Department of Health

Our NHS care objectives

A draft mandate to the NHS Commissioning Board

Annexes

DH INFORMATION READER BOX

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covering the broad aims of each domain
Twenty-seven improvement areas
looking in more detail at key areas within each domain
Sixty indicators in total
measuring overarching and improvement area outcomes

The NHS Outcomes Framework 2012/13
at a glance

*Shared responsibility with the public health system and Public Health England and local authorities - subject to final publication of the Public Health Outcomes Framework.

** A complementary indicator is included in the Adult Social Care Outcomes Framework

***Indicator replicated in the Adult Social Care Outcomes Framework

Indicators in italics are placeholders, pending development or identification of a suitable indicator.

Annex B: Key measures for assessing progress

Chapter 2: Improving our health and our healthcare

Objectives 1-8

- Objective 1: Secure an additional X life years for the people of England, through the reduction of avoidable mortality, by 2015; X life years by 2018 and X life years by 2023.
- Objective 2: Increase the number of Quality Adjusted Life Years[1] for people in England with long term conditions to X by 2015; X by 2018; and X by 2023.
- Objective 3: Improve recovery from illness or injury through increasing the number of Quality Adjusted Life Years for NHS patients in England by X by 2015; X by 2018; and X by 2023.
- Objective 4: i) Increase the proportion of NHS patients in England who would rate their experience as "good" (an additional X patients by 2015); ii) increase the proportion[2] of patients who would recommend their hospital to a family member or friend as a high-quality place to receive treatment and care; iii) increase the proportion of doctors, nurses and other staff who would recommend their place of work to a family member or friend as a high-quality place to receive treatment and care; and iv) provide evidence that poor performance is being tackled where patients and/or staff say they would not recommend their hospital to family members or friends as a high-quality place to receive treatment and care.
- Objective 5: Improve patient safety, reducing Quality Adjusted Life Years lost to NHS patients in England through avoidable harm by X% by 2015; X% by 2018; and X% by 2023.
- Objective 6: Ensure continued improvement of health outcomes, as measured by the indicators in the NHS Outcomes Framework, in relation to baselines set out in the technical annex.

1 This is subject to establishing meaningful data and a baseline. The patient aspect of the "friends and family test" currently only applies to acute inpatient and A&E services. We will be undertaking further work to establish the feasibility and costs of implementing it more widely.

2 Quality Adjusted Life Years (QALYs) attempt to capture the importance of quality of life as well as the length of life. This means that increased quality of life will be reflected in the number of QALYs for people with long-term conditions, even if life is not extended.

- Objective 7: Provide an assessment of progress in narrowing inequalities for all domains of the NHS Outcomes Framework, and work towards a greater understanding of effective interventions to narrow health inequalities.
- Objective 8: Ensure continuous improvement in reducing inequalities in life expectancy at birth (as measured by the Slope Index of Inequality[3]) through greater improvement in more disadvantaged communities.

Key measures for assessing progress

- Evidence that all objectives are being met. Baselines are set out in the technical annex.
- Evidence of progress towards the outcomes which the NHS Outcomes Framework indicators track, as well as improvements of the indicators themselves.
- In relation to objective 4:
  - Collection of standardised data across all acute inpatient wards and A&E services from April 2013.
  - Publication of available data at ward and A&E level (as well as aggregated to Trust level) from April 2013, in a way that is meaningful to the public and informs choice and accountability.
  - Ensuring that local feedback data, including data from the friends and family test, is acted upon to improve services and root out poor care.
  - Development of a robust and meaningful national measure for use beginning in April 2014, with improvements against a baseline established from 2013-14 performance.
  - Measurable improvements in national performance from April 2014.
- In relation to objective 6, the technical annex sets out the baselines against which progress will be assessed for the indicators in the framework, and expectations of performance for indicators which are currently declining or flat.
- In relation to objective 8, the technical annex sets out the baseline against which progress will be assessed.

3 The Slope Index of Inequality (SII) summarises social inequalities across a whole population in a single number, which represents the gap in health status (e.g. as measured by life expectancy) between the most and least deprived within the population. It is based on a statistical analysis of the relationship between the indicator and deprivation across the whole population.

Objective 9
• Develop a collaborative programme of action to achieve the ambition that mental health should be on a par with physical health.
Key measures for assessing progress
• Improving Access to Psychological Therapies (IAPT): Of those completing treatment it is expected that at least 50% will recover. • Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%. • Evidence that commissioning plans for mental health are proportionate to assessed local needs. • Agreed timetable for development of national quality and outcome measures for mental health services.

Objective 10	
• Uphold, and where possible, improve performance on the rights and pledges for patients in the NHS Constitution and on the service performance standards set out below.	
Key measures for assessing progress	
• Demonstrate that performance on the rights and pledges for patients in the NHS Constitution that are not specifically mentioned below are being upheld and where possible that performance has improved. • Demonstrate that performance is being upheld and where possible improved on the following service performance standards:	
Referral to treatment (RTT) waiting times for non-urgent consultant-led treatment	Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%
Diagnostic test waiting times	Patients waiting for a diagnostic test should have been waiting no more than 6 weeks from referral – 99%

A&E waits	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%
Cancer waits – 2 week wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%
Cancer waits – 31 days	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%
Cancer waits – 62 days	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set
Category A ambulance calls	Category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately) Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%
Mixed Sex Accommodation Breaches	Minimise breaches

Objective 11
• Develop a collaborative programme of action (to commence by April 2014) to further the ambition that healthcare professionals throughout the NHS should take all appropriate opportunities to support people to improve their health.
Key measures for assessing progress
• Evidence of the development of a programme of action by April 2014, working in partnership with professional bodies, Health Education England, and Public Health England. • Evidence that delivery of that programme is underway by April 2014.

