

Corporate	CCG CO01 Access and Choice Policy
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Document History

Version	Date	Significant Changes
V1	1 April 2013	Policy adopted by Clinical Commissioning Group (CCG) as part of policy suite developed by NECS.
V2	10 th March 2016	Release of new guidance (Department of Health Choice Framework 2015)
V2.1	July 2018	<ul style="list-style-type: none"> Extension. No guidance or legislation change. Updated Equality Impact Assessment

Equality Impact Assessment

Date	Issues
May 2018	See Section 21



POLICY VALIDITY STATEMENT

This policy is due for review on the latest date shown above. After this date, policy and process documents may become invalid.

Policy users should ensure that they are consulting the currently valid version of the documentation.

Contents

1. Introduction	4
2. Background.....	4
3. Status, Purpose and Scope	5
4. Choice of GP Practice and Particular GP	6
5. Choosing where to go for first outpatient appointment for physical and mental health conditions.....	6
6. Patients waiting longer than maximum waiting times.....	7
7. Choosing who carries out a specialist test.....	8
8. Maternity Services	8
9. Community Services	10
10. Health Research	10
11. Personal Health Budget	11
12. Treatment in another European Economic Area	12
13. End of Life Care	13
14. Planning your long-term care	14
15. Principles & Process for Ensuring Patient Choice.....	15
16. Duties and Responsibilities	16
17. Implementation	17
18. Training Implications	17
19. Documentation.....	17
20. Monitoring, Review and Archiving.....	18
21 Equality Analysis.....	18

For the purposes of this policy, NHS Northumberland Clinical Commissioning Group (CCG) will be referred to as 'the CCG'

The CCG aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the CCGs will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

1. Introduction

- 1.1 Choice is fundamental to the delivery of a truly patient-centred NHS as it empowers people to get the health and social care services they want and need. Giving the public and patients good information helps them to make effective choices that are right for them and their families.
- 1.2 It is firmly written into the NHS Constitution that 'patients will be at the heart of everything the NHS does' and therefore have the right to make informed choices about their healthcare. This means that, by law, patients should be offered the opportunity to compare and make choices that suits their needs.
- 1.3 This policy sets out the mechanisms that the CCG will adopt to fulfil its legal obligations.

2. Background

- 2.1 Patient choice began when the NHS was founded in 1948, providing ability for patients to choose their GP, optician and dentist. Since then there have been numerous developments in support of patient choice and in 2009 the NHS Constitution was published which set out the rights of patients and the pledges that the NHS makes, which includes patient choice as a right and includes the right to information to support that choice.
- 2.2 In July 2010 The Government's White Paper, 'Equity and excellence: liberating the NHS' set out proposals relating to increasing choice and control over care and treatment, choice of treatment and healthcare provider becoming the reality in the vast majority of NHS-funded services by no later than 2013/14.
- 2.3 Liberating the NHS: Greater Choice and Control (October 2010) sought views on proposals for extending choice in the NHS. In July 2011 the NHS published operational guidance to the NHS: Extending Patient Choice of Provider which provided guidance to providers and commissioners on implementation of the Government commitment to extend patient choice of provider.

- 2.4 In 2012 the legal framework within the NHS changed with the Health and Social Care Act 2012 making clear the duties on NHS England and clinical commissioning groups to promote the involvement of patients and carers in decisions about their care and treatment, and to enable patient choice. The Act sets out specific provision in relation to procurement, patient choice and competition which is detailed in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013. The new regulations are designed to ensure that NHS England and clinical commissioning groups procure high quality and efficient healthcare services that meet the needs of patients and protect patient choice.
- 2.5 In March 2015 the Department of Health published the Choice Framework for 2015/2016 which set out the choices that people have in the NHS. This document reflects that framework and sets out the current elements of patient choice, how the CCG meets its obligations and goes beyond to support patients in choosing their care.

3. Status, Purpose and Scope

3.1 Status

This policy is a corporate policy.

3.2 Purpose & Scope

This document sets out the current position of the CCG in support of patient choice and the strategic direction it will head in. As the background section illustrated, patient choice is a subject that sits within a broad legislative and regulatory framework. The scope of this document includes all patients registered with CCG GP practices and their rights to choice in relation to the following service areas:

- Choice of GP practice and particular GP
- Choosing where to go for your first outpatient appointment
- Patients waiting longer than maximum waiting times
- Choosing who carries out a specialist test
- Maternity services
- Mental Health services
- Community services
- Health research
- Personal health budget
- Treatment in another European economic area
- End of life care
- Planning long-term care

There are a number of exclusions that relate to choice and these are outlined within the respective sections. The following sections provide more detail in relation to each of the areas identified above.

4. Choice of GP Practice and Particular GP

4.1 Current Arrangements

4.1.1 The CCG is committed to a patient's right to choose which GP practice to register at and which doctor or nurse to see there. GP practices must try to make sure this happens.

4.1.2 This is a legal right, but there are occasions when a practice might have reasonable grounds for not doing so. This might be where a patient lives outside the boundaries that NHS England has agreed or because the GP practice has approval to close their list to new patients. In rare circumstances, the GP practice may not accept a patient if there has been a breakdown in the doctor-patient relationship or because the patient has behaved inappropriately at a practice. The practice has a duty to inform patients of the reason why they are refused.

4.1.3 **Who is responsible for offering this choice?** First the patient should contact the GP practice where they want to register. If there is any difficulty registering with a GP practice, the next point of contact is NHS England or local Healthwatch who can provide advice and support. Healthwatch is an independent consumer champion for health and social care in England.

