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HOT TOPICS

Right to choose

Background

The COVID-19 pandemic has placed unprecedented pressure on healthcare systems across the world, including the NHS. This has resulted in a significant backlog of elective or planned care and treatment across the UK.[1]

An increasing awareness of mental health conditions, such as Attention Deficit Hyperactivity disorder (ADHD) and attention deficit disorder (ADD) in both children and adults during this period has led to an increased demand in referrals for initial outpatient assessment in these clinical pathways.

In March 2023, the BBC reported a five year wait for adult ADHD assessment in the South East; referrals for adult ADHD assessment to Surrey and Borders NHS Partnership NHS Foundation Trust have risen from more than 2,200 in 2020/21 to over 4,400 in 2021/22.[2]

Several virtual NHS commissioned ADHD services with private providers have been established across the UK offering online assessment and treatment services. The virtual nature of these services allows patients to choose to be referred and accepted from any geographical location in the UK. This increased demand along with a lack of understanding regarding the rules governing the NHS patient choice and right to choose programmes has led to a number of challenges for Integrated Care Boards (ICBs) and systems.

Whilst these issues have been raised in relation to ADHD and ADD pathways to date, it is anticipated that similar issues could arise with commissioned virtual or digital services for other indications (e.g. weight management or obesity services and digital apps and transgender services).

This briefing aims to summarise the key points in relation to the patient choice and highlights the current issues being experienced by Integrated Care Systems.

Patient choice

Patient choice is at the heart of the NHS. The NHS in England has offered patients choices on where they receive healthcare services since it was established, and these choices have been extended over time in legislation. Choice is also highlighted as a key consideration in other priorities for the NHS, including in the NHS Long Term Plan and as part of elective care recovery within the Delivery Plan For Tackling the COVID-19 Backlog of Elective Care. The NHS Constitution for England sets out the principles and values of the NHS. The Handbook to the NHS Constitution describes in more detail the rights in relation to informed patient choice.[4,5,6,7,8]

Choice is one of the six components of the Comprehensive Model of Personalised Care.

There are a range of choices that patients should expect to be offered in the NHS services they use. The Department of Health and Social Care NHS Choice Framework sets out the main types of nationally set choices that should be available to patients in the NHS.[6,7,8]

The entitlements to choice set out in this framework reflect those in the NHS Constitution and the NHS Responsibilities and Standing Rules . Some of these choices are legal rights, while some are subject to local determination and/or specific exceptions.[4,7,8]

In 2014 the Government established the same legal right to choice of provider and team for people with mental health conditions as has existed for several years in physical health, representing a major step towards realising parity between physical and mental health.[13]

For elective care, patients are entitled to choose any provider, including private or independent providers in England, that hold a relevant NHS commissioning contract for the services the patient requires.

However, the legal rights to choice of provider and team only apply when the:

- Patient has an elective referral for a first outpatient appointment.
- Patient is referred by a GP, Dentist or Optometrist. Patients cannot self-refer.
- Referral is clinically appropriate (as determined by the referrer).
- Provider service and team are led by a consultant (physical and mental health) or a mental healthcare professional (mental health only).
- Provider has a commissioning contract with any ICB or NHS England for the required service.

The rights to choice do not apply if the patient:

- Is already receiving care following an elective referral for the same condition.
- Has been referred to a service that is commissioned by a local authority (not part of joint commissioning arrangement) or delivered through primary care.
- Accessing urgent or emergency (crisis) care.
- Serving as a member of the armed forces.
- Is a prisoner; on temporary release from prison; detained in hospital under Mental Health Act 1983 or another secure service.[7]

Patients cannot self-refer themselves directly to the provider, under the NHS. The patient must contact their GP (or Dentist or Optometrist if appropriate) and speak to them about a referral and the choices available to them. If clinically appropriate, they may then refer the patient. There may be several considerations which go into this assessment, for example a patient's personal circumstances/ comorbidities, interactions with pathways of care, ongoing prescribing responsibilities and the type of assessment which is most appropriate for the patient (i.e. face to face or online). The rules apply to both physical and mental health and are not place based so a referral to Consultant led or mental health provider may include services provided in the community or virtually through an online digital service. Assessment services for Autism Spectrum Disorder (ASD), ADD and ADHD are within the scope of the legal right to choice.