Chapter 3: Putting patients first

Objective 12
• Enable shared decision-making, and extend choice and control for NHS patients. This includes: – ensuring that commissioners support people to be involved in decisions about their care and treatment; – extending the availability of personal health budgets to anyone who might benefit; and – subject to the outcome of pilots during 2012/13, ensuring that patients are able to choose from a range of alternative providers if they either have waited, or are likely to wait, for more than 18 weeks after referral to start consultant-led treatment for a non-urgent condition.
Key measures for assessing progress
• Evidence of the Board's role in: – commissioning that supports people to be involved in decisions about their care and treatment; – demonstrating that patients are as involved as they want to be in decisions about their care and treatment; – delivering and enforcing with immediate effect the rights to make choices about healthcare as set out in the NHS Constitution and associated documents; – continuing the extension of the Any Qualified Provider (AQP) policy in community and mental health services where this is in the interests of patients and aligns with local priorities. The 2012-13 NHS Operating Framework asked Primary Care Trusts (PCTs) to ensure that at least three services are delivered through AQP, and we expect phased implementation of AQP to continue where appropriate;

- extending choice in primary care (choice of GP practice), subject to the outcome of pilots; in secondary care (choice of named consultant led team or for secondary mental health services, choice of the team led by a specific professional); and in maternity care wherever possible;
- extending personal health budgets more widely to anyone who might benefit, especially those with long-term health needs, informed by evidence from the pilots;
- ensuring that personal health budgets are available for anyone eligible for NHS Continuing Healthcare, and to children with special education needs or disabilities, from April 2014;
- subject to the outcome of pilots during 2012/13, ensuring that patients are able to choose from a range of alternative providers if they either have waited, or will wait, for more than 18 weeks after referral to start consultant-led treatment for a non-urgent condition;
- ensuring that patients are aware of the choices available to them; and
- ensuring that, where appropriate, personalised care plans are available to all patients with long-term conditions and that they are developed and agreed with a named professional.

Objective 13

- Ensure that the new commissioning system promotes and supports the integration of care (including through joint commissioning) around individuals, particularly people with dementia or other complex long-term needs.

Key measures for assessing progress

- Evidence that:
  - the Board has provided leadership and practical support for CCGs on commissioning integrated services;
  - the Board has prioritised investment in social care services which support the health system;
  - system levers and incentives, such as contracts and currencies, have been developed with a view to enabling integration;
  - the Board has effectively engaged with service users, local and national partners, including local government, in determining packages of care that are patient-centred;
  - patients report more integrated care – to be measured by a new indicator in the NHS Outcomes Framework; and

  - commissioners are jointly commissioning health and social care services with local authorities (using pooled budgets where appropriate) for key populations requiring integrated approaches; and, if not, can demonstrate that they have fully and properly explored the potential benefits of doing so.
- We will also look at the symptoms of fragmented care, including delayed discharge, inappropriate admissions, and missed appointments. For example, we will look specifically at unnecessary time spent in hospital by people with dementia.

Objective 14
• Improve the quality and availability of information about NHS services, with the goal of having comprehensive, transparent, and integrated information and IT, to drive improved care and better healthcare outcomes.
Key measures for assessing progress
• Evidence of: – easy and quick access where appropriate to patient records, for patients and professionals (including social care professionals); – increased use of technology to improve care and make health services easier to interact with (e.g. the ability for people to book appointments online); – fast and efficient transfers of information through different healthcare settings (and sharing of information between health and social care), supported by use of information standards; – improved breadth and quality of information (available at the level of clinical teams) about the quality and outcomes of services, including Patient Reported Outcome Measures (PROMs) and clinical audit (collected efficiently and effectively); and – comprehensive information on health services and health, including support for people using information at a local level.

Objective 15
• Improve the support that carers receive from the NHS, in particular by: – early identification of a greater proportion of carers, and signposting to information and sources of advice and support; and – working collaboratively with local authorities and carers' organisations to enable the provision of a range of support, including respite care.
Key measures for assessing progress
• Evidence that carers: – are increasingly identified by health professionals and treated as expert partners in care; – have access to information, advice and support to enable them to care effectively and to look after their own health and well-being; and – are supported to have a life of their own alongside caring, in particular through breaks for carers.

Chapter 4: The broader role of the NHS

Objective 16
• Contribute to the work of other public services where there is a role for the NHS to play in delivering improved outcomes. This includes, in particular: – ensuring that children and young people with special educational needs have access to the services identified in their agreed care plan; – continuing to improve safeguarding practice in the NHS; – contributing to multi-agency family support services for vulnerable and troubled families; – upholding the Government's obligations under the Armed Forces Covenant; – contributing to reducing violence, in particular by improving the way the NHS shares information about violent assaults; and – developing better integrated healthcare services for offenders.

