Summary: Intervention & Options

Department /Agency: **DH**	**Title:** **Impact Assessment of the introduction of a right to access services within maximum waiting times into the NHS Constitution**

Stage: Implementation	**Version:** 1	**Date:** 8 March 2010

Related Publications: NHS Constitution, Handbook to the NHS Constitution, The NHS Constitution: A consultation on new patient rights, and the guidance on implementation of the new right

Available to view or download at:

http://www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm

Contact for enquiries: Ian Bishop **Telephone:** 0207 210 5939

What is the problem under consideration? Why is government intervention necessary?

There is a need to ensure patients continue start consultant-led treatment within 18 weeks of GP referral, and to see a cancer specialist within 2 weeks in cases of urgent referrals Establishing a right to the 18-week and 2-week suspected cancer waiting time operational standards 'locks in' the level of delivery already being met by the NHS and ensures that it becomes an enduring NHS commitment.

What are the policy objectives and the intended effects?

To ensure delivery of the 18-week and 2-week waiting time standards and, through the creation of a public right to an alternative provider, incentivise providers to further improve their performance against the standards.

What policy options have been considered? Please justify any preferred option.

Option 1: Create new patient rights (preferred).

If a new right to waiting time standards was not introduced it is believed performance would continue to be high. However, there is a risk if performance should slip, the current pledge to meet waiting time standards may not be robust enough to address this.

Option 2: Do not create new rights.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects? A report on the impact of the Constitution will be made every 3-years. Measurement of the impact of the new right will be considered as part of this.

Ministerial Sign-off For final proposal/implementation Impact Assessments:

> ***I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.***

Signed by the responsible Minister:

Andy Burnham

Date: 8 March 2010

Summary: Analysis & Evidence

Description: Create new rights

COSTS	**ANNUAL COSTS**		Description and scale of **key monetised costs** by 'main affected groups' The Evidence Base contains estimates of costs of communication support material (£3m) and travel and accomodation costs for patients choosing an alternative provider (£0.67 - £20.1m).
	One-off (Transition)	**Yrs**	
	£ 0	1	
	Average Annual Cost (excluding one-off)		
	£ 3.67 - 20.1m		**Total Cost** (PV) **£ 3.67 - 20.1m**
	Other **key non-monetised costs** by 'main affected groups'		

BENEFITS	**ANNUAL BENEFITS**		Description and scale of **key monetised benefits** by 'main affected groups' Benefits have been identified in relation to driving up efficiency by ensuring that NHS capacity is used more effectively. Introducing the new rights will help prevent current performance slipping and thus avoid the need for costly corrective measures.
	One-off	**Yrs**	
	£ Unknown		
	Average Annual Benefit (excluding one-off)		
	£ Unknown		**Total Benefit** (PV) **£ TBC**
	Other **key non-monetised benefits** by 'main affected groups' Patients will benefit from greater clarity about their rights and entitlements, and from an enduring commitment to maintaining waiting time standards.		

Key Assumptions/Sensitivities/Risks Assumptions have been made around the number of patients choosing an alternative provider, accepting an offer of an alternative, and the costs associated with providing an alternative. These have been based on patient choice data, where available, but this is not directly comparable to the situation under consideration.

Price Base Year	Time Period: Ongoing	**Net Benefit Range** (NPV) £	**NET BENEFIT** (NPV Best estimate) £

What is the geographic coverage of the policy/option?			England	
On what date will the policy be implemented?			April 2010	
Which organisation(s) will enforce the policy?			PCTs and SHAs	
What is the total annual cost of enforcement for these organisations?			£ N/A	
Does enforcement comply with Hampton principles?			Yes	
Will implementation go beyond minimum EU requirements?			N/A	
What is the value of the proposed offsetting measure per year?			£ N/A	
What is the value of changes in greenhouse gas emissions?			£ N/A	
Will the proposal have a significant impact on competition?			No	
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
Are any of these organisations exempt?	No	No	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices) (Increase - Decrease)

Increase of £ Decrease of £ **Net Impact** £

Key: **Annual costs and benefits: Constant Prices** **(Net) Present Value**

Evidence Base (for summary sheets)

General Background

The NHS Constitution was published on 21 January 2009. It brings together, for the first time, the principles, values, rights and responsibilities that underpin the NHS. It is designed to renew and secure our commitment to the enduring principles of the NHS, making sure that the NHS continues to be relevant to the needs of patients, the public and staff in the 21st century.

The Constitution contains:

- A short **introduction**, which outlines the purpose of the NHS and of the Constitution;
- The **principles** of the NHS, which are the enduring high-level ‘rules’ that govern the way that the NHS operates, and define how it seeks to achieve its purpose;
- NHS **values** - that inspire passion in the NHS and should guide it in the 21st century. Individual organisations will develop and refresh their own values, tailored to their local needs; and
- **Rights** and **pledges** for patients, the public and staff, as well as their **responsibilities**.

