



Practice Based Commissioning
Choice and Contestability
at a glance

Increasing the choices open to patients is central to NHS health reform strategy, and practice based commissioning is an important mechanism for making this a reality.

- **Choice policy** is aimed at giving patients access to genuine options regarding where, when and how they are treated as well as being given the support they need to help them decide.
- **Contestability policy** is about ensuring the choices commissioned on behalf of patients are the very best possible in terms of patient care and value for money.

What is *Patient Choice*?

In 2004 patients awaiting treatment in London were given the choice of quicker treatment at alternative hospitals and this was rolled out nationally throughout the year. From January 2006 patients have had the right to choose from at least four providers when they need hospital treatment. The Extended Choice network was launched by the government in May 2006, extending choice to NHS Foundation Trusts and approved Independent Sector Treatment Centres. The Department of Health is now scoping how Choice can be extended beyond time and place towards the type of treatment open to patients.

Initiative	Nationally from	Choices for Patients
Choice at 6 Months	August 2004	To be treated quicker somewhere else if patient waits over six months for treatment
Choice at Referral	January 2006	Choice of date, time and location for first outpatient appointment from at least 4 providers
Extended Choice	May 2006	As above, but many more providers including NHS Foundation Trusts and approved independent sector treatment centres (ISTCs) from a new national menu
Free Choice	April 2008 (phased implementation by specialty during 07/08)	Choice of any provider that meets eligibility criteria and NHS clinical and financial standards (for patients who need planned elective care).
Wider Choice	To be confirmed	Including choice of primary care provider, treatment for long term conditions, choices at different points in the patient pathway.

What is included and excluded from *Patient Choice*

Since January 2006 patients have been entitled to a choice of provider for first out-patient appointment. However, choice currently applies only to consultant-led services. This means that patients can be referred to a GP-led or nurse-led clinical assessment or triage service in a

primary care or community care setting without offering choice of provider. If however a consultant-led service is offered in a primary care or community care setting, then patients should still be allowed to choose from at least four providers.

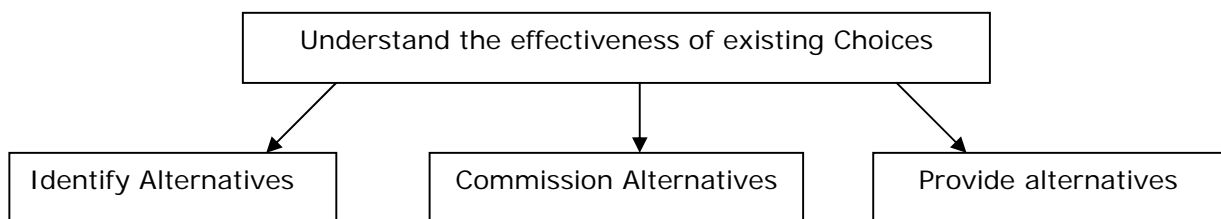
Choice is **not** currently being offered where speed of access is paramount (e.g. Cancer 2 Week Waits and Rapid Access Chest Pain clinics). There is also no obligation to offer Choices where the type of treatment pathway is as important as the location (e.g. Long Term Conditions, Mental Health and at the end of life).

However, these rules may be changed in the future. The Department of Health is looking closely at how the number of "choice points" along the patient pathway can be increased, and it is likely that choice of primary care provider will be introduced in the future. Work has begun with pilots, and best-practice guidelines are under development to embed the concept of choice within patient pathways and treatment plans.

It is in these areas (choice of treatment or pathway) that the innovations in service delivery facilitated by PBC can start to make the most impact. This may be particularly true in rural areas where existing elective choices are more difficult to access due to distance or availability.

Choice and PBC

PBC allows primary care to:



Practices and PCTs need to be aware of the rules governing when choices should be offered to patients and how they can be presented to patients.

Ensuring contestability

PCTs have an obligation to ensure genuine contestability (choice) of healthcare provision to their population. Genuine contestability, where patients are exercising the choices open to them and where money follows patients (under the set PbR tariff), encourages providers to compete with each other on the quality and appropriateness of their services. For non-tariff (closer to home) services, people should use benchmarking costs or other methods to assure value for money, if tendering has not been necessary (see paragraphs 3.40 and 3.41 in *PBC: Practical Implementation*, DH, November 2006). The choice and contestability policies should therefore be a means to improving the quality of services overall.

To increase contestability of services primary care clinicians may identify new providers or wish to provide services themselves. Because of potential conflicts of interest for GPs who may be commissioners and also potential providers the procurement and contracting process must be entirely transparent.

Further clarification on governance and accountability arrangements and on the procurement routes for new clinical services (including the clarification of when tendering is required) are provided in the November 2006 policy guidance, *PBC: practical implementation*.

Developing services when 'choice' is not offered

To ensure that all 'closer to home' health services are patient-focused it is particularly important to engage stakeholders and patients in service development for those services where referrers are under no obligation to offer a choice. PCTs will be required to have an increasingly formal interaction with their population to ensure their needs are being met. This includes the new PCT prospectus and Local Involvement Networks (LINks). Further details can be found in the framework for patient involvement, "A Stronger Local Voice" which was published alongside the Commissioning Framework in July 2006.

Frequently asked Questions

Q: Why should GPs bother getting involved in commissioning alternative services if they may not be providing it?

A: GPs have a dual role of controlling how they would like their indicative budgets spent (in partnership with PCTs), and providing the services for the budget to be spent on. If new services offer improvements in both patient experience and value for money the practice will gain at both points. By ensuring transparency and contestability in the procurement process new providers are challenged to ensure they are proposing the best for patients on both levels.

Q: How can we ensure patients are not influenced too strongly by GPs who may be providing services themselves?

A: Many factors influence the choices patients make. These include proximity to home, information they receive through the media or PCT and the recommendations of both friends and their GP. If PCTs or other providers feel that patients are being unduly influenced then they must ensure information about all options gets to patients and that the alternatives are what they want.

Q: The November 2006 PBC Practical Implementation guidance refers to the principle of offering patients a choice of provider in primary care. Is this set out in formal guidance?

A: No. Formal guidance has only been issued concerning patient choice in secondary care, and this does not currently cover instances where primary care provides similar services. At the moment the principle of offering patient choice in primary care is only a direction of travel in which PCTs should be heading.

Further Information

Department of Health practice based commissioning policy documents can be found at:
<http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Commissioning/index.htm>

- Practice based commissioning: practical implementation, DH, November 2006
- Commissioning Framework, DH, July 2006
- A stronger local voice, DH July 2006

Department of Health choice policy documents can be found at:
<http://www.dh.gov.uk/en/Policyandguidance/PatientChoice/index.htm>

- Choice matters: increasing choice improves patients' experiences, DH, 31 May 2006
- Choice at referral- guidance framework for 07/08, DH, 30 May 2007