

## Mental Health

### Benefits

139. The benefits from expanding choice of consultant-led team in mental health services will be the same as those identified under the shared decision making model in paragraphs 94 to 109. Patients should be able to choose a clinically appropriate team that they prefer, perhaps because they have received services from them before and wish to see the same person or because the team was recommended to them. This is likely to improve adherence to treatment, improve efficiency and improve outcomes. Also, patients will have greater convenience from being able to select appointments that suit them at the point of referral. There is also the intrinsic value patients place on choice that was discussed in the King's Fund paper.
140. To date, choice in secondary care mental health services has been limited. Therefore, we do not have evidence of the direct impact of choice in mental health services that would allow us to quantify the benefits. The paper presented by Gaynor et al (2012) in paragraphs 101 to 104 shows that benefits of this nature would be achieved, and that such benefits are greater than zero.
141. A Cochrane Collaboration by Duncan et al (2010) reviewed available evidence on shared decision-making interventions for people with mental health conditions<sup>66</sup>. They reviewed two papers which looked at inpatient treatment for schizophrenia and depression in primary care. The studies found patient involvement in the decision-making process significantly improved, improved satisfaction among providers and no substantial change to the consultation times under the shared decision-making process.

<sup>66</sup> Duncan, E., Best, C., Hagen, C. (2010) Shared decision making interventions for people with mental health conditions (Review), The Cochrane Collaboration

## Costs

142. As with diagnostic services, an area of potential costs for increasing choice of mental health services is the cost of adding services and appointments to the Choose and Book system. The marginal cost is zero as the system is already capable of having mental health services added to it. The key themes discussed for Choose and Book in diagnostic services also apply to mental health services.
143. The expansion of choice for services under the Improving Access to Psychological Therapies (IAPT) programme is included in this expanded choice offer. The Government has committed over £400m to increase access to psychological therapies, which will be delivered through the any qualified provider framework<sup>67</sup>. These funds were announced in the cross-government mental health outcomes strategy. As such, we do not assign these as costs in this impact assessment as they will be incurred to fund a planned extension of IAPT independently of our policies. The costs associated with using the any qualified provider framework has also been covered in a separate impact assessment, so those costs are not assessed here.
144. Choice of named consultant-led teams in secondary mental health services may require commissioners to amend their contracts with providers. The inclusion of clauses requiring choice of named consultant team for secondary mental health care should result in a small administrative cost on commissioners and providers to negotiate the terms of their agreement. In addition to the legal requirements set out through the Health and Social Care Act (2012) and the Mandate to the NHS Commissioning Board, amending contracts should not take long to complete. Assuming it would take £25 per provider to make such a change, the additional cost would overall be less than £10,000.
145. The main channel through which choice of named consultant team-led will work is through Choose and Book. There is a discussion of the costs falling on the Choose and Book service from paragraph 115 – therefore, there is no need to repeat it here.

## Assumptions and risks

146. There are a number of potential risks that might impose other costs arising from this policy, as well as risks that might depress the potential benefits available. These risks are discussed below; many have been covered in previous impact assessments in the *Greater Choice and Control* consultation process<sup>68, 69</sup>.

## Healthcare Professionals' time

147. Previous impact assessments relating to the *Greater Choice and Control* consultation have discussed the possibility that extending patients' choices to new areas could lengthen GP appointment times. The evidence in the report by the King's Fund (see reference 23) provides a range of views from GPs themselves. Some believe that delivering choice via the Choose and Book System takes a considerable amount of time while others do not. Evidence from other papers (see paragraph 141 ) finds no significant change in consultation time.
148. Providing more say over care and treatment is about more than the use of an appointment booking system. It is a model of care with open patient engagement with their healthcare professional in making decisions about their care, where the options of treatment and provider are an integral part of the discussion between the two. The General Medical Council<sup>70</sup> acknowledge this in their guidance. Therefore, this policy does not ask for increased time for an appointment necessarily but a change in the way that patients and clinicians make decisions.
149. Delivering increased patient involvement will require healthcare professionals to have good communication skills. The level of competence may vary between individuals and there remains a risk that poor communicators may require longer than average appointment times.