Background to the proposed new right

New right to start consultant-led treatment / see a cancer specialist within waiting time standards

Unless patients choose otherwise, or it is not clinically appropriate to do so, the NHS aims to start patients’ consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions. Again, subject to patient choice, it also aims to provide a maximum two-week wait to see a specialist for all patients referred with suspected cancer by their GP.

The Constitution previously reflected these commitments in a pledge that patients can expect:

- to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions where they want this and where it is clinically appropriate; and
- a maximum two-week wait to see a specialist for all patients referred with suspected cancer by their GP.

The 18-week waiting time standard and cancer 2-week waiting time standard are reflected in the NHS’s minimum operational delivery standards (these are that 90% of admitted patients and 95% of non-admitted patients will start treatment within 18 weeks of referral, and 93% of cases for the cancer 2-week wait). The NHS has been meeting the 18-week waiting time standard at a national aggregate level since August 2008. The 2-week operational standard was introduced on 1 January 2009, in order to align the monitoring of cancer waiting times with the existing 18 weeks data collection. Whilst the method by which performance against the 2-week operational standard is calculated changed on 1 January 2009, the NHS had previously sustained a level of performance at or above 99%.

For these two waiting time standards we are therefore in a position to ‘lock in’ the level of delivery that the NHS has achieved through a patient right to start consultant-led treatment (or to seeing a cancer specialist) within these operating standards. The new right creates an enduring standard that patients can expect of the NHS. Any changes to the NHS Constitution can only be made after full public consultation.

The creation of a right to meeting waiting time standards is only meaningful to individuals with the introduction of a mechanism for individuals to take action if the start of their consultant-led treatment or appointment with a cancer specialist would not take place within the standards. The new right will therefore take the following form, which will require the NHS to take further action if a patient's original provider is unable to meet the waiting time standards:

You have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution'.

Options for the new right

If the right to waiting time standards was not introduced we believe performance would continue to be high. However, there is a risk that, if performance should slip, the current pledge to treatment / seeing a specialist within the standards would not be robust enough to address this. The introduction of a new right to treatment within the 18-week and 2-week waiting times standards translates the pledge into a right. It builds upon the existing pledge and entrenches the improvements that have been made and, effectively, 'locks it in'. As the NHS is already meeting this standard, there is unlikely to be any additional expenditure involved in ensuring that it continues to be met. In addition, the new rights are likely to further improve performance against the waiting time standards by improving efficiency (see 'Benefits of the new rights', below).

Alongside the right it is necessary to require the NHS to take all reasonable steps to offer a range of alternative providers if it is not possible to meet the waiting time standards in individual cases. This is needed to ensure that the right becomes meaningful to individuals when treatment is not provided within waiting times, although there are costs associated with it (see 'Costs of the new right …' below).

Implementing the new right

The new right is being created by issuing legal directions to Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs). The directions require PCTs (and SHAs in relation to nationally commissioned services) to commission services in a way that ensures waiting time standards are met, and that ensures that systems are in place to offer a suitable alternative to patients when they are not met.

Benefits of the new right

The introduction of the new right has the potential to offer significant benefits to patients.

The right to start consultant-led treatment / see a specialist within waiting time standards is likely to stimulate change that would mean that patients are more likely to start their consultant-led treatment / see a cancer specialist within waiting time standards. This is because the directions will encourage PCTs and SHAs to take action in advance to ensure that providers meet the standards, rather than have to take more resource intensive steps to find and offer suitable alternatives to patients where the standards are not met.

In addition, providers may be incentivised to meet waiting time standards in order to ensure they do not either lose income or incur a financial penalty. This is because, where a patient chooses to move to another provider, the original provider is unlikely to receive full or part payment for that treatment. Providers could also receive a contractual penalty when they do not meet the waiting time standards.

As noted earlier, there are other benefits of introducing the new right:

- It 'locks in' the progress the NHS has made in delivering waiting time standards.

- The waiting time standards will become enduring standards that patients can expect of the NHS and on which the NHS can be challenged if they are not delivered.
- Patients will be clearer about their entitlements to start treatment / see a specialist.

Costs of the new right to start consultant-led treatment / see a specialist within waiting time standards or to the NHS taking reasonable steps to offer a range of alternatives where this is not possible

General

As the 18-week waiting time standard and cancer 2-week waiting time standards are already being met, a right to treatment within waiting times is unlikely to attract costs associated with providing treatment. Whilst some providers will lose the income associated with individual patients who are not treated within waiting time standards and choose to move to another provider, the alternative providers will receive the same sum in payment for providing the treatment. The new right will also help drive up efficiency by ensuring that NHS capacity is used more effectively. It will also deliver benefits to patients by helping to ensure that waiting times are kept as short as possible.

