



The Barriers to Choice Review

How are people using choice in public services?

David Boyle

24 January 2013

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Foreword

To: Rt Hon Oliver Letwin, Minister for Government Policy
and Rt Hon David Laws, Minister of State at the Cabinet Office

Cabinet Office

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I am delighted to deliver the findings of the review which you asked me to undertake, with the support of a small team based at the Cabinet Office.

I was asked to look at the barriers faced by disadvantaged people, in particular, when it came to accessing choice in public services, and the results of my work are in this report and the accompanying appendices.

It has been a fascinating journey, meeting service users, professionals and a range of different interest groups around the country. The central finding is that, although people welcome choice in the services they use, there is a minority of people who – for a variety of reasons – are excluded from those benefits, often because they lack the confidence, the information, or the advice that they need.

I am enormously grateful to the many individuals and organisations that helped me by contributing their ideas and experience through the call to evidence, the review sessions and other meetings. I also owe a huge amount to the effective team that supported me, based at the Cabinet Office but from other places too, and the people from government departments who gave so generously of their time and advice. They have all been the most enormous help, although the recommendations and omissions are my responsibility alone.

I very much hope that the analysis and recommendations that were developed in this review will help to extend the benefits of choice – and the scope of choice as well – to a wider population.

Yours sincerely

David Boyle
Independent Reviewer

Executive Summary

This review was set up to answer the question: how do people use the choices they have been given in public services? In particular: how much are these choices used and valued by the most disadvantaged? The review included a call for evidence, a series of round tables around England, a literature review and an extensive survey by Ipsos MORI, the headline findings of which concluded that:

- Somewhere around half the population are currently choosing, but the difficulties vary between different services.
- There is strong public support for being able to choose, but still around a third of the population find it difficult.
- People are generally happy with their service once they get it, even if they had no choice.
- The biggest barriers are a combination of access and information.

Three repeated themes emerged from the round tables, which gave rise to the following questions which this report proposes to answer

1. **How can the system give more power to service users, and especially disadvantaged groups**, given that they are less comfortable about exercising choice, more frustrated by bureaucratic barriers and more affected by other difficulties like transport? There are a range of barriers before people exercising choice which are peculiar to particular services. But there is often an underlying problem, which is that the rhetoric of choice is overlaid across the original system that drives public services – the old systems and financial machinery – which are still in place. Wherever people’s right to choice is in any way ambiguous, those systems can tend to take over and deny them what they want, which makes difficulties for less confident or otherwise disadvantaged people.
2. **How can disadvantaged groups navigate the choices before them**, when they don’t use the internet and are often more bewildered by choices? Access to information, especially in social care, but also across the major public services, is a major problem for disadvantaged people, especially if they do not have access to the internet. This is not just a problem of basic information, but a problem about a lack of signposting and interpretation of that information, which needs to be addressed if people are going to exercise choice more broadly.
3. **How can we align people’s expectations with the reality of choice**, by making services responsive and flexible enough to support disadvantaged people in a more confident use of choice? There is often a gap between what people expect choice to mean for them and what it actually means in practice. The difficulty is that the kind of flexibility in the services that people want, and are increasingly demanding, is also a pre-requisite for many people to exercise any choice at all.

Healthcare

In all the public services the review looked at, it was clear that people without access to computers or cars are at a double disadvantage when it comes to exercising choice, and also that making choice more widely available in practice means providing, not just access to information, but access to personal face-to-face interpretation.

The review also found that strict GP catchment areas are sometimes contributing to the difficulties of accessing GP practices, and that accessing appointments can be a problem for some older or disadvantaged groups. They also found that patients need rights they can use to break through the bureaucratic barriers, so they can have open, honest conversations with doctors, and act on these rights to access healthcare in the way that suits them best. Decisions about abolishing catchment areas will have to wait until the results of the GP Choice pilots have been analysed, but some areas avoid these difficulties by giving practices two sets of boundaries – a strict inner area and a much wider outer area, closer to local government boundaries but not necessarily the same: existing patients can stay on lists if they move within the outer boundary. There were also concerns about the difficulties disadvantaged groups find accessing GP appointments.

Recommendation 1

Build flexibility into the way GPs interact with their patients, by:

- Giving patients, especially from disadvantaged groups, the right to remain with existing GP practices when they move house, irrespective of catchment area. Consideration should be given to drawing up town or city specific catchment areas for this purpose while lessons from the GP Choice pilots are being learned.
- Lead a discussion with the Royal College of General Practitioners and other bodies about how surgeries can better engage with their patients, particularly around issues such as appointment systems.

The review found that people who are less confident or articulate find it more difficult to navigate the choice system, or to make other choices – like how to communicate with doctors or consultants – and that they needed more authority in the system they could use when the existing system frustrates them.

Recommendation 2

Build flexibility into the way patients interact and communicate with hospitals, including:

- Giving patients a right under the NHS constitution to ask for consultations (with either GPs or consultants) using a range of means of communication such as telephone or Skype, where both sides agree it is appropriate.
- Evaluating gaming behaviour and perverse incentives that serve to undermine patient choice and include this in the Choice and Competition Framework.

Social care

The review looked broadly at the social care system and people's experience of it, and particularly at the provision of information across the social care market. Many of the problems the review heard about are covered by the Social Care White Paper and the draft Care and Support Bill, including the need for better information and feedback. The review concluded that there are problems with the complexity of the personal budget system, the bureaucracy and rules around using it, delays in the system in some areas and especially with a lack of information.

Recommendation 3

Make sure that plans for a national website of registered social care providers, currently under construction, will make it searchable by postcode. This will enable people to easily identify residential or home care providers in their local area. Such a national website should include:

- Comparable information about the quality of individual providers, according to measures that are meaningful to service users.
- Opportunities to leave user feedback on provider profiles.
- Access to online decision aids.
- Transparent information about pricing and navigation to other sources of information, local and national.
- Signposting to local information sources (a priority).

There is a need, not just for information, but also for signposting, interpretation and support, and particularly for intermediaries capable of supporting people who prefer not to employ personal assistants directly. The review also decided that the current system assesses people too late in the process, and in a way that emphasises need and financial support. This approach tends to ignore other non-financial resources. The review's proposal addresses not just the complexity of the system, but also the way it waits for people to be in crisis and then over-emphasises needs over strengths and resources.

Recommendation 4

Replace the current entitlement to an 'assessment of needs for care and support' with an entitlement to an asset-based assessment. This would take into account someone's capabilities as well as their needs and the various informal and community resources available to them, rather than assuming that formal services are the only solution to support needs.

The review also heard evidence of a need for a much wider diversity of services, including potential competitors to the more impersonal care providers. The shortage of choice in the market, both for funded care and for self-funders, means that a more diverse social care market is needed. More diverse provision could be developed by encouraging new start-ups and by speeding up the emergence of new micro providers. Policy needs to be designed in such a way that it can tackle a series of related needs for:

- More intermediary organisations capable of supporting people to employ personal assistants.
- Competition to provide alternatives to poor social care providers, and in such a way that provides a better choice for self-funders and provides a standard which can improve services for people on funded care.
- A wider range of services available for people on direct payments.
- People to have access to informal or mutual services, like time banks or help to pool budgets so that they can go further.

The other requirement is that local authorities need to let go their tightening control over where people on direct payments and personal budgets spend their money. The review set out proposals for making it easier for people allocated with personal budgets to spend them in ways that make better sense to them – specifically by phasing out the use of ‘preferred supplier lists’ as a way of narrowing the choice of personal budget holders.

Recommendation 5

Develop a more diverse social care market, by:

- Phasing out the use of preferred provider lists for buying social care services, and in the meantime making sure that they – and virtual marketplaces – are open to new entrants and are not used as the only menu of options in support planning.
- Giving local authorities a duty to signpost social care users to where they can access independent advice and support so that they can spend their personal budget to best meet agreed outcomes.

Schools

The review looked broadly at people’s experience of choice of schools, as well as wider choices that people make in schools, and concluded that some people need more help to steer effectively through an increasingly complex system.

The review also concluded that there is a need to find ways of making sure the least advantaged children have fair access to the best schools, as they define them, without increasing the stresses of the system for everyone else. There are also so many constraints to the expansion of good schools that it would be sensible to find other ways to give the least advantaged more power to overcome their barriers to choice – which means finding ways of making schools feel more responsible for meeting their needs, given that the existing league tables discourage schools from taking Pupil Premium pupils.

Recommendation 6

Devise and publish a parallel ‘opportunity transformation’ league table, comparing the performance of schools in achieving the best outcomes for free school meal children and narrowing the attainment gap.

The review heard about the difficulties parents find in getting hold of detailed information about the subjects, atmosphere and diverse successes of each school and concluded that there was a need for other sources of advice and information. The review also concluded that parents and children at secondary level needed more power to study what they want to, and the report proposes a 'right to request' a different subject. This would not force schools to comply when it is genuinely impossible, but it would encourage them to make an effort – to find ways of teaching after school or swapping with other federated schools, or providing the service for a range of local schools – or explaining why not.

Recommendation 7

Increase the diversity of schools, by:

- Trialing an annual online 'Friends and Family' test for schools, asking parents if they would recommend the school and why, with data collated by Ofsted, and made available, paid for by less frequent inspections of the more successful schools.
- Giving pupils a right to ask to study subjects which curriculum arrangements currently make difficult, with a responsibility for schools to comply or respond with good reasons if they are unable to.

Cross service issues

Two cross-service barriers emerged, both from the round tables organised by the review, and from the Ipsos MORI survey. These are:

- The need for better information about choices, and access to face-to-face advice capable of interpreting it
- The gap between people's expectations of choice and what they actually get

The most obvious barriers to choice which emerged was the simple lack of information that people need to make informed choices across public services, especially where people need more than just data, and require face-to-face advice or interpretation to make sense of it. Most public services have tried to address this problem by experimenting with 'choice advisors' or 'choice navigators', but they were an extra professional cost and most have now disappeared, though there are some exceptions. The Ipsos MORI survey found that 38 per cent of people named face-to-face, independent support as necessary for them to exercise choice.

The review, therefore, proposes that existing peer-to-peer or co-produced services, and existing service volunteer schemes like hospital friends, should pilot a trained extension to their role to provide more formal choice advice to other service users. If this turns out to be cost-effective, it would be a forerunner to a more ambitious attempt to roll out peer-to-peer support networks across public services. Local groups could be linked together through a national network which would be diverse and locally controlled. This would bring the energy and effectiveness of the co-production approach to public services in every area.

Recommendation 8

Pilot training for volunteers and mentors in ten existing peer support programmes, mainly but not exclusively in health settings. Evaluation should be carried out over a two year period to examine how well choice, option and navigation support can be provided in that way and the impact that has – with a view to providing peer support much more widely in public services.

There is a paradox at the heart of the review findings which has implications about the way disadvantaged people use choice. Polling evidence shows that the most disadvantaged people are the most enthusiastic about choice in theory. On the other hand, as the review team consistently discovered in their round tables, the most disadvantaged tend also to be the most suspicious about choice in practice. This is not just a peculiar anomaly. It is potentially a barrier to the development of public service choice, because what people think they are being offered under the banner of choice is sometimes different to what they actually get.

The review drew the following conclusions from this:

- The choice agenda is politically unstable because it has been too focused on competition, and not focused enough on the other choices people actually want.
- Broader measures are needed to make public services more flexible for individuals and to increase their bargaining power.
- Choice needs to be extended to other services which focus particularly on disadvantaged people.

These issues require the choice agenda to be broader than simply competition between rival service providers, important though that is. The review heard repeatedly how important service users feel it is to be treated with dignity and respect. People assume they have the right, when this is not forthcoming from professionals, to move somewhere else, on the very rare occasions when their children are bullied at school or when consultants are less than respectful.

This choice exists already, in effect, for people using direct payments or personal budgets, as long as their own choice of provider is genuine. In some other services, it can be a choice that is dragged out of the system by articulate service users but nobody else, and always under the threat that they will have to go back to the beginning, and will need tests and assessments repeated. The report proposes a similar package to the one that that requires banks to make shifting simple, and which returns customers to the status quo in their new bank.

Recommendation 9

Pilot the idea of giving health and social care users the formal Choice to Switch providers, in extremis, and to go to another provider with capacity, using existing data, to the same position in the queue.

The review also heard from a range of people who wanted the choice to opt for flexibilities within their service – to talk to consultants on the phone, to study a different combination of subjects at school, to be put to bed by carers later than 5pm. There is a case for this to be a new cross-service Right to Request Flexible Service Delivery. In each case, the provider would not be obliged to provide it if it is impossible, but they would be obliged to explain why and that letter would have to be posted on their website.

This kind of right has a political power beyond its immediate effect. It could potentially shift power in the system and do so without expensive changes in institutional framework. But it requires some consideration across government about the best way in which it can be made effective. Either way, the broad choice agenda needs to embrace the kind of shared decision making between users and professionals that is required to underpin progress so far, to improve treatment and share responsibilities better between professionals and clients. The implication of the choice agenda – so far unrealised – is that everyone might not be treated alike, even if they have the same symptoms or problems. It implies that different options are available, and different possible outcomes, and that there needs to be a contribution from the service user to reach that decision.

There needs to be a voice closer to the heart of government which can look critically at regulations that are preventing creative local solutions for social care problems, and at onerous and potentially destructive insurance rules, and which can generate a shared responsibility between leaders in the key government departments, in order to drive a broader choice agenda. At present, the leadership for choice is spread too widely between departments. It makes for the agenda to be articulated and led publicly by the appointment of a key advisor to the Prime Minister.

Recommendation 10

Appoint an advisor to the Prime Minister on broader choice in public services, who will:

- Lead initiatives such as the Right to Request Flexible Delivery of public services.
- Champion broad choice across public services.
- Increase awareness of the need for broader choice.
- Work across departmental and service silos to tackle barriers to choice.
- Advise on complaints procedures.

1. Introduction

This review was set up to answer the question: how do people use the choices they have been given in public services? In particular: how much are these choices used and valued by the most disadvantaged?

To answer it, the review set out to talk to as many service users as possible about their real experience on the ground, to use this evidence to interpret the figures and – as far as possible – to bring reality and rhetoric into a better alignment. There has been polling about choice before now, but this review constitutes an ambitious project to find out about what is *actually* happening on the ground.

The review team also carried out a detailed literature review, commissioned research to fill some of the gaps, and to put some quantitative interpretation on the information gleaned from local round tables with service users and providers. The findings of the literature search are in Appendix G, but the implication is that there is not as much quantitative evidence as expected. There is a weight of research about the economic theory of choice and competition, and how related offers have been seen to work in other countries, but there still remains very little direct research in the UK about how choices are actually used. This report pulls together what research there has been, adds to the insights, qualitative and quantitative, draws conclusions and makes recommendations about overcoming the barriers to choice in public services.

Background and method

The Chief Secretary to the Treasury and the Minister for Government Policy commissioned the review to understand the barriers to choice in publicly-funded services as part of the Open Public Services programme. The review was announced in the Open Public Services 2012 publication on 29 March 2012, which said: “Where choice is available, everyone should be able to exercise it. To address the barriers to choice, we will instigate an independent review to identify the factors that prevent people from understanding and exercising the choices available to them in using specified individual services.”

The independent reviewer began in June 2012, supported by a small team of officials. The terms of reference are in Appendix A. It was agreed that the review would concentrate on services where formal choice already exists, but draw on evidence from broader audiences, including more disadvantaged people.¹ Since the launch of the review in June, the team drew evidence from the following:

¹ The review defined ‘disadvantaged’ along the same lines that Bristol University defined ‘social exclusion’: “Social exclusion is a complex and multi-dimensional process. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in a society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole.” (See: Ruth Levitas et al (2007), *The multi-dimensional analysis of social exclusion*, Bristol Institute for Public Affairs). Disadvantage might not simply be about income but about the range of issues that might exclude them from mainstream life and experiences, whether that is illness, disability or lack of information. Even people on average incomes might be disadvantaged by the birth of disabled child, especially where there are no obvious sources of information to help them.

- 20 round tables with users and professionals were held. These focused on the practical barriers to choice as experienced by service users.²
- In total, 112 users were engaged face-to-face across the country (majority of which are disadvantaged or in more deprived areas). 92 professionals were engaged through the round tables (mixture of practitioners, providers and commissioners of services across public service areas).
- A further 6 meetings were held with local authorities.
- Meetings with 50 specialists, academics and other relevant stakeholder organisations helped provide useful insight through 1:1 meetings.
- 84 organisations (across public, private and voluntary sectors) were invited to provide written evidence (through a public call to evidence) and an opportunity to feed into the review (including other government departments). Approximately 35 organisations and individuals have provided written evidence.

The review had its own space on the Cabinet Office website. There was also a blog www.BarriersChoiceReview.blogspot.com which amassed more than a thousand followers, a twitter account @TheChoiceReview and dedicated email account to which anyone could send views and evidence.

Broad themes

The review carried out a range of round tables (see Appendix D) to hear directly from users of services what their experiences and frustrations were. Three repeated themes emerged from this, and these emerge again in different ways in the sections that follow, giving rise to the following questions which this report tries to answer:

1. **How can the system give more power to service users, and especially disadvantaged groups**, given that they are less comfortable about exercising choice, more frustrated by bureaucratic barriers and more affected by other difficulties like transport? There are a range of barriers before people exercising choice which are peculiar to particular services. But there is often an underlying problem, which is that the rhetoric of choice is overlaid across the original system that drives public services – the old systems and financial machinery – which are still in place and, wherever people’s right to choice is in any way ambiguous, those systems can tend to take over and deny them what they want.
2. **How can disadvantaged groups navigate the choices before them**, when they don’t use the internet and are often more bewildered by choices? Access to information, especially in social care, but also across the major public services, is a major problem for disadvantaged people, especially if they are excluded for whatever reason from the internet. This is not just a problem of basic information, but a problem about a lack of signposting and interpretation of that information. This needs to be addressed if people are going to exercise choice more broadly.

² Examples of user groups seen include: disabled adults (health and social care), elderly (in receipt of social care and personal budgets), NHS patients with chronic or long term illness, parents of children with disabilities e.g. Down Syndrome and diabetes, school children and children in receipt of youth services, parents of school children, ex-offenders.

3. **How can we align people's expectations with the reality of choice**, by making services responsive and flexible enough to support disadvantaged people in a more confident use of choice? There is often a gap between what people expect choice to mean for them and what it actually means in practice. This is partly beyond the scope of this review, which was charged with investigating the choices that already exist. The difficulty is that the kind of flexibility in the services that people want, and are increasingly demanding, is also a pre-requisite for many people to exercise any choice at all.

Basic experience of choice

The review commissioned Ipsos MORI to carry out a survey looking at people's experience of choice in practice and to help put a context on what people were saying at the round tables.³ Headline findings included:

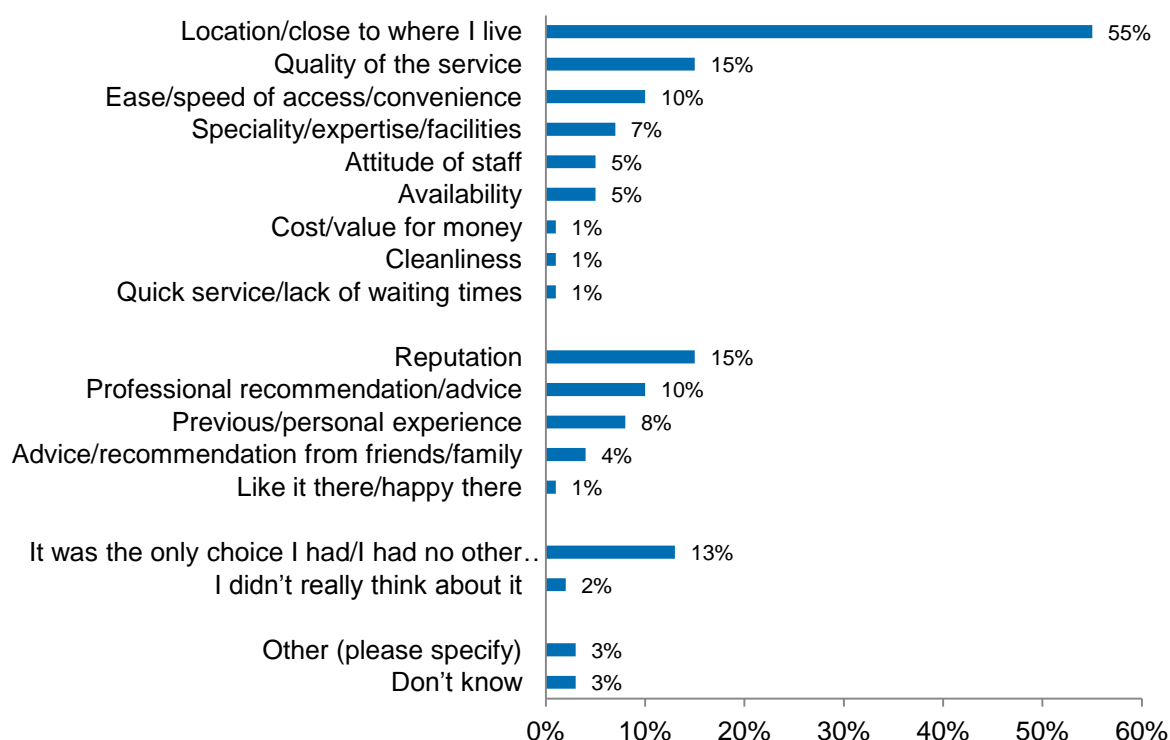
Somewhere around half the population are currently choosing, but the difficulties vary between different services.

The survey found that, across public services, 46% of service users felt they had a choice (51% did not) (see Section 3). This is very different for each service: real choice went down to 35 per cent for hospitals and 27 per cent for social care.⁴ There is also support for this from the finding that 55 per cent chose on the basis of location, which means that choice is not in their cases having a competitive effect, and may in some cases not actually involve choosing at all.

³ The data here is based on 2,573 telephone interviews with English adults aged 18+. The interviews took place over three waves of an omnibus survey (29 Nov-2 Dec, 7-9 Dec, 14-16 Dec 2012). Data have been weighted to match the profile of the population. All respondents were asked a series of four screener questions to establish whether they had recent experience (in the last two years) of: registering a child at a school, registering with a GP surgery, being a patient at a hospital (excluding A&E), or being a user of or carer of someone that uses social care services. If a respondent had experience of any of these services in the last two years, they progressed through to the main part of the survey where they were asked more detailed questions about their attitudes towards and experiences of either choosing a school, GP surgery, hospital, or social care provider.