Key measures for assessing progress
• Evidence that children and young people with Special Educational Needs or disabilities have access to healthcare services (including through use of personal health budgets where appropriate) identified in care packages which have been jointly developed and agreed between the NHS, the local authority and the school. • Evidence of continued improvement in safeguarding practice in the NHS, and the maintenance of appropriate and clear responsibilities for safeguarding children, young people and vulnerable adults throughout the system. • Evidence that the NHS is working with troubled families coordinators and other relevant agencies to contribute to the delivery of the troubled families programme. • Evidence that the Board is upholding the obligations under the Armed Forces Covenant, in particular by ensuring no disadvantage to the Armed Forces, their families and veterans in accessing health services (particularly infertility services) when they move locations; and ensuring priority treatment (subject to the clinical needs of others) for veterans requiring treatment for service related conditions. • Evidence of greater integration of healthcare services between custody and community for offenders. • Evidence that commissioners make a contribution to reducing violence, in particular by ensuring that hospitals share anonymous, aggregated assault data with Community Safety Partnerships.

Objective 17
• Ensure that the new commissioning system promotes and supports participation by NHS organisations and NHS patients in research funded by both commercial and non-commercial organisations, to improve patient outcomes and to contribute to economic growth through the life science industries: – ensure payment of treatment costs for NHS patients who are taking part in research funded by Government and Research Charity partner organisations; and – promote access to clinically appropriate drugs and technologies recommended by NICE, in line with the NHS Constitution.

Key measures for assessing progress
• Evidence that the treatment costs for patients who are taking part in research in the NHS are paid by the Board when it commissions services. • Evidence that the Board has used its systems and processes to ensure that treatment costs for patients who are taking part in research in the NHS are paid by CCGs when they commission services. • Evidence that patient recruitment to research in the NHS has increased. • Evidence that performance of the NHS in initiating and delivering clinical research to time and target has increased. • Develop and publish an innovation scorecard to track compliance with NICE Technology Appraisals.

Chapter 5: Effective commissioning

Objective 18:
• Transfer power to local organisations and enable the new commissioning system to flourish, so that: – CCGs are established across England by 1 April 2013; – as many CCGs as are willing and able are fully authorised by April 2013; – CCGs are in full control over where they source their commissioning support; – clinical networks and senates are highly-valued sources of advice and insight to commissioners; – there is a transparent, principle-based system for the Board's interactions with CCGs, including the effective management of poor performance and financial risk; and – there is effective partnership working between CCGs and Health and Wellbeing Boards.
Key measures for assessing progress
• Evidence of progress towards all the components of the objective, for example evidence from surveys of CCGs.

Objective 19
• Ensure that financial incentives for commissioners and providers support better outcomes and value for money; extend and improve NHS pricing systems so that money follows patients in a fair and transparent way that enables commissioners to secure improved outcomes.
Key measures for assessing progress
• Evidence that financial incentives for commissioners and providers support better outcomes and value for money. • Evidence of progress in extending and improving NHS pricing systems as above, including an ambitious work plan to be agreed between Monitor and the Board for developing NHS pricing.

Objective 20
• Support changes in services that lead to improved outcomes for patients. Priority should be given to changes to services which improve outcomes whilst also maintaining access, and changes must meet the Secretary of State's four tests, that there is: – support for proposals from clinical commissioners; – strong public and patient engagement; – a clear clinical evidence base; and – consistency with current and prospective need for patient choice.
Key measures for assessing progress
• Evidence of the Board's role in supporting appropriate service redesigns that lead to improved outcomes and meet the Secretary of State's four tests.

Objective 21
• As part of the work to improve healthcare outcomes, put in place arrangements to demonstrate transparently that the services commissioned by the Board are of high quality and represent value for money.
Key measures for assessing progress
• Evidence of arrangements as set out in the objective.

Chapter 6: Finance and financial management

Objective 22
• Ensure the delivery of efficiency (QIPP) savings in a sustainable manner, to maintain or improve quality in the current Spending Review period and beyond.
Key measures for assessing progress
• Evidence that the objective has been met.

Annex C: The legal duties of the NHS Commissioning Board

The Board's accountability for meeting its legal duties

1. This document summarises the legal duties of the National Health Service Commissioning Board, as set out in the Health and Social Care Act 2012 ("the Act").[1]

2. The Secretary of State and Parliament will hold the Board to account for meeting its legal duties, as well as for its performance against the mandate. The Board must seek to achieve the objectives in the mandate, and comply with any requirements it contains (which must be backed by regulations).

The Board's overarching legal duties and functions

3. The Act makes clear that the Board has an overarching responsibility for promoting a comprehensive health service, concurrently with the Secretary of State (except to the extent that the Board's duty does not cover the Secretary of State's public health functions). The Board must promote a comprehensive health service designed to secure improvements in the physical and mental health of the people of England and in the prevention, diagnosis and treatment of physical and mental illness. Health services must be free of charge, except where charges are provided for by law.

4. In order to discharge the Board's duty under the Act to promote a comprehensive health service, the Act gives the Board the function of arranging for the provision of services for the purpose of the health service in England. The Act also gives the Board specified functions in relation to clinical commissioning groups (CCGs) – functions which the Board must exercise in such a way as to secure that services are provided in accordance with the provisions of the Act.

5. The Board has a number of general duties in exercising its functions:

   - A duty to have regard to the NHS Constitution; to act with a view to securing that health services are provided in a way which promotes the NHS Constitution; and to promote awareness of the NHS Constitution among patients, staff and members of the public.