<sup>67</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_124058.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf)

<sup>68</sup> [http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH\\_125442](http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_125442)

<sup>69</sup> [http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH\\_130425](http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_130425)

<sup>70</sup> [http://www.gmc-uk.org/guidance/good\\_medical\\_practice/contents.asp](http://www.gmc-uk.org/guidance/good_medical_practice/contents.asp)

150. If some healthcare professionals with poorer communication skills cannot adjust to new ways of working, the level of engagement with the patient falls short of the ambition of the policy and the possibility of longer consultation times do emerge. Finally, there is a risk that where healthcare professionals do not engage with patients, there is less patient involvement in decisions and the benefits identified above are not realised.

### Patient time

151. For patients to make an informed decision about their healthcare, they will need to get the information necessary to support their choice from one source or another. Otherwise, they risk making choices that do not align with their preferences.
152. The amount of information patients seek will vary depending on their condition and preferences. Patients may receive the information they need from their GP, other healthcare professionals or through condition-specific charity and voluntary sector organisations. Websites like NHS Choices are another source of information. Patients who spend time gathering information will incur an opportunity cost.
153. We have no evidence on how long a patient might spend gathering information or the different approaches patients use to research choices. Patients can decide whether or not they seek out information and we assume that patients will only research their choices where they believe there is a benefit from doing so.
154. It is important to note patients who do not want to make a choice or who prefer to delegate it to their healthcare professional can do so. We have not monetised the potential cost to patients as it is impossible to model the choices people make and the time they spend researching information.

### Spare capacity

155. Some commentators have suggested that the policy of more patient choice in the NHS will require the NHS to maintain spare capacity to allow for choice (Fotaki et al 2005)<sup>71</sup>. This is a misunderstanding of the way in which choice policy operates and the way in which appointments for elective care are booked. In practice, providers do not have to carry spare capacity in order for any patient to be treated. Patients select an appointment from a range of available slots at a specified point in the future; for instance a first outpatient appointment will be a number of weeks after a referral is made. The time between the point at which the choice was made and when the appointment takes place reduces the need for providers to maintain spare capacity to facilitate choice. Patients can only choose from appointments that are available. If a provider, or individual healthcare professional, is popular, patients will have to wait for the next available slot. This mitigates the risk that all patients choose appointments with the same provider or consultant-led team which could potentially destabilise the system. Consequently, providers will get an indication of their demand through patients' preferences and decide how much capacity they need on the basis of, for instance, how many appointments they wish to offer. Some providers could carry excess capacity but this would be a consequence of poor planning and such risks exist now.
156. Patients' willingness to wait reduces the need for providers to maintain spare capacity. By being willing to wait the cost of allowing choice is shifted onto the patients themselves in terms of the time they must wait.
157. In the short term, the result could be that popular providers will have longer waiting lists and longer waiting times than those that are less popular. The change in waiting times between providers will indicate the difference in value patients assign to the relevant providers relative to the supply of appointments. Waiting times and lists may fluctuate but are unlikely to rise indefinitely. As the waiting time for a popular provider goes up so does the cost to the patient of waiting (for example anxiety), until it becomes preferable to switch their choice and go to a provider with a shorter waiting time. Therefore, in the short term, the choices patients make act as a mechanism to match the demand for a service with the available supply and send signals about the demand for particular services.

<sup>71</sup> Fotaki, M., Boyd, A., Smith, L., McDonald, R., Roland, M., Sheaff, R., Edwards, A., Elwyn, G., (2005) *Patient Choice and the Delivery of Health Services: Scoping Review*; Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation (NCCSDO)

158. There is some evidence to suggest that large, sudden movements in patient choices do not occur. Research from Bloom (2010)<sup>72</sup> and Gaynor (2012)<sup>73</sup> found that the volume of patients that moved from one hospital to another was not large and that the capability of the hospitals to deal with changes in patient numbers was not doubted.
159. Prior to patient choice no mechanism existed to allow this matching except through central planning and large regional variation in waiting times persisted. An extreme scenario could materialise where a healthcare professional is so popular that he/she has long waiting times for his/her appointments while others have free appointment slots. In this scenario the system would be inefficient. However, there is no evidence to suggest this situation is realistic. Even if it did happen, it is unlikely to be a problem in anything other than the short run.
160. In the medium to long term, rising and falling waiting times and list sizes will act as a signal to providers about where more capacity is required and from where some capacity can be disinvested. Again, this provides an efficient means to allocate resources and ensure that unused spare capacity does not persist.