4.1.4 Information is available on 'NHS Choices' and a search for GP practices can be filtered by postcode and by those currently accepting new patients. This is a national website for patients. If the patient cannot register with their preferred GP practice, NHS England will help find another.

5. Choosing where to go for first outpatient appointment for physical and mental health conditions

5.1 Current Arrangements

5.1.1 If a patient needs to see a consultant or specialist as an outpatient, the patient can choose to go to any hospital or clinic in England that offers NHS services for the first appointment. This is a legal right, but the patient can only choose a hospital or clinic that offers the right treatment and care for their condition. A patient can also choose which clinical team will be in charge of their treatment within their chosen organisation. There might be circumstances where the choice is not available and this includes when urgent or emergency treatment is necessary or if the patient is:

- A prisoner;
- A serving member of the Armed Forces;
- Detained under the Mental Health Act 1983;
- Using mental health services;
- Using maternity services.

5.1.2 Where the patient is being seen for an outpatient appointment and it is determined they need treatment for a different condition that the clinic does

not assess for, the patient has the right to choose where to have the initial outpatient appointment for that condition. This could be most convenient to be treated at the same location, but it is the patients right to choose another location.

5.1.3 **Who is responsible for offering this choice?** The patient should speak to the GP, dentist or optometrist who is referring them.

6. Patients waiting longer than maximum waiting times

6.1 Current Arrangements

6.1.1 Where a patient is referred to a consultant, they will be given an appointment to see the consultant or a doctor who works with that consultant in his or her team. The patient can ask to be referred to a different hospital if they:

- Have to wait more than 18 weeks before starting treatment, if the treatment is not urgent;
- Have to wait more than two weeks before seeing a specialist, if the patient's GP thinks it is possible they have cancer.

6.1.2 This is a patient's legal right but this right is forfeit if:

- They choose to wait longer for treatment to start;
- They choose to wait longer for an appointment with a specialist after being urgently referred with suspected cancer;
- Delaying the start of treatment is in the patient's best interests. For example, if needing to lose weight or stop smoking before starting treatment;
- There are medical reasons which mean it is better to wait;
- They fail to attend appointments that they chose from a set of reasonable options;
- They are on the national transplant list;
- They are using maternity services;
- They are using services not led by a consultant or a member of their team
- They refuse treatment;
- A doctor has decided that it is appropriate to monitor the patient for a time without treatment;
- They cannot start treatment for reasons not related to the hospital (for example, they are a reservist posted abroad while waiting to start treatment);
- The treatment is no longer necessary.

6.1.3 **How will I know I have been waiting 18 weeks or two weeks?** The patient should ask their GP or the hospital to confirm this as there are specific rules laid down on how the time is calculated.

6.1.4 **Who is responsible for offering this choice?** The organisation responsible for arranging your treatment will be the CCG or NHS England (specialist services). GP's (commissioned by CCG's) will take all reasonable steps to offer patients a choice of other hospitals which can see or treat them more quickly.

7. Choosing who carries out a specialist test

7.1 Current Arrangements

7.1.1 If the GP decides the patient needs a specialist test, the patient can choose to have this done by anyone providing that NHS service in England. This is a legal right if:

- The test has been ordered by the GP; and
- It will be the patient's first appointment as an outpatient with a consultant or a doctor in the consultant's team.

7.1.2 It is not a right if:

- The test is not part of a first appointment as an outpatient with a consultant or a doctor in the consultant's team;
- They are already at the first appointment as an outpatient, and the doctor decides they need a test. There may be a choice about who carries out that test, but there is no legal right to choose once they are being seen as an outpatient.

7.1.3 The choice is only available from organisations which carry out the test needed in a proper and safe way. There is no choice of who carries out the test if a test is needed urgently or the patient is admitted to hospital.

7.1.4 Support in making the choice is available from the GP or the doctor who has asked for the test. More information about the hospitals and clinics to choose from is on the 'NHS Choices' website.

8. Maternity Services

8.1 Current Arrangements

8.1.1 A range of choices over maternity services is available, although these depend on what is best for the mother and baby, and what is available locally. On first finding they are pregnant they can (subject to availability):

- Go to their GP and ask to be referred to a midwifery service of their choice;
- Go directly to a midwifery service of their choice, without asking the GP to refer first

8.1.2 Whilst pregnant the patient can choose to receive 'antenatal' care from (subject to availability):

- A midwife;

- A team of maternity health professionals, including midwives and obstetricians
(This will be safer for some women and their babies).

8.1.3 When they give birth the patient can choose where to give birth (subject to availability):

- At home, with the support of a midwife;
- In a local midwifery facility (for example, a local midwifery unit or birth centre), with the support of a midwife;
- In any available hospital in England, with the support of a maternity team. This type of care will be the safest option for some women and their babies. If this is the case they should still have a choice of hospital.

8.1.4 After going home, the patient can choose where to receive postnatal care (subject to availability):

- At home;
- In a community setting.

8.1.5 Depending where the mother lives, they may have other choices about maternity care and should contact their midwife or the CCG for information.

8.1.6 **Is this a legal right?** No. It depends what is best for mother and baby, and what is available locally. Every pregnancy is different.

8.1.7 **When is choice not available?** The mother can choose where to give birth, but this may mean some kinds of pain relief are not available during the birth as they are only available in hospitals. If urgent or emergency treatment is needed, there is no choice of who to see and it may not be possible to choose where to give birth.