1 The Act amends the National Health Service Act 2006, inserting the provisions which establish the Board and confer its legal duties and powers. See sections 9 and 23, and Schedule A1, of the Act, available at http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

- A duty to exercise its functions effectively, efficiently, and economically.
- A duty about securing continuous improvement in the quality of health services.
- A duty about promoting autonomy.
- A duty about reducing inequalities, both in the ability of patients to access health services and in the outcomes to be achieved for patients by health services. This builds on the existing legal duties of all public bodies in relation to promoting equality, under the Equality Act 2010.
- A duty to promote the involvement of patients, their carers and representatives in decisions relating to their care or treatment.
- A duty to act with a view to enabling patients to make choices about aspects of health services provided to them.
- A duty to take appropriate advice from people with professional expertise in public health.
- A duty to promote innovation.
- A duty to promote research on health service related matters, and the use in the health service of evidence obtained through research.
- A duty to have regard to the need to promote eduction and training, so as to assist with the Secretary of State's duty to ensure that there is an effective system for the planning and delivery of education and training.
- A duty to exercise its functions with a view to securing that health services are provided in an integrated way where this would improve the quality of those services, or reduce inequalities.
- A duty to take into account the impact of commissioning decisions on services for people who live in an area of Wales or Scotland that is near the border with England.
- A duty to avoid exercising its functions for the purpose of causing a variation in the proportion of services provided by any particular type of provider, such as those in the private (or public) sector.
- A duty to involve the public – for example by consulting them or providing them with information – in plans for commissioning or changing services.
- A duty to establish and operate systems for collecting and analysing information relating to the safety of services provided by the health services.

6. The Board also has a number of specific duties that relate to particular functions; these are summarised below.

Establishing and holding to account clinical commissioning groups

7. The Board's duties include:

- Ensuring that each provider of primary medical services is a member of a CCG; and ensuring a comprehensive system of CCGs is in place, so that the areas of CCGs taken together cover the whole of England and do not coincide or overlap.
- Authorising GCGs, granting applications from any prospective CCG that can satisfy the Board of certain matters including concerning its constitution, the area it will cover, the ability of the applicant to discharge its functions, and appropriate governance arrangements.
- Holding CCGs to account. For example the Board must allocate funding to CCGs; publish guidance for CCGs; and conduct a performance assessment of each CCG every year. It also has powers to intervene where a CCG is failing, has failed, or is at significant risk of failing, to perform its functions.

The Board's direct commissioning of services

8. The Act gives the Secretary of State the power to make regulations requiring the Board to directly commission certain specified services, including prescribed types of dental services, services for members of the armed forces or their families, services for people in prison and other prescribed custodial settings, and such other services as may be prescribed (which it is intended will include specialised services).[2] The intention is to lay regulations using this power in October.

9. The Act also gives the Secretary of State the power to make directions as to the exercise of any functions relating to arrangements for the provision of primary care services and high security psychiatric services.

10. The Act allows the Secretary of State to agree with the Board that it will commission certain public health services on the Secretary of State's behalf.

Partnership working and cooperation with other bodies

11. As part of a set of reciprocal duties for all arm's-length bodies, the Board has a duty to cooperate with Monitor, the Care Quality Commission, NICE, the Health and Social Care Information Centre and special health authorities, in the exercise of its functions.

12. In particular, the Act provides for the Board to work jointly with Monitor to agree the system of prices for paying providers of NHS services.

2 See section 15 of the Act

13. The Board has duties about:

- working with the Department of Health;
- contributing to the work of Health and Wellbeing Boards, as well as other statutory local partnerships of which it is a member;
- working with agencies and organisations outside the NHS in order to improve health and wellbeing and to achieve more efficient and integrated delivery of services; and
- meeting safeguarding duties for children and vulnerable groups.

Emergencies

14. The Board and CCGs have duties to ensure they are properly prepared for emergencies which might affect them. The Board also has duties to take steps to secure that CCGs and providers of NHS services are prepared for emergencies. The Secretary of State may direct the Board to exercise some of his functions relating to emergencies.

Financial duties

15. The Board's duties will include managing overall expenditure on commissioning and on administration within budget, and producing annual accounts that include the consolidated accounts of every CCG.

Annex D: Choice Framework

This is a draft document, published as an illustration to accompany the Government's consultation on the mandate to the NHS Commissioning Board. The document illustrates the Government's intended approach to explaining the choices that will be available for people receiving NHS services as part of the health service in England. For information about the current legal rights to make choices about your healthcare, please see the NHS Constitution. The choices set out here are in many cases subject to ongoing consultation and/or the outcome of pilot studies. As such they may be liable to change.

This is a guide to the choices that you can expect to have over your NHS-funded care and treatment in England. It explains:

- the choices you can expect to be offered about your care and treatment;
- when you can expect to be offered choices about your healthcare;
- where to get more information to help you make informed decisions; and
- how to make a complaint when you are not offered a choice.

The tables that follow explain your choices in the following areas:

Table 1. Choosing a provider for elective secondary care.

Table 2. Choosing your GP practice.

Table 3. Choosing a provider for some community and mental health services.

Table 4. Requesting an alternative provider for consultant-led treatment for a non-urgent condition.

Table 5. Choosing a team led by a named professional when you are referred to secondary care (e.g. a hospital) for non-urgent care as an outpatient.

Table 6. Choosing maternity services.

Table 7. Choosing your diagnostic test provider.