⁴ Most polls asking people about NHS choice come out with similar findings: see the latest National Patient Choice Survey.

Figure 1. What were the most important factors in selecting your (child's school/provider of support or social care services/GP surgery/hospital)? (N=1485)⁵



There was considerable variation in the Ipsos MORI survey between the different service users. While location is most important for eight in ten (80%) of those registering at a GP surgery, it is only mentioned by 11 per cent of social care users. Those registering their child at a new school (58%) and those who have been to a hospital (57%) hover around the average on this. The difference between the services is largely reflective of the way in which people consume each service. For example, the expectation of walking to a GP surgery or school is a reflection of their local nature, while proximity of a social care provider is less vital given that delivery is often in the users' home.

There is strong public support for being able to choose, but still around a third of the population find it difficult.

As many as 81 per cent believed it was important to have a choice.⁶ Most found the business of choosing pretty simple, and more than three quarters (84%) said they had enough information. Again, there was a difference across services with 41 per cent of social care users saying they found choosing difficult. The people who find it difficult to exercise choices tend to be women, non-white, renters rather than owners and not working.⁷ About 36 per cent experienced some kind of difficulty with choice.

⁵ IpsosMORI, Choice Review Survey 2012

⁶ Women and people with children are more likely to rate choice as important. Evidence from the King's Fund suggests that about three quarters of patients want choice. See: Anna Dixon et al (2010), *Patient Choice: How patients choose and how providers respond*, King's Fund, London. A similar proportion said that they wanted a variety of suppliers (CBI/ACEVO poll, July 2012).

⁷ The BME finding is based on a very low base size,

Figure 2. "It is important to have a choice of service?"⁸

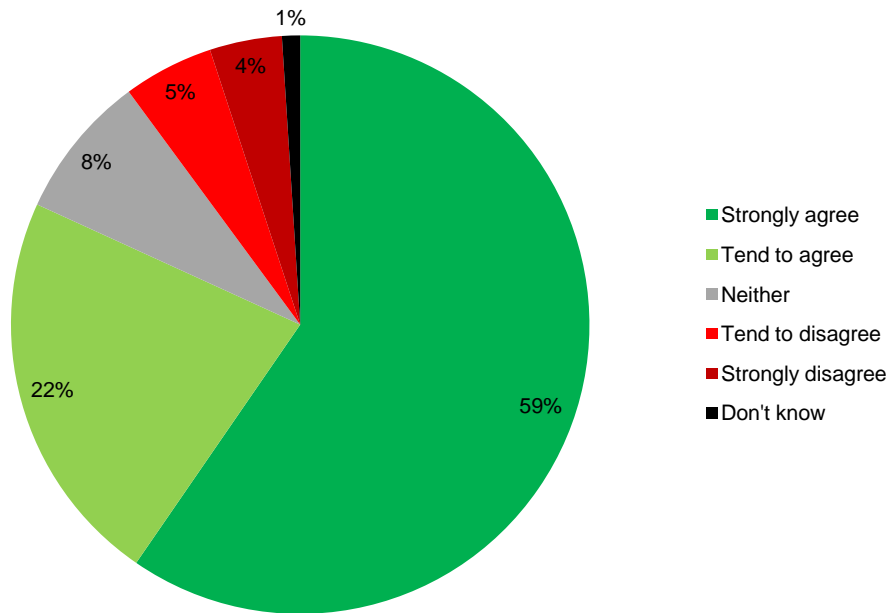
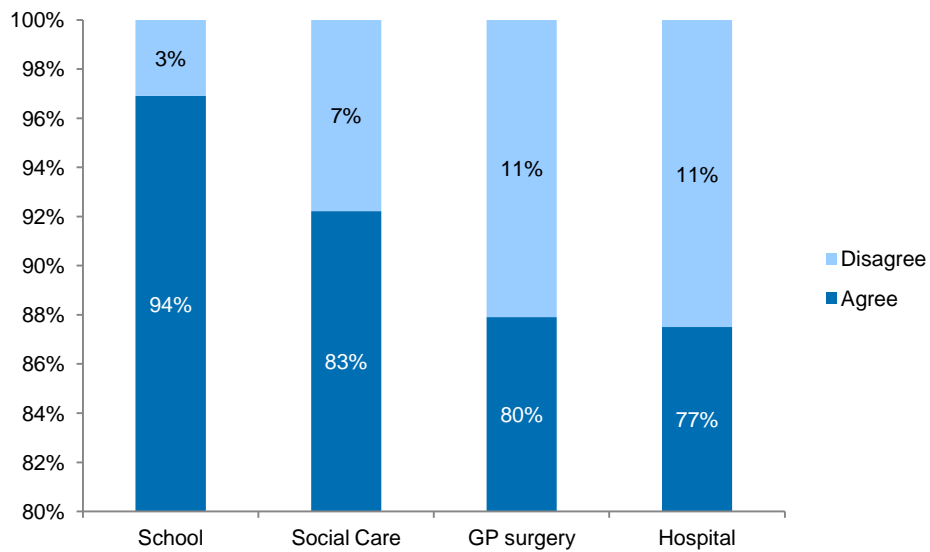


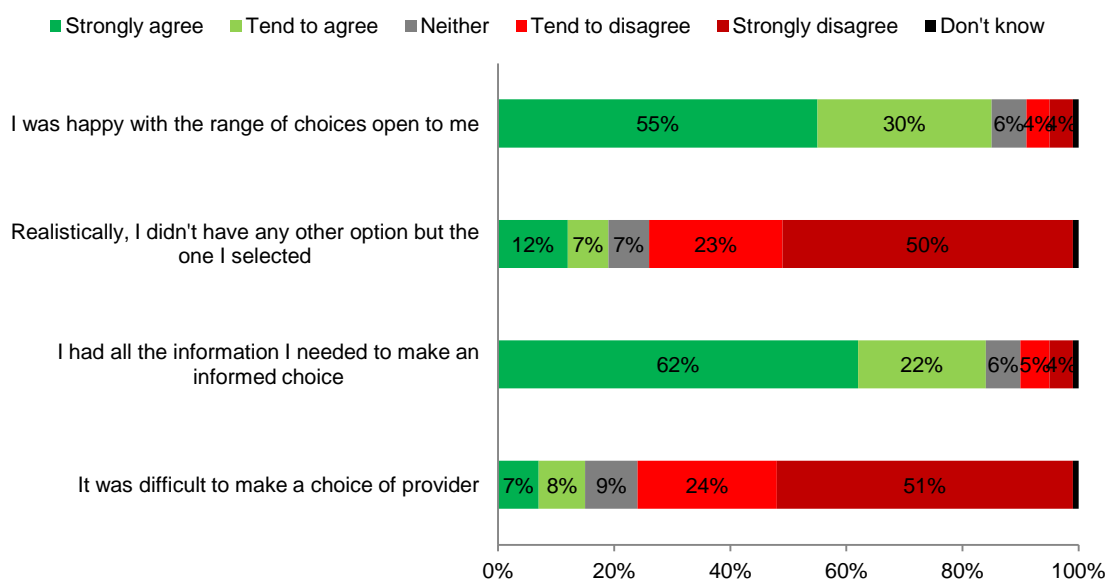
Figure 3. "It is important to have a choice"⁹



⁸ IpsosMORI, Choice Review Survey 2012

⁹ IpsosMORI, Choice Review Survey 2012

Figure 4. To what extent, if at all, do you agree with the following statement?¹⁰



The following table provides some information about who these people are who are finding aspects of choice difficult:

		% agree "it was difficult to make a choice"
Age	Under 55	17
	55+	10
Ethnicity	White	14
	BME	25
Work status	Full-time	13
	Not working	19
Service user	School	22
	Social care	41
	Hospital	6
	GP surgery	13

The review paid particular attention to the experiences of the most disadvantaged people. There is certainly evidence that the least advantaged in society are the most positive about choice.¹¹ But this needs to be weighed in the balance against what might be referred to as the Great Paradox of Choice (see Section 5), that the least advantaged are both the most

¹⁰ IpsosMORI, Choice Review Survey 2012

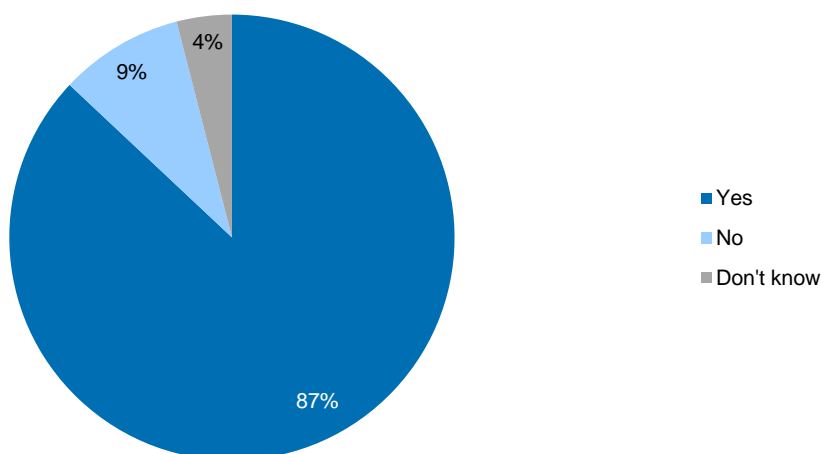
¹¹ Audit Commission (2004), *Choice in Public Services*, London. See also evidence in Sean Worth and Colleen Nwaodor (2012), *Do the Public Back More Reform of Public Services? An overview of the latest opinion research*, Policy Exchange, London.

positive about choice in theory and the most suspicious of choice in practice.¹² This report suggest some reasons why this is the case.

People are generally happy with their choice, even if they had no choice.

Around nine in ten (87%) service users said they got the provider they wanted. When set against the 51 per cent who say they did not have a choice, this suggests that service users tend to be happy with the service they end up with, even if they are not offered a choice. Service users least likely to say they got the provider they wanted are social care users, although even then three in four (76%) got the provider they wanted. This requires some explanation. The answer appears to be that choice is not the biggest priority for them. The review also heard that, in schools and hospitals, there may be an element of *post hoc* justification: people tend to find they are happy with the school they had tried to avoid once their children are pupils there.

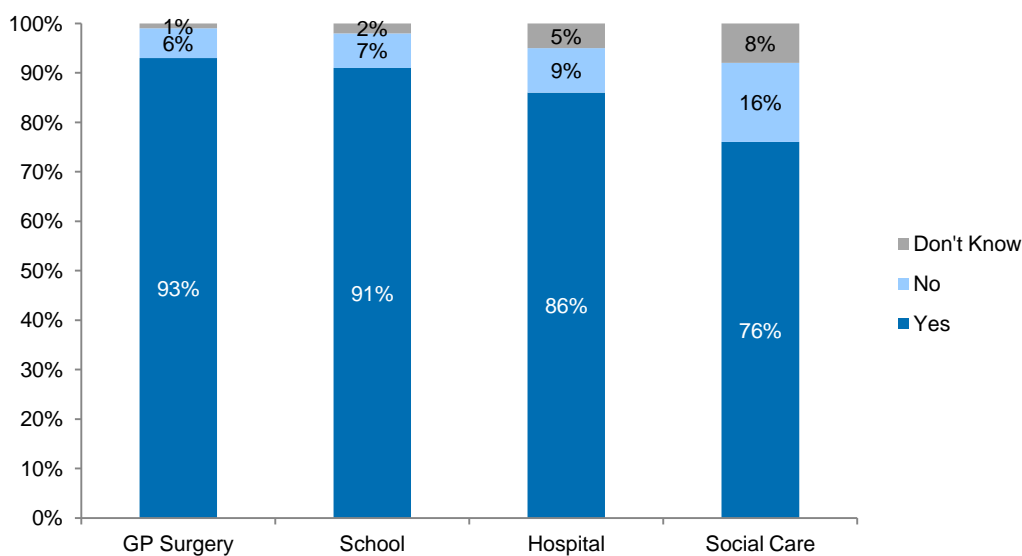
Figure 5. Did you get the (child's school/provider of support or social care services/GP surgery/hospital) that you wanted? (N=1485)¹³



¹² See for example Worth and Nwaodor (2012), and for the scepticism see the MORI research in Aug/Sept 2003 which found that pensioners, working class and BME groups were the most sceptical about feeling comfortable about making choices themselves.

¹³ IpsosMORI, Choice Review Survey 2012

Figure 6. Did you get the (child's school/provider of support or social care services/GP surgery/hospital) that you wanted? (N=1485)¹⁴



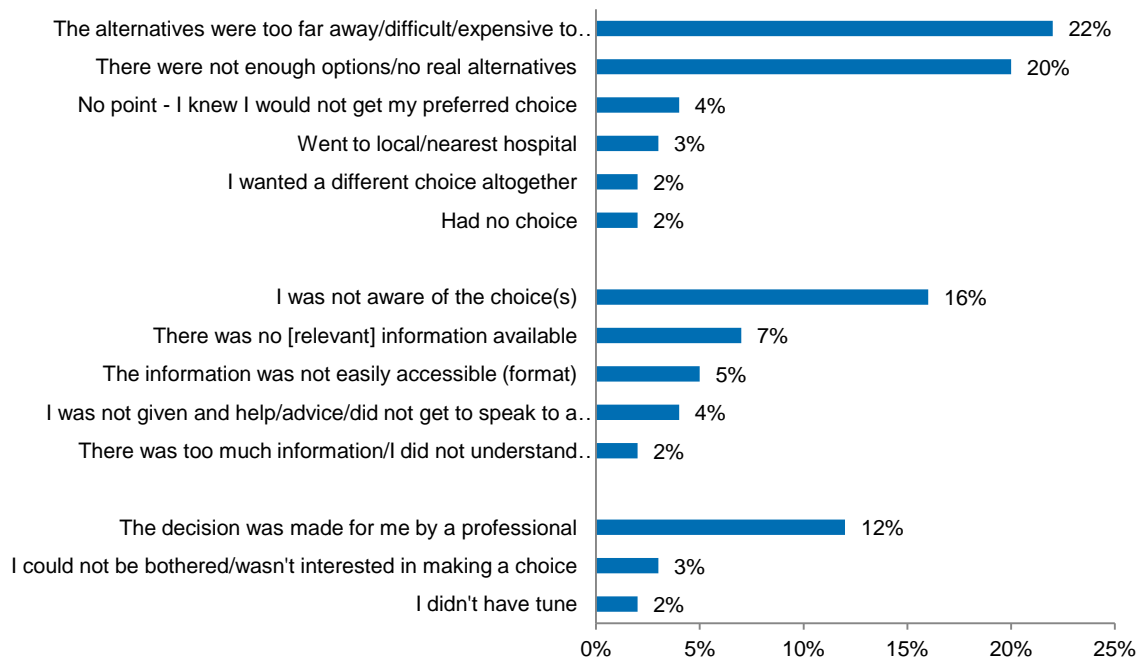
The biggest barriers are a combination of access and information.

The biggest barrier to choice is the difficulty and expense getting to any of the other alternatives (22%).¹⁵ The other main barriers mentioned are not having any other real alternatives (20%), not being aware of alternatives (16%) and having the decision made for them by a professional (12%). Despite the sense that people had enough information, there was a demand for more face-to-face support for choosing (38%) (see Section 5).

¹⁴ IpsosMORI, Choice Review Survey 2012

¹⁵ Respondents who were asked about the barriers to choice include those who said they had difficulties or had no other option. For wave two and three those who said they did not have a choice were included as well as those who said they did not have all the information they needed or were not happy with the choices available.

Figure 7. What were the main reasons why you found it difficult and/or did not feel you had a real choice? (N=702)¹⁶



¹⁶ IpsosMORI, Choice Review Survey 2012

4. Choice in healthcare

The review team concentrated on two aspects of choice in health: choice of hospital and choice of GP. Basic conclusions from the round tables and the Ipsos MORI survey indicated that some patients can be at a disadvantage when it comes to choice, because:

- Disadvantaged groups can face particular difficulties when it comes to navigating the NHS system, accessing GP appointments and, in some circumstances, accessing or registering with surgeries.
- They also can find difficulties, not just accessing information to support choices, but in getting vital advice and interpretation too.
- People often want, and sometimes believe they have a right to, other choices and variations in healthcare, beyond the simple choice of hospital.

A key theme that emerged out of the review round tables (health) is that choice is not necessarily valued for its own sake. It is valued in certain circumstances and at certain times. When that moment to choose comes and when it is valuable to the patient, then the right mechanisms need to be in place to support it. Choice should not always be measured by quantity of providers or the distances people travel. Meaningful choice is about having the right information, the right support, the confidence and ability to take part in joint decision making around health needs and treatment.

Existing choices

As things stand, these are among the rights that people have in healthcare:¹⁷

“You have the right to choose your GP practice and to change to another if you are not happy with the service they receive. The surgery must accept you unless there are good reasons for not doing so, for example, if you live outside the boundaries that it has agreed with the local primary care trust (PCT), or because it has no capacity to take you on”.

“Within your GP surgery, you have the right to say which particular GP you would like to see.”

“If you are referred to a specialist, you have the right to choose which hospital to go to for your first out-patient appointment. There are exceptions to this right, for example in emergency, maternity services and mental health services.”

“You have the right to be involved in decisions about your healthcare and to be given the information they need to do this (and there is information on NHS Choices to help you).”

Current policy

Since publication of the White Paper, *Equity and Excellence: Liberating the NHS*, patients have been given more choice and control over their care and treatment. They have been given more choice about which provider of health services they can use within the NHS. Under Any Qualified Provider (AQP) arrangements, commissioners have extended choice of provider in at least three community services permitting patients to be able to choose from a

¹⁷ Department of Health (2012), *NHS Constitution for England*, London.

range of approved providers, such as hospitals or high street service providers. The Department of Health (DH) has recently set out the choices that have been made available locally and nationally in its Choice Framework, and supporting material raising awareness of where patients can access more choice in healthcare.¹⁸

Research evidence

There is evidence that shows that choice of hospital has begun to drive competition, that people are beginning to choose providers further from home, and that it does encourage a more efficient allocation of resources.¹⁹ Some of the structures, like the Choose and Book appointment system, clearly also carry a cost.

Public support for choice of hospitals is somewhat ambiguous. On one hand, there is overwhelming support for the basic idea.²⁰ On the other hand, this needs to be compared with consistent polling evidence that reveal that other priorities come first for many people.²¹ Research from the King's Fund suggests that about half of all patients are aware that they can choose their hospital. Half are also given a formal choice by their GP about where they want to go for diagnosis or treatment, or they were when this research was carried out in 2009/10.²² Research since then confirms that the figure is probably rising: a recent report by the Policy Exchange which found that 52 per cent of patients said they had a choice of good places for surgery and could access somewhere good.²³ The rising trend was also confirmed by the National Patient Choice Survey 2010, which showed rising awareness since 2006.²⁴ The Ipsos MORI survey confirmed that proximity was the most important factor for people when it came to choosing.²⁵

There seems to be no real difference between people's education, ethnicity or employment status; the same proportion of people are offered choices across the board.²⁶ Yet patients with previous bad experience of a local hospital are more likely to travel to a non-local hospital, as are those with higher levels of education, those who live outside cities and large towns, and older people.²⁷ Recent research by the Centre for Health Economics found no evidence that choice or competition increase inequalities and, if anything, may have slightly increased use of elective inpatient services in poorer neighbourhoods.²⁸

The Ipsos MORI survey (see Section 1) confirmed that proximity to home is the most important factor for choosing a hospital, and overwhelmingly so for choosing a GP surgery.

¹⁸ <https://www.wp.dh.gov.uk/publications/files/2012/12/2013-14-Choice-Framework.pdf>.

¹⁹ See for example Martin Gaynor et al (2010), *Death by Market Power: Reform, competition and patient outcomes in the NHS*, CMPO Working Paper 10/242, Bristol.

²⁰ British Social Attitude Survey (2009), 25th report.

²¹ See Gideon Skinner (2005), 'Public attitudes to choice: an overview', presentation by Ipsos MORI Research Institute, London.

²² Anna Dixon et al (2010), *Patient Choice: How patients choose and how providers respond*, King's Fund, London.

²³ Sean Worth and Colleen Nwaodor (2012), *Do the Public Back More Reform of Public Services? An overview of the latest opinion research*, Policy Exchange, London.

²⁴ Department of Health (2010), *Report on the National Patient Choice Survey, England*, London, Feb

²⁵ Another figure cited was 38%: see Department of Health (2010), *Report on the National Patient Choice Survey, England*, London, Feb

²⁶ Anna Dixon et al (2010), *Patient Choice: How patients choose and how providers respond*, King's Fund, London.

²⁷ Anna Dixon et al (2010), *Patient Choice: How patients choose and how providers respond*, King's Fund, London.

²⁸ Richard Cookson and Mauro Laudicella (2011), *Effects of health reform on health care inequalities: Final report to the NIHR SDO Programme and the DH Health Reform Evaluation Programme*, York University.

School	Social care	Hospital	GP surgery
Location/close to where I live (58%)	Professional recommendation (21%)	Location/close to where I live (57%)	Location/close to where I live (80%)
Reputation (42%)	Quality of service (17%)	I had no other choice (18%)	Ease/speed of access (16%)
Quality of service (29%)	I had no other choice (15%)	Quality of service (12%)	Reputation (13%)
Previous/personal experience (13%)	Reputation (12%)	Professional recommendation (11%)	Quality of service (9%)
Speciality/expertise/facilities (12%)	Location/close to where I live (10%)	Ease/speed of access (10%)	Attitude of staff (9%)

Most GPs interviewed by the King's Fund supported choice in principle, but believed that only a few patients want to choose anywhere further away than their local hospital, and those that do are more likely to be in urban areas, to be younger and better educated.²⁹

Choice barriers

Despite the evidence of support for choice, both in the Ipsos MORI survey and the review found that both patients and professionals are often sceptical about it (see Section 5). Some professionals doubted whether it was important to patients and, most of the time, patients seemed happy with less choice as long as the service they got was good enough. Certainly, most patients are content to ask their GP what they would recommend.³⁰ Yet this is not, in any way, an expression of support for the old days of deference to professionals. Nor does it mean that patients were happy with inflexible, unvaried and invariable services. There was repeated demand for greater flexibility, especially among people with chronic conditions. There is also evidence that patients are generally becoming more confident and more demanding.³¹

"You want it [choice] when you want it – we need to find a way of meeting this need for patients, help them get what they need at the time they need it."