8.1.8 **Who is responsible for offering this choice?** The midwife should discuss the choices available locally with the patient.

8.1.9 **Where is information and support available?** The midwife will be able to give information, advice and support to help mothers decide. A number of charitable and voluntary organisations can also help. These include:

- The National Childcare Trust, the UK's largest charity for parents. Visit www.nct.org.uk or call their Helpline: 0300 330 0700;
- Birth Choice UK, helping women choose maternity care. Visit www.birthchoiceuk.com;
- AIMS – Association for Improvements in the Maternity Services. Visit www.aims.org.uk, or email helpline@aims.org.uk or call the Helpline: 03003650663 for advice from volunteers;
- Start4Life at: www.nhs.uk/InformationServiceForParents for information and advice.

9. Community Services

9.1 Current Arrangements

9.1.1 **What choices are available?** The patient may be able to choose who they see for services provided in the community.

9.1.2 Different choices are available in different areas. In future, the number of services and locations available is expected to increase.

9.1.3 **Is this a legal right?** No.

9.1.4 **When is choice not available?** The choice of services will depend on what the CCG, GP practices and patients think are priorities for the community.

9.1.5 **Who is responsible for offering this choice?** The GP or the health professional that refers to the service.

10. Health Research

10.1 Current Arrangements

10.1.1 **What choices are available?** A patient can take part in approved health research (for example, clinical trials of medicines) relating to their circumstances or care. The patient is free to choose whether they take part in any research and do not have to take part if they do not want to.

10.1.2 **When is the choice not available?** The patient cannot take part in research if:

- There is currently no research relating to their circumstances or care; or
- They do not meet the requirements for a particular study.

10.1.3 **Who is responsible for offering this choice?** The health professional who provides the care, for example, the hospital doctor, GP or nurse.

10.1.4 **Where is information and support available?**

- Healthtalkonline explains what clinical trials are and why we need them. Visit www.healthtalkonline.org and search for 'clinical trials';
- National Institute for Health Research explains how patients can help with research. Visit <http://www.nihr.ac.uk/awareness/Pages/default.aspx> and click on 'Patients and public';
- For information on what research is currently under way: Visit the UK Clinical Trials Gateway: www.ukctg.nihr.ac.uk;
- NHS Choices explains why the NHS carries out research and the different types of research there are. Visit www.nhs.uk and search for 'Getting involved in research'.

11. Personal Health Budget

11.1 Current Arrangements

11.1.1 **What choices are available?** For some NHS services, there is the right to have and in other areas the right to request and choose to have a personal health budget and a direct payment if eligible. A personal health budget is an amount of money and a plan to use it. The plan is agreed between a patient and their healthcare professional and clinical commissioning group. It sets out the patient's health needs, the amount of money available to meet those needs and how this money will be spent.

11.1.2 With a personal health budget, the patient (or representative) can:

- Agree with a health professional what health and wellbeing outcomes to achieve;
- Know how much money is available for this health care and support;
- Create their own care plan with the help of their health professional or others;
- Choose how to manage their personal health budget;
- Spend the money in ways and at times that makes sense to the patient, in line with their care plan.

11.1.3 There is a choice to manage the personal health budget in three ways, or a combination of these:

- "A 'national budget: here, the money is held by the CCG or other NHS organisation who arrange the agreed care and support on the patient's behalf."
- A 'third party budget: Here, the money is paid to an organisation which holds the money on the patient's behalf (such as an Independent User Trust) and organises the care and support agreed;
- Direct payment for health care: the money is paid to the patient or their representative who can buy and manage the care and services as agreed in the care plan.

11.1.4 In each case there will be regular reviews to ensure that the personal health budget is meeting the patient's needs. Direct healthcare payments will be subject to regular reviews of how the money is being spent.

11.1.5 **Is this a legal right?** There is a legal 'right to ask' for a personal health budget, which has been available since April 2014, which was extended to a legal 'right to have' a personal health budget (with some exceptions) since October 2014 for people receiving NHS Continuing Healthcare (including children). NHS Continuing Healthcare is a package of care arranged and funded solely by the NHS and provided free to the patient. This care can be provided in any setting – including an individual's own home. An assessment is carried out by the CCG using a multi-disciplinary team of health and social care professionals. There is now a 'right to have' from October 2014 for CHC and CCC patients, there is a 'right to request' as part of the SEND reforms as part of the Education Health and Care plan.

11.1.6 More information about NHS Continuing Healthcare is available via NHS Choices:
www.nhs.uk.

11.1.7 **When is this choice not available?** Personal health budgets are not available for all NHS services (for example, acute or emergency care or visiting the GP). A few groups of people may not be eligible for a personal health budget or a direct healthcare payment (for example, people who have been ordered by the Court to have drug rehabilitation treatment).

11.1.8 **Who is responsible for offering the choice?** The CCG.

11.1.10 **Where is information and support available?** Patients should:

- Talk to their GP or health professional; or
- Contact the CCG (www.southteesccg.nhs.uk)

11.1.11 Further information about personal health budgets is available from:

- NHS Choices: www.nhs.uk;
- NHS England's website has a section dedicated to personal health budgets. This has information about national policy, the implementation toolkit, stories and other resources. www.personalhealthbudgets.england.nhs.uk;
- The Peer Network, a user-led organisation for personal health budgets, has its own website: www.peoplehub.org.uk;

12. Treatment in another European Economic Area

12.1 Current Arrangements

12.1.1 **What choices are available?** The right to choose to receive treatment, normally available on the NHS, in other countries within the European Economic Area (EEA) and is subject to certain conditions. This is a legal right set out in the NHS Constitution and in EU law.