Table 8. Choosing to participate in research.

Table 9. Choosing a personal health budget.

Table 10. Choosing to be treated in another European Economic Area country.

The Government wants to help people make informed choices about the publicly funded services they use. Choice Frameworks will be published to set out and raise awareness of the choices available in publicly funded services, and how to raise a complaint if you are unhappy with the choice of services available.

Choice Frameworks will also be available for the following publicly funded services:

- Early years childcare
- Schools
- Social Housing

1. Choosing a provider for elective secondary care	
a. What choices are available?	You have the right to choose any provider in England for your first outpatient appointment with a consultant or a member of the consultant's team for most acute elective (non-urgent) care. This is a legal right, and is set out in the NHS Constitution. From April 2013, subject to consultation and legislation, you could have the legal right to choose a named, consultant-led team for your first outpatient appointment in secondary care where that is clinically appropriate. From April 2013, subject to consultation and legislation, you could also have the legal right to choose any named consultant-led or professional-led team within your secondary mental health service provider.
b. When is choice not available?	You can only choose a provider that is considered to be clinically appropriate given your condition. And you do not have the legal right to choose your provider if you are referred to: • Services for which it is particularly important to be diagnosed and treated quickly, including: – accident and emergency services; – cancer services for which there is a two-week maximum waiting time; and – services provided at Rapid Access Chest Pain Clinics for which there is a two-week maximum waiting time. • maternity services; • acute secondary care mental health services; or • any other services where it is necessary to provide urgent care. Where services are excluded from the legal right to choose, this does not necessarily mean that you will not be offered an opportunity to make a choice. For example, you can expect to be able to make choices over maternity services as described below (table 6).

	You do not have this right if you are prisoner, a serving member of the Armed Forces, or if you have been detained under the Mental Health Act 1983.
c. Who is responsible for giving me choice?	Your GP, dentist or optometrist must offer you a choice of any provider when referring you to your first consultant-led outpatient appointment. If they do not, your Primary Care Trust (from April 2013, your clinical commissioning group or the NHS Commissioning Board) must make arrangements to ensure that you have a choice. See: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_093004
d. Where can I find information to support my choice?	Please see: • NHS Choices: www.nhs.uk • Care Quality Commission: www.cqc.org.uk
e. What organisations can I approach for support in making decisions?	You have the right to information to help you make a choice. Primary Care Trusts (from April 2013, clinical commissioning groups) are required to publicise and promote awareness of information to help you make choices.
f. How do I complain if the choices outlined in section (a) are not available?	You can complain to your local Primary Care Trust. If the complaint is upheld, the Primary Care Trust is required to make sure that you are offered a choice. Primary Care Trusts (and from April 2013, clinical commissioning groups and the NHS Commissioning Board) have a duty to publish their procedures for complaints relating to these choices. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk Subject to the introduction of secondary legislation, from April 2013 this right to make choices could be enforceable by the independent regulator Monitor, making other forms of redress available.

2. Choosing your GP practice	
a. What choices are available?	You have a right to choose which GP practice you register with. You have the right to express a preference for using a particular doctor within your registered GP practice, and for the practice to try to comply. These are legal rights, and are set out in the NHS Constitution.
b. When is choice not available?	A GP practice should accept you unless it has reasonable, non-discriminatory grounds for not doing so, for instance because you live outside its catchment area or because the practice has gained approval to close its list. Pilots are currently underway testing the best way of enabling people to choose from the widest possible range of GP practices. Under the pilots, GP practices may register patients from outside their normal catchment areas, whilst not having to provide home visits for them.
c. Who is responsible for giving me choice?	You will need to contact the GP practice with which you wish to register. If you are having difficulty registering with a GP practice, contact your Primary Care Trust (from 1 April 2013, the NHS Commissioning Board).
d. Where can I find information to support my choice?	Please see: • NHS Choices: www.nhs.uk • Care Quality Commission: www.cqc.org.uk
e. What organisations can I approach for support in making decisions?	Your Primary Care Trust (from April 2013, the NHS Commissioning Board) will provide information to help you make decisions.
f. How do I complain if the choices outlined in section (a) are not available?	If a GP practice does not accept you (without good reason), you can complain to your Primary Care Trust (from April 2013, the NHS Commissioning Board). If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

3. Choosing a provider for some community and mental health services	
a. What choices are available?	Where commissioners have chosen to commission a service using an 'Any Qualified Provider' approach, you can expect to choose between a range of providers for that service. Choice of provider is being extended for some community and mental health services, where it is in patients' interests. Services which could be included are: physiotherapy, adult hearing services, psychological therapies or podiatry services. The services for which there will be choice of provider will differ from area to area depending on local commissioners' decisions. This is not a legal right, but an area in which you can expect to be able to share in decisions about your care and treatment. From April 2013, you can expect to be able to choose from any qualified provider for a wider range of community and mental health services. It will be for CCGs to decide where it is in patients' interests to use an 'any qualified provider' approach to offer greater choice of provider. As such, the services where this choice is available will vary across the country, reflecting local priorities. These are not legal rights.
b. When is choice not available?	In 2012/13, commissioners have selected at least three community and mental health services identified as local priorities for giving patients greater choice of who provides their care. Choice of provider may not be available for other services. From April 2013, it will be for clinical commissioning groups to decide where to commission services using an 'any qualified provider' approach to offer greater choice of providers. It is expected that the range of services for which choice of provider is available will increase over time.
c. Who is responsible for giving me choice?	You should contact your Primary Care Trust (or from April 2013, your clinical commissioning group) to identify for which local services there will be a choice of who provides your care. If you are referred to one of these services you should discuss the choices available with your GP (or the other health professional who made the referral).