### Differing costs of treatment

161. Expanding the current choice offer can lead to the costs of patients' treatment being different than under the do nothing option. This could manifest in two ways. Firstly, patients choose an appointment with a healthcare professional that offers a different range of treatments for their condition. If these treatments are more expensive than the treatments the service user would otherwise have received, the cost of delivering the service to that patient would rise.
162. Secondly patients could choose to receive services from out of area providers, leading to higher costs for some commissioners if those providers have a higher market forces factor<sup>74</sup>. The impact assessment on choice of named consultant-led team<sup>75</sup> gave an example where some patients living in areas within easy travel of London may choose named consultant-led teams at institutions with celebrated reputations in London. It found that if this risk materialises the projected impact on the budgets of affected commissioners would be small.
163. For both of these scenarios, we do not have any evidence that either of these would materialise. The proposals covered in this impact assessment are about generating options for patients to choose services which best suit their need, which for many patients will equate to services that are closer to home<sup>76</sup>. Conversely there is the possibility that patients may choose appointments with professionals delivering treatments that are less expensive.
164. Some services covered under this expanded choice offer may not be covered by the national price tariff, for instance diagnostic testing. This creates a risk where the cost of treatment could be different. We have no evidence to suggest that costs for non-tariff services would be significantly more expensive, and conversely there is the possibility that costs could be much cheaper than they are now. The Department of Health has proposed to set tariffs for diagnostic imaging services which are separate to the outpatient attendance tariff<sup>77</sup>. In doing so, this will mean providers will be paid the same amount in tariff (after adjusting for market forces) as other providers in that area. This will prevent the costs of diagnostic testing changing substantially.

### Transport

165. Policies to give patients more say in decisions about their care have the potential to increase transport costs. For example, patients may prefer to travel to a provider of the service that is

<sup>72</sup> 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

<sup>73</sup> Gaynor, M., Moreno-Serra, R. and Propper, C. (2012) Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service

<sup>74</sup> The market forces factor (MFF) is applied to the tariff for activity under the Payment by Results framework, to take account of the cost of different inputs (e.g. wages) in health care in different parts of the country.

<sup>75</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_130469.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130469.pdf)

<sup>76</sup> This stems from a general principle that, if offered two identical services, but one is closer to the patient's home than the other, the patient will naturally prefer to go to the closest provider.

<sup>77</sup> <https://www.wp.dh.gov.uk/publications/files/2012/09/2013-14-David-Flory-sense-check-letter.pdf>

located further away from them than the provider from whom they would receive the service, had patient choice not been extended.

166. These arguments were considered in previous impact assessments<sup>78</sup> and gave a suggested cost to NHS transport schemes of £885,000 per year as an upper bound. The cost to patients paying for their own travel was estimated to be in the range of £2million - £2.9million under some specific assumptions. Both estimates assume that the extra cost comes from patients attending appointments at locations that require more travel. It also assumes patients cannot choose a provider closer to home because this is the default position for the 'no choice' scenario.
167. The latter assumption does not apply to the proposals considered in this impact assessment. The proposals are designed to encourage providers to move services out of the hospital and deliver them in the community closer to home. Therefore, when a patient makes a choice they will have options of a range of locations, which will include those closer to home. There is no evidence to model potential referral patterns as services from these locations are not yet available, but the suggested locations are (for instance, in the context of diagnostic services) High Street or retail units in shopping centres.
168. The assumption used in this impact assessment is that patients will choose options that suit them best, for some this will mean shorter journey times and for others it may be longer. The net effect is assumed to be no increase in journey distance or cost. In reality, the expectation is that the journey distances should be shorter overall as the emphasis of the policies under consideration are to encourage provision closer to home.
169. In addition, one of the key considerations for patients when making a choice for their treatment could be the distance to the respective providers. The benefits of a patient receiving more personalised care might be outweighed by the cost of travelling a long distance to receive it. Hence, patients will travel further distances if they see the marginal benefit from treatment at that provider is greater than the additional time taken to travel.

## Direct costs and benefits to business (following OIOO methodology)

170. The main impact of this policy will fall on providers of NHS-funded services, whether they are public sector, private sector or civil society organisations. The levers for giving patients more say in decisions about their care and treatment are primarily legal and contractual, for instance the Mandate to the NHS Commissioning Board and the NHS Standard Contract. Any private or civil society organisation wishing to deliver NHS-funded services must accept these obligations as a precondition for delivery of these services. On this basis, this policy is out of scope of the One In One Out process.