12.1.2 Under a new EU directive on patients' rights in cross-border healthcare, there is the right to access any healthcare service in another Member State that is the same as or equivalent to a service that would have been provided in the circumstances of each case. This means that the treatment must be one that is available through the NHS. There is then a right to claim reimbursement up to the amount the treatment would have cost under the NHS – or the actual amount if this is lower.

This means that the patient will normally have to pay for the full cost of the treatment upfront (though other arrangements may be available via the CCG or NHS England). The directive covers treatment provided in state-run hospitals and services provided by private clinics and clinicians.

12.1.3 **When is choice not available?** The directive does not cover:

- Long-term (i.e. social) care;
- Access to and allocation of organs (for transplantation); or
- Public vaccination programmes against infectious diseases.

12.1.4 In some cases, prior authorisation may be required before treatment is accessed in another EEA country. This will enable the patient to confirm that they are entitled to the treatment requested, as well as the level of reimbursement that will apply.

12.1.5 The process of prior authorisation will also ensure that the patient is aware of all of the possible treatment options within the NHS, which may be more convenient than going abroad. If the patient is unable to access treatment on the NHS without undue delay, authorisation must be granted.

12.1.6 **Who is responsible for offering this choice?** To access treatment in another EEA country, the GP, dentist or CCG will outline the choices that are available.

13. End of Life Care

13.1 Current Arrangements

13.1.1 Patients have the right to be involved in discussions and decisions about their health and care, including end of life care, and to be given information to enable them with support from family or carer where appropriate to make decisions about the end of life care they want to receive, including preferred place of care.

13.1.2 **What does this right mean for patients?** The Health and Social Care Act 2012 addresses the Government's commitment to 'no decision about me without me'. The CCG has a duty to promote the involvement of patients, carers and representatives in decisions, which relate to the prevention and diagnosis of illness in the patients, or their care or treatment. Clinicians will discuss your preferences and circumstances with patients and these will be reflected in the decision that is made. Patients will be listened to and treated as an individual.

13.1.3 Where a range of potentially suitable treatments or forms of healthcare are available, a competent person has the right to receive the information they need in order to decide their preference. NHS staff will involve patients in discussions to decide on the right choice for the patient, the discussions can include family and carers.

13.1.4 Not everyone will wish to take up this right. Some people will not be able to do so for themselves, for example if they are not conscious or if they have lost mental capacity. The Mental Capacity Act and its Code of Practice set out how others can make healthcare decisions under such circumstances.

13.1.5 In relation to both GP and secondary care (e.g. hospital treatment), doctors registered with the General Medical Council have a duty to work in partnership with patients. This must include listening to patients and responding to their concerns and preferences, and giving patients the information they want or need in a way they can understand.

14. Planning your long-term care

14.1 Current Arrangements

***“The NHS commits to involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one.”
(Section 3a of the NHS Constitution)***

14.1.1 The Government is committed to a patient-led NHS, strengthening patient’s choice and management of their own care. The CCG wants to support shared decision-making and focus on improving patient outcomes. Involving patients (and carers and family, where appropriate) in discussions about planning care is key to helping patients understand what choices are available, and what support might be needed to manage their condition and stay healthy.

14.1.2 What does this right mean for patients? For people with long-term conditions, the aim is to identify how their condition is impacting on the things that are important to them. A care planning discussion can help to identify a range of personal goals, and how the health system will support in achieving them. It can also include wishes around end of life care if this is relevant or appropriate. The discussion can also identify the range of support available, the extent to which the patient is able to self-care, what support groups are available and the most convenient way for patients to access further information.

14.1.3 In this way, patients will have more control over the care and support received, and this should help reduce unplanned emergencies or unscheduled admissions to hospital. The care planning discussion is generally led by the main health or care professional, so that could be in primary or secondary care (e.g. with a GP or a hospital doctor). It may also be offered by a community pharmacist, e.g. after a medicines use review or a healthy lifestyle discussion. For people with long-term conditions, it is likely to be led by the GP and then added to by other health/care professionals as appropriate.

14.1.4 The NHS has developed a range of patient decision aids to support patients and health professionals in discussions about care planning. Patient decision aids are specially designed information resources that help people make decisions about difficult healthcare options and why one option is better than another.

14.1.5 The outcome of the discussion about the care decisions will usually be recorded.

- 14.1.6 This record could be called a care plan, a health plan, a support plan, a self-management plan or an information prescription. For some people their 'plan' will be very detailed, for others it might be something simpler.
- 14.1.7 It is good practice to offer the patient a written record of what is agreed. The care planning approach is well established in mental health services and in aspects of social care. The aim is to make this type of practice more generally available.
- 14.1.8 The patient may not want a written document, but just have the agreement recorded in their patient notes.
- 14.1.9 The Department of Health's End of Life Care Strategy (2008) outlined a number of measures to be put in place to ensure that patients' needs are met. At a local level, we are supporting the roll-out of the electronic palliative care co-ordination systems. These enable the recording and sharing of information about people's needs, wishes and preferences for end of life care, with their agreement, so that care provision is delivered in line with people's choices.