d. Where can I find information to support my choice?	You can find out what choices are offered in your area by contacting your Primary Care Trust or viewing the 'any qualified provider' map: www.nhs.uk/aqpmap. Please also see: • NHS Choices: www.nhs.uk • Care Quality Commission: www.cqc.org.uk
e. What organisations can I approach for support in making decisions?	Your Primary Care Trust (from April 2013, your clinical commissioning group) will provide information to help you make decisions.
f. How do I complain if the choices outlined in section (a) are not available?	You should raise the matter (in writing or by speaking to them) with your practitioner, e.g. your nurse or doctor, or with your Primary Care Trust (or clinical commissioning group or the NHS Commissioning Board, from April 2013) but not to both. Your complaint should be resolved within 12 months. For assistance with your complaint, contact the Patient Advice and Liaison Service available in all hospitals or the Independent Complaints Advocacy Service. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

4. Requesting an alternative provider for consultant-led treatment for a non-urgent condition	
a. What choices are available?	You have the right to request a range of alternative providers if you either have waited or will wait for more than 18 weeks after referral to start your consultant-led treatment for a non-urgent condition. You also have the right to request an alternative provider if you will be waiting to be seen by a cancer specialist for more than two weeks since an urgent referral from your GP, where cancer is suspected. In response to your request, your Primary Care Trust (from April 2013, your clinical commissioning group or the NHS Commissioning Board) must investigate offering you a range of alternative providers that would be able to see or treat you more quickly. These are legal rights, and are set out in the NHS Constitution. From April 2013, subject to the outcome of pilots during 2012/13, you can expect to be able to choose from a range of alternative providers if you either have waited or will wait for more than 18 weeks after referral to start your consultant-led treatment for a non-urgent condition.
b. When is choice not available?	The right to request an alternative provider if you have waited for more than 18 weeks to start consultant-led treatment does not include non-medical consultant-led mental health services or maternity services. These rights will not apply if: • you choose to wait longer; • delaying the start of your treatment is in your best clinical interests, for example where smoking cessation or weight management is likely to improve the outcome of the treatment; • it is clinically appropriate for you to wait longer; • you fail to attend appointments which you had chosen from a set of reasonable options;

	• you are placed on the national transplant list; • you are referred for maternity services; • you refuse treatment; or • your treatment is no longer necessary.
c. Who is responsible for giving me choice?	To request an alternative provider you can contact either the organisation providing your treatment (e.g. your hospital) and/or the organisation commissioning your treatment (e.g. your Primary Care Trust, or from April 2013, your clinical commissioning group or the NHS Commissioning Board). They must take all reasonable steps to offer you a range of alternative providers that would be able to see or treat you more quickly.
d. Where can I find information to support my choice?	Please see: • NHS Choices: www.nhs.uk • Care Quality Commission: www.cqc.org.uk
e. What organisations can I approach for support in making decisions?	Primary Care Trusts (from April 2013, clinical commissioning groups and/or the NHS Commissioning Board) must establish a service for providing advice or assistance to patients whose treatment will be delayed beyond 18 weeks and to publicise that service.
f. How do I complain if the choices outlined in section (a) are not available?	You can complain to your local Primary Care Trust. If the complaint is upheld, the Primary Care Trust is required to take all reasonable steps to offer you a range of alternative providers that would be able to see or treat you more quickly. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

5. Choosing a team led by a named professional when you are referred to secondary care (e.g. a hospital) for non-urgent care as an outpatient	
a. What choices are available?	You can expect to choose a named, consultant-led team for your first outpatient appointment in secondary care. (see: www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_130425) This is not currently a legal right, although may become a legal right, subject to consultation and legislation. Subject to consultation, from April 2013, you could also be entitled to choose a specific professionally-led team when referred for a first outpatient appointment for secondary care mental health services.
b. When is choice not available?	Your choice must be clinically appropriate given the nature of your referral. For example, the provider you choose must offer the service that you require.
c. Who is responsible for giving me choice?	You should contact your Primary Care Trust (or from April 2013, your clinical commissioning group) to discuss the choices available.
d. Where can I find information to support my choice?	Providers are required to publish information about their services so that people can use this to make informed choices about their healthcare. Services listed on Choose and Book should name the responsible consultant or professional to allow you to choose a specific team. New consultant profiles have been launched on www.nhs.uk. These new profiles provide consultants with an opportunity to publish details about themselves and their areas of specialty. Please also see: • NHS Choices: www.nhs.uk • Care Quality Commission: www.cqc.org.uk • www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130450.pdf
e. What organisations can I approach for support in making decisions?	There should be a discussion between the referrer and the patient about where and when the patient wants to be seen. This includes discussion of whether the patient wishes to be referred to a particular named consultant-led team.

f. How do I complain if the choices outlined in section (a) are not available?	Choice of named consultant-led team applies where patients have a legal right to choose their healthcare provider (table 1, above). If you do not feel you have been offered a choice of provider you may complain, as set out above. If you have been offered a choice of provider but not of named consultant-led team then you should raise the matter (in writing or by speaking to them) with your practitioner, e.g. your nurse or doctor, or with your Primary Care Trust (or clinical commissioning group or the NHS Commissioning Board, from April 2013) but not to both. Your complaint should be resolved within 12 months. For assistance with your complaint, contact the Patient Advice and Liaison Service available in all hospitals or the Independent Complaints Advocacy Service. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