Health professional, Leeds

"No one ever comes to me and says 'I want choice'. They only ever say 'I want help'."

²⁹ Anna Dixon et al (2010), *Patient Choice: How patients choose and how providers respond*, King's Fund, London.

³⁰ Anna Dixon et al (2010), *Patient Choice: How patients choose and how providers respond*, King's Fund, London.

³¹ Al Mulley et al (2012), *Patient Preferences Matter: Stop the silent misdiagnosis*, King's Fund, London.

General practitioner

“Person-centred help is not about giving someone a smorgasbord of choice when all they want is something else, like support and confidence. Choice comes at a later stage.”

Health professional, Leeds

System barriers

The round tables carried out by the review described a range of ways in which more disadvantaged groups are prevented from making the same choices as everyone else, partly because they often have less money (transport) and sometimes because there are barriers and complexities that require people to be more confident and articulate if they are going to overcome them.

Access

The review found three important barriers for disadvantaged groups: access to GP lists, access to GP appointments and lack of affordable transport.

Access to GP lists

There is an argument that choice of GP underpins other kinds of choices in the NHS, because GPs are the main gatekeepers – and if people can choose the right gatekeeper, then they will get the kind of attention and choice, and care they need. But GP practices traditionally operate lists which restrict access on the basis of residence. This means that choice of GP practice is really only a choice within a given locality (provided you can get to it, which many disadvantaged groups and elderly struggle with).

Research suggests that people are pretty satisfied with the service from their GP.³² But for those who are not satisfied, and for those disadvantaged groups that the review set out to talk to, there are difficulties. Basic information is often not available online to compare surgeries, and the bureaucracy can be onerous. The review heard from one patient who was expected to come in two or three mornings in one week, taking that time off work, to fulfil their joining requirements – which means that finding a new surgery can be distressing and exhausting. It is a particularly urgent problem for people with chaotic backgrounds or circumstances. One adolescent girl, who had a frequent change of emergency housing, explained how she had to change GP surgery every time she was moved. This rules out continuity of care, which patients often say is very important. She also suffers from epilepsy and the constant change of GP means constant referrals to new specialists who do not know her history or background.³³

There is a shortage of GPs and surgeries where it matters, and some evidence that the least patient-friendly practices are in the poorest areas.³⁴ Part of the problem is that catchment areas tend to confuse GP choice. The main reason why these remain is that GPs say, quite reasonably, that home visits would be too difficult if patients live far away. The current GP

³²As many as 80% are happy with the quality and access to their GP, according to Ipsos MORI research for the Department of Health in 2005.

³³Professionals consulted in this instance did not understand why the change of GP resulted in the change of consultant and said this should not have happened.

³⁴Veena S Raleigh and Francesca Frosini (2012), 'Improving GP services in England', *Data Briefing*, King's Fund, London.

choice pilots exclude patients from home visits if they live somewhere else, and any extension of that idea would mean that this would have to apply more widely.³⁵ Conclusions will have to wait for the results of the pilots but the implication for this review was that catchment areas may no longer play a useful role.

“I was told the GP surgery was full – but I think it’s because my record said I was a [recovering] drug user.”

Service user, London

“I was registered with a GP until March this year when I informed her that I had moved nearby. I was shocked when she said that I would need to change GPs as I thought that my right to choose meant that I would be able to stay with this GP. I was sent a letter stating that I would be taken off their books by a certain date in April and I would need to find another GP.”

Patient, Manchester

Access to GP appointments

Complaints about getting an appointment to see a doctor was a constant theme at the review round tables with users. Many patients described the appointments booking system as a major barrier because they can often only be booked on the day and it can be difficult to get through on the telephone (some patients believed they were using a premium rate number which added more barriers to disadvantaged groups).

Again, patient surveys suggest that people are largely happy with access to their local surgeries: the most recent GP survey suggests that less than a fifth of patients find it difficult to get appointments, but one explanation could be that the review’s focus on disadvantage resulted in a greater number of users who were dissatisfied.³⁶ The review heard from patients who complained that they were sometimes required to hang on at 8am and again at 2pm. Others complained that their surgery did not allow the flexibility of phone or email consultations with doctors if they wanted them, which means face-to-face appointments were necessary even for minor queries.

The arrangements for making appointments are covered by indicators under the Quality and Outcomes Framework (QOF), but the fact that these complaints emerged so often suggests that these indicators are not effective incentives when it comes to providing more disadvantaged or older patients with what they need. In practice, there is also a move towards doctors running telephone triage systems, which reduce demand but may do so sometimes at the expense of their patients’ time and goodwill. Some surgeries are also allowing patients to go online and book their own appointments, which – while definitely a step forward – may leave those without access to the internet at a disadvantage.³⁷

³⁵ <http://mediacentre.dh.gov.uk/2011/12/30/choose-the-best-gp-for-you/>

³⁶ For most patients (78%) it is easy to get through to someone at their GP surgery on the phone, but almost one in five (18%) patients say it is not easy. Few patients (just 4%) haven’t tried to get through to their GP surgery on the phone. The majority of patients (90%) usually book their appointments by phone, while three in ten (30%) book their appointments in person. Few patients (3% or less) book their appointments online, or by fax machine. /.../ The majority of patients (77%) wanted to see a GP the last time they contacted their GP surgery, and just under a fifth of patients (18%) wanted to see a nurse. Just one in twenty (5%) wanted to speak to a GP on the phone. See: the GP Patient Survey 2011/2012, Ipsos MORI, Summary report.

³⁷ This covers only 3% of patients (GP Survey, Ipsos MORI 2011), so it may not have a huge impact.

“I have to book my illness in advance!”

Service user, Leeds

“It’s the fastest finger first. By 8.10am, all the appointments have gone.”

Community worker, Burnley

Transport

Lack of local transport can make choice difficult for people who are unable to afford cars. Inner city GPs tend to be more positive about choice than their rural colleagues probably for this reason. It also explains why most people choose a hospital close to home or work and why it still remains the single most important factor in choosing a hospital.³⁸ There are patient transport schemes run by hospitals, but people are often not aware of these, and eligibility depends on medical need.

In rural areas, patients can be limited in their choice of GP surgery too if they have no easy access to buses. The review team heard from people who were forced to switch GP practice because the alternative required changing buses twice. This is a particular issue for people with mobility difficulties.

In fact, bus routes were often mentioned by disadvantaged groups as key barriers to accessing both GPs and hospitals. It can also be lonely going to hospital where relatives and friends are too distant to visit, and for many people who find it difficult to afford the transport, it is very hard to choose anywhere that is not local – especially as relatives are sometimes expected to do laundry for their in-patient relatives. It is particularly difficult for people who have to pay bridge or ferry tolls to travel.

Capacity

Capacity is a major barrier to exercising choice. This is particularly so in areas where GP surgeries and new providers are scarce, but also in services which are being run-down because of changes in best practice, like mental health in-patient services.

Mental health is an area that is being opened up to formal choice under AQP rules, but which has traditionally found choice difficult. The review heard that it can be hard to change psychiatrist or provide much in the way of options for mental health in-patients, partly because in-patient services are now used less often, so the capacity is not there. In sectors like these, where capacity is being taken out of the system for good clinical reasons, it does put an extra responsibility to tackle quality.

“When you attempt to choose outside their framework of choice, you are labelled ‘vexatious’. In mental health, if you say you want a different psychiatrist, it is used as evidence that you do actually need that particular psychiatrist.”

Mental health worker, Leeds

Bureaucracy

The sheer complexity of the health system can be a barrier to people exercising choice. This is partly because the old financial architecture of the NHS still operates beneath the

³⁸ Department of Health (2010), *Report on national patient choice survey*, Feb.

mechanics of choice. Where choices are complex, unusual or disputed – or sometimes just where local budgets are tight – the old system of block contracts, individual funding requests etc. tends to predominate. This becomes a barrier where patients are not confident or articulate enough to insist otherwise.

Although patients are given various rights to choose through the NHS Constitution, including the right to choose the first out-patient appointment at a hospital, the system from then on is not designed or aligned to facilitate that choice. For example, the review heard that there are incentives for hospitals to refer patients back to their GP rather than straight on to a specialist within the hospital (due to tariff) causing both cost and delay to the patient. In other instances, patients can sometimes be given options to choose from an existing pre-approved provider list.

The Choose and Book system is intended partly to tackle some of this complexity, but it often provides only one option, and normally all the choices are local. It involves complicated passwords, which are not appropriate for some older or disadvantaged people, and in practice booking usually falls to the booking clerk at GP practice. Booking your own arrangements is still relatively rare, and there are still problems about trusts booking into phantom slots to be cancelled later while they co-ordinate consultants – another example of the old administrative systems continuing to exist beneath the choice systems.³⁹

The review heard that choosing more distant hospitals is certainly possible, but there has to be a clinically sound judgment behind the choice (the GP must justify it in a letter) and the patient has to have thought through the implications of a distant hospital. These can also be difficult choices to make. One patient told the review he had regretted his decision to go to a distant hospital, made on the basis of waiting times as he could not manage the travel required. He was forced to switch to a more local hospital.

Information

A basic pre-requisite for choice is that public service users have to know that it is available. The Ipsos MORI survey suggested that the basic information is relatively easy to access for most people, though there was a strong demand for face-to-face interpretation (see Section 5). But patients at the review round tables talked about how little they knew about the choices before them. Disadvantaged groups like disabled and visually impaired users, in particular, said they did not know or understand what options were available. Nor did they know where to go for information that would allow them to make a choice in health.

“I’d value choice if [I knew] I had it.”

“As individuals – we need to know what choices we have. And beyond that we need advocacy.”

“People are trapped indoors because they are not aware of the choices available to them.”

Service users, Bradford

³⁹ *Pulse* (2012), 24 Oct.

GPs as gatekeepers

Many saw their GP as a crucial gatekeeper for getting access to services. For a brief period, GPs were incentivised to offer a formal choice (and it was during this period that the King's Fund survey was carried out). But the review found resistance from patients and professionals to the idea of formalising the relationship between them too much, because it is often the informality and openness of that doctor-patient relationship which makes the kind of equal two-way conversation about options possible. If professionals are going to be prevented from giving advice – the 'what would *you* do?' question – it would seriously impoverish the relationship they have with patients, and in practice that would undermine choice for the least confident.

One difficulty is that doctors have only eight to ten minutes (in the average consultation) to explain complicated options to patients, especially if they have complex needs.⁴⁰ Nor are patients always practised in the art of asking the right questions in order to reach a decision that will satisfy them later.⁴¹ Consultations are often too short to allow a genuine conversation to take place, which is a pre-requisite for choice to be effective for some people.

There is a problem for patients if their relationship with their GP is uneasy, particularly for patients recovering from drug addiction or substance abuse. The review found that people who have mental illnesses, or other vulnerable service users, can come into conflict with their GPs because they find it difficult to communicate and they distrust the system. Then they fail to turn up for appointments and get excluded from the GP list. This creates a vicious circle, often ending in crisis and significant cost.

"Lack of hope means you're likely to spiral [back] into chaos. They tell you to stop but you can't. So you alienate yourself."

Service user recovering from drug addiction, Bramley

"People who are disadvantaged don't understand the language or the system – they just want to go to one person, have continuity of care."

Paediatrician, Cambridge

There is also a potential conflict of interest in the relationship between GPs and patients. As GP surgeries increasingly undertake simple procedures themselves, there is a need for safeguards to make sure choice is genuine and advice provided independently and without bias.⁴²

Basic information

Some disadvantaged groups talked about a lack of information in a relevant format (digital information is seen as inaccessible), while others complained about information overload. They find it difficult to access genuinely helpful information they can use to choose between hospitals, for example. There is also a tendency for patients to interpret 'quality' differently, and more broadly, than policy-makers.

⁴⁰ Royal College of General Practitioners (2011), *It's Your Practice: A patient guide to GP services*, London.

⁴¹ Mulley (2012).

⁴² The Department of Health's Competition and Co-operation Panel also warned against collusion between commissioners and providers.

There are several new ways of gathering data and providing feedback about professionals and institutions from other users, like iwantgreatcare.org. Such online tools will provide a new source of information for many people, but not those who have no access to the internet, and it will not be enough for those who want to combine their choice with some face-to-face advice.⁴³ Those who are able to often research options available and arrive at the GP with a clear preference, whether or not that is based on clinically sound evidence. GPs were concerned about choice exercised without a conversation about it, though recent research suggests that patients informing themselves on the internet tends to be beneficial.⁴⁴

“There is an assumption by government that everyone has a computer and a car.”

Service user, Bradford

Complex needs

A particular problem about accessing information emerged from people with complex medical issues, and for parents of children in the same position. The review heard that this can be a problem in hospital, and where – even for confident and articulate people – the business of finding out about options and chasing appointments in different departments can be daunting. Parents of children with chronic conditions talked about their feelings of helplessness in the absence of any real signposting of what services or assistance would be available. These were often parents who would not consider themselves disadvantaged but still found themselves forced to rely on other parents they met by chance in order to find out where they could access help. The review met one mother of a child with complex medical needs who has to deal with 27 different teams in and around one hospital.

One parent of a child with multiple and complex needs explained that choice of hospital was not a reality for her. She needed to be in a place where her child is known and she can get help instantly when the child’s health deteriorates. She described a key barrier to making informed choices about her child’s care as the lack of joined up information about community services available, and a lack of clarity about the differences in health care and social care services.

“There is no-one who signposts when your disabled child is born. You have to find everything out from other parents and word of mouth.”

Parent of child with chronic condition, Peterborough

Interpretation

There is a particular problem when doctors are the only gatekeepers of choice yet they lack the information as much as the patients. The review heard that this is often the case if patients have drug or alcohol problems or even diabetes or Down Syndrome as described above. If doctors lack information about available services, it means that support can be provided in the wrong order: what comes first, for example: anti-depressants or debt advice? There is also frustration among GPs with the Choose and Book system.⁴⁵ This feeds into difficulties for patients, especially those who are nervous about technology, who are not

⁴³ *Which?* (2011), Consultation response to *Liberating the NHS*, 14 Jan.

⁴⁴ Bowes P, Stevenson F, Ahluwalia S, Murray E (2012), “I need her to be a doctor”: patients’ experiences of presenting health information from the internet in GP consultations’, *Br J Gen Pract*: 62:574-5.

⁴⁵ Anna Dixon et al (2010), *Patient Choice: How patients choose and how providers respond*, King’s Fund, London.

given the right information or numbers and are therefore unable to have choice discussions with Appointments Line service.

There is a trade-off to be made between raw data and information which is too complicated to fully understand. Raw data is not useful for everyone, and puts off many others. On the other hand, there is a fear of manipulation if the data is crunched so systematically that people are too obviously pointed towards one option too simplistically. In fact, the evidence is that, if people feel they have been nudged into a decision on healthcare, they tend to agonise about it and then regret it.⁴⁶

In practice, people often seem to assume that all public services meet basic quality thresholds.⁴⁷ This assumption may make choosing less stressful, especially if people are unable to travel anyway. On the other hand, there is scepticism about the official data in health and in education.⁴⁸

That is why the need for some interpretation emerged as so important at the review round tables. Beyond the relationship with the GP, patients valued the assistance and navigation provided by charities, without which some disadvantaged groups would be left without key services. But this face-to-face interpretation is only available to a minority of people.

“Until [charity] became involved, I had no choice.”

Service user, Bradford

Flexibility

Long-term patients consistently told the review that they valued a range of different choices but that they make their choices on the basis of preferences that vary greatly. They are sometimes much broader than they are intended to be by policy-makers in government, who have defined a narrower set of options based on safety or cleanliness. One patient in Leeds spoke of his choice of consultant based on the fact that he seemed like a “nice person who you could trust”. There was some frustration with a system that emphasises choice between institutions rather than between people. Where surgeons move from hospital to hospital, as they often do, then choosing any local hospital will bring you in touch with the same consultant.

This does not necessarily imply that people are confused about choice. Quite the reverse: the review was told by patients that, for choice to mean something to them, they expect to interpret it more broadly if necessary. The review found that patients sometimes assume that choice implies, not just a choice of hospital for an out-patient appointment, but a choice of individual consultant (Choose and Book usually anonymises bookings, though named consultant teams have been bookable since April 2012). Some assume that they get a choice of treatment and a choice of the way they interact with doctors and consultants. In practice, this kind of choice tends to be open only to those who are demanding or those who

⁴⁶ Al Mulley et al (2012), *Patient Preferences Matter: Stop the silent misdiagnosis*, King's Fund, London.

⁴⁷ This is the assumption made in Anna Dixon (2010), 17.

⁴⁸ See for example the poll commissioned from MORI by the General Teaching Council of England in 2005, which found scepticism by parents – though not up to the level of the scepticism by professionals.

have the kind of relationship with their GPs which allow them to have an open conversation.⁴⁹

One of the most important areas where the old bureaucratic structures impact adversely on choice, and impact on the flexibility of the doctor-patient relationship, is where there are referrals to hospital consultants. The review heard that hospitals are paid for outpatient attendance, but only about a quarter of the amount for phone calls or online consultations (and in practice these tariffs are often not used). This means that hospitals tend to encourage appointments, even when patients would prefer some other kind of consultation, and even when letting patients choose other options might allow for extra capacity. This has the effect that long term hospital out-patients are often expected to travel to see their consultant at regular six month intervals when they are quite well, but are unable to see them when they really need to.

The review heard about one hospital which had forbidden doctors and consultants from talking to GPs, in case it discouraged them from seeing patients in person, when a quick phone call might save patients and doctors time and create more capacity for the NHS as a whole. The review is aware of one city where consultants and GPs have agreed between them to maintain open communication.

“How we make our decisions vary greatly, and the difference in values and how that affects our choosing is not understood by professionals. When you’re not experienced in making choice – you make a choice based on the familiar, like choosing washing powder. And [in the absence of that] what helps you arrive at a choice is dialogue.”

Service user, Leeds

“I have the education, confidence and stropiness to choose.”

Carer, Bradford

“I have seen my consultant every six months. It’s a two hour round trip and he says ‘how are you?’ and I say ‘I’m fine’. Why can’t I use Skype when I’m fine and see him when I’m not fine? But his secretary told me I would be struck off if I didn’t come to the last appointment.”

Patient with long-term condition, Lincolnshire

Next steps

The review drew the following conclusions from our round tables and research:

- People without access to computers or cars are at a double disadvantage when it comes to exercising choice.
- Making choice more widely available in practice means providing, not just access to information, but access to personal face-to-face interpretation.

⁴⁹ Recent research by the King’s Fund confirmed that patients often want something more than simple choice. They want skilled people they could trust, and services to provide assistance, attention and support at points of crisis or difficulty in their lives. Al Mulley (2012), *Patient Preferences Matter: Stop the silent misdiagnosis*, King’s Fund, London.

- Strict GP catchment areas are sometimes contributing to the difficulties of accessing GP practices – and accessing appointments can be a problem area for some older or disadvantaged groups.
- Patients need rights they can use to break through the bureaucratic barriers, so they can have open, honest conversations with doctors, and act on them to access healthcare in the way that suits them best.

Interpretation and transport

GPs are the best gatekeepers to choice, but there are practical reasons why they are unable always to provide access to the information people need, whether it is comparative information between hospitals or signposting for local services. Shortage of time is the most important of these. Some other kind of support and navigation service is required. Choice 'advisors' have largely disappeared from the NHS, but the review found a number of successful experiments with 'health champions' (notably in Yorkshire), in Turning Point's Connected Care projects (in a number of different cities) and in time banks which provide expert patient, transport and advice services (notably in London). Choice requires some kind of expansion of these services (see Section 5), especially if it can be used to bring improvements in more than one area – navigation, peer support, and perhaps transport – at the same time.

Primary care

The second area where attention is required is in making access to GPs and GP appointments easier and more flexible for people who feel excluded from them. Decisions about abolishing catchment areas will be the responsibility of the NHS Commissioning Board after April, and will have to wait until the results of the GP Choice pilots have been evaluated and analysed in the Summer. But some areas avoid these difficulties by giving practices two sets of boundaries – a strict inner area and a much wider outer area, closer to local government boundaries but not necessarily the same: existing patients can stay on lists if they move within the outer boundary.

The difficulties some disadvantaged groups find with the appointment system may require more thought. It is difficult for national policy to lay down the best kind of appointment system. It may be that rival appointment systems all have disadvantages for different groups, and what this suggests is that surgeries should make decisions about systems in conversation with as many of their patients as possible. Research in other countries suggests that doctors tend to have a poor understanding of what their patients prefer about the way they organise their practices.⁵⁰ There was a requirement under the old contract for surgeries to promote engagement with patients, but some barely do so. There is evidence that shared decision-making for individual patients improves their care outcomes, so it is reasonable to assume that more effort to involve patients in decisions about opening times and booking systems would have further benefits.⁵¹

⁵⁰ L. Pedersen et al (2012), 'Do general practitioners know patients' preferences? An empirical survey on the agency relationship at an aggregate level using a discrete choice experiment', *Value in Health*,

⁵¹ The evidence about outcomes is in M. Roland (2012). 'Continuity of care: betrayed values or misplaced nostalgia?' *International Journal of Integrated Care*, forthcoming. Quoted in Veena Raleigh et al (2012), *General Practice in London*, King's Fund, London.

There are limits to how far specific targets are effective in regulating the relationship between surgeries and their patients, especially as they ignore the importance of building trusting relationships between them, which are a pre-requisite for exercising choice for some people. Now that the contract is up for renewal, this may be an appropriate moment to accelerate the process of shifting regulations from narrow outputs and towards broad patient outcomes and satisfaction, and marking the beginning of a professional debate about having effective conversations with patient.

Recommendation 1

Build flexibility into the way GPs interact with their patients, by:

- Giving patients, especially from disadvantaged groups, the right to remain with existing GP practices when they move house, irrespective of catchment area. Consideration should be given to drawing up town or city specific catchment areas for this purpose while lessons from the GP Choice pilots are being learned.
- Lead a discussion with the Royal College of General Practitioners and other bodies about how surgeries can better engage with their patients, particularly around issues such as appointment systems.

Hospital care

Another area that needs attention is making sure patients' interaction with hospitals more flexible. One recent King's Fund report suggests that the underlying problem is the attitude of physicians, but that is not the whole story.⁵² There are certainly ways in which a narrow interpretation of choice can make choice meaningless in practice. The advent of health budgets on a much wider basis will also provide more flexibility in the system, but none of this will be enough for some patients unless there is flexibility in the conversations they are able to have with professionals.