## Summary and weighing of options

171. Option 2 sets out the expected impacts, costs and benefits that would arise from introducing the proposals as set out in the document "*Response to the consultation 'Liberating the NHS: No decision about me, without me'*". The proposals extend choice into areas where little patient choice existed previously. Insufficient evidence exists to allow detailed modelling of the effects. Therefore, to present quantified costs and benefits is likely to give a false impression of the expected impacts. It is worth noting further that we invited respondents to the previous consultations to provide comments on the impact assessment. No respondents were forthcoming with any details that suggested the costs would be unaffordable.
172. The mechanisms for delivering the proposals exist at present or are being introduced as part of the wider reforms of the healthcare system or are in place already. The marginal cost of many of the mechanisms to support these proposals is low as giving patients more say over decisions about their care does not place an additional burden on the mechanisms. This is particularly true for priority areas of diagnostic test provision, maternity and mental health services.

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<sup>78</sup> "Extension of choice from choice of provider for first outpatient hospital appointment" and "Choice of named consultant-led team for first outpatient hospital appointment"

173. Research by Cooper et al (2010a, 2012b) and Bloom et al (2010) show that where choice of provider has been introduced to routine elective services in secondary care, outcomes and efficiency have improved. This evidence is insufficient to support detailed modelling of the areas which the associated policy documents outlines. Nevertheless, it suggests that introducing patient choice to other areas of the NHS could deliver similar types of benefits.
174. An attempt has been made to illustrate the scale of potential costs and benefits in this impact assessment using conservative assumptions. We cannot, however, formally quantify these costs and benefits as any attempt to do so will give a false impression. Overall we consider that using the evidence available on patient choice, the proposals can be implemented at very low cost. The evidence and illustrative examples in this document shows these policies will generate positive benefits. It follows that the proposals are likely to be cost-beneficial.

## Annex A: Specific Impact Tests

### Competition

- A1. The Office of Fair Trading has published screening questions to help determine whether a policy is likely to have an impact on competition. These are:
- A2. *Would the proposals directly limit the number or range of suppliers?*  
The proposals allow patients more say in decisions about their care and treatment, including the provider of the care or treatment. It does nothing to directly limit the number of providers of care.
- A3. *Would the proposal indirectly limit the number or range of suppliers?*  
No. Under this policy, NHS patients have greater choice over providers of NHS-funded services. Providers can offer NHS-funded services if they have met the terms of the NHS Standard Contract. The NHS Standard Contract does limit the number and range of suppliers, but this specific policy does not add any additional constraints on suppliers.
- A4. *Would the proposals limit the ability of providers to compete?*  
No. The proposals are intended to allow any organisations that meet requirements and service specification to compete. The proposals open up the range of services about which patients can make choices. However, all holders of NHS contracts will still have to register with the Care Quality Commission and with Monitor. The proposals here do not change these requirements.

### Small Firms

- A5. The proposals aim to give patients more say in decisions about their care; and to increase the range of service to which the principle of ‘no decision about me, without me’ applies. Some services may well be suitable for small firms. Therefore, one would expect the policy to have a positive impact on small firms as it facilitates their entering of the market.

### Environmental Impacts

- A6. There is no reason to expect any significant environmental impacts.

### Human Rights

- A7. There is no reason to expect any significant impact on human rights.

### Justice System

- A8. There is no reason to expect any significant impact on the justice system.

### Rural Proofing

- A9. Providing more say in decisions about care and treatment could potentially have an impact on those living in rural areas. People living in these areas may have different priorities and therefore

different considerations when making choices than those living in urban or sub-urban areas, and may face greater difficulties in exercising choice.

- A10. While around 20% of the population in England live in rural areas, only around 10% of hospitals are located in these areas. This can be explained by a lack of 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. The proposals for more choice are designed to make it easier for new providers to offer services and to be more responsive to patients. However, with rural areas having higher costs, the change in rural provision of health services may be small.
- A11. Despite the barriers to choice that exist in rural areas, research from the Kings Fund (2010) found that respondents living in small towns and villages or in rural settings were significantly more likely to be aware of their rights to be involved in decisions about their care, to be offered a choice and to choose a non-local hospital than those in cities, large towns or suburbs.
- A12. This impact assessment covers the proposals for more patient involvement, all across the NHS. Access to information about choice can be an issue for people living in rural areas, whether that is from a library, directly from healthcare providers or by computer via the internet connections. It is not expected that providing more say will disadvantage rural patients, but they might not benefit as much as patients in urban areas.