15. Principles & Process for Ensuring Patient Choice

- 15.1 The CCG recognises that providing people with greater choice is a priority of the modern NHS. Research in the UK and overseas has shown that treatments are more effective if patients choose, understand and control their care. The CCGs will regularly review the health provision in the market place to ensure choice of provider and locations of care are available for patients on a regular basis.
- 15.2 Where gaps in the market are identified the organisation may choose to engage with providers to create more choice in a service if it is appropriate to do so.
- 15.3 The CCG recognises its obligations under The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 and is working with the provider market to establish assurance mechanisms that support all patients being offered choice where they are at risk of breaching the 18 week or two week waiting time targets.
- 15.4 The CCG will work with Public and Patient Involvement leads, and patient involvement forums to gain an understanding of patients' needs, priorities and perceptions to inform and influence the choice agenda
- 15.5 The CCG will build on existing relationships whilst forging new ones to improve choice. It will be proactive in engaging with referrers through workshops, meetings and regular communication.

- 15.6 It will bring together for patients with long term conditions their healthcare professional, information about their life, available care and treatment options and choices, and together decide on a personalised package of treatment and care.
- 15.7 Maternity services will have the four national choice guarantees available to all women and their partners. Women and their partners will be given the opportunity to make informed choices throughout pregnancy, birth and during the postnatal period.
- 15.8 Working in partnership, clinical commissioners will identify events, services and local opportunities to promote choice to the wider local population.
- 15.9 The CCGs will publicise and promote awareness of, information about secondary care providers and where that information can be found to enable a person to choose a clinically appropriate secondary care provider within 18 weeks from the time of their initial referral, unless it is not clinically appropriate or they choose to wait longer
- 15.10 It will support GPs and other health professionals in promoting patient's choice from within their services through:
- Providing choice posters to GP Practices for display in their practices.
 - Distributing patient leaflets to GP Practices, Health Centres and Community Health services for display in their services.
 - Monitoring the distribution and the displaying of choice information by spot checking GP Practices, Health Centres and Community Health locations.

16. Duties and Responsibilities

Governing Body	The Governing Body have delegated responsibility to the Clinical Management Board for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Accountable Officer	The Accountable Officer has overall responsibility for the strategic direction and operational management, including ensuring that CCG process documents comply with all legal, statutory and good practice guidance requirements.
Contract Managers/Accountant	The Contract Managers/Accountant have the responsibilities to ensure the policy is kept current and is disseminated to all relevant staff via an implementation plan.

All Staff	<p>All staff, including temporary and agency staff, are responsible for:</p> <ul style="list-style-type: none"> • Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken. • Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities. • Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly. • Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager. • Attending training / awareness sessions when provided.
CSU Staff	<p>Whilst working on behalf of the CCG, CSU staff will be expected to comply with all policies, procedures and expected standards of behaviour within the CCG, however they will continue to be governed by all policies and procedures of their employing organisation.</p>

17. Implementation

- 17.1 This policy will be available to all staff for use in relation to access and choice.
- 17.2 All managers are responsible for ensuring that relevant staff within the CCG have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

18. Training Implications

It has been determined that there are no specific training requirements associated with this policy/procedure.

19. Documentation

- 19.1 Choice at referral, supporting information for 2008/09 published on 18 March 2008.
- 19.2 The Primary Care Trust Choice of Secondary Care Provider Directions 2009, published 21 January 2009.
- 19.3 NHS Choices;
<http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Yourrightstochoice.aspx>

- [19.4 Government White Paper: Equity and excellence: liberating the NHS' July 2010](#)
- 19.5 Liberating the NHS: Greater Choice and Control: October 2010
- 19.6 NHS: Extending Patient Choice of Provider: July 2011
- 19.7 Health and Social Care Act 2012
- 19.8 National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013.
- 19.9 Department of Health; Choice Framework for 2015/2016
- 19.10 The National Childcare Trust; www.nct.org.uk
- 19.11 Birth Choice UK; www.birthchoiceuk.com;
- 19.12 Association for Improvements in the Maternity Services (AIMS); www.aims.org.uk
- 19.13 Start4Life at: www.nhs.uk/InformationServiceForParents
- 19.14 Healthtalkonline; www.healthtalkonline.org
- 19.15 National Institute for Health Research: <http://www.nihr.ac.uk/awareness/Pages/default.aspx>
- 19.16 UK Clinical Trials Gateway: www.ukctg.nihr.ac.uk
- 19.17 Personal Health Budgets: www.personalhealthbudgets.england.nhs.uk
- 19.18 The Peer Network: www.peoplehub.org.uk;
- 19.19 Department of Health's End of Life Care Strategy (2008)
- 19.20 Securing Meaningful choice for patients: CCG planning and improvement guide: August 2016

20. Monitoring, Review and Archiving

20.1 Monitoring

20.1.1 The Governance Group will oversee, on behalf of the Clinical Management Board, a method for monitoring the dissemination and implementation of this policy.

20.1.2 Monitoring information will be recorded in the policy database.

20.1.3 Patient Surveys will be conducted to identify the uptake of choice and the results will be fed back to GP Practices, Secondary Care and appropriate Clinical Commissioning Group.

20.1.4 Clinical Commissioners will develop processes which ensure patients who complain about a lack of information or a lack of choice will still be entitled to start treatment

20.2 Review

20.2.1 The Governance Group will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

20.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The Governance Group will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

20.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

20.3 Archiving

The Governance Group will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: Code of Practice for Health and Social Care 2016.