There are already rules that are designed to prevent hospitals from wasting patients' time in order to earn extra revenue, especially as this also clutters up the system unnecessarily. There are target ratios for follow-up appointments that are intended to prevent abuse, but in the end targets are probably too blunt an instrument to be effective. Patients need to have basic rights which they can appeal to. Some kinds of behaviour may also need to be ruled out by NHS regulators or under the NHS constitution. In particular, free communication between doctors and patients, and between professionals, needs to be protected. There is provision for 'Advice and Guidance' under the Choose and Book system, but it is inflexible and not useable for conversations. Monitor should investigate gaming the system by trusts, and understand the forces that give rise to this, but also to define as anti-competitive any behaviour which unnecessarily takes up capacity or wastes valuable time and resources in the system as a whole.

Patients also need to be given explicit rights to ask for different ways to communicate, if appropriate, so that they can have more flexibility around follow-up appointments that suit them, so they can get access to consultants when they need it. It is also necessary to make sure that patients are not caught in a treadmill of unnecessary follow-ups if they do not need

⁵² Mulley (2012).

it. Many hospitals block access to Skype in practice, and there are other complications about using Skype for medical consultations.⁵³ The Mandate to the NHS Commissioning Board wants e-consultations with GPs to be “much more widely available”, but this needs to be a right in the NHS constitution.⁵⁴

Recommendation 2

Build flexibility into the way patients interact and communicate with hospitals, including:

- Giving patients a right under the NHS constitution to ask for consultations (with either GPs or consultants) using a range of means of communication such as telephone or Skype, where both sides agree it is appropriate.
- Evaluating gaming behaviour and perverse incentives that serve to undermine patient choice and include this in the Choice and Competition Framework.

⁵³ Skype recently refused to let the Singapore government use it for health consultations.

⁵⁴ Department of Health (2012), The Mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015, Crown Copyright, 10.

5. Choice in social care

The review looked broadly at the social care system and people's experience of it, and particularly at the provision of information across the social care market. The review round tables indicated that there are some groups who feel at a greater disadvantage accessing choice in social care, because:

- Some service users who rely on state support find the process of assessment exhausting and stressful, partly because it often takes place at a moment of crisis, partly because of the emphasis on needs – rather than objectives and assets – and partly because of the bureaucratic hurdles that remain in the way of personal budgets and direct payments in some places.
- Despite the range of advice and support, there remains a lack of accessible information and a need for intermediaries and independent advice and support, so that more people can have the benefits of direct payments.
- The rules on how you can spend personal budgets vary hugely between local authorities and some are very prescriptive, limiting choice in practice.
- The range of options available is limited, especially in some areas, by a shortage of the diverse range of providers that real choice requires.

Existing choices

For some time now, personalisation and 'choice and control' have been key aims of social care reform. People also have the right to express a preference between care homes, even if their fees are being paid by the council. The Department of Health explains that: "As with all aspects of service provision, there should be a general presumption in favour of individuals being able to exercise reasonable choice over the service they receive. The limitations on councils' obligation to provide preferred accommodation set out in the Directions and the Regulations are not intended to deny individuals reasonable freedom of choice but to ensure that councils are able to fulfil their obligations for the quality of service provided and for value for money."⁵⁵ Four considerations are mentioned: suitability of accommodation, cost, availability and terms and conditions. The circular also makes it clear that, if someone wants to be put in a more expensive care home than the local authority is willing to fund, they are allowed to make up the difference.⁵⁶

Direct payments and personal budgets have been at the heart of this process as mechanisms for giving people who use social care more choice over the type of support and services that they want. Since the Health and Social Care Act 2001 was implemented in 2003, local authorities have been required to offer direct payments to all adults eligible for council-funded social care services.⁵⁷ These include:

- Older people who have been assessed as needing community care services.
- Disabled people aged 16 and over, including those with short as well as long term needs.

⁵⁵ Department of Health (2004), Local Authority Circular LAC(2004)20, 14 Oct.

⁵⁶ "In certain circumstances, councils can make placements in more expensive accommodation than they would usually expect to pay for, provided a resident or a third party is able and willing to make up the difference (to 'top up')." Department of Health (2004), Local Authority Circular LAC(2004)20, 14 Oct.

⁵⁷ Health and Social Care Act 2001.

- Carers, in place of receiving carers' services.
- Families with disabled children for children's services.
- Disabled parents for children's services.
- People receiving a direct payment on behalf of someone else who lacks mental capacity⁵⁸.

The role of personal budgets is to “ensure people receiving public funding use available resources to choose their own support services – a right previously available only to self-funders.”⁵⁹ The same document suggests: “There are only very limited circumstances when direct payments would not be offered [to these groups].”⁶⁰ In reality, many local authorities have experienced challenges in implementing these policies and the pace of change has been slower than anticipated, though personal budgets are emerging in other areas of policy, like health and education.

Current policy

In November 2010, the Coalition committed itself to providing everyone who is eligible, with a personal budget by 2013.⁶¹ In practice, in October 2012, the target was reduced to 70 per cent.⁶² Putting people in control of their own care and support is a key theme of the recent White Paper, including an emphasis on volunteerism and encouraging peer support.⁶³ There is also a commitment to set up a new national information website, to provide a clear and reliable source of information on care and support – and online customer feedback – and to give people access to clear and comparative information about the quality of care providers and the options they offer. This would give people the power to make informed decisions. The commitment to a national source of information on care and support is not in the Care and Support Draft Bill (see below).

There is also a commitment to removing barriers that disrupt care if people move across local authority boundaries, and to carers, who will get the right to an assessment of their own needs and a new entitlement to support.⁶⁴ There are also two planned reforms that are directly relevant to this review:

- A requirement for local authorities to develop and maintain a diverse range of high-quality care providers in their area, so that people have different care options to choose from.⁶⁵
- A promise of choice and control over who carries out their assessment.⁶⁶

The Draft Care and Support Bill, published in July 2012, set out plans for a social care advice service in every local authority area.

⁵⁸ Department of Health (2009), *A guide to receiving direct payments from your local council*, London.

⁵⁹ HM Government (2007), *Putting People First: A shared vision and commitment to the transformation of Adult Social Care*, London.

⁶⁰ Department of Health (2009), *A guide to receiving direct payments from your local council*, London, 5.

⁶¹ http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_121690

⁶² <http://www.communitycare.co.uk/articles/26/10/2012/118640/lamb-scraps-100-personal-budgets-target.htm>

⁶³ Department of Health (2012), *Caring for our future: reforming care and support*, July, 3.

⁶⁴ Department of Health (2012), *Caring for our future: reforming care and support*, July, 35.

⁶⁵ Department of Health (2012), *Caring for our future: reforming care and support*, July, 45.

⁶⁶ Department of Health (2012), *Caring for our future: reforming care and support*, July, 33.

Research evidence

The number of personal budgets rose last year (2011/12) by 38 per cent, less of a rise than the year before but still a big increase (there are now over 432,000).⁶⁷ They now cover 52.8 per cent of eligible people. There is also substantial local variation in the rate of personal budget take-up that councils have achieved. ADASS's 2012 survey found that 58.8 per cent of councils provide personal budgets to more than half of all people who get community based services. But nine of the local authorities surveyed provide them to less than a quarter.⁶⁸

Progress in rolling out direct payments appears to be slowing down. The number of people receiving direct payments "has remained stable overall" between 2011 and 2012, with a slight reduction in the number of people of working age with a direct payment (0.8 per cent) and slight increase in the number of people aged 65 or over (1.6 per cent).⁶⁹ Other research suggests that, in 2010/11, nearly all the new personal budgets were in the form of managed personal budgets as opposed to direct payments.⁷⁰

Research also suggests that service users see choice more broadly than just direct payments. They tend to give more priority to their health, quality of life and 'personal dignity and respect' than to exercising choice.⁷¹ On the other hand, personal budgets are designed to help them achieve this (76%).⁷² That may explain why the most popular reason given for choosing one option rather than another was staff who 'know you personally' and provide continuity (47%).⁷³ There is some evidence, with two thirds of personal budgets still being managed by local authorities rather than being transferred to the service user as a direct payment, that this may have a dampening effect on social care users' access to choice of services.⁷⁴

Although 46 per cent of respondents to the Ipsos MORI survey suggested they got a genuine choice (see Section 1), that figure falls to 27 per cent for social care:

⁶⁷ Association Directors of Adult Social Services (2012), Personal Budgets Survey, March.

⁶⁸ Association of Directors of Adult Social Services (2012), Personal Budgets Survey, March.

⁶⁹ Association of Directors of Adult Social Services (2012), Personal Budgets Survey, March.

⁷⁰ <http://www.communitycare.co.uk/Articles/16/06/2011/117022/councils-failing-to-offer-choice-to-personal-budget-holders.htm>

⁷¹ Wood C. (2010), *Personal Best*, Demos, London.

⁷² National Audit Office (2012), *Oversight of User Choice and Provider Competition in Care Markets*, Stationery Office, London.

⁷³ People who funded their own care found it particularly important that services had been recommended to them. See, Wood C. (2010), *Personal Best*, Demos, London.

As in healthcare, advice and recommendations are very important to people, not just disadvantaged people.

⁷⁴ Chris Hatton and John Waters (2010), *The National Personal Budget Survey*, In Control and Lancaster University.

Figure 8. Did you select the school/provider of support or social care services/GPs surgery/hospital from a number of options, or was there no choice at all? (N=1485)⁷⁵

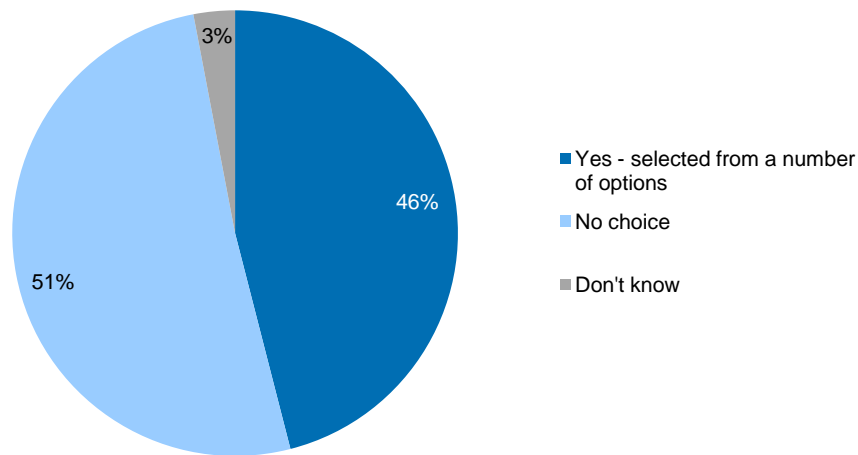
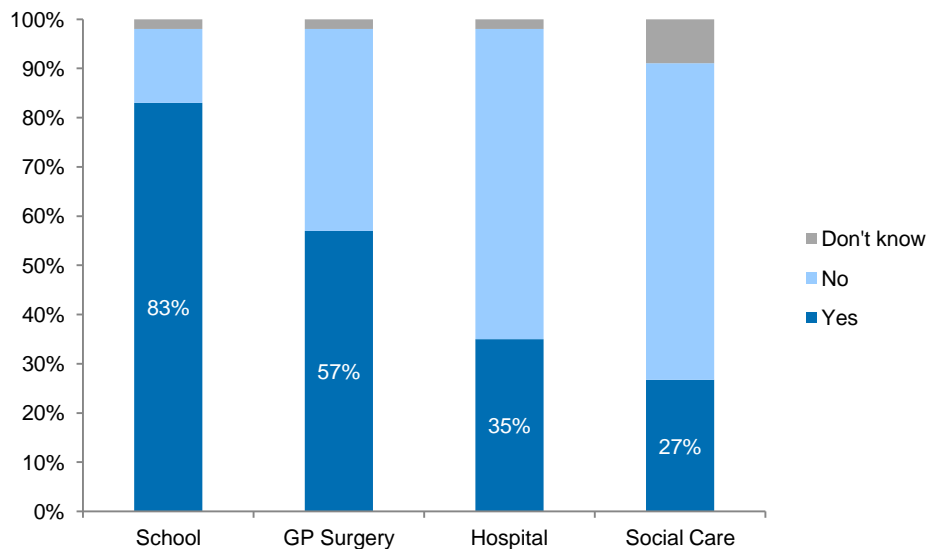


Figure 9. Did you select the school/provider of support or social care services/GPs surgery/hospital from a number of options, or was there no choice at all? (N=1485)⁷⁶



The issue of how much direct payments improve outcomes remains controversial, but a recent Lancaster University study found that there was evidence of better well-being (63%) and better physical health (59%).⁷⁷ Despite the improvements, direct payments are clearly not a panacea and will not suit everyone.

⁷⁵ IpsosMORI, Choice Review Survey 2012

⁷⁶ IpsosMORI, Choice Review Survey 2012

⁷⁷ Wood C. (2010), *Personal Best*, Demos, London.

Choice barriers

Social care is different from other areas of public service partly because the word ‘choice’ is rarely used, and partly because personal budgets are usually recognised and supported – by professionals and users alike – as a potential way to give people resources and options which put them on a similar footing to self-funders. The review encountered nervousness about direct payments and discussion about how appropriate they were for everybody, but less scepticism about the basic idea of ‘choice’ than you find in other public services.

The review heard from a wide range of professionals and service users, and their comments coincided with a period of rapid change in social care, and growing concern about the very poor level of home care provided by some providers and the variable quality of residential care. The review has also been conducted at a time when there are fears about budget pressures and concerns about the rigidity of the service and potential reduction of options available. The number of block contracts are also shrinking in many local authorities, which is likely to mean less choice in the medium term for those still not on direct payments, and – if preferred supplier lists are used to limit the choice of service users on personal budgets – it will reduce theirs too.

Most of the people the review encountered on direct payments and personal budgets acknowledged the benefits for them, despite the difficulties that can be involved. On the other hand, it is difficult to talk to those involved in social care without becoming aware of people’s fears. The review heard from users who described their offhand treatment at moments of crisis or assessment as ‘abuse’ and ‘bullying’.

“What I want the government to remember is that choices as a blind person make it possible for me to be a member of the community. Choices make me a citizen.”

Visually impaired service user, Bradford

“I’m being frightened by my service provider. I’ve never felt bullied before. Why should I be made to feel this by my government’s representatives? I have worked in places that are incredibly poor and I’ve never seen people treated with this dishumanity. I felt just humiliated and demeaned.”

Disabled and wheelchair bound service user, Dorset

System barriers

Users of social care told the review that the inflexibilities and bureaucracy involved in direct payments were an important barrier to anyone who is less confident and able, especially older people.

Access

The review heard from users who felt unable to access personal budgets because of the bureaucratic hurdles, and there is certainly a wide variety of approaches that are taken locally. The time taken to process assessments can take between two days or less and very

much longer. The review heard a report of one case where it took two years to set up a personal budget.⁷⁸

The review also heard from users who had been put off having direct payments because of the potential stresses of dealing with personal budgets on their own, such as tax liabilities and employment regulations, including redundancy payments.⁷⁹ What would be considered to be straight-forward by the majority of people such as keeping their receipts, might be a source of enormous stress for a vulnerable person.

These are significant barriers. Some personal budget holders can fall back on the council legal department if they run into difficulties, but most are unable to. Some intermediaries provide payroll support. Other intermediary organisations can take on the employment of personal assistants and insure against redundancy costs. But these services are not available everywhere, and in any case must be paid for out of the personal budget. User-led organisations, which have been able to provide some of these services, are also having increasing difficulties now that local authority budgets are shrinking.⁸⁰

Some local authorities discourage people from taking a personal budget by emphasising the complexities but there is no doubt that they are a barrier to choice.

“For a miserable git like me fighting the system like mad, as I did for my parents, it is difficult enough – but most elderly people haven’t a hope in hell, quite honestly.”

Older man, Dorset

Trust

There is a parallel problem about vulnerable people, often with learning difficulties, who become dependent on their personal assistants. The review heard from one parent who is afraid that her son’s PA is taking advantage of him.

The other area of difficulty is where people have severe mental health difficulties and are denied choice because they have nobody who is legally empowered to override the choices made for them by their care professionals. The review heard that the process of naming individuals as deputies through the court of protection is highly bureaucratic, complex and expensive but, without this, decisions affecting lives are taken by social workers or, more usually, care home managers.

Capacity

Once users have their personal budgets, the review found there were difficulties finding the right kind of services to spend their money on in some areas, especially given the closure of so many day centres and the difficulties some small projects have with raising the basic grant funding. This is a difficult transition period for choice, given that so many local

⁷⁸ The figures say simply ‘more than three months’ and this is not sub-divided so there is no data on 12 months plus, for example. In 41,625 cases, assessment took longer than 3 months (out of a total of 61,2150 assessments for people aged 18+). This is about 7 per cent of cases. See: Health and Social Care Information Centre, Adult Social Care Statistics, 2012.

⁷⁹ The National Audit Office found that 31 per cent of personal budget holders found it difficult to cope with being an employer: NAO (2012), *Oversight of User Choice and Provider Competition in Care Markets*, Stationery Office, London.

⁸⁰ Report by London Joint Improvement Partnership: ‘People using DPs told us that having support to build their confidence to take them up was vital, alongside options that removed or reduced their responsibilities as an employer.’ See: Sam Bennett and Simon Stockton (2011), *London Joint Improvement Partnership (JIP): Best practice in Direct Payments Support – a guide for commissioners*, Joint Improvement Partnership, London Councils, 9.

authorities are reducing their contracts down to a very few which they can monitor better, but before a major growth in the market to inject more diversity into the system.

Yet micro-providers have their own difficulties in some areas, where they find themselves excluded from council contracts – which might provide them with basic financial stability – because they are not on the local ‘preferred supplier’ list. Sometimes, these lists are either closed or the bureaucracy involved in getting onto them is so onerous that it discourages start-ups. The review heard from micro-providers who were unable to get referrals from the PCT, for example, because the PCT was only half way through a contract with a big provider.

Micro-providers can start up independently from preferred supplier lists, and there are many social care providers that survive outside these lists. The review heard how some local authorities confuse lists of their own contractors with lists of acceptable local suppliers for spending public money, tying the hands of people on direct payments. Others use preferred supplier lists as an extra layer of assurance for any local people, including self-funders, on the grounds that the monitoring provided by the Care Quality Commission (CQC) is inadequate. But when preferred supplier lists are given to self-funders as if they are a proxy for quality, then that restricts choice.

Local authorities will be given duties to shape the local care market under the Care and Support Bill, but this will take some time to take effect in areas where there is little diversity.

“I have a big care package – 25 hours per week – doing basic essentials, nothing extra except basic care. Once a week, I have 3 hours to go out. I used to go to a day centre – but this was stopped because funding for the day centre was stopped. Now I just go food shopping.”

Personal budget holder, Lincolnshire

“A personal budget is fine, but what if people have nothing to buy with it. If there’s nothing available, then choice is no use.”

Care user, Middlesbrough

“Getting rid of preferred supplier lists is the biggest act that could improve choice.”

Care provider

Poor quality care

Poor quality care reduces choice in practice, especially if there are systemic reasons for it. The review round tables heard that one of the few areas where local authorities can squeeze their budgets is in social care contracts for people who are not on direct payments. In practice, increasing demand for quality, and reductions in costs at the same time, has meant that costs are sometimes being shifted onto self-funders and that care is sometimes becoming less personal.⁸¹ The review heard examples of poor, rushed, impersonal care, and

⁸¹ Users engaged in the review roundtables returned constantly to fears about cost-cutting, and the government estimates that councils with social services responsibilities in England will have cut their budgets by 4.7 per cent this year, and the Association of Directors of Adult Social Services has found that councils have made savings of £1bn in adult social care for 2011-12. One recent survey found that 83 per cent of social care professionals said that cuts to adult care budgets in their areas would impede personalisation. See: <http://www.communitycare.co.uk/Articles/25/05/2011/116868/social-workers-losing-faith-in-personalisation.htm>

abusive assessors. The Social Care White Paper committed the government to ending time-based care slots, but that is now the reality for many users – often down to 15 minutes.⁸² Part of the problem appears to be that people are not choosing poor care providers deliberately, but that they are allocated them in moments of crisis. People do not qualify for help until needs are critical, but crisis is not an effective moment to exercise choice.

“Local authorities will only look at critical care needs – if we could prevent needs from becoming critical, it will save a lot of pain as well as money.”

Social care professional, Wiltshire

“It all comes down to money. If you can pay for a carer, it’s more personalised.”

Social care user, Poole

“Old age comes out of the blue, and one is horrified that one experiences changes in body and person so quickly. If only young people understood this. They are well meaning, but they have no idea of what is needed. They never see the same patient twice. The human touch needs to be restored.”

“When they told me that, if I couldn’t wash in 45 minutes, they would only offer me a strip wash, I was appalled and frightened. They made me feel I had nowhere to go. I’m in my own home I’m being told how long to take washing my body. I’m not being told where I can find help elsewhere. I’m not being offered any other options for support. I’m being told I can’t have any help with food even though I can’t get out of bed.”

“They arrive to get me out of bed at 7 and then they’re back at 5 o’clock to undress me ready for bed.”

Care users, Dorset

Bureaucracy

The review heard consistent reports that the bureaucracy around direct payments was growing, and there are an increasing number of local rules emerging about what must not be done with the budget as opposed to what can be done. The review also heard about long bureaucratic sign-off processes, and sometimes multiple assessments.⁸³ This confirms recent reports which found the paperwork extremely difficult to manage without support.⁸⁴

⁸² A recent *Which?* investigation found that care workers often have to hurry between visits, propping up poorly managed care from over-stretched agencies, sometimes even jeopardising safety as a result. Those who got the best service often have to shout loudly to get it, needing to be skilled and persistent in making complaints: *Which?* (2012), Apr.

⁸³ Another recent study found that fewer than half of personal budget holders (37-46%) felt that their council had made it ‘easy’ or ‘very easy’ for them to change their support, choose the best service options or voice their opinions or complain. Between 13 and 24 per cent felt that councils had made it ‘difficult’ or ‘very difficult’ to do these things. See C. Wood (2012), *Personal Best*, Demos, London.

⁸⁴ Only a fifth of professional respondents said they had enough time with service users to effectively support self-assessment, and only 1 per cent of respondents felt the paperwork relating to assessments was suitable for users to complete without support. See <http://www.communitycare.co.uk/Articles/25/05/2011/116867/bureaucracy-is-damaging-personalisation-social-workers-say.htm>

“Only one person in the whole of County Hall knows how direct payments and ILF (Independent Living Fund) payments fit together. She goes on holiday for three weeks every year and we are all in a panic.”