## Annex B: Further evidence to support shared decision-making and choice

- B1. The original design of the NHS combined the purchaser and the provider arms of the healthcare system. Secondary care services were given a block grant to deliver healthcare to local populations. Doctors responsible for delivering services had a large influence over what should be provided. By giving incumbent providers a say over service design, the NHS proved to be slow to react to change as health services evolved, the range of services grew, treatments became more complex, and expectations rose. 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.
- B2. Successive governments implemented reforms to split the purchaser and provider arms, and introduce elements of the market into healthcare. The aim was to allocate resources better and improve patient experience. These reforms have encouraged competition between providers, given patients the ability to choose between them, and employed a payments regime that allows resources to follow the patient.
- B3. A central aspect of these reforms is to give patients more say in decisions about the care and treatment they receive. This can drive up the average quality of services and deliver better outcomes through a number of mechanisms:
- a) Greater patient empowerment, including shared decision making and choice of treatment, allows a better match of patient preferences with treatment characteristics, and is considered a benefit in its own right. It may also lead to better adherence and clinical outcomes as the patient is in explicit agreement with the treatment decision.
  - b) Competition through choice of provider creates a genuine threat of lost revenue for providers, as patients choose their provider based on a number of factors including quality. This gives strong incentives to providers to improve the quality of their services, and therefore drive improvement in the quality of care.
  - c) Individualised, patient-centred services can reduce health inequalities and promote equality of access by encouraging patients to voice their needs, ensuring that treatment is tailored to their requirements, and increasing the number of access points of access.
- B4. The following sections discuss each of these mechanisms in turn and give a summary of the supporting evidence.

### Patient Empowerment (Shared Decision-Making and Control)

- B5. Broad evidence on patient centred care shows that involving patients in their treatment can improve their health outcomes across a range of health contexts, including medicine, surgery, obstetrics, and chronic diseases. More patient centred care was associated with lower unexpected mortality and complication rates (Bechel et al 2000), higher satisfaction and health status scores (Fremont et al 2002), and improved communication and health status (Kaplan et al 1989). Shared decision-making is considered by many as the pinnacle of patient-centred care (Barry 2012; Weston 2001); further promoting its use should therefore improve health outcomes.
- B6. Shared decision-making is defined by Coulter and Collins (2011) as the process where patients and clinicians work together to consider options, outcomes, and goals of clinical treatment and/or management of conditions. The aim is to arrive at a mutual agreement on the best course of action for the patient. This is appropriate whenever there is no clear, single best treatment option, and a trade-off may exist between the benefits and harms of treatment. In these 'preference sensitive' decision situations, the patient's preferences should be the key factor in making the decision, taking into account their experience of illness, social circumstances, attitude to risk, values, and preferences (Coulter and Collins 2011).
- B7. Additionally, there is evidence to show that patients place intrinsic value on the notion and availability of choice itself; for example, they place value on having a choice of provider, even when they do not choose to change provider as a result (Coulter 2010). In one survey 75 per cent of patients declared choice as either 'important' or 'very important' to them (Dixon et al. 2010). There is a range of literature to support this view, which finds that patients regard discussing their medicines with healthcare professionals as important, useful, and are happy to share concerns when prompted (Stevenson 2004).
- B8. The two key ways to encourage and enhance shared decision making that have been explored in the evidence base are patient decision aids and interventions to educate and train medical professionals (including clinicians and pharmacists). The following paragraphs review this evidence base and discuss the potential impacts of these interventions.
- B9. Patient decision aids are evidence-based tools to support shared decision making between patient and clinician. They are detailed, specific, and make explicit the possible options and outcomes of the decision under consideration. They have the intention of helping patients to make decisions that are best aligned with what they value, and to supplement advice from the clinician. Often these are used for elective surgery options (e.g. knee replacements or hernia repair) but patient decision aids are also useful at certain decision points for long-term conditions such as starting insulin treatment or a disease-modifying drug for rheumatoid arthritis.
- B10. The latest systematic review of patient decision aids literature (Stacey et al 2012) found mixed results. Studies showing positive results found that decision aids 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 improved patient-clinician communication in some cases. Some, though not many, of the studies found significant improvements in patient satisfaction (Barry 1997; Heller 2008; Laupacis 2006; Montgomery 2007), and adherence to treatment (Mullan 2009), and no studies found significant improvements in health outcomes.
- B11. The literature also focuses on evidence of two-way communication between patients and practitioners, as a key enabler to realising shared decision-making. Studies evaluating training interventions for physicians found that it led to improvements in doctors' communication with patients and their families; to the extent that parents felt better able to manage care at home, and in some cases children experienced significantly reduced symptoms and hospitalisations as a result (Clark et al 2000;2008). Interventions targeting pharmacists also showed increases in health outcomes, adherence to medication, satisfaction with pharmacist services, and significant reductions in medicines prescribed (Blenkinsopp et al 2000; Gourley et al 1998; Raynor et al 2000; Solomon et al 1998).