21 Equality Analysis



Partners in improving local health



North of England
Commissioning Support



Introduction - Equality Impact Assessment

An Equality Impact Assessment (EIA) is a process of analysing a new or existing service, policy or process. The aim is to identify what is the (likely) effect of implementation for different groups within the community (including patients, public and staff).

We need to:

- ✓ Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- ✓ Advance equality of opportunity between people who share a protected characteristic and those who do not
- ✓ Foster good relations between people who share a protected characteristic and those who do not

This is the law. In simple terms it means thinking about how some people might be excluded from what we are offering.

The way in which we organise things, or the assumptions we make, may mean that they cannot join in or if they do, it will not really work for them.

It's good practice to think of all reasons why people may be excluded, not just the ones covered by the law. Think about people who may be suffering from socio-economic deprivation or the challenges facing carers for example.

This will not only ensure legal compliance, but also help to ensure that services best support the healthcare needs of the local population.

Think of it as simply providing great customer service to everyone.

As a manager or someone who is involved in a service, policy, or process development, you are required to complete an Equality Impact Assessment using this toolkit.

Policy	A written statement of intent describing the broad approach or course of action the Trust is taking with a particular service or issue.
Service	A system or organisation that provides for a public need.
Process	Any of a group of related actions contributing to a larger action.



STEP 1 - EVIDENCE GATHERING

Name of person completing EIA:	Sudhir Jayakrishna
Title of service/policy/process:	ACCESS AND CHOICE POLICY
Existing: <input checked="" type="checkbox"/> New/proposed: <input type="checkbox"/> Changed:	
What are the intended outcomes of this policy/service/process? Include outline of objectives and aims	
<p>Choice is fundamental to the delivery of a truly patient-centred NHS as it empowers people to get the health and social care services they want and need. Giving the public and patients good information helps them to make effective choices that are right for them and their families.</p> <p>This policy sets out the mechanisms that the CCG will adopt to fulfil its legal obligations</p>	
Who will be affected by this policy/service /process? (please tick)	
<input type="checkbox"/> Consultants <input type="checkbox"/> Nurses <input type="checkbox"/> Doctors <input type="checkbox"/> Staff members <input checked="" type="checkbox"/> Patients <input checked="" type="checkbox"/> Public <input type="checkbox"/> Other	
If other please state:	
What is your source of feedback/existing evidence? (please tick)	
<input checked="" type="checkbox"/> National Reports <input type="checkbox"/> Internal Audits <input type="checkbox"/> Patient Surveys <input type="checkbox"/> Staff Surveys <input type="checkbox"/> Complaints/Incidents <input type="checkbox"/> Focus Groups <input type="checkbox"/> Stakeholder groups <input checked="" type="checkbox"/> Previous EIAs <input type="checkbox"/> Other	
If other please state:	

Evidence	What does it tell me? (about the existing service/policy/process? Is there anything suggest there may be challenges when designing something new?)
National Reports	<p>Patient choice began when the NHS was founded in 1948, providing ability for patients to choose their GP, optician and dentist. Since then there have been numerous developments in support of patient choice and in 2009 the NHS Constitution was published which set out the rights of patients and the pledges that the NHS makes, which includes patient choice as a right and includes the right to information to support that choice.</p> <p>In July 2010 The Government's White Paper, 'Equity and excellence: liberating the NHS' set out proposals relating to increasing choice and control over care and treatment, choice of treatment and healthcare provider becoming the reality in the vast majority of NHS-funded services by no later than 2013/14.</p> <p>Liberating the NHS: Greater Choice and Control (October 2010) sought views on proposals for extending choice in the NHS. In July 2011 the NHS published operational guidance to the NHS: Extending Patient Choice of Provider which provided guidance to providers and commissioners on implementation of the Government commitment to extend patient choice of provider.</p> <p>In 2012 the legal framework within the NHS changed with the Health and Social Care Act 2012 making clear the duties on NHS England and clinical commissioning groups to promote the involvement of patients and carers in decisions about their care and treatment, and to enable patient choice. The Act sets out specific provision in relation to procurement, patient choice and competition which is detailed in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013. The new regulations are designed to ensure that NHS England and clinical commissioning groups procure high quality and efficient healthcare services that meet the needs of patients and protect patient choice.</p> <p>In March 2015 the Department of Health published the Choice Framework for 2015/2016 which set out the choices that people have in the NHS. This document reflects that framework and sets out the current elements of patient choice, how the CCG meets its obligations and goes beyond to support patients in choosing their care.</p> <p>The CCG recognises that providing people with greater choice is a priority of the modern NHS. Research in the UK and overseas has shown that treatments are more effective if patients choose, understand and control their care. The CCGs will regularly review the health provision in the market</p>

place to ensure choice of provider and locations of care are available for patients on a regular basis.

Where gaps in the market are identified the organisation may choose to engage with providers to create more choice in a service if it is appropriate to do so.

The CCG recognises its obligations under The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 and is working with the provider market to establish assurance mechanisms that support all patients being offered choice where they are at risk of breaching the 18 week or two week waiting time targets.

The CCGs will work with Public and Patient Involvement leads, and patient involvement forums to gain an understanding of patients' needs, priorities and perceptions to inform and influence the choice agenda

<http://www.nhs.uk/choiceinthenhs/Pages/choicehome.aspx>

The CCGs will build on existing relationships whilst forging new ones to improve choice. It will be proactive in engaging with referrers through workshops, meetings and regular communication.

It will bring together for patients with long term conditions their healthcare professional, information about their life, available care and treatment options and choices, and together decide on a personalised package of treatment and care.