6. Choosing maternity services	
a. What choices are available?	You can expect to have the option of going to your GP for a referral to a midwifery service, or going directly to a midwifery service without a referral from your GP. Depending on your circumstances, you can expect to be able to choose to receive antenatal care either from a midwife-only service or from a team of maternity health professionals including midwives and obstetricians. For some women, team care will be the safest option. Depending on your circumstances, you can expect to be able to choose between the following options for where you give birth: birth supported by a midwife at home; birth supported by a midwife in a local midwifery facility such as a designated local midwifery unit or birth centre; birth supported by a maternity team in a hospital. You will be able to choose any available hospital in England. After going home, you will have a choice of how and where to access postnatal care. This will be provided either at home or in a community setting, such as a Sure Start Children's Centre. Depending on where you live, you may have other choices about your maternity care. Contact your local Primary Care Trust (from April 2013, your clinical commissioning group) for information. These are not legal rights.
b. When is choice not available?	In making a decision about where to give birth, you will need to understand that your choice will affect the choice of pain relief available. For example, epidural anaesthesia will only be available in hospitals where there is a 24-hour obstetric anaesthetic service.
c. Who is responsible for giving me choice?	Your midwife will be able to tell you about the choices available locally. Alternatively, you can contact your Primary Care Trust (or from April 2013, your clinical commissioning group) to discuss the choices available.

d. Where can I find information to support my choice?	Please see: • your midwife • NHS Choices: www.nhs.uk • Care Quality Commission: www.cqc.org.uk • The Birthplace in England Research Programme: www.npeu.ox.ac.uk/birthplace • Information Service for Parents:www.nhs.uk/InformationServiceForParents/pages/home.aspx
e. What organisations can I approach for support in making decisions?	Your midwife will be able to give you information, advice and support so that you can make an informed decision. There are a number of charitable and voluntary organisations who are able to support you in your decision making. These include the National Childcare Trust, Birth Choice UK and Association for Improvements in the Maternity Services (AIMS).
f. How do I complain if the choices outlined in section (a) are not available?	Speak to your midwife or the Head of Midwifery in the first instance. You can also raise the matter with your Primary Care Trust (or clinical commissioning group or the NHS Commissioning Board, from April 2013). Your complaint should be resolved within 12 months. For assistance with your complaint, contact the Patient Advice and Liaison Service available in all hospitals or the Independent Complaints Advocacy Service. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

7. Choosing your diagnostic test provider	
a. What choices are available?	You have a legal right to choose from any secondary care provider in England when referred for a diagnostic test undertaken as a consultant-led first outpatient appointment. From April 2013, you can expect to have a choice of diagnostic test provider when referred by your GP for some of the more common diagnostic tests. Subject to consultation and legislation, this could become a legal right in time.
b. When is choice not available?	Choice of diagnostic test provider will only be available where clinically appropriate and safe. It will not be possible to choose who provides diagnostic tests offered as part of admitted or inpatient care or when tests are needed urgently.
c. Who is responsible for giving me choice?	You should contact your Primary Care Trust (or from April 2013, your clinical commissioning group) to discuss the choices available. For example, some Primary Care Trusts may be offering choice of any qualified provider for diagnostics such as Magnetic Resonance Imaging (MRI) and non-obstetric ultrasound. The choices available to you will be listed on the Choose and Book system.
d. Where can I find information to support my choice?	The Choose and Book system will show some information about the appointments listed. Please also see: • NHS Choices: www.nhs.uk • Care Quality Commission: www.cqc.org.uk
e. What organisations can I approach for support in making decisions?	There should be a discussion between the referrer and the patient about where and when the patient wants to be seen. You can contact your Primary Care Trust (or from April 2013 your clinical commissioning group) to discuss the choices available.

f. How do I complain if the choices outlined in section (a) are not available?	You should raise the matter (in writing or by speaking to them) with your practitioner, e.g. your nurse or doctor, or with your Primary Care Trust (or clinical commissioning group or the NHS Commissioning Board, from April 2013) but not to both. Your complaint should be resolved within 12 months. For assistance with your complaint, contact the Patient Advice and Liaison Service available in all hospitals or the Independent Complaints Advocacy Service. Diagnostic tests undertaken as part of a consultant led first outpatient appointment fall under choice of provider (table 1, above), and you should refer to that section if you wish to make a complaint in these circumstances. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

8. Choosing to participate in research.	
a. What choices are available?	You can expect to be offered the opportunity to participate in ethically approved research which is relevant to you, and will be free to choose whether you wish to do so. This is not a legal right.
b. When is choice not available?	If there is currently no research being conducted which is relevant to you, or if you do not meet the criteria for inclusion in a particular research study.
c. Who is responsible for giving me choice?	You should discuss with the clinical team (e.g. the hospital doctor, GP, nurse etc) that is providing your care.
d. Where can I find information to support my choice?	Information to help you decide about participating in research: www.nhs.uk/Conditions/Clinical-trials/Pages/Gettinginvolvedinresearch.aspx www.healthtalkonline.org/medical_research/clinical_trials www.crncc.nihr.ac.uk/ppi/ppi_involve The UK Clinical Trials Gateway provides information about clinical trials that are currently taking place: www.ukctg.nihr.ac.uk/aboutclinical.aspx http://public.ukcrn.org.uk/search/ http://apps.who.int/trialsearch/ You can get mobile phone access to the UK Clinical Trials Gateway via the iTunes and Android stores. Search for "clinical trials" to find the applications for iphone, ipad, android phone and tablet computers.
e. What organisations can I approach for support in making decisions?	The organisations whose websites are listed in section (d) above can help support you in deciding about participating in research. From April 2013, clinical commissioning groups will be required to promote patients' recruitment to and participation in research.