### **Patient choice of provider (competition)**

- B12. Allowing patients to choose where to go for treatment, not constraining them only to their local provider, removes the power of monopoly. This can lead to improvements in the average level of quality as patients choose to go to high performing providers over poor performers. Poorly

performing hospitals' response to losing patient volumes (and therefore revenues) is either (i) to improve performance to attract and increase patient volumes; or (ii) to reduce capacity, or it will be forced to close down. Overall, this will alter the distribution of patients receiving good and poor quality care.

- B13. There is a rich body of research investigating the relationship between competition, prices and capacity (see Dranove and Satterthwaite 1992; Hughes and Luft 1991, Joskow 1980), and the impact of hospital competition on clinical performance (Gaynor 2004; Gowrisankaran and Town 2003; Propper et al 2004, 2008). There is a broad consensus that higher levels of competition in a fixed-price environment lead to improved clinical performance, so long as reimbursement price is high enough to cover the marginal cost of treatment. UK NHS based evidence also support these findings, as providers are forced to compete on quality when there is no price competition (Beckert et al 2012; Cooper et al 2011, 2012; Gaynor et al 2012; Bloom et al 2010).
- B14. Cooper et al (2011) show that increasing internal competition through the introduction of patient choice of provider policy in 2006 led to improvements in 30-day acute myocardial infarction (AMI) mortality rates, which is also correlated with waiting times and length of stay. Beckert et al (2012) find that quality does matter to patients as choices are influenced by mortality rates, waiting times, CQC rates, and MRSA infection rates. Bloom et al (2010) suggest that quality improvement occurs through the mechanism of improved hospital management, effected through increased hospital competition.
- B15. Two key determining factors in these results are that quality is observable, and that information on observable quality is transparent, available, and understandable to patients. As with any agency relationship, the outcome of interest, quality, must be observable and measurable in order that providers can prove the quality of the services they provide, and in turn reap the rewards of increased patient volumes and revenues. If quality is unobservable, this form of competition carries the risk of creating perverse incentives for providers to lower quality in the bid to lower average costs, thereby crowding out high quality delivery. These are crucial requirements for providers to have incentive to deliver high quality care; and for patients to be able to make informed choices, and be able to distinguish between high and low quality providers.

### Health Inequalities

- B16. A full equality analysis is published separately alongside this document. A summary of the evidence is outlined below.
- B17. Concern has been raised that choice can widen inequalities because less articulate and vulnerable groups are less likely to exercise choice. Also, some population sub-groups may find it more difficult to digest performance data (Burge et al. 2006). In 2006 the King's Fund found that PCTs felt equity of choice may be difficult to deliver, particularly for non-English speaking groups. However, Dixon et al (2010) find that 51-80 year olds are significantly more likely than the younger population to value choice as important. They also find that those with no formal qualification, those from mixed or non-white backgrounds, and those who had already bad experiences with their local hospital, are more likely to place importance on choice.
- B18. 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 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 reduce the barriers of access making them accessible to a larger section of the population.
- B19. A study by Cookson and Laudicella (2011) considered the impacts on inequalities of choice and competition reforms introduced in 2006. They examined socio-economic equity and utilisation of hospital services. They found that the reforms had not undermined socio-economic equity in hospital care and, if anything, may have 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

- B20. A truly patient-centred approach to care can improve health outcomes and the overall patient experience with the health service. Ensuring that services are suitably tailored to the individual can improve inequalities through improved access to care. Increasing patient involvement ensures patients have this input into decisions made over their care, and the preceding discussion has shown that embedding this culture of concordance within the decision-making process can lead to better patient satisfaction, better management of health problems, and better health outcomes.
- B21. As part of this paradigm of patient-centredness, the choice of provider was introduced in the NHS in 2006. Rigorous academic evidence has shown that this has been effective in driving up quality in hospitals over a range of indicators. Gaynor et al (2012) estimated that net benefits to the NHS from improved mortality equate to approximately £302 million.
- B22. The available evidence lends strong support to the positive impacts of the proposed expansions to patient choice. Alongside the Health and Social Care Act 2012, and the Information Strategy (Department of Health 2012), these changes will aid the evolution of the NHS into providing better quality, patient-centred care.

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