“I am an employee, but I am also an employer [of a personal assistant]. I had different tax codes. I got investigated and I had to get my social worker to sort it out.”

Personal budget holders, Wiltshire

Rules and assessments

Most local authorities use a resource allocation system (RAS) to estimate individual budgets, but the rules they use are often obscure.⁸⁵ The review heard evidence that many local authorities also enforce across-the-board percentage reductions in RAS estimates for people requiring direct payments, which are unhelpful to the choice agenda and may undermine spending reductions elsewhere.⁸⁶

The final figure for budgets is intended to be negotiated but, in practice, sometimes has to go through an appeals system to be changed from the RAS estimate. There is an underlying problem that direct payments are often assessed in terms of hours of support from a personal assistant, when the whole purpose was to make other kinds of service possible. In some cases, services have to be bought from the council’s preferred supplier list. Sometimes, as the review heard, the service user has to buy their services at precisely the minimum price that council has stipulated, locking them into the very providers they had wanted to escape.

The review heard from one provider about a client who took a direct payment and started getting herself dressed by standing between two single beds to keep her upright, so that she could spend her payment on going to a pottery class once a week. But the assessors said that, if she could get herself dressed, this affected her eligibility. By basing the assessment entirely on needs, this gave the user no incentive to be independent and put her at risk of social isolation because she needed help to go out. It also meant that informal, cheaper options of support were ruled out early on in the process.

The review heard that choice can be even more constrained, not just by approved provider lists, but also by spending rules for those on direct payment. Quite reasonably, local authorities are nervous about challenge by the media, though other benefits are not normally treated in this way.⁸⁷ The review heard from service users who were not allowed to choose gym membership or to buy pets to help with walking or companionship. They heard about money clawed back for a range of reasons too, including older people who had used it for classes rather than day care.

⁸⁵ They have been known to be deliberately opaque to prevent people gaming the system, see; Alex Fox (2012), *Personalisation: Lessons from social care*, Royal Society of Arts, London, 13.

⁸⁶ This is confirmed in Daly and Woolham (2010), *Do personal budgets lead to personalisation?* UK Social Policy Association, London.

⁸⁷ The legal status of direct payments is ‘social assistance’ not ‘social benefits’. Recent research confirms the onerous rules: “Systems of regulation and auditing put in place to allow local authorities to guard against the risk of misuse of public funds limit the flexibility offered by Direct Payments. This may mean that any increase in choice is restricted by local authorities’ power to determine the allocation of public funds and responsibility to enhance the wider societal benefits of social care”. See: Stevens M. et al (2011), ‘Assessing the Role of Increasing Choice in English Social Care Services’, *Journal of Social Policy*, 40, 2, 257–274.

“There are far too many people saying what you can and can’t have. Should be fewer.”

“My social worker has to approve and I’m not allowed gym membership. I am supposed to have a choice about how I can spend.”

Personal budget holders, Grimsby

“If you ask what service a person needs – you’ve already eliminated 95 per cent of choice. If you ask about what they want to do with their life – that is real choice. If you ask what respite services do you want, that’s the wrong question. The user doesn’t want any services. They want to live independently.”

Social care professional, Middlesbrough

“People can’t have unfettered choice, but the fettering is the amount of money, not who provides the service.”

Social care professional

Information

The review round tables identified a serious lack of signposting right across social care, from the difficulties in finding out about which personal assistants are available locally to the quality of local care homes, but – where this information is available – it is sometimes only available informally.⁸⁸ These problems are addressed in the Social Care White Paper, but it is important that national online directories should also be able to include customer feedback, along the lines of similar web portals emerging in healthcare.

The review heard that official information available is often limited to statutory services, and misses out vital facts about what is available from the voluntary sector.⁸⁹ Even when there is brokerage information available for people on direct payments, it often omits details about more informal local solutions, from pooling budgets to time banks. The result is that people often have to pay more money out of personal budgets than they need to.⁹⁰

There are online directories of personal assistants but these are not everywhere and sometimes very basic information is missing, like how much your personal budget is for (only 77 per cent have this information).⁹¹ There is also the problem that key local information is only available online, which is not accessible for everyone (see Section 5).

⁸⁸ When the Care Quality Commission abandoned its star ratings of care homes in 2011, it left people with little or no useful data on which to base a decision.

⁸⁹ This confirms research by Demos in 2010 which asked people what help they would need to make changes to their lives. The most common answers for all care users were: more information about what I can do (54%), more face to face advice (52%), and someone to speak to in an emergency (46%). See: Wood C. (2010), *Personal Best*, Demos, London.

⁹⁰ The famous story of the man on a direct payment who used some of it to pay someone to go to the pub with him is a good example of this, see *Daily Mail* (2008), 24 Apr. If he had been given access to a time bank, he could have spent the money on something else.

⁹¹ Wood C. (2010), *Personal Best*, Demos, London, 15.

“If you’re looking for a personal assistant, where do you go? If you’re looking for a service without a form of accreditation, there is nothing to say ‘this is what they offer and they’re good’.”

Microprovider, Nottinghamshire

“Adult social care will not supply an electric wheelchair but will allow user to buy one – the barrier is we don’t know what choices we have, how to choose, or who can help us bang on doors.”

“‘Do it online’ seems to be answer to everything. Some of us hate computers. If you’re not online, how would you know?”

Social care service users, Trowbridge

“I couldn’t find any information on local services. I just got gobbledegook from the phone.”

Older woman, Dorset

Gap between self-funders and funded

There is also a perceived divide between homeowners and those who have no assets. The review heard how local authorities and hospitals tend to concentrate all their attention on the latter, despite duties to assess everyone for support if they want it. This makes it particularly hard to navigate the system if you do not qualify for financial support. It also means that the emphasis is again on demonstrating needs to access support, rather than looking at needs and assets together. The draft Care and Support Bill sets out duties for local authorities to provide assessments for everybody and to launch advice services at local authority level, which will go some way to tackling this gap, but this may not be enough.

“For old people, it’s scary to go down a new pathway, looking at residential nursing care – and the first question is ‘do you own your own home?’ There is no choice. Lots of information, but it’s difficult to wade through it. What I wanted was to keep my mother at home – but there was no support for making that decision. I had to sell her property to get a place in a home.”

Carer, Trowbridge

“If you are old, you are constantly asked if you own your own home, so they can wash their hands of you.”

Service user, Trowbridge

Complex needs

It was clear that basic information is particularly necessary for people with complex needs, especially where they straddle health and social care. The review round tables heard about the complexity of dealing with a multiplicity of different agencies with overlapping information requirements, unable to share information between them (see Section 5). Co-ordination is particularly important for people with chaotic lives, and the review heard from people who emphasised how important their key worker was. Drug services in Camden have given service users the right to choose their key worker, which is an important innovation.

“A good key worker is key. But there were seven months where I had no key workers at all. When I was doing bad, it was driven by the lack of direction, and being ignored by key worker. This spirals out of control and I turned to drink. Some key workers want you to do badly. They are only too happy to chuck you out on the street.”

Service user, London

“I had a choice to go to a dry or wet hostel. The dry hostel is now being turned into a wet hostel, because the wet hostel is closing – I will now be surrounded by drinkers. You need somewhere to seek refuge – cannot be surrounded by drink. The end result is my initial choice which was right for me is now changing and I have no choice if I want to stay in the hostel.”

Rehabilitation service user, London

Flexibility

The choices available to people on direct payments are potentially far wider than the kind of choices available in healthcare or education, though bureaucracy increasingly frustrates these choices in some places – and, as the review heard, the diversity of provision is not yet available everywhere (see above). But the review was told repeatedly that the inflexibility of the current system also narrows choice: these problems are exacerbated by disjointed care, by professional groups which do not communicate and by formulaic solutions which may not actually suit people.

This can leave people feeling more powerless than before, unclear where decisions about them are being made and confused by the number of different professionals they have to deal with. The current system also tends, at its least effective, to wait until people are in crisis before it provides support. This is understandable at a time of shrinking budgets, but it may build in costs which could have been prevented if intervention came earlier. The increasing emphasis on eligible needs also tends to turn needs rather than abilities into marketable assets and provides a perverse incentive to need more. It tends to encourage desperation at the expense of planning ahead, and expensive care packages rather than more precise support. Paradoxically, it also tends to narrow choice.

“I had four different social services for my son with learning difficulties last year. Social services only look at what the home looks like. No one is interested in my son and what his real needs are.”

“People are tired of compartmentalising themselves just to make themselves easier to deal with.”

Service users, Middlesbrough

Next steps

Many of the problems the review heard about are covered by the Social Care White Paper and the draft Care and Support Bill, including the need for better information and feedback. The review reached the following conclusions:

- There is a problem with the complexity of the personal budget system and the bureaucracy of the rules around using it, and of delays in the system in some areas.
- There is a need, not just for information, but also for signposting, interpretation and support, and particularly for intermediaries capable of supporting people who prefer not to employ personal assistants directly.
- The current system assesses people too late in the process, and in a way that emphasises need and financial support, and tends to ignore other non-financial resources
- Developing choice is going to depend on broadening the market for social care providers.

These issues are all related. They are also related to the underlying problem of so much of what the review heard, which is how to make a system with finite resources more humane.

Information and intermediaries

The review met professionals who have been able to address this problem to some extent. The Local Area Co-ordinators in Middlesbrough have designed one cost-effective way of providing support and coaching for people and families with this kind of signposting problem (See Appendix F). Other agencies, like Care Plus in Grimsby, have a self-imposed rule that nobody who phones them up should simply be palmed off onto another phone number. This area of complex signposting is one area of choice that badly requires attention.⁹² This issue is addressed more fully in Section 5.

Making self-assessment tools available online will also help people plan ahead, though these are not yet as sophisticated as they need to be, and they will need to be local. There are also effective online decision aids for health, to help people make decisions, but few yet in social care.⁹³

There is already a multiplicity of different, and sometimes rival, sources of information about social care options beginning to emerge online, nationally and locally. The role for government should be to provide online signposts to what is available and to simplify rival information lines, as the 311 telephone number has done in New York and other American cities. One proposal would be for the 111 phone service, currently for non-emergency health inquiries, also to cover social care.⁹⁴ But the most urgent requirement in social care is still for proper information. The ratings system is currently under review and there is a commitment to a national information website in the Social Care White Paper. When this does emerge, it needs to be searchable by postcode, include uploadable profiles of individual care providers, an objective quality rating and also opportunities for user feedback on individual providers – which need to include unregulated micro-providers as well. It also needs to include decision aids, along the lines that already exist in health. It needs to provide clear information about pricing, both what the provider charges and what they charge the local authority.

⁹² Recent *Which?* research on those who have organised care found that, of the formal advice channels used, local authority advice performed worse than other providers on all counts of quality (independence, range of options, knowledge) apart from one (professionalism) where the PCT came last. See *Which?* (2011), Nov.

⁹³ See for example www.nhsdirect.nhs.uk/decisionaids

⁹⁴ See Kate Blatchford and Tom Gash (2012), *Commissioning for Success: How to avoid the pitfalls of open public services*, Institute for Government, London, 24.

Recommendation 3

Make sure that plans for a national website of registered social care providers, currently under construction, will make it searchable by postcode. This will enable people to easily identify residential or home care providers in their local area. Such a national website should include:

- Comparable information about the quality of individual providers, according to measures that are meaningful to service users.
- Opportunities to leave user feedback on provider profiles.
- Access to online decision aids.
- Transparent information about pricing and navigation to other sources of information, local and national.
- Signposting to local information sources (a priority).

Re-organising assessments

Personal budgets were expected to reduce bureaucracy, which they have not generally done. Part of the problem is that care managers are the gatekeepers, and that social workers are often not given the power by financial managers to sign off care packages. This means that another approval stage is required.⁹⁵ Another aspect of the problem is that assessment happens too often at moments of crisis when choices are severely narrowed.

The proposal here addresses not just the complexity of the system but also the way it waits for people to be in crisis and then over-emphasises needs over strengths and resources. A crisis-only service encourages people to focus on their needs as the necessary pre-requisite for higher budgets. A more informal and timely approach will allow them to focus also on other resources that they have at their disposal, including non-state, collaborative and informal resources. This can only broaden the choices before them.

Among the recommendations in the Social Care White Paper is a proposal that assessment and navigation should take place together, and in the context of a wider group of people. This would allow some chance of using non-service solutions as well, using the resources represented by other users, their families and their neighbours.⁹⁶ There may be informal or group solutions, for example, that might save money from their budget – for example providing companionship – and fulfil the brief more effectively. But unless these processes are integrated, then people getting direct payments may well miss out. This is the thinking behind the light touch shared assessment Common Assessment Framework used in children's services.

⁹⁵ One fruitful proposal suggests providing people with low, medium and high set budget packages, and reserving detailed assessment just for those who need budgets above that. At the moment, this is too complicated to envisage, given the way that values and prices are so different around the country, though there may be areas – like mental health – where this might work. See: Simon Duffy (2012), *Peer Power: An evaluation of the Personalisation Forum Group*, Centre for Welfare Reform, Sheffield.

⁹⁶ Department of Health (2012), *Caring for Our Future*, London.

Many local authorities fail to provide everyone with an assessment before advising them what their options should be, which is how the system was intended to work.⁹⁷ Officials in Nottinghamshire County Council told the review that they have a policy of delaying the financial assessment so that they can advise people on informal options first, and are able in this way also to give some support to people who are entirely self-funded.

This is a better way forward, and it is the intention of the new Care and Support Bill. But local authorities need to advise on the basis of helping people plan their support needs as early as possible, so that they can draw on a range of informal options for support around them, rather than just formal services – and with the intention of helping people avoid formal services if they can. This represents a new offer to people, even those who will be self-funders, and it means that people should also be asked what could be done to help them avoid the need for formal services.

This means that local authorities will have to merge the money they are spending on assessment with the various local services providing advice and brokerage. This would mean that people could be provided with help to work out their options at an earlier stage.⁹⁸ The Care and Support Bill will also allow local authorities to devolve assessments to social enterprises and other outside organisations, which will make this process easier and probably cheaper, because brokerage appears to cost less when it is done independently. The assessment also needs to be broader: people should be assumed to want to give back as well as receive, and will be able to do so through linkage to local peer-to-peer services (see Section 5). This is intended to help make the approach pioneered by Local Area Co-ordination in Australia much more widely available.

Recommendation 4

Replace the current entitlement to an ‘assessment of needs for care and support’ with an entitlement to an asset-based assessment. This would take into account someone’s capabilities as well as their needs and the various informal and community resources available to them, rather than assuming that formal services are the only solution to support needs.

Diverse social care market

The review heard evidence of a need for a much wider diversity of services, including potential competitors to the more impersonal care providers. The shortage of choice in the market, both for funded care and for self-funders, means that a more diverse social care market is needed, especially by encouraging new start-ups and by speeding up the emergence of new micro providers. The other concern is that every area needs, not just a range of new providers, but specifically a range of independent support brokers and advocates. Some of this can be provided by large private sector companies in the social care market, but it also requires small providers too.

⁹⁷ The National Audit Office found that 60 per cent of local authorities have no idea how many self-funders there are in their area: National Audit Office (2012), *Oversight of User Choice and Provider Competition in Care Markets*, Stationery Office, London.

⁹⁸ This builds on the experience of Local Area Co-ordinators in Western Australia who have been able to use this approach very successfully to provide people with more appropriate social care since the 1980s. See Ralph Broad (2012), *Local Area Co-ordination: From service users to citizens*, Centre for Welfare Reform, London.

This policy needs to be designed in such a way that it can tackle a series of related problems:

- The need for more intermediary organisations capable of supporting people to employ personal assistants. The review found examples of local authorities making the legal and HR departments available to direct payment recipients, and of intermediary organisations which take responsibility for employing personal assistants (the National Audit Office found a range of different amounts of planning support available).⁹⁹ Charities like Age UK provide this service in some areas, and other options are facilitated by the National Brokerage Network, but again more options are needed, like MySupportBroker (see Appendix F).¹⁰⁰ If direct payments are going to be expanded rapidly, then the market is still too narrow to provide them with a broad choice.¹⁰¹
- Competition to provide alternatives to poor social care providers, and in such a way that it provides a better choice for self-funders and provides a standard which can improve services for people on funded care.
- The need for a wider range of services available for people on direct payments.
- The need for people to have access to informal or mutual services, like time banks or help to pool the budgets so that they can go further.

The review team visited Nottinghamshire and saw how one worker, in this case employed by the charity Community Catalysts, was able to encourage the emergence of 45 new micro-providers over two years, and to work closely with the county council to shape the new care market (see Appendix F). This personal approach to creating new businesses, using techniques like coaching and support, needs to be rolled out more widely, especially in areas that are suffering economically.

The review heard from micro-providers that the main barriers to growth was not so much start-up finance, because many of these start as sole traders, but start-up advice and support and an end to the local authority approved provider lists. The review heard the argument that there needs to be a continuing role for lists in the absence of more stringent quality assurance from the Care Quality Commission, but in practice these lists are used too often to keep out innovative new entrants to the local market. The review heard about local authorities which have closed their approved supplier lists, but – even when they are open – there is often an ambiguity over whether these are simply lists of local authority contractors or lists of local suppliers with some kind of quality kitemark.

The London Borough of Bexley has managed to end block contracts altogether, although there may still be a transition role for these as a means of reducing prices for local authority care. This has to be the direction of travel (see Appendix F). In the meantime, local

⁹⁹ National Audit Office (2012), *Oversight of User Choice and Provider Competition in Care Markets*, Stationery Office, London.

¹⁰⁰ In Control found that only 15 per cent of those surveyed had received help in planning their personal budget from someone independent of the council or the NHS. This research found that people who had received help from somebody independent of the council or NHS 'reported more positive outcomes particularly relating to getting and controlling better paid support.' The authors concluded that independent support with planning apparently had 'the most positive impact'. See: Chris Hatton and John Waters (2011), *The National Personal Budget Survey*, In Control and Lancaster University, 27.

¹⁰¹ Sam Bennett and Simon Stockton (2011), *London Joint Improvement Partnership (JIP): Best practice in Direct Payments Support – a guide for commissioners*, Joint Improvement Partnership, London Councils, London, 6.

authorities need to be able to demonstrate that their provider lists are open to new entrants regulated by CQC without demanding bureaucracy.¹⁰²

Letting go controls

The other requirement is that local authorities need to let go of control over where people on direct payments and personal budgets spend their money. There ought to be a clear ruling that, once a personal budget has been agreed, the sole constraint is that they must spend it in line with the broad outcomes agreed at the assessment. There needs to be a wider understanding that – as long as spending is designed to achieve the agreed outcomes – then the choice belongs to the personal budget holder, not the local authority.¹⁰³

The new Care and Support Bill might help this situation by defining personal budgets in law, but these statements have been made before, and there is no evidence that articulating this message again will change the way some local authorities micro-manage personal budgets. What can be done is to make sure everyone who is applying for a personal budget should have access to independent advice and support if they need it – and that this should apply to all personal budgets, and not just to direct payments (both need to have the same freedom to choose). In the medium term, this might be achieved by top-slicing all personal budgets so that advice services could be funded locally for everyone. But what can be done immediately is to lay a duty on local authorities to signpost them towards local and national advice services early in the process.

Recommendation 5

Develop a more diverse social care market, by:

- Phasing out the use of preferred provider lists for buying social care services, and in the meantime making sure that they – and virtual marketplaces – are open to new entrants and are not used as the only menu of options in support planning.
- Giving local authorities a duty to signpost social care users to where they can access independent advice and support so that they can spend their personal budget to best meet agreed outcomes.

¹⁰² Jenny Fisher, Mary Rayner and Sue Baines (2011), *Personalisation of social care and health: A co-operative solution*, Manchester Metropolitan University and Co-operatives UK..

¹⁰³ Think Local, Act Personal, 'Improving Direct Payment Delivery', October 2011.

6. Choice in education

The review looked broadly at people's experience of choice of schools, as well as wider choices that people make within schools. Responses indicated that:

- The system of expressing choice of schools succeeds in keeping most people happy, partly by downplaying the word 'choice' - but there are exceptional areas where education choice has become complex and stressful.
- There is a gap in available information when it comes to providing parents with information they really want about schools. This has exacerbated the stressful competition between schools in some areas.
- There is some frustration about the inflexibility of subject choices within schools.

Existing choices

Parental choice of school has been in place since the Education Reform Act of 1988, though this is more accurately described as 'expressing preferences'. Existing rights include requesting a place at a school other than your local catchment area school, and appealing against the decision if the request is turned down. Education authorities have a duty to meet this request if there is space at the school, but not if it is over-subscribed.

Information is provided via Ofsted reports and school league tables. Schools also have to show on their website various details, including how much money they get from Pupil Premium pupils, what they do with it and the effect it has had, how parents view the school as well as details of the curriculum, admission criteria, behaviour policy and various performance data.

Current policy

The Schools White Paper, *The Importance of Teaching*, set out a reform programme for the schools system, including more academies and free schools, a strong strategic role for local authorities, and changes to school performance tables, Ofsted inspections and governance.¹⁰⁴ There are also tougher standards, which rise over time. The Pupil Premium now allows money to follow the most disadvantaged pupils to try and redress the imbalance of funding, which has tended to go to the wealthier schools, and this goes hand in hand with policies to devolve more responsibility to schools.

Academies are taking more responsibility for their own admissions, including appeals against refusal, though their systems must comply with the Schools Admissions Code. The Academies Act 2010 allows schools that already select any pupils on the basis of ability to carry on doing so, but stops schools from adopting new selection by ability. But schools can still decide to take up to ten per cent on particular aptitudes.

The new law lets academies give priority to children "who are wholly or mainly drawn from the area" where the school is. This means that an academy's admission arrangements must allow for the majority of pupils admitted to be those living close to the school. Academies and free schools have to stay part of the admissions procedure co-ordinated by the local authority. When drawing school catchment areas, schools "must not exclude particular

¹⁰⁴ Department for Education (2010), *The Importance of Teaching*, London.