If the choice criteria are met and a service is commissioned anywhere in England under an NHS commissioning contract, then the legal right to choice applies, regardless of whether the responsible commissioner directly contracts the chosen service/provider or provides similar services locally. Once a patient has chosen a provider, that provider will normally treat the patient for their entire episode of care, unless the patient's diagnosis changes significantly or shared care with the patients GP is possible. No prior commissioner approval is required for referrals where the patient has exercised choice of provider/team under their legal rights. Where initiatives such as clinical assessment services, referral management or single point of access are put in place, these should not obstruct the patient's legal rights. In these circumstances, choice should be offered at the most appropriate point in the pathway prior to an elective referral.[7,8,10]

The legal right to choose does not apply to choice of medication.[7,8] The online providers may also offer a medication titration and ongoing medication supply service. Over the last 18 months virtual assessment and treatment services for ADHD patients have been commissioned by several different ICBs across England to deal with the increased patient demand and elective care backlog. The Right to Choose provisions in the NHS standard contract and the virtual nature of these services allows patients to choose to be referred, by their GP and accepted from any geographical location in England whereas previously the need for physical attendance at a specific provider site naturally limited the capacity needed for each commissioned service.

Current challenges at local level

Contractual

Patient choice is currently underpinned by two separate sets of regulations. These are:

- The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 ("the Standing Rules"); and
- The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 ("the PPCCRs").

The technical guidance for the 2023/24 contract (paragraph 25.19) states that the provisions of Part 8 of the Standing Rules are relevant where choice is to apply on the basis of non-contract activity(NCA) arrangements as set out in the earlier parts of paragraph 25.[10]

Since the NHS "internal market" was introduced, there has been a pragmatic system for managing low-value flows of activity to distant providers as "non-contract activity" (NCA). For small volumes of activity, there has been no expectation that a separate written contract would be put in place between the commissioner and the distant provider; rather, the provider would see and treat patients as necessary from the distant commissioner, under an implied contract, on the terms of the provider's contract with its main host commissioner.[11]

The current technical guidance to the 2023/24 NHS Standard Contract specifically states that NCA is undertaken by the provider on the same terms of the NHS Standard Contract in place between that provider and its host commissioner(s). A contract on those terms will be implied as between the patient's responsible commissioner and the provider (except where specific different arrangements are agreed between the patient's responsible commissioner and the provider) and services will be delivered in accordance with the service specifications and other terms and conditions of the provider's contract with its host commissioner.[10]

The NHS Standard Contract (full-length) includes a specific requirement on providers (Service Condition (SC6.8.2)) to accept every referral, regardless of the identity of the responsible commissioner, where this is necessary to enable a patient to exercise his/her legal right of choice of provider. This applies whether or not the responsible commissioner for the patient affected is a party to a written contract with the provider.[10] If the individual is exercising their legal right to choice as set out in the NHS Choice Framework, the responsible commissioner must pay for the services of the provider under the terms of the contract.[10]

The legal right of choice only applies to the service as commissioned, on the basis specified in the provider's contract with the host commissioner. So, if the provider has a contract for service X to be provided in location A, that of itself does not allow that provider, on a NCA basis, to open a new facility and offer service X in location B, a hundred miles away. Neither does it of itself allow that provider, on a NCA basis, to offer service Y in location A or in location B.[10]

Commissioners and providers are expected to work together in good faith to minimise disagreements relating to prices and payment for NCA, but any formal disputes must be resolved in accordance with the dispute resolution procedure set out in General Condition (GC14) of the Contract; and whilst a commissioner dealing with a provider on an NCA basis may take some comfort from the fact that that provider's host commissioner should be holding that provider to account under the terms of the host's contract, it should always be remembered that it is not their role to monitor the performance of services under the NCA commissioner's implied contract. That is an entirely separate contract, which is for the NCA commissioner to monitor and manage, using the provisions of General Condition 9 (GC9), and Service Condition 28 (SC28) as necessary.[10]