Maternity services will have the four national choice guarantees available to all women and their partners.

Women and their partners will be given the opportunity to make informed choices throughout pregnancy, birth and during the postnatal period.

Working in partnership, clinical commissioners will identify events, services and local opportunities to promote choice to the wider local population.

The CCGs will publicise and promote awareness of, information about secondary care providers and where that information can be found to enable a person to choose a clinically appropriate secondary care provider within 18 weeks from the time of their initial referral, unless it is not clinically appropriate or they choose to wait longer

It will support GPs and other health professionals in promoting patient's choice from within their services through:

- Providing choice posters to GP Practices for display in their practices.
- Distributing patient leaflets to GP Practices, Health Centres and Community Health services

	<p>for display in their services.</p> <ul style="list-style-type: none"> Monitoring the distribution and the displaying of choice information by spot checking GP Practices, Health Centres and Community Health locations. <p>Evidence Base</p> <p>Choice at referral, supporting information for 2008/09 published on 18 March 2008. The Primary Care Trust Choice of Secondary Care Provider Directions 2009, published 21 January 2009. NHS Choices; http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Yourrightstochoice.aspx Government White Paper; Equity and excellence: liberating the NHS' July 2010 Liberating the NHS: Greater Choice and Control: October 2010 NHS: Extending Patient Choice of Provider: July 2011 Health and Social Care Act 2012 National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013. Department of Health; Choice Framework for 2015/2016 The National Childcare Trust; www.nct.org.uk Birth Choice UK; www.birthchoiceuk.com; Association for Improvements in the Maternity Services (AIMS); www.aims.org.uk Start4Life at: www.nhs.uk/InformationServiceForParents Healthtalkonline; www.healthtalkonline.org National Institute for Health Research: http://www.nihr.ac.uk/awareness/Pages/default.aspx UK Clinical Trials Gateway: www.ukctg.nihr.ac.uk Personal Health Budgets: www.personalhealthbudgets.england.nhs.uk The Peer Network: www.peoplehub.org.uk; Department of Health's End of Life Care Strategy (2008) Securing Meaningful choice for patients: CCG planning and improvement guide: August 2016</p>
Patient Surveys	A patient survey, developed by NECS and the CCG, will be distributed in all current provider premises to get up to date, targeted patient feedback.
Staff Surveys	N/A

Complaints and Incidents	Clinical Commissioners will develop processes which ensure patients who complain about a lack of information or a lack of choice will still be entitled to start treatment
Results of consultations with different stakeholder groups – staff/local community groups	<p>The Communications and Engagement leads are members of the project team.</p> <p>The NECS Market Engagement Tool has been completed. The summary of final recommendations shows there is a fair to average understanding of the market and recommends some market engagement such as request for information or some market engagement event.</p> <p>The tool also recommended utilisation of some category management market engagement tools to evidence understanding of the market.</p> <p>This EIA will be used to inform patient/public engagement requirements.</p>
Focus Groups	To be arranged in liaison with Engagement and Communications Leads.
Other evidence (please describe)	N/A



STEP 2 - IMPACT ASSESSMENT

What impact will the new policy/system/process have on the following: (Please refer to the 'EIA Impact Questions to Ask' document for reference)

Age A person belonging to a particular age

While overall population growth is forecast to be small over the next five years (8,454 people, 1.59% 2013-18) a higher proportion of the increase will be in the over 75 age group in all areas of the CCG.

Healthwatch England found that many young adults lacked confidence in accessing services and felt GPs did not listen fully or always believed what they had to say. Coupled with health literacy and education, pre-bookable appointments on week days and at weekends will support encouragement to access a GP of choice rather than attend the Emergency Department.

Many older people require help from another person to access services

Long term conditions and complex needs of an aging population will increase pressure on services and caring. Pre-bookable appointments in advance will provide ongoing support for these patients' health needs.

This policy empowers people to make choices regarding health and social care services they want and need. Whilst it is recognised that this policy predominately impacts on the older population it relates to all ages supporting the delivery of patient centred care. Giving the public and patients good information helps them to make effective choices that are right for them and their families.

Alternative communications such as information provided in large font/audio will need to be made available as required.

Disability A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities

People with disabilities face a range of access issues. These include environmental, accessible information, support of British Sign Language interpreter and deaf/blind interceptor, staff attitudes (clinical and non-clinical) and understanding.

Studies have shown that common barriers to health care are exacerbated for many disabled people, not just in relation to their impairment or long-term health condition, but because of reduced access to services and generally higher levels of social deprivation. This is particularly the case for those with visual, hearing and mobility impairments.³

Pre-bookable appointments across all general practices should facilitate improved access through provision of GP appointments in the right place in that they may find a surgery more accessible than another for their disability. They will also be assured of accessing an appointment suitable to them, either alone or accompanied. For example, the potential to have easier access to appointments during day light hours when vision impaired can more easily travel alone.

The Accessible Information Standard will need to be taken into account and a process outlined for patients with a disability or sensory need that require alternative communication methods. Further information:

<https://www.england.nhs.uk/ourwork/accessibleinfo/>

Gender reassignment (including transgender) Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self perception.

This group face complex challenges such as isolation, fear, rejection and lack of understanding or acceptance from others. They subsequently suffer depression, anxiety and other mental health issues. Additional consultation capacity and the opportunity to be able to access a general practice of their choice should benefit this group.