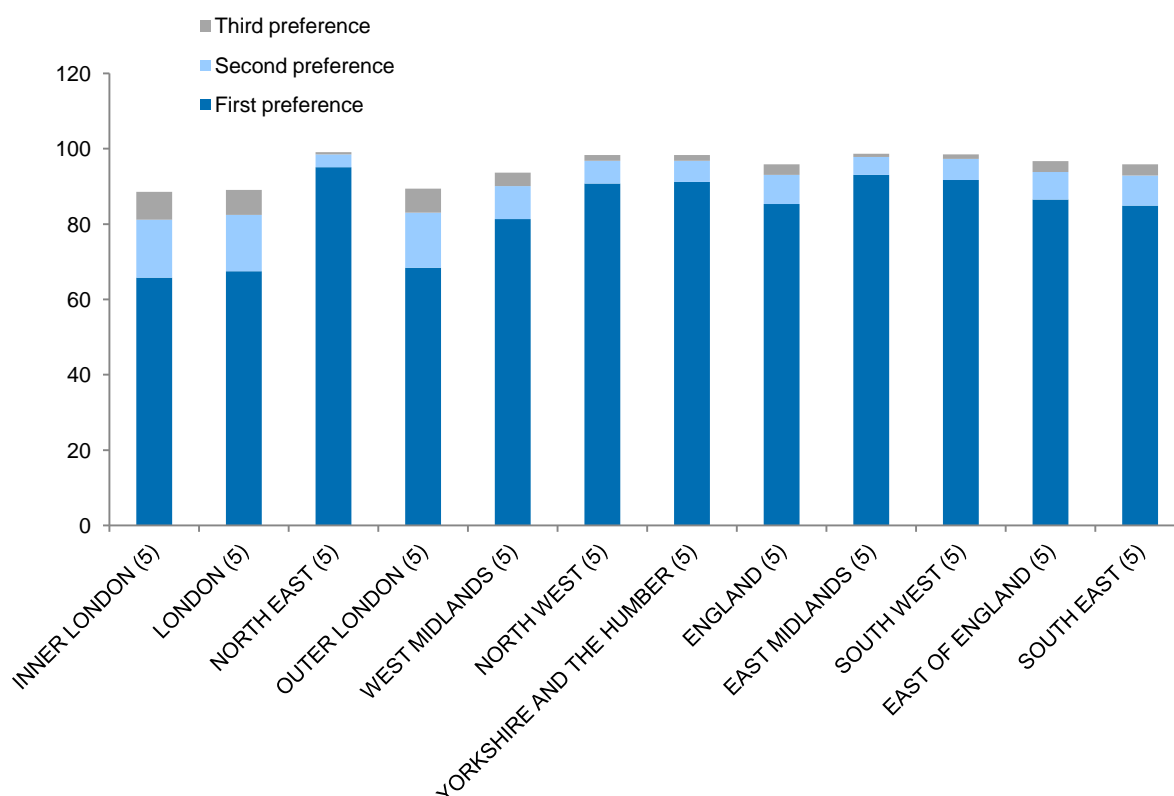
housing estates or addresses in a way that might disadvantage particular social groups" - and choices of feeder school should not "unfairly disadvantage children from more deprived areas".¹⁰⁵

Since 2002, league tables have included indicators of the value added by each school. The national pupil database will allow that information to be available on a pupil basis.

Research evidence

The current admissions system, though highly complex to administer, is relatively simple to use. Although it has different features in different local authority areas, it covers everyone. There is no issue about whether everybody is able to take part. On that basis, 85 per cent of parents got their first choice of school in 2011.¹⁰⁶ This varies across the country: the following table shows the regional variation, with the north east providing 95 per cent of people with their first choice of school.¹⁰⁷

Figure 10. Applications and offers for entry to secondary schools in England, academic year 2012/13¹⁰⁸



This high figure needs to be tempered by the estimated 9 per cent of parents who censor their first expressed preference because they do not believe they will get it.¹⁰⁹ But this still implies that three quarters of all parents were given what was a genuine first choice. The high level of appeals against the decisions shows that areas like London are particular

¹⁰⁵ Department for Education (2009), *Schools Admission Code*, London.

¹⁰⁶ Department for Education (2011).

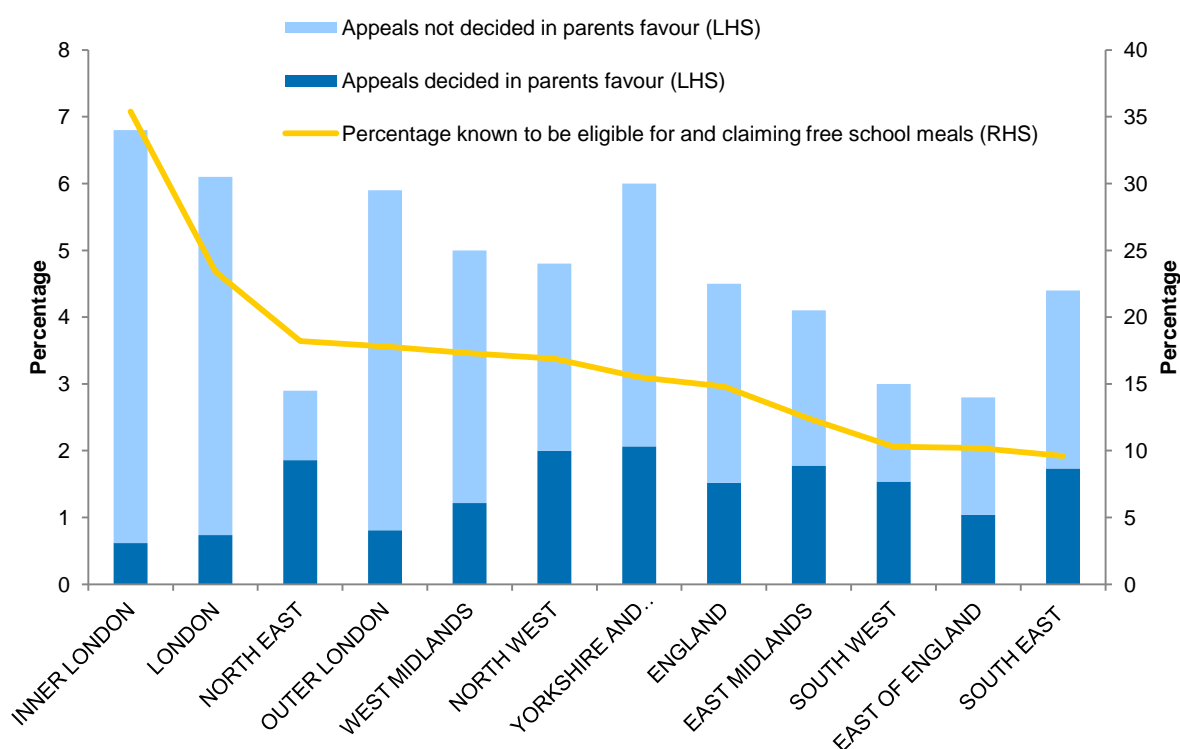
¹⁰⁷ The north east also has the lowest number of appeals at secondary level and by far the highest proportion upheld.

¹⁰⁸ Departments for Education figures

¹⁰⁹ Audit Commission. (1996) *Trading Places: The Supply and Allocation of School Places*, London.

problem areas. But in most places this is a success story. There is also good widespread support for the idea of being able to choose schools.¹¹⁰

Figure 11. Admission appeals for local authority maintained secondary schools in England, 2010/11¹¹¹



Less than half (46 per cent) of secondary school pupils go to their nearest school and, in London, this falls to a quarter, which could imply that people are exercising preferences where they can.¹¹² There is also evidence that about ten per cent of pupils travel more than 6.6km to go to school.¹¹³ The implication is that a small minority is taking advantage of their preferences to travel to better schools some distance away, though it is possible that some of these are simply pupils who have failed to find places nearer home. In London, pupils eligible for free school meals are proportionally more likely to live and attend school within the same local authority than their peers (83.3% compared to 75.1%).¹¹⁴ The implication of this could be that the more disadvantaged children are either choosing less, or are less able to exercise choice. Research also suggests that more educated parents tend to value academic standards, while less educated ones value proximity.¹¹⁵

The other difficulty about school choice is that, where the competition is fiercest, then the schools increasingly do the choosing, not the parents. This is an inverse of the implication of 'school choice'. This is one area where competition and choice do not work hand in hand. The way that proximity is used as a tie-breaker to decide between pupils applying to

¹¹⁰ 81% say that parents should have a great deal of choice or quite a lot of choice of schools. See: British Social Attitudes Survey (2009), Sage Publications, London. The Ipsos MORI survey found that this rises to 94 per cent.

¹¹¹ Department for Education figures

¹¹² Simon Burgess, Adam Briggs, Brendan McConnell and Helen Slater (2006), *School Choice in England, Background facts*, CMPO Discussion Paper 06/159, Bristol.

¹¹³ Burgess et al (2006), 6.

¹¹⁴ Department for Education (2010), *Statistics of Education: School Destinations of Secondary School Pupils Resident in London Boroughs*, 2010.

¹¹⁵ Simon Burgess et al (2009), 'What parents want: school preferences and school choice', CMPO working paper 9/22, Bristol.

oversubscribed schools, means that equality of access is not yet a reality.¹¹⁶ There are particular barriers for migrant children.¹¹⁷

Choice barriers

The review team heard from parents, grandparents, pupils and those who administer the system. Their evidence suggested that the idea that parents can express preferences between schools now seems to be widely accepted and understood by people, even taken for granted. But although education is said to be an area where people can choose between service providers, most parents seem to accept the system more or less at face value, and understand that it is not 'choice', strictly speaking, but the opportunity to express preferences. They are encouraged in this by local education authorities, which consistently explain that this is about preferences, and that it is these preferences – not people's 'choices' – which have to be taken into account.

The parents the review engaged with suggested that, in most places, arrangements around school choice were meeting their needs, though there were some important exceptions to this and there are clearly areas – like London and Kent – where this is not the case.

“There were 31 siblings going into the school we wanted for the twins, and our second choice offered only one place, so now we have to drive five miles.”

Parent, Hertfordshire

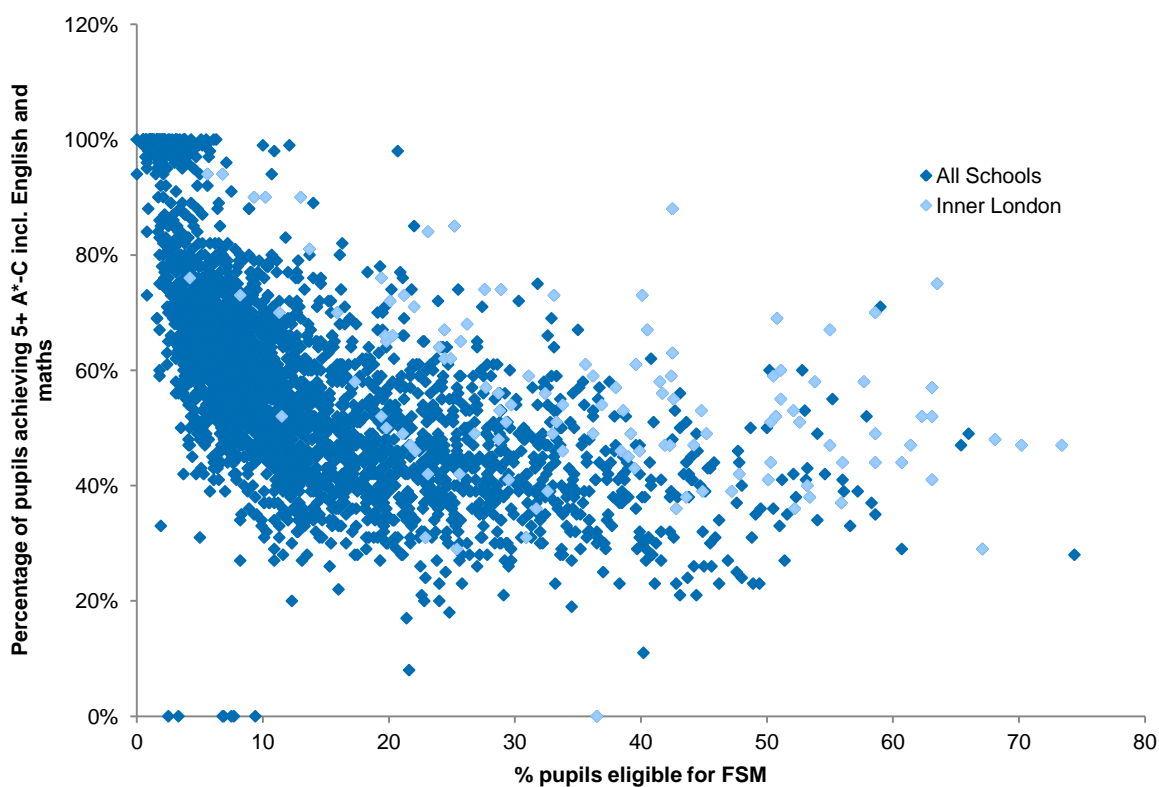
System barriers

Despite the introduction of school choice, and as the research above showed, the basic pattern remains that the better-off tend to congregate in the best performing schools, giving wealthier people a better range of school choices. Those more disadvantaged pupils are often excluded from the best schools simply by high house prices in the catchment areas of the better schools, but also because the league tables provide incentives to schools not to take them. The table below shows how Free School Meal pupils tend to be in the less successful schools:

¹¹⁶ Simon Burgess et al (2011), 'Parental choice of primary school in England: what types of school do different types of families really have available to them?' *Policy Studies*, No 5, March.

¹¹⁷ See for example Bridget Byrne and Carla De Tona (2012), 'Trying to find the extra choices: Migrant parents and secondary school choice in Greater Manchester', *British Journal of Sociology of Education*, Vol 33, No 1; and C. Bagley, P. A. Woods and G. Woods (2001), 'Implementation of school choice policy: Interpretation and response by parents of students with special educational needs' *British Educational Research Journal*, Vol 27, No 3.

Figure 12. Performance for Maintained secondary schools that were open for the period April 2009 to March 2010, showing how free school meal pupils tend to be in lower performing schools¹¹⁸



Access

The difficulties around school choice that the review heard about tended to be in areas where the competitive pressures are highest, in London and Kent for example.¹¹⁹ If pressures on school places intensify – as they almost certainly will in a period of rising population – we can expect this to impact most powerfully on the most disadvantaged. A recent report by the Academies Commission said that the improvement across academy schools has not been strong enough to transform the lives of children from the poorest families, and that some schools manipulate admissions criteria to select more able pupils.¹²⁰ As population pressures increase, these crisis areas seem set to grow. As many as 34 per cent of parents in London already say they don't have an option of a good school.¹²¹ The number of pupils who got their first preference at secondary level in London last year was only 67.2 per cent, though that was a slight improvement on the previous year.

Capacity

The review was told about the stresses caused to parents when they believe the choices before them are inadequate.¹²² The medium-term solution may be to encourage better

¹¹⁸ Department for Education figures

¹¹⁹ The number of appeals are running at 4.5% at primary level and 5.9% at secondary:

<http://www.education.gov.uk/rsgateway/DB/SFR/s001068/sfr11-2012.pdf>

¹²⁰ Academies Commission (2013), *Unleashing Greatness: Getting the best from an academised system*, London, Jan.

¹²¹ Sean Worth and Colleen Nwaodor (2012), *Do the Public Back More Reform of Public Services? An overview of the latest opinion research*, Policy Exchange, London.

¹²² There are more than 444,000 spare places in the English schools system.

schools to expand, and equally to find ways of shifting the capacity in failing schools, as well as opening new ones. In the meantime, the evidence suggests that school expansion, which is supposed to be providing more places at the better schools, is not working as intended (there is anecdotal evidence that the poorer performing full schools tend to be expanding faster than the better performing full schools, which are often reluctant to risk losing the atmosphere and scale which they believe contributes to their success).

The review heard that there is stress around applying for the better schools, and frustration that people are able to get siblings into schools after they have moved away from the area. Not having access to transport seems to put poorer children at a disadvantage.

The least advantaged in the system, looked after children, have been given more powerful privileges. They can go to the top of the queue in most schools, but research suggests that these are often not being used.¹²³ In fact, looked after children are much more likely to be in the lowest performing schools.¹²⁴ It is true that schools selecting on academic ability alone do not have to give looked after children priority, but this is not enough to explain the figures. More research is needed to find out why these places are not taken up before we can fully understand this problem, but lack of transport seems one likely explanation.

“Choice needs to be tempered with reasonable expectation and an understanding that what people are getting is not genuine choice.”

Local education official

“They go into these secondary schools and they are vast and very overwhelming, and it isn’t right for all kinds of children.”

Parent, Hertfordshire

Bureaucracy

The review heard that the system for allocating school places is extremely complicated. Where capacity is in the right places, and where standards are regarded as generally high, then the burden of this complexity falls largely on the officials charged with making the system work. Where there are problems, either because of capacity or diversity of standards or a combination of the two, and parents want to be able to use their preferences more effectively, then the stress falls also on them. This means they need to understand the rules and arrangements better.

Free schools are a mechanism for expanding choice. But the review heard that the emergence of free schools, and the independence of academies, has added an extra layer of complexity to an already complex system. All these schools, as well as the faith schools, have their own criteria for dealing with over-subscription, involving a complex mixture of proximity, religiosity, academic ability and catchment areas.¹²⁵

¹²³ In London, where the total number of FSM pupils are, they travel less far to school than non-FSM pupils: Department for Education (2010), *Statistics of Education: School Destinations of Secondary School Pupils Resident in London Boroughs*, 2010.

¹²⁴ Department for Education (2011), *Raising the aspirations and educational outcomes of looked after children: a data tool for local authorities*, July.

¹²⁵ The rules governing the secondary schools in Kent are a good example of this, see: <https://shareweb.kent.gov.uk/Documents/education-and-learning/school-education/applying-for->

The downside of choice emerges for people, in practice, where the system is fraught, and the business of choice becomes stressful. This can mean difficulties for parents who search for more certainty by uprooting their families, or for children who have to take exams or prepare for exams intensively, sometimes from the age of six. That complexity can complicate life for people in the state system, whatever their circumstances, but it is bound to impact most on the most disadvantaged children.

“There are children being coached in Kent from the age of six. There are private schools here which have the sole aim of getting children into grammar schools. A lot of the children who are sent there are also coached privately outside the school. What a life.”

Independent education advisor, Kent

Information

As the system becomes over-stretched, as it is doing in some areas, the review heard how the ability to choose a school becomes limited by the ability or willingness to understand the way the rules work in each school. In London, where the system is under the most intense strain, the review heard about a gap between the information that parents say they want in order to make a good decision – indicators to suggest the happiness of pupils and the range of the curriculum – and the information they are actually given by Ofsted and in the league tables.¹²⁶ This may change in the future as more online tools become available, but they do not exist in the necessary format yet. In the meantime, the disappearance of the Connexions service has ended some sources of advice for pupils. A basic pre-requisite for choice to be available is for public service users to know that choice is available. There are now regulations about what schools must publish on their websites. The emergence of websites like ParentView are part of the answer.

As is in other public services, there is a trade-off to be made between raw data and information which is too processed and crunched together to fully understand. There is also scepticism about the official data in education, both among parents and professionals.¹²⁷ They can see, from their own experience, that league tables can be manipulated by schools – to the extent that schools higher in the league tables may be there partly because they have taught too closely to the tests, perhaps at the expense of a more rounded education.

There are ‘choice advisors’ remaining in 88 per cent of local education authorities, a reduction over the previous year, after the cut in the ‘area based grant’ which was used to pay for it in 2010.¹²⁸ In practice, many of these are existing staff with extra outreach duties. They are charged with providing advice independent from the admissions team, and some local authorities have shifted those resources into training other outreach staff. The difficulty is that, if they are council employees, they are often not able to tell parents what they really need to know – about the likelihood or advisability, for example, of getting into particular schools. The review heard that they tend to get trumped by informal advice from other parents at the school gate, which may or may not be accurate.

[school/Arrangements2012/Consultation%20on%20Admissions%20to%20Community%20VC%20Secondary%20Schools%20in%20Kent%202012.pdf](#)

¹²⁶ Fiona Millar and Gemma Wood (2011), *A new conversation with parents: how can schools inform and listen in a digital age?*, Family Lives, London.

¹²⁷ MORI poll for General Teaching Council for England, 2005.

¹²⁸ Office of the Schools Adjudicator (2011), *Annual Report*, Darlington.

The review was also urged to recommend communication training for teachers to help them find it easier to communicate with parents.

“I want to know whether my child will be happy in the school. That is more important than academic record. I want a school that can help with emotional development as well.”

Parent, Hertfordshire

Flexibility

While some measure of choice of schools seems to have been achieved in some parts of the country, partly by reducing people’s expectations, the review heard from young people that there is frustration about the lack of choice *in* schools. Inflexible streaming and complex timetabling decisions tend to lock children into pathways without the chance to do the combination of subjects that most excites them.¹²⁹

Sometimes courses are offered and then withdrawn from one year to the next. This must often seem inevitable because it depends partly on staff available. But, in practice, articulate parents can often persuade schools to be more flexible in the way that disadvantaged people tend not to, and some schools are more flexible than others at accommodating individual needs with the help of other schools or by teaching after hours. This is partly an information problem. It can be difficult finding out about what courses are on offer before admission to secondary schools, despite what is on individual school websites which do not always explain the intricacies of combinations of subjects.

“What maths set you were in determined what languages you could learn. I was in such a low maths set that I couldn’t do Spanish. I would have loved to have learned Spanish.”

School leaver, Norfolk

“I really wanted to do a music diploma, but they told us that they couldn’t get the teachers on the very last day of term.”

“The academic split encourages bullying. I am in the same year as [xxx] but we haven’t spoken before and I wanted to do a subject from her stream, but I wasn’t allowed to.”

School students, Leeds

Next steps

The review talked to a range of education authorities charged with administering an increasingly complicated system with transparency and fairness and, with demographic and competitive pressures rising, this may become increasingly difficult. Local education authorities will then bear the brunt of this with few resources or powers to increase capacity. The need for new capacity in the system is a clear conclusion to be drawn, but this is outside the scope of this review. Other conclusions:

¹²⁹ There is a continuing problem of a lack of information for sixth form applicants: see Office of the Schools Adjudicator (2012), Annual Report 2012, Darlington.

- Some people need more help to steer effectively through an increasingly complex system.
- We need to find ways of making sure the least advantaged children have fair access to the best schools, as they define them, without increasing the stresses of the system for everyone else.
- Choices inside school are often too rigid and inflexible.

Giving access to the least advantaged

The review considered how it might be possible to find ways of spreading demand more equally through the system. Lotteries are unpopular and assume that everyone has an equal right to a place in a popular school, which is not always accurate.¹³⁰ But without some action, the danger is that – in some places – intense competition between the best schools can undermine the choice agenda, when a handful of the best performing schools become the focus of attention from parents. This is an inversion of the basic idea of choice, where the users are supposed to be able to do the choosing, and it risks trading off competition against choice.