Further details regarding the principles around NCA can be found in the NHS Standard Contract Technical Guidance.[10]

Governance and safety

Referral and referral criteria

The electronic referral system (e-RS) is well established as the principal electronic means of referring patients to outpatient services and aims to provide a full directory of all the secondary care services available under Choice via the Directory of Services as well as those services commissioned locally by ICBs. It is increasingly being used for referrals to mental health services.[12] The NHS Choice Framework asks all referrers to ensure they shortlist on average five choices from which the patient may choose, where this is practicable, clinically appropriate and preferred by the patient.[7]

No prior commissioner approval is required for consultant-led elective care or in the case of mental health, services led by a healthcare professional, where the patient has exercised choice of provider under the legal rights set out in the NHS Constitution.

The judgement on the clinical appropriateness of the referral is for the referring clinician to make and therefore the referrer must be satisfied that the patient's chosen provider can provide safe, effective and evidence based care in accordance with standard quality and patient outcomes.[13] In addition, the referrer must be satisfied that the patient meets the usual clinical threshold criteria for specialist referral in relation to the indication needing investigation as detailed in the relevant NICE clinical guidance or Royal College guidance if available and there is no applicable NICE guidance. NICE Clinical Knowledge Summaries may also provide guidance on key diagnostic criteria and when to refer patients.

Shared care and ongoing monitoring

There are significant concerns regarding ongoing treatment including provision of medication, monitoring and medication review, particularly in relation to who takes responsibility for these key tasks as part of a continuing care plan.

Referrals to specialist providers will often involve treatment with new medicines and requests from the provider back to the GP to prescribe the medication under a shared care arrangement. As the contract is a standard NHS contract, these requests should be considered in the same way as any local request for shared care.

Whilst most of the requests have been in line with current NICE guidance, there have been a few anecdotal reports of requests from private or independent providers, providing NHS services for shared care with primary care which are not in accordance with national guidance and consequently will often be out of alignment with local formularies. In some instances, the provider requests that the GP takes responsibility for the ongoing or continuing care without any shared care agreement or continued support from the specialist team.

The current General Medical Council (GMC) guidance on good prescribing practice, makes several clear recommendations regarding what to consider when requesting or agreeing to shared care[14]

Whilst the decision about who should take responsibility for continuing care or treatment after initial diagnosis or assessment should be based on the patients best interests, rather than on convenience or the cost of the medicine and associated monitoring or follow up, ultimately the prescribing health care professional must be satisfied that the prescription is needed, appropriate for the patient and within their limits of the competence. The prescriber is responsible and liable for any prescription they sign and therefore retains the right to refuse to prescribe any medicine or device. If the patients GP feels unable to agree to shared care with the chosen provider, they must explain this to the patient and any other clinician involved and make appropriate arrangements for continuing care.[14]

This often results in the Right to Choose private or independent provider supplying the medication and conducting the necessary monitoring at a significant financial burden to the NHS under the terms of the original contract when a formal shared care arrangement is not possible between the Provider and the patient's primary care health professional. If the referring GP is likely to have reservations about participation in ongoing care and prescribing, this should be discussed with patient and alternative arrangements considered (i.e. agreeing for another GP to look after the patient for this episode of care).

Where the GP is happy to take on prescribing responsibility, if appropriate, medicines choices can be switched to local formulary choices or products that are in line with national guidance. This should be clearly communicated to the specialist team if prescribing is to be done under a shared care agreement.

Medicines shortages

A National Patient Safety Alert has been issued in September 2023 in relation to current supply disruption and stock shortages with the ADHD medications: methylphenidate, dexamphetamine and lisdexamfetamine.[15] Whilst the reasons for the stock shortages are complex and multi factorial and not solely related to right to choose, increased demand for these medicines is a factor.