f. How do I complain if the choices outlined in section (a) are not available?	You should raise the matter (in writing or by speaking to them) with your practitioner, e.g. your nurse or doctor, or with your Primary Care Trust (or clinical commissioning group or the NHS Commissioning Board, from April 2013) but not to both. Your complaint should be resolved within 12 months. For assistance with your complaint, contact the Patient Advice and Liaison Service available in all hospitals or the Independent Complaints Advocacy Service. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

9. Choosing a personal health budget	
a. What choices are available?	Personal health budgets are currently being piloted. Subject to the evaluation, clinical commissioning groups across the country will be able to offer them to patients on a voluntary basis. Subject to affirmative resolution and secondary legislation, this will include the use of direct payments by summer 2013. It is the Government's aim to introduce a legal right to a personal health budget for people who would benefit from them, informed by the evaluation. Subject to the evaluation, people in receipt of NHS Continuing Healthcare and children with special educational needs or disabilities will be the first to have this right, by April 2014. This would be a legal right, set out in the NHS Constitution.
b. When is choice not available?	We do not believe personal health budgets will be right for all NHS services a person may receive. For example, they would not be appropriate for acute or emergency care or for GP services. The evaluation will help inform the decision on what NHS funded care can be included in a personal health budget. The evaluation will also help inform the decision on who should be eligible for a personal health budget. Currently the only people excluded from holding a direct payment are people subject to court-ordered drug rehabilitation requirements.
c. Who is responsible for giving me choice?	You should contact your Primary Care Trust (or from April 2013, your clinical commissioning group) to discuss having a personal health budget.
d. Where can I find information to support my choice?	Please see: • NHS Choices: www.nhs.uk • Personal health budget learning network www.dh.gov.uk/personalhealthbudgets
e. What organisations can I approach for support in making decisions?	Contact your Primary Care Trust (or from April 2013, your clinical commissioning group) to discuss having a personal health budget.

f. How do I complain if the choices outlined in section (a) are not available?	You should raise the matter (in writing or by speaking to them) with your practitioner, e.g. your nurse or doctor, or with your Primary Care Trust (or clinical commissioning group or the NHS Commissioning Board, from April 2013) but not to both. Your complaint should be resolved within 12 months. For assistance with your complaint, contact the Patient Advice and Liaison Service available in all hospitals or the Independent Complaints Advocacy Service. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

10. Choosing to be treated in another European Economic Area country	
a. What choices are available?	You have the right to choose, subject to certain conditions, to receive treatment which is normally available to you on the NHS in other countries within the European Economic Area (EEA).[1] This is a legal right set out in EU law. Subject to the legislative process, this will be set out in UK secondary legislation. Subject to consultation, this will also be set out in the NHS Constitution. Under a new EU Directive on patients' rights in cross-border healthcare, you have 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 to you in the circumstances of your case. This means that **your treatment must be one that is available through the NHS.** You then have 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 you will normally have to pay for the full cost of your treatment upfront (though other arrangements may be available via your Primary Care Trust – or from April 2013, your clinical commissioning group or the NHS Commissioning Board). The Directive covers treatment provided in state-run hospitals and services provided by private clinics and clinicians.
b. When is choice not available?	The Directive does not cover: • social care; • access to and allocation of organs (for transplantation); or • public vaccination programmes against infectious diseases In some cases, prior authorisation may be required before you access treatment in another EEA country. This will enable you to confirm that you are entitled to the treatment requested, as well as the level of reimbursement that will apply.

1 The member states of the European union, plus Iceland, Liechtenstein and Norway.

	The process of prior authorisation will also ensure that you are aware of all of the possible treatment options within the NHS, which may be more convenient to you than going abroad. If you are unable to access treatment on the NHS without undue delay in your particular case, you must be granted authorisation.
c. Who is responsible for giving me choice?	If you wish to have your treatment in another EEA country, your GP, dentist or local commissioner must outline the choices that are available to you.
d. Where can I find information to support my choice?	Please see: • NHS Choices: www.nhs.uk • From 2013, you will be able to refer to the NHS Commissioning Board and National Contact Point websites.
e. What organisations can I approach for support in making decisions?	Contact your Primary Care Trust (or from April 2013, your clinical commissioning group or the NHS Commissioning Board) to discuss the choices available.
f. How do I complain if the choices outlined in section (a) are not available?	You can complain to your local Primary Care Trust (from April 2013 your clinical commissioning group or the NHS Commissioning Board). If the complaint is upheld, the Primary Care Trust is required to make sure that you are offered a choice. Primary Care Trusts (and from April 1st 2013, clinical commissioning groups and the NHS Commissioning Board) have a duty to publish their procedures for complaints relating to these choices. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

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