It seems likely also that, in parts of the country with rapidly increasing populations, this alone will bring extra pressure to bear on the choices of the most disadvantaged pupils (see above). There are other elements which complicate the situation, for example the existence of ‘super-selective’ state schools, and other areas where school places seem artificially scarce because one school hugely outperforms the others.

The usual response is that policy-makers must shift where the capacity exists by getting the best schools to expand, and by replacing the worst. But there is resistance to expanding among the best schools (see above). This is not unreasonable if they believe that their human scale is part of the secret of their success. In cities, in particular, there are other constraints to expanding on existing sites or where it would mean losing valuable green space.

Schools are now able to change their admissions policies to include more free school meal pupils, but have no real incentive apart from the value of the pupil premium to compensate them for the extra cost and the danger to their league table positions. The pupil premium may provide some of that extra power to disadvantaged applicants; equally it may encourage the poorer performing schools to expand faster, given that they have more free school meal pupils.¹³¹ There is a therefore danger of a gulf opening up between successful, smaller schools and the increasingly large-scale institutions that cater for the rest of the population, which can give that much less individual attention. There may be so many constraints on good schools expanding that it would be foolhardy to rely on it happening.

Giving the least advantaged more power to overcome their particular barriers to choice means finding ways of making schools feel more responsible for meeting their needs. The review considered whether inward-looking admissions criteria, for example by faith and super-selective schools, ought to be balanced by a broad duty to promote a social balance inside the school. State-funded schools which do not adopt some responsibility for the wider well-being of their neighbourhood may not be fulfilling the social contract that people might

¹³⁰ They were less than popular when used in Brighton.

¹³¹ There is some evidence that this is happening now.

reasonably expect of them.¹³² This is complicated by the debate about faith schools. These play an important role providing a faith alternative way of providing education for their own adherents. But the original purpose of faith schools was also to fulfil the demands of their faith by providing for the local neighbourhood, and this objective may have become too secondary.¹³³

A duty along these lines would not undermine the academic focus of super-selective schools. But if schools narrow their intake to those who can afford the coaching to pass entrance exams, then they may owe their neighbourhood some route whereby less advantaged local people can aspire to get their children up to that standard.

But the real problem here is that the existing league tables discourage schools from taking pupil premium pupils. For that reason, the review proposes an additional approach to devising league tables, aware that even value added tables benefit the better off, because they are believed to be easier to add value to.

The position on the league tables is an extremely powerful counter-pressure on schools not to risk varying the social balance of their intake. The debate about how to measure contextuality looks as though it will remain unresolved. But, as a first step, there needs therefore to be a new league table which measures prospect transformation.¹³⁴ It would be published in parallel, showing the performance of all schools with their free school meal pupils, and excluding those schools which accept well below the national average of free school meal pupils. The impact of the transformation league table will depend on it being celebrated, and providing strategic advantages for those schools which score well.

Recommendation 6

Devise and publish a parallel 'opportunity transformation' league table, comparing the performance of schools in achieving the best outcomes for free school meal children and narrowing the attainment gap.

Building the diversity of schools

One way of broadening the choice in problem areas is to increase the diversity of schools, so that the focus is less relentlessly on too few of the best schools as narrowly defined. Providing broader information about the varied curriculums and areas of special expertise of schools is likely to increase the choice, because you can find schools that suit your child more precisely, and this seems likely to happen under current policies (see Section 5). Increasing the number of specialist schools can also seem to reduce local choice, especially if your only local school is a maths specialist school, for example, and that is not what you want. But if diversity could go beyond simple specialisms, then this may provide a genuine basis for broadening people's interest in a wider range of schools.

¹³² The Academies Commission has proposed that academies should publish socio-economic data about pupils who apply and pupils who are admitted, see Academies Commission (2013), *Unleashing Greatness: Getting the best from an academised system*, London, Jan, 8.

¹³³ See the Bishop of Oxford's intervention along these lines, BBC News (2011), 22 Apr.

¹³⁴ Hampshire County Council experimented with parallel information to the league tables to help schools understand their own value-added abilities in the late 1990s. See: Beth Foley and Harvey Goldstein (2012), *Measuring Success: League tables in the public sector*, British Academy, London, 28.

The review heard about the difficulties parents find in getting hold of detailed information about the subjects and successes of each school. The league tables are too narrow to provide what parents need, and tend to focus attention on a smaller number of schools. There is also a need for other sources of advice on schools admissions, and independent information about how best to express preferences locally with the greatest likelihood of success, which is covered further in Section 5. Other information required includes:

- Other measures of success including truancy and staff absenteeism.
- Information about specialisms, subjects and combinations of subjects, after-school activities and projects.
- Comments by other parents about atmosphere, bullying, successes and different approaches.

This data is often available and is increasingly being released. The review team also met parent groups who had organised to meet their own information needs with websites or Facebook pages, sometimes independently of the schools. New sources online will also emerge, with detailed feedback from service users, but they need to be tested out in similar formats to those emerging for health and which are planned for social care. There are fears that online feedback will come mainly from disaffected parents, and maybe even pupils, and it is important that schools pilot the kind of systematic Family and Friends test – asking parents whether they would recommend their children’s schools, asking why and publishing the results online – that is being tested out in health.

This can be organised regularly through Ofsted and may allow the best schools to delay formal and more expensive inspections when they are organising these tests regularly and the feedback is positive, which would eventually allow savings of £3-£4m that would be required to cover the whole country.¹³⁵

Diversity of subject

But information is not enough to provide the kind of flexibility about the range of subjects that pupils told the review team that they wanted. Schools are in a difficult situation here, dependent on staff who may leave and change what they can offer, just as they need to juggle existing resources to maximise the subjects on offer. On the other hand, one reason seems to be that schools put the less able pupils in for a narrower range of qualifications so that they can contribute more effectively to their league table position.¹³⁶

The review heard enough stories of disappointment – especially among children who were in lower streams – to know that this could have an important impact on some pupil’s education. It is also an area where confident and articulate parents can make a difference, but those who are less confident find themselves having to go along with whatever limitations the schools impose. Equally some schools are prepared to be more flexible: the Physics Factory has been one successful project sharing resources which allowed pupils to cover other

¹³⁵ This is based on comparisons with healthcare.

¹³⁶ Dale Bassett et al (2009), *Core Business*, Reform, London. Alison Wolf also showed that inclusion of non-academic qualifications in league table measures led to very dramatic increases in the numbers being taken, see Alison Wolf (2011). *Review of Vocational Education: The Wolf Report*, Department for Education, London.

subjects like engineering, and there are many examples of schools sharing resources to give pupils more of a choice.

What is required is a right to request a different subject – perhaps limited to subjects that are being taught in other schools in the same local authority area. This would not force schools to comply when it is genuinely impossible, but it would encourage them to make an effort – to find ways of teaching after school or swapping with other federated schools, or providing the service for a range of local schools – or explaining why not. Their answers should be published along with other information about the school.

Recommendation 7

Increase the diversity of schools, by:

- Trialing an annual online 'Friends and Family' test for schools, asking parents if they would recommend the school and why, with data collated by Ofsted, and made available, paid for by less frequent inspections of the more successful schools.
- Giving pupils a right to ask to study subjects which curriculum arrangements currently make difficult, with a responsibility for schools to comply or respond with good reasons if they are unable to.

7. Cross-service issues

Two cross-service barriers emerged, both from the round tables organised by the review, and from the Ipsos MORI survey. These were:

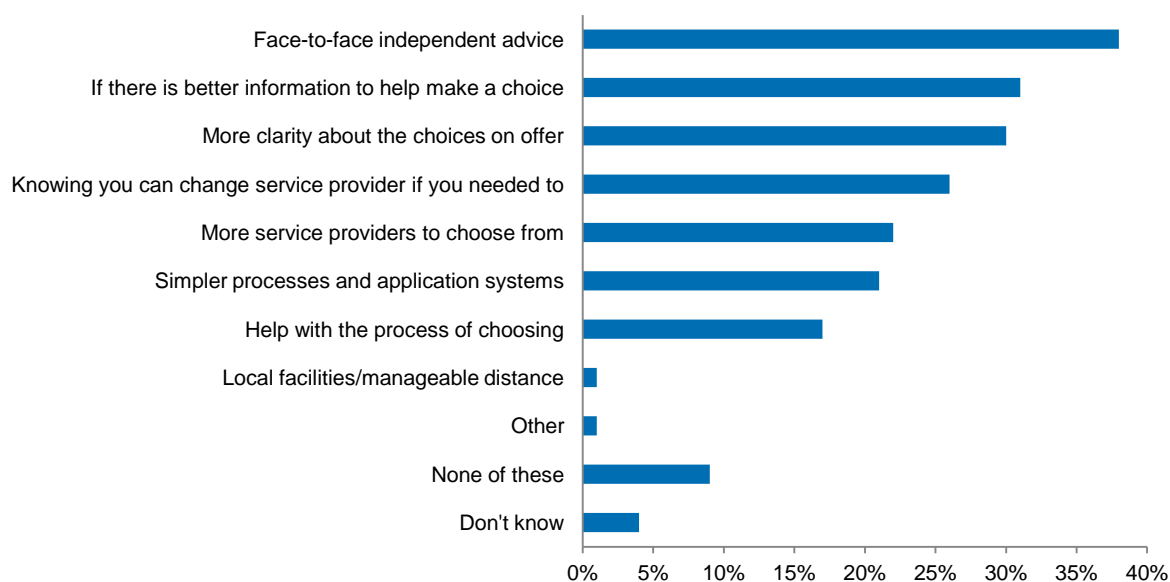
- The need for better information about choices, and access to face-to-face advice capable of interpreting it.
- A gap between people's expectations of choice and what they actually get.

This section looks at these two issues and proposes solutions which are capable of providing broad impacts across services. In both cases, the recommendations propose measures which might tackle multiple issues at the same time.

Navigation

The most obvious barriers to choice which emerged from evidence to the review was the simple lack of information that people need to make informed choices across public services, especially where people need more than just data, and require face-to-face advice or interpretation to make sense of it. The issue came up in all the other sections in this report.¹³⁷ This may explain why the most common answers to the Ipsos MORI survey about how to improve the way choice works were all about information, with face-to-face independent advice at the top of the list:¹³⁸

Figure 13. Which two or three, if any of the following, would be helpful when making a decision about what (school/provider of support or social care services/GP surgery/hospital) to choose? (N=1485)¹³⁹



¹³⁷ Jones and Mayes (2009). Poor information was identified as a key barrier to choice in the evaluation of the London Choice Pilots in 2005. See: Ferlie E. et al (2005), *NHS London Patient Choice Project Evaluation, Organisational Process Strand, final report*, Royal Holloway, London.

¹³⁸ Face-to-face independent advice is the top way of improving decision making across all four services. Respondents who stated they did not make a choice of service are more likely than those who had a choice of options to say more clarity about the choices available (34%) would be helpful, as would having more providers to choose from (26%). Low earners (earning up to £21,000) are more likely than higher earners (£48,000+) to say they want help with the process of choosing (21% and 7% respectively).

¹³⁹ IpsosMORI, Choice Review Survey 2012

“I struggle with the internet. I don’t know about half the services on offer. I have got a lot of people involved in my care and I don’t know where to turn.”

“The average person in the street would not be aware of the system. Navigation is part of what needs to be available – signposting people.”

Care service users, Lincolnshire

This is a problem for some disadvantaged groups, particularly if key information is only available on the internet, and for a range of reasons they are unable to access the internet directly, perhaps because they are visually impaired, or perhaps because they have never mastered computers.¹⁴⁰ This is especially a problem for people who find written descriptions, and especially written descriptions online, difficult to access.¹⁴¹ It is sometimes because key information is too voluminous for people unused to processing it in that form. The review heard from people who said that they found too much data unhelpful when making a decision and preferred to rely on advice from professionals.¹⁴²

“Choice – do people use this term? Do they care? No, because they don’t know it’s out there.”

“It all comes down to which door you knock on.”

Social care service users, Poole

Choice is fine, but it needs to come with advocacy – so people understand what that means to them, how navigate the system. It’s a very confusing place. A piece of paper is no good.”

Social care user, Grimsby

The challenge

Some public services have tried to address this problem by experimenting with ‘choice advisors’ or ‘choice navigators’, but they were an extra professional cost and most have now disappeared, though there are some exceptions. There are some choice advisors still employed by local education authorities, some also whose task is to advise on subject choice rather than school choice (see Section 4). There are still some professional choice advisors in youth services. GPs play a continuing and vital role.¹⁴³ Often people will use specialist nurses like physiotherapists, who people see for more often and for longer periods, to advise them informally. Apart from doctors, there was praise for patient care advisors and

¹⁴⁰ This mainly applies to older groups, but there is evidence that some young people do not find the internet easy for making decisions, see: Jamie Bartlett and Carl Miller (2011), *Truth, Lies and the Internet: A report into young people’s digital fluency*, Demos, London.

¹⁴¹ Research suggests that one in three people over 65 are unable to understand basic written instructions about taking an aspirin tablet, see: Sophie Bostock and Andrew Steptoe (2012), ‘Association between low functional health literacy and mortality in older adults: longitudinal cohort study’, *BMJ*, 15 Mar, 344. In social groups DE, only 64 per cent of men and 50 per cent of women have access to the internet, see: Ipsos MORI Social Research Institute (2011), ‘No decision about me without me: Challenges for the NHS’, presentation, June. Many older people in all classes do not use computers. For visually impaired people and some other disabled people, there is really no alternative to face to face conversation.

¹⁴² One of the main reasons why people decide not to choose differently is that they say they had too little information to help them decide. Very few seem to use official sources of information. The 2009 study found that only 8 per cent used a booklet about choice to help them, and only 5 per cent used NHS Choices. See: Jones L. and Mayes N. (2009), *Systematic review of the impact of patient choice of provider in the English NHS*, London School of Hygiene and Tropical Medicine, London

¹⁴³ 49 per cent of people offered a choice of hospital used their GPs to provide the information they need (see: Department of Health (2008), *National Patient Choice Survey*). As many as 67 per cent *want* information from their GPs to help them choose, (see: Coulter et al (2005)).

the help they used to give, not just advising on choices, but facilitating them too.¹⁴⁴ There is also a formal navigator system set up through Choose and Book where patients can ask for a ‘choice discussion’ over the phone.¹⁴⁵ The evaluation of the personal budgets in health pilots also pinpointed the need for information if the full cost saving potential was going to be realised.¹⁴⁶

One area of public service where choice is extremely hard to roll out without advice and support is in social care. This advice or ‘brokerage’ for people who get direct payments is often done by social workers, but is sometimes provided by specialist brokers who are contracted as part of the personal budget in return for a set percentage (see Section 3).

The review heard that professionals were resistant to formalising their relationship with clients with formulaic offers of choice. They are right to resist: it is often the informality and openness of that relationship which makes the kind of equal two-way conversation about options possible. Professionals need to be able to give advice – the ‘what would you do?’ question. Evidence heard by the review suggests that ‘informal’ approaches to choice are more effective: a face-to-face conversation with a professional is able to absorb variety, and is therefore more useful – and incidentally more cost-effective – than a formal, standard, call centre or online response.¹⁴⁷

“I couldn’t find any information on local services. I just got gobbledegook from the phone.”

Older woman, Dorset

“There was an information kiosk, but I played with it for ten minutes and it broke.”

Disabled man, Lincolnshire

“There is lots of information and leaflets but the human touch missing. I want to know what does this means for me? Someone who can help – a person not a leaflet or automated message.”

Social care user, Wiltshire

Potential solutions

The review looked at how existing institutions might be able to help. The proposed shift in the way social care assessments are done (see Recommendation 4) will provide some of this support. The review also looked at a range of projects, voluntary and public sector, which provide signposting using either professional ‘navigators’, or from local people who have some local knowledge and have been trained to listen effectively and help people make decisions, or from a combination of the two. Each of these methods have elements of navigation that they emphasise differently (see Appendix G):

¹⁴⁴ Jones L. and Mayes N. (2009), *Systematic review of the impact of patient choice of provider in the English NHS*, London School of Hygiene and Tropical Medicine, London.

¹⁴⁵ In practice only 55 per cent who phone Choose and Book have only actually been offered one hospital by their GP (information from NHS Direct). This makes a choice discussion difficult, and another 9 per cent should have been given a local number to call by their GP and haven’t. In any case, the Choose and Book service can only advise on hospitals and only on the narrowest aspects of the choice before patients.

¹⁴⁶ Julien Forder et al (2012), *Evaluation of the personal health budget pilot programme*, PSSRU/Department of Health, London.

¹⁴⁷ See for example John Seddon (2008), *Systems Thinking in the Public Sector*, Triarchy Press, Axminster.

- Local Area Co-ordinators (professional navigators and coaches, encouraging mutual support).
- Time banks (mutual support embedded in public services).
- Health champions (trained volunteers)
- Connected Care (participatory service planning and a variety of navigation solutions).
- Navigators (professional navigators and handyperson scheme)
- Village agents (signposting)
- Choice Champions (volunteers).¹⁴⁸

What all these projects have in common is that they cross departmental boundaries, acting as glue between people and a complex system, and that they start from where the client is rather than simply testing eligibility for set services. They all, to a greater or lesser extent, involve peer support.¹⁴⁹ They are also dedicated to relieving pressure on mainstream services. There is evidence that projects providing confident, trusted, independent support from fellow citizens are popular and cost-effective, and there is considerable experience now with social action through peer advice or support.¹⁵⁰ All of these co-produced projects (above) provide something of what is needed, but peer support network members would need extra training to provide people with face-to-face navigation as well.

Next steps for navigation

The extension of the benefits of choice to some disadvantaged groups depends on providing more information, advice and face-to-face navigation, and doing so across the whole range of signposting needs. But providing this using professionals alone has disadvantages: professionals carrying out this single function have tended not to survive in mainstream services when they were there before. The review concluded that it would be unsustainable to create another professional function in an already complex system. Any sustainable solution will have to:

- Be funded locally, on the basis of the savings it creates to local funders.
- Involve existing peer-to-peer networks, or co-produced services where they exist.
- Be able to impact on multiple problems around choice and beyond, rather than just one.
- Be able to advise on issues and provide support across public service boundaries.
- Knit with, rather than undermine, existing projects that are already working well.
- Be available where people are, in surgeries, hospitals, day centres and other public service settings.

There is considerable evidence about the cost-effectiveness of co-produced services which are able to provide peer-to-peer support in ways that broaden what public services are able to achieve (see Appendix F). There is also evidence that people believe what they are told

¹⁴⁸ These have begun in Wokingham after the Open Public Services report 2012, but are in their early stages.

¹⁴⁹ The idea of 'citizen advisors' in public services was also suggested in Ipsos MORI (2010), *Citizen Engagement: Testing policy ideas for public services reform*, 2020 Public Services Trust, London.

¹⁵⁰ Safran, Miller and Beckman (2006), *The Organizational Dimensions of Relationship-centred Care: Theory, Evidence, and Practice*. See also Department of Health (2004), *Chronic Disease Management: A compendium of information*, London.

by peers and volunteers more than council employees or professionals.¹⁵¹ There are broader advantages in giving people a more active voluntary role in public services.¹⁵²

The review therefore proposes that existing peer support or co-produced services, and existing service volunteer schemes like hospital friends, should pilot a trained extension to their role to provide more formal navigation, signposting and choice advice to other service users. If this turns out to be cost-effective, it would be a forerunner to a more ambitious attempt to roll out peer support and navigation across public services, linked together as a national network, diverse and locally controlled, which would bring the energy and effectiveness of the co-production approach to public services in every area.

There are many reasons why this co-produced approach is so important for the future of public services, and they have been rehearsed elsewhere.¹⁵³ But evidence suggests not just that this kind of project is able to improve the health and well-being of those involved, and provide a vital role for those outside formal work – including the young and old – but that it can also help prevent ill-health and other related social problems. By keeping people active and giving them a sense of usefulness, schemes along these lines can reduce the cost of public services and bring informal resources from the community to bear on problems.¹⁵⁴ Peer support groups can also rebuild social networks around services by tackling the following problems:

- Some of the transport needs for people who are unable to exercise choice of public services anywhere except at a very local level (though this will of course require additional local support to cover petrol and insurance).
- Some long-term support for people coming out of professional care, whether it is for depression, family breakdown or a range of other problems.
- Support and advice from long-term patients with diabetes, depression, asthma and other conditions for new patients with the same thing.
- Support for people just out of hospital, and a range of other DIY or befriending services which can broaden and deepen what public services can offer.
- The need to divert the most demanding patients or other users into mutual support which might be more beneficial.
- Support needs for patients with complex needs and their families navigating hospital systems (see Section 2).

The review's contention is that this kind of project, embedded in public services, is where navigation advice can be provided most effectively, as it is to some extent in the Community Health Champions project in parts of Yorkshire and in some of the Connected Care projects pioneered by Turning Point.¹⁵⁵ In a different way, with professionals at the heart – but the same co-produced approach – this is also the kind of service that is provided by the Local Area Co-ordinator approach in social care, which provided some of the evidence for the new-style assessments in social care (see Recommendation 4).

¹⁵¹ See for example Sloane B. C., Zimmer C. G. (1993), 'The power of peer health education', *Journal of American College Health* 41:241-245; and Milburn K.(1995), 'A critical review of peer education with young people with special reference to sexual health', *Health Education Research*; 10:407-420.

¹⁵² Department of Health (2006), *National Evaluation of the pilot phase of the Expert Patient Programme*, London.

¹⁵³ See for example: David Boyle and Mike Harris (2009), *The Challenge of Co-production*, Nesta, London.

¹⁵⁴ See for example Nesta (2012) *People Powered Health: Progressing towards co-production*, London.

¹⁵⁵ See Judy White et al (2010), *Altogether Better Thematic Evaluation: Community Health Champions and Empowerment*, Centre for Health Promotion Research, Leeds. Also: Turning Point (2012), *Connected Care: Impacts and Outcomes*, London.

Purpose: To pilot navigation advice and support in public services, via existing support schemes, and to test the impact on people's lives.

What we want to achieve: In the short term, the proposal is that training for navigation advice (interpreted broadly) should be provided for ten existing peer support volunteering projects in public service settings around England, mainly in health – and that this pilot should be evaluated to provide critical learning. The purpose is to provide choice, option and navigation advice, alongside other kinds of peer support, on a much broader basis.