Marriage and civil partnership Marriage is defined as a union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters

The working hours associated with providing extended access (early evening, weekend and bank holiday working) may create new employment opportunities for people who are married or in a civil partnership, so likely to have a positive impact.

Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.

Expectant and nursing mothers will have greater flexibility to fit around other children and work commitments

Race It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.

Not being able to match a patient's first or preferred language can impact on patient experience and health outcomes, the frequency of missed appointments and the effectiveness of consultations. It may have serious implications such as misdiagnosis and treatment, ineffective interventions and, in extreme circumstances, preventable deaths.

There is currently widespread variation in the quality of interpretation services and how patients can book an interpreter. The use of an inadequately trained (or no) interpreter poses risks for both the patient and healthcare provider. The error rate of untrained interpreters (including family and friends) may make their use more high risk than having no interpreter at all.

It is recognised that individual characteristics including socioeconomic, educational and religious beliefs will shape cultural beliefs to health care.

Information to be provided in alternative languages as required.

Religion or belief Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

There should be little or no impact on religion or belief. GP practices will offer appointments with male and female GPs to meet cultural needs.

Sex/Gender A man or a woman.

Women are much more likely to use health services routinely. Consequently, when they are ill, they are more likely to know how to access services and feel more comfortable with a healthcare professional. Nearly twice as many men as women visit their GP less than once a year.

Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes

Like Trans, LGB report negative experiences of healthcare in relation to their sexual orientation. These include being treated as heterosexual, unable to discuss their sexual orientation or have their partner welcome during a consultation. Challenges include failure by general practices to put in place a non-discrimination policy or have a clear policy on confidentiality. Additional consultation capacity and extended hours to make appointments with a general practice of choice should benefit this group

Carers A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person

We know from involvement work with carers that their caring responsibilities make it difficult to access health services. Managing complex health needs and reviewing unpaid carers to ensure they can cope will be supported by the assurance of pre-bookable appointments. In addition, many older people need support to access healthcare which may be time-restricted and within certain hours; for example a working age carer.

Patients and carers affected will be asked their views. Any reasonable adjustments to enable them to respond will be put in place, and used in the development of the future service to ensure fair and equal access.

Other identified groups such as deprived socio-economic groups, substance/alcohol abuse and sex workers

Socio-economic deprivation is strongly associated with poor health. Improving education, income and employment are key to reducing the resultant health inequalities and improving the health status of the population

We will ensure that the engagement process and delivery of the services is accessible to patients and carers and reasonable adjustments will be put in place to ensure equitable access.



STEP 3 - ENGAGEMENT AND INVOLVEMENT

How have you engaged stakeholders in testing the policy or process proposals including the impact on protected characteristics?

This EIA is about the engagement process, any feedback will be fed into the commissioning plans

Please list the stakeholders engaged:

Patients & Carers
GPs and healthcare providers



STEP 4 - METHODS OF COMMUNICATION

What methods of communication do you plan to use to inform service users of the policy?

- Verbal – stakeholder groups/meetings Verbal - Telephone
 Written – Letter Written – Leaflets/guidance booklets
 Email Internet Other

If other please state:

ACCESSIBLE INFORMATION STANDARD

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Tick to confirm you have you considered an agreed process for:

- Sending out correspondence in alternative formats.
 Sending out correspondence in alternative languages.
 Producing / obtaining information in alternative formats.
 Arranging / booking professional communication support.
 Booking / arranging longer appointments for patients / service users with communication needs.

If any of the above have not been considered, please state the reason:



STEP 5 - SUMMARY OF POTENTIAL CHALLENGES

Having considered the potential impact on the people accessing the service, policy or process please summarise the areas have been identified as needing action to avoid discrimination.

Potential Challenge	What problems/issues may this cause?
1 Service users with a disability.	Accessing buildings e.g. no wheelchair ramps, lifts, wide doors. Barriers to communication – outline the process in place for Accessible Information Standard. Difficulties in accessing services.
2 Carers	Barriers to attending engagement events and therefore being unable to put forward views/ideas/opinions. May cause difficulty in accessing services.
3 Deprived socio-economic groups	Barriers to attending engagement events, e.g. travelling costs/means, caring responsibilities. May cause difficulty in accessing services.



STEP 6- ACTION PLAN

Ref no.	Potential Challenge / Negative Impact	Protected Group Impacted (Age, Race etc)	Action(s) required	Expected Outcome	Owner	Timescale/ Completion date
1	Barrier to engagement	Disability Race Age	<p>Ensure buildings are accessible – wheelchair friendly, hearing loops are available.</p> <p>Outline the process in place for the Accessible Information standard. Including information available in large print/BSL/Audio.</p> <p>Outline process in place for people who require information to be available in alternative languages or for an interpreter as required. interpretation</p>	Equal access for people of this protected characteristic.		
2	Barrier to engagement	Carers	Have market engagement events in a variety of local settings at different times of the day (including evenings/weekends) to make sessions more accessible to carers.	Equal access for people of this protected characteristic.		
3	Barrier to engagement	Socio-economic	Have market engagement events in a variety of local settings to make them easier and more affordable to get to.	Equal access for people of this protected characteristic.		

Ref no.	Who have you consulted with for a solution? (users, other services, etc)	Person/ People to inform	How will you monitor and review whether the action is effective?
1	Colleagues	NECS Engagement & Communications Leads, NHS Property Services, building custodians, clinicians, service employees, interpreter services, service users/carers.	Pre-event preparation, observation, feedback.



SIGN OFF

Completed by:	Sudhir Jayakrishna
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