This has required good communication between the GP and on-line providers to find alternative treatment options and any similar situation arising in future for other services would also require good communications around medicines shortages and alternative treatment options.

Financial

Patients exercising their legal right to choice of provider and team can highlight areas of unmet demand and in turn can initially cause additional unforeseen financial pressure for integrated care systems in several ways:

- Unplanned costs due to NCA from the out of area contract.
- Most ICBs will provide additional funding on a per patient per year basis to primary care to support the provision of the shared care activity by GPs via a local enhanced service (LES); either known as a shared care LES or near patient monitoring LES.
- Additional and significant ongoing costs can also occur due to refusal of shared care by the patients GP, either as an individual or local system policy regarding the use of shared care. The host contract will often include an agreed private provider fee per patient per year if the GP refuses to accept any ongoing requests for shared care and the private provider then has to make further arrangements for continuing care. Other costs can also be incurred e.g. blood pressure monitors, medicine costs, as well as non-attendance or "did not attend" (DNR) charges, in accordance with the original contract.

Where the provider supplies medication, there is an inherent lack of transparency as the data cannot be scrutinised and benchmarked against other providers and is therefore difficult to monitor as part of the contract oversight process.

Quality assurance and oversight

ICB responsibilities

There are several specific responsibilities ICBs have to ensure legal rights to choice operate effectively. These are set out in the NHS Standing Rules and include:

- Duty to ensure patients are offered a choice of provider and team
  - » Commissioners have a duty to ensure patients they are responsible for are offered a choice of provider and team for outpatient appointments where the legal rights apply. This includes rectifying when informed that patients were not offered these choices at the point of referral.
- Duty to publicise and promote information about choice
  - » ICBs and NHS England must ensure that the availability of choice is publicised and promoted to patients so they can exercise their rights in a meaningful way (in line with constitutional commitments).
- Duty to offer an alternative provider and team when maximum waiting times are exceeded.

If a patient's consultant-led treatment has not, or will not start within referral to treatment (RTT) waiting times then patients can ask to be offered suitable alternative providers and teams. ICBs must take all

reasonable steps to offer alternative provision and where there is more than one alternative provider/ team who can deliver treatments more quickly, a choice should be offered to patients.[7,8,9]

In addition, from a public value-for-money perspective, it is important that, where a commissioner receives an invoice for the first time from a provider with which it does not have a written contract, it checks the basis on which that invoice is being submitted before making any payment in respect of that invoice, rather than simply paying it without question. Checking that the provider does indeed hold an NHS Standard Contract with another commissioner, which properly entitles it to provide those specific services to the first commissioner's patients, at the location at which they have been provided, and on an NCA basis, will be a necessary first step. A provider wishing to provide services on an NCA basis must, on request, share with the NCA commissioner full details of the written, signed contract/contracts it holds with another commissioner/other commissioners and on which it is relying in order to undertake NCA or right to choose activity. Having a written contract will always be more robust and clearer than having an implied contract on an NCA basis; there will be less scope for misunderstanding and dispute with a written contract in place. Written contracts, using the NHS Standard Contract format, should be put in place by commissioners with a provider in all cases where there are established flows of patient activity with a material financial value.[10]

NHS England responsibilities

NHS England has regulatory responsibility for oversight of the patient choice requirements.[7] NHS England's power to enforce certain requirements that commissioners must comply with relating to patient choice is set out in the NHS Standing Rules.[9]

These requirements safeguard the rights of patients, set out in the NHS Constitution, to choose who provides their health care in certain circumstances.[4,7,8]

Where possible NHS England also undertakes informal work to help resolve ongoing issues and advise commissioners of their obligations under the Regulations by providing advice, understanding barriers to choice and supporting compliance, as well as ensuring individual patients can access appropriate referrals where they have a legal right to choose their provider.[8]

The NHS England National Choice Team (NCT) offers support to commissioners, providers, regional teams, national programmes and the wider system and manages enquiries and complaints from the public, organisations, commissioners and providers.[8] The NCT can be contacted via england.choice@nhs.net

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