Who will provide the support: The trainees will be existing service volunteers, hospital friends, time bankers, village agents, health champions, and will normally be long-term service users with experience. Evidence suggests that there will be no difficulty finding people who are interested in helping. Grimsby's Care Plus organisation has 270 volunteers providing more than ten hours a week. Newcastle's Hospitals Trust League of Friends has 150 members. The time bank at Rushey Green Group Practice in Catford has 200 members. Health Champions have 17,500 trained volunteers across Yorkshire.

Who will be supported: Anyone who requires navigation advice, across public services – and especially in healthcare, education and social care – or help with the internet or expert patient advice, either because they meet volunteer navigators on duty in public service settings or because they are referred by professionals.

Where will the pilots take place: Existing peer support schemes will need to apply for this funding to pay for the training and mentoring, which would be provided centrally under a contract that would also need to be open to bids from existing organisations providing similar services.

Cost effectiveness: There is considerable evidence of the savings in spending made possible by peer support generally (see Appendix F), and the evaluation of the Expert Patient Programme – which looked just at the savings from improvements in the health of those who were trained expert patients – found it was cost-effective.¹⁵⁶ Connected Care in Basildon has claimed net impacts of over £1,000 per client, and a total of over £500,000 across the town.¹⁵⁷ Health Champions training has a proven record of improving self-esteem and getting trainees into full-time work.¹⁵⁸ By embedding navigation advice in schemes with a proven record of reducing costs, it will mean that the net long-term costs of this approach are covered by savings, and that navigation advice would therefore be sustainable over the long term.¹⁵⁹

In the long term, the problem is that public and professional awareness of peer support is still low, funding is insecure and bureaucratic and the efforts of the people running these groups is often unrecognised and unsupported, despite the demand for mutual support.

¹⁵⁶ "The results indicate that provision of a lay-led self care support programme to a heterogeneous group of patients with long-term conditions results in significant increases in self-efficacy and energy, and is likely to be cost-effective," see: Anne Rogers et al (2006), *The National Evaluation of the Pilot Phase of the Expert Patients Programme*, National Primary Care Research & Development Centre. This just covered savings for the expert patients and it is possible to assume that similar savings would accrue to those trained under this pilot.

¹⁵⁷ Annette Bauer et al (2011), *Economic Evaluation of an "Experts by Experience" Model in Basildon District*, LSE Health and Social Care, London.

¹⁵⁸ Judy White et al (2010).

¹⁵⁹ The evaluation of the Health Champions project, which is close to what is proposed here, found that it improved the well-being and health of those taking part, improved local social cohesion, and opened up new education opportunities too. See: James Woodall et al (2012), 'Improving health and well-being through community health champions: a thematic evaluation of a programme in Yorkshire and Humber', *Perspectives in Public Health*, Aug 13.

Traditional performance management systems also tend to ignore their importance.¹⁶⁰ If the pilots are successful, embedding navigation advice into existing volunteer peer support networks, the next stage will be to find ways in every area to create these networks and extend them, learning from the way the National Trust embeds its volunteers by encouraging local loyalty but supporting them with a national branding.¹⁶¹

The pilots would not just provide peer supported navigation advice to public services users, but would show how this is a sensible and cost-effective approach for local commissioners to maintain. The peer support networks will require local funding but they need to be able to supplement this from other local service providers, because they are providing a service which is demanded from other providers by local commissioners. Service contractors will need to be asked how they plan to build mutual support among their clients in order to reduce demand over the lifetime of the contract, and to contract with local peer support providers in order to fulfil their promises. The long-term feasibility of this idea stands or falls according to whether it is worth the money at local level – and whether health, schools and other public service agencies are prepared to pay for it because it saves them money elsewhere.

There will need to be some national support: a Cabinet Office discussion document in 2009 proposed the following rights for peer support groups:¹⁶²

- Use commissioners' and providers' rooms and facilities for meetings.
- Apply for local grant funding based on simple criteria like the number signed-up and number of members.
- Publicity by local services and on government websites.
- Automatic enrolment for patients, carers and service users (with an opt out).
- Flexible working for staff who volunteer to run peer support groups.

Organised right, this would also provide a whole new dimension to choice – an option to give and receive mutual support – as well as providing a cadre of volunteer navigators. It would also potentially unleash energy from public service users capable of underpinning the long term survival of services with a human face, and of broadening the scope of services that are provided. The new mutual support network would not take work from existing professionals or managers, but it would also be able provide the kind of options that services ought to provide – befriending, advising, DIY, changing light bulbs for older people – which they are currently unable to.

Recommendation 8

Pilot training for volunteers and mentors in ten existing peer support programmes, mainly but not exclusively in health settings. Evaluation should be carried out over a two year period to examine how well choice, option and navigation support can be provided in that way and the impact that has – with a view to providing peer support much more widely in public services.

¹⁶⁰ See for example David Boyle et al (2010), *Right here, right now: Getting co-production into the mainstream*, NESTA/New Economics Foundation, London.

¹⁶¹ The National Trust currently uses 60,000 volunteers around the country.

¹⁶² Matthew Horne and Tom Shirley (2009), *Co-production in public services: a new partnership with citizens*, Cabinet Office, London.

Future choice

The review found that, despite the rhetoric of choice and the rights that users of services have been given, the culture of services – whether this is the culture of professionals or the ethos of the managers – sometimes gets in the way, especially for disadvantaged groups. This is a problem for people who are less confident and prepared to push, as this report has described, but also for people who believe choice means they are offered other kinds of choices.¹⁶³

Academic studies suggest that people are becoming more assertive in their dealings with public services, and more willing to say what they need and challenge professionals.¹⁶⁴ But the review found that ‘choice’ has increasingly complex meanings for people. For some service users, ‘choice’ implies more flexibility and responsiveness in the way services are delivered. For some users, they need that flexibility – someone they can trust, or services which pay them individual attention when they need it – in order to exercise choice at all.¹⁶⁵ Again, the evidence heard by the review suggests that flexible, face-to-face relationships with frontline professionals are more able to absorb variety – and therefore underpin choice – than formal, formulaic or online responses (see above).

“I say hello to my carer when they put their head round the door and introduce themselves. Within seven minutes, I am naked with them in the shower. It’s a strange relationship.”

“Choice is something people wish for, but it is not always possible if the service looks at people as if they were really a piece of meat on a conveyor belt.”

Service users, Dorset

“Choice sounds like someone wants to sell you something, as if it was a kind of trick to make you buy more.”

“You need to be able to suggest your own choice, and say ‘what if I did this?’ and that requires confidence.”

NHS patients, Leeds

Information

It was apparent during the review round tables that the factors people use to make choices tend to go beyond the narrow set of factors that government policy-makers originally imagined. In schools, they are interested in a range of factors beyond the information about results, including behaviour, atmosphere and other information.¹⁶⁶ In social care, users want to know about non-financial and informal services as well as financial ones (see Section 3). In healthcare, patients might decide to see one consultant because they have a sympathetic style, or are prepared to put up with questions, rather than necessarily choosing the one with the best safety record. The information they are actually offered recognises few of these as legitimate concerns.

¹⁶³ Older people feel particularly reluctant to complain if they feel they are going to need the service again, see: C. Potter (2009), *Waiting for Change*, Age UK, London.

¹⁶⁴ Mulley (2012).

¹⁶⁵ J. Clarke and L. Westmarland (2007), *Creating Citizen Consumers: Changing relationships and identifications*, Sage, London.

¹⁶⁶ Fiona Millar and Gemma Wood (2011), *A new conversation with parents*, Family Lives, London

This requirement for other forms of information, and for professionals they can trust, adds a new dimension to formal choice. It implies a requirement for service flexibility and informality which was not part of the original agenda for competition, but which service users told the review they felt was implied by the word 'choice'. The metrics and league tables imply, by the obvious limits to what they can tell you, that there are approved reasons for making one choice rather than another – usually those choices which can drive competition between suppliers. The way people actually decide is sometimes on a very different basis.

“When service users feel you care, they are more likely to engage with services and share their difficulties and problems. The higher the degree of problems, the higher the degree of distrust.”

Service professional, Leeds

“Service users need people they can trust, who will listen, who are from the area, know the area – understanding and empathy. They have been let down so many times. It takes time to build up the trust.”

Service user, Middlesbrough

“Personal choices have to be dealt with on a one-to-one basis. Trying to put people in boxes is unhelpful, and you have to start with the question: what do YOU want?”

Service user, Grimsby

Rights

There is another paradox at the heart of the review findings which has implications about the way disadvantaged groups use choice. Polling evidence shows that the most disadvantaged people are the most enthusiastic about choice in theory.¹⁶⁷ On the other hand, as the review team consistently discovered in their round tables, the most disadvantaged tend also to be the most suspicious about choice in practice.¹⁶⁸ This is not just a peculiar anomaly. It is potentially a barrier to the development of public service choice, because what people think they are being offered under the banner of choice is sometimes different to what they actually get.

The review also found that people described choice in a variety of ways, especially in the NHS. There were those who were primarily suspicious of the word – often speaking on behalf of patients – because, as they put it, they didn't want a choice of hospital, they just wanted a good quality local hospital to go to. But patients often referred to a different kind of choice – the option of a different treatment (which they didn't have) or other kinds of choice altogether.¹⁶⁹

¹⁶⁷ Audit Commission (2004), *Choice in Public Services*, London.

¹⁶⁸ See the MORI research in Aug/Sept 2003 which found that pensioners, working class and BME groups were the most sceptical about feeling comfortable about making choices themselves, in: Gideon Skinner (2005), 'Public attitudes to choice: an overview', presentation by Ipsos MORI Research Institute, London.

¹⁶⁹ There is evidence that, given the choice, patients will tend to opt for the less aggressive treatment, and that this kind of choice may be more effective. See: John Wennberg (2010), *Tracking Medicine: A researcher's quest to understand health care*, Oxford University Press, New York.

One patient talked about the desperate measures she was prepared to take in order to change the consultant who failed to treat her with respect.¹⁷⁰ This was a different kind of choice – not one of those she was formally given – and it underlined that the word ‘choice’ covers a whole range of possible approaches, including the following:

- **The choice of providing institution:** this is the choice which is largely offered under recent policies. It provides people with a choice of school, hospital or social care provider, as set out in the choice ‘frameworks’, and is designed to encourage competition between providers.
- **The choice of professional:** this is implied by the choice of provider, but is actually something different, though people are increasingly able to choose a named professional as well. When surgeons or consultants work peripatetically between local hospitals, as many do, then the choice of provider may deliver patients exactly the same professional.
- **The choice to switch:** this is the choice of ‘exit’; in a rare emergency – when your consultant is unpleasant or your children are being bullied at school – it means the choice to change provider. It is something that confident people tend to get, just by demanding it, but there are usually no guarantees under the current system.
- **The choice of solution:** this is the choice of different treatments, curriculums or styles of social care, which most service users are not normally given (though personal budgets holders get it, in theory). This requires a flexibility of service which rarely exists at present, and which depends very much on the presiding professional and how constrained they are.
- **The choice to share responsibility:** this goes beyond choice, and implies the option – which many users certainly prefer – of a grown-up conversation with a professional, which might include discussions about options but which also implies a shared responsibility for the decision. This is guaranteed under the NHS constitution.
- **The choice to contribute:** this is the option, rarely given at the moment, to give back in some way, and to play a role in the delivery of public services, using your time or specific knowledge of your own condition to help others, and broadening the range of choices before other users. It is also known as *co-production*, as defined by the social innovator Edgar Cahn.¹⁷¹

These are all different kinds of choice, some of which are offered and some of which are not. The implication is that, even when patients welcome choice, there is still some confusion that exists, particularly for disadvantaged people.¹⁷²

“I would have travelled to another country to get another choice. They said I could have a second opinion. I said, I don’t want a second opinion, I want another choice.”

NHS patient, Leeds

¹⁷⁰ The highest number of complaints on the website Patient Opinion is about ‘staff attitudes’. See: Patient Opinion (2011), *Patient Opinion Report*.

¹⁷¹ See for example: Edgar Cahn (2000), *No More Throwaway People: The co-production imperative*, Essential Books, Washington DC.

¹⁷² The Management Consultants Association has suggested a typology which distinguishes between ‘horizontal choice’ (between providers) and ‘vertical choice’ (between different solutions). See: Paul Connolly (2012), *Making Choice Real*, Management Consultants Association, London.

“[Choice] sort of helps you feel more confident in yourself and your diabetes and to a certain extent your doctors, if they feel that you are sensible enough to let you choose something then it sort of helps. The sort of choices I would like to be able to make would be the type of insulin pump you get - Medtronic, Cell-novo, Omi-pod, Accu-check, Animass and so on, the consultants you have... and the hospitals to go to”

Young diabetes patient, Peterborough

Politics

Economists have known for some time that some kinds of choice can be confusing, even disempowering. Too many choices which appear identical can undermine people’s confidence.¹⁷³ The review team was constantly reminded that, among some groups, the narrow kind of choice they are offered – between different providers – is sometimes regarded as a confidence trick, a sleight of hand which involves them in what they fear is actually an agenda to privatise services. Those who feel this do not share the idea that the choice agenda is actually about raising standards. The mismatch between the rhetoric and choice as experienced can undermine the willingness of some people, often the most disadvantaged, to use the choices they are currently offered in the system.

This is not helped by confusion at official level – even among professionals and policy-makers – between words like choice, competition and co-production, which are occasionally used interchangeably. As service users know very well, there are times when choice and competition are aligned, but there are also times when they cancel each other out. This is so, for example, when the actual choice is made, not by patients, but by service commissioners choosing between two alternative candidates for block contracts. Or when the weight of demand is such – as it is for some popular schools or GP surgeries – that the choice is made by the institution, not by the user. In both cases, there is competition, but no user choice.

This is a long-term problem for the choice agenda. It means that choice is politically unstable, vulnerable to a change of political leadership just as it is vulnerable to professionals who disapprove of or misunderstand it. In social care, the vast majority of professionals have bought into the agenda of control and personalisation, although there are disagreements about how this is best promoted. In other areas of public service, ‘choice’ is sometimes seriously contested.

For disadvantaged people, this includes a chicken and egg dilemma. The long-term objective of choice, from the user’s point of view, is to raise standards and to create a flexible system that can meet their needs effectively, whatever they happen to be. But this flexibility is also vital to creating the kind of public services where all users feel confident enough to use the formal choices they are offered now.

“I want people to treat me with dignity and respect. That is the choice I want, not a choice between location A, B or C.”

¹⁷³ See for example Barry Schwartz (2004), *The Paradox of Choice: Why less is more*, Ecco/HarperCollins, New York. People can process around seven pieces of information at one time, T. Boyce et al (2010), *Choosing a high quality hospital: the role of nudges, scorecard design and information*, King’s Fund, London.

“People’s method of making choices is not understood and therefore not respected.”

NHS patients, Leeds

Pushing forward

Some services directed at the most disadvantaged people are notable by their almost complete absence of choice. If choice encourages responsibility, flexibility and better success rates in other areas of public services, then it is probably time some element of choice of providers was introduced also in drug and alcohol rehabilitation services, and in employment services. None of these services are intended to be punishments – they are there to support people back to work or out of addictions – and they would benefit from the same kind of choices that users enjoy in other services.

The other area where progress can be made is in encouraging better feedback. It is always necessary to underpin choice with ‘voice’ solutions to strengthen feedback systems, whether through new online complaints systems like Resolver or simply by putting the Twitter hashtag prominently in public service buildings, ask for feedback and respond to it.

Next steps for future choice

The review drew the following conclusions from this:

- The choice agenda is politically unstable because it has been too focused on competition, and not focused enough on the other choices people actually want.
- Broader measures are needed to make public services more flexible for individuals and to increase their bargaining power.
- Choice needs to be extended to other services which focus particularly on disadvantaged people.

Increasing user power

These issues require the choice agenda to be broader than simply competition between rival service providers, important though that is. The review heard from people who had either insisted on or would welcome a formal ‘Choice to Switch’ providers. This idea exists in other countries, which regulate the number of times you can switch GP (France) or the number of times you can switch insurer (Switzerland), but has not been explicitly set out in the UK. This is not to say that switching is always forbidden. In practice, it is open to patients as a ‘second opinion’, usually those who are confident enough to demand it. It is also open to care home residents, even those paid for by local authorities, though the evidence suggests they very rarely use it, even in extremis, partly because of the disruption, but also partly because they don’t know about it.¹⁷⁴

The review heard repeatedly how important service users feel it is to be treated with dignity and respect. People assume they have the right, when this is not forthcoming from professionals, to move somewhere else, on the very rare occasions when their children are bullied at school or when consultants are less than respectful. In practice, this is can be a choice that is dragged out of the system by articulate service users but nobody else, and

¹⁷⁴ This was the finding in GHK Consulting (2011), *Evaluating the impact of the 2005 OFT study into care homes for older people*, Office of Fair Trading, London, 112-3.

always under the threat that they will have to go back to the beginning, and will need tests or assessments repeated.

This choice exists already, in effect, for people using direct payments or personal budgets, as long as their own choice of provider is genuine. The broad choice agenda would be fairer and more comprehensible if people were also given this Choice to Switch more widely, within certain limitations.¹⁷⁵ It would be a choice they could keep in reserve for when problems become intractable, but could then be exercised simply and without fear of repercussions. It would be possible to use perhaps no more than once in one episode of care or one school career. People who exercised the Choice to Switch would then only be able to move to somewhere with available space: this must not be a back door method of accessing the most popular providers. Most people will never use it, but the fact that they *can* do so would give them significant extra power in what can be an unequal relationship between patients and care users, professionals and their managers.

The review heard that the main reason people feel uneasy about demanding this kind of right is that they are afraid that, even if they do manage to switch providers, they will go to the back of the queue and all their exhausting and maybe painful tests will have to be carried out again. This is a parallel problem to the one faced by people who wanted to shift bank account or mobile phone provider. This report proposes a similar package to the one that requires banks to make switching simple, and which returns customers to the status quo in their new bank.

Asserting the Choice to Switch would mean that service users must be returned to the same place in the system in the new institution, using the same test results as in the old – unless the new institution can make a very good case for needing to repeat them. It would also be necessary to move the funding package from the old institution to the new one, otherwise it could be financially advantageous to drive patients out.

Recommendation 9

Pilot the idea of giving health and social care users the formal Choice to Switch providers, in extremis, and to go to another provider with capacity, using existing data, to the same position in the queue.

Tackling the service user records problem

Broadening choice by giving extra rights and responsibilities to service users implies that action should be also taken to address the continuing problem of personal records. The review heard about the complications, especially for people with complex problems, that are caused by data protection concerns, preventing professionals from sharing access to patient notes or social care records. This complicates social care assessments and adds to the bureaucratic stress for everyone involved (see Section 3).

Giving service users the right to control their own data, and to give or deny access to professionals, would increase their power and confidence in the system and help simplify assessments. A system along these lines is being used by NHS patients with certain complex conditions, notably at Great Ormond Street Hospital, using UK technology

¹⁷⁵ One in four of the respondents to the Ipsos MORI survey said that “knowing you could change service provider if you needed to” would help with choice (see table above).

developed by Patients Know Best, but something similar needs to be piloted across all public services (see Appendix G). This is an important reform, which would increase the power of service users, would be to give them the right to control their own data, and give professionals access to it more easily. Its adoption depends on more progress having been achieved with roll-out, and it goes beyond the scope of this report to recommend it – but it would underpin the broader choice agenda.

Right to request flexible service delivery

The choice to contribute is covered by the proposed volunteer navigation support network (see Recommendation 8). But the review also heard from people who wanted flexibilities *within* their service – to talk to consultants on the phone, to study a different combination of subjects at school, to be put to bed by carers later than 5pm (see Recommendation 7).

There is a case for this to be a new cross-service Right to Request Flexible Service Delivery. In each case, the provider is not obliged to provide it if it is impossible, but they will be obliged to explain why and that letter must be posted on their website. This could not be an obligation on service providers, but it could be organised along similar lines to the ‘right to request’ parental leave. For the time being, it would not be able to cover choice of NHS treatment, which in practice is already dealt with using the Individual Funding Request system. But it could cover the administrative arrangements of how services are delivered.

This kind of right has a political power beyond its immediate effect. It could potentially shift power in the system and do so without expensive changes in institutional framework. But it requires some consideration across government about the best way in which it can be made effective (see below).

Building a broader choice agenda

The final area requiring attention is to broaden the choice debate to include these other aspects of choice, beyond just formal competition between providers. This is an opportunity to involve the professions in a broader debate about how to involve service users as equal partners in the delivery of services. There is evidence that aligning patient treatment, in healthcare, more closely to patient preferences, would not just lead to better results, it would also lead to lower costs.¹⁷⁶ This has to be the direction of travel.

Making the choice agenda broader and more sustainable may require a new language, if people have already made up their mind about the word ‘choice’. Either way, the broad choice agenda needs to embrace the kind of shared decision making between users and professionals that is required to underpin progress so far, to improve treatment and share responsibilities better between professionals and clients. The implication of the choice agenda – so far unrealised – is that everyone might not be treated alike, even if they have the same symptoms or problems. It implies that different options are available, and different possible outcomes, and that there needs to be a contribution from the service user to reach that decision.

This aspect of choice is not yet central to the policy debate, and there needs to be a voice close to the heart of government to push for this broader choice agenda, to speak for patients who want more flexible kinds of treatment and for social care users who want more

¹⁷⁶ Al Mulley et al (2012), *Patient Preferences Matter: Stop the silent misdiagnosis*, King's Fund, London.

humane and more flexible homecare – as well as school students who want a broader choice of subjects.

There needs to be a voice which can look critically at regulations that are preventing creative local solutions for social care problems, and at onerous and frustrating insurance rules, and which can generate a shared responsibility between leaders in the key government departments, to drive a broader choice agenda. At present, the leadership for choice is spread too widely between departments. It suggests that for the agenda needs to be articulated and led publicly by the appointment of a key advisor to the Prime Minister. This advisor would also work with a cross-departmental team, with the purpose of co-ordinating ideas and ending departmental rivalries, to speak for the new choice agenda, and crucially to make the Right to Request Flexible Service Delivery a reality.

Recommendation 10

Appoint an advisor to the Prime Minister on broader choice in public services, who will:

- Lead initiatives such as the Right to Request Flexible Delivery of public services (see main text).
- Champion broad choice across public services.
- Increase awareness of the need for broader choice.
- Work across departmental and service silos to tackle barriers to choice.
- Advise on complaints procedures.