We are requiring the NHS to take all reasonable steps to offer individuals a range of alternative providers if they do not start treatment or are not seen within waiting time standards. Reasonable steps are unlikely to include providing treatment in a way that would increase costs to the NHS, such as through increasing capacity (either temporarily or permanently) or providing treatment privately at above tariff rates. In addition, we know from focus group and other research that not all patients would choose to go to an alternative provider even if a range of alternative providers was offered (as, for example, they may value quality of service, cleanliness and working with a known hospital or consultant over speed of treatment[1]). We therefore believe that taking reasonable steps to provide alternatives to individuals who are not seen within waiting time standards would, in effect, be largely **cost neutral**.

However, there are three sources of additional cost associated with ensuring that there are mechanisms in place to ensure that patients can be offered a range of alternative providers when they seek this. These are: costs involved in appropriately communicating the new right and mechanism for seeking alternatives; costs in administrating the system; and the cost of payment of travel and, in certain circumstances, accommodation expenses for patients who whose to go to an alternative provider.

There is some variation between PCTs in performance against the standards, as illustrated in the 18-week referral to treatment and cancer waiting times statistics[2], and so impact may not be seen evenly across all PCTs. However, all PCTs are expected to meet the standards and action is already being taken through the performance management framework where standards are not met. The introduction of the new right will not change this situation, though it is anticipated that the new right will generally drive up efficiency (as set out under ‘Benefits of the new rights’, above).

Risks and assumptions

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[1] Understanding Patients’ Choices at the Point of Referral (2006); Peter Burge, Nancy Devlin, John Appleby, Federico Gallo, Edward Nason, Tom Ling; (Rand Europe Report prepared for Department of Health)

[2] http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/18WeeksReferraltoTreatmentstatistics/index.htm and http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/HospitalWaitingTimesandListStatistics/CancerWaitingTimes/index.htm

In estimating costs, a number of assumptions have had to be made, in particular data on patient choice has had to be applied to a new scenario. This means that there is a risk that we have under or over estimated the number of patients who would seek an alternative provider when their waiting time standard has been breached, and the proportion of those patients who would then choose to go to an alternative provider. We have therefore costed a wide range of scenarios based on the likely upper and lower bounds of these estimated figures.

Communication costs

The mechanism will only be meaningful if patients are aware of their right, and properly supported in seeking an alternative provider (should they wish to) when it is not met. Communication tools have already been developed to help patients understand when 18 weeks ‘clocks’ start and stop, explain what they can expect along their 18 weeks pathway, and give them contacts to approach if they need assistance.

Based on the costs associated with resources that have previously been produced to promote understanding of waiting times amongst patients (such as an ’18-week treatment planner’ which could be given to patients by their GPs, or could accompany letters confirming appointment times), we estimate that making appropriate information available in hard copy to every patient referred onto an 18-week pathway would cost in the region of **£3m** annually. However, there are a large number of communication options that could be explored and so it is not possible to give detailed costing of the communication efforts that will be needed to support the introduction of the new right.

Administrative costs

There may be some administration costs for PCTs, as they may need to invest in setting up administrative systems and devote staff time to deal with approaches from patients. Brokering between providers to find new appointments for patients can be skilled and intensive work, and raising awareness of waiting time standards amongst patients will naturally result in more contact from patients asking about their options when they have not had treatment within 18-weeks. However, as this will only be needed for patients who actively choose to seek alternatives, these costs will be minimised.

Analysis undertaken as part of the DH 18-weeks programme in 2008/09 estimated that, based on sample data, around 2 per cent to 3 per cent of the 13.4 million patients on an 18 weeks pathway annually breached the 18-week standard for reasons other than patient choice or clinical exception (268,000 – 402,000 patients).

We cannot estimate how the right to access services within waiting time standards will affect the number of breaches of the 18-week standard, although it is reasonable to assume that it will reduce them through incentivising PCTs and providers to meet the waiting time standards (and, in any case, we know that the number of patients starting treatment within 18-weeks has increased in the last year). Similarly, we cannot calculate the effect that increasing the communication of the new rights may have on the likelihood of a patient who may breach their waiting time standard approaching their PCT, although it is reasonable to assume that it will encourage patients to take action. Our calculations are therefore based on the current number of breaches, and we recognise that this may overestimate administrative costs.

It is likely that patients who are willing to travel to a non-local provider and who consider length of wait important are those who are most likely to approach a PCT when their waiting time standard has not been, or will not be, met. We know from focus group and other research[3] that,

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[3] Understanding Patients’ Choices at the Point of Referral (2006); Peter Burge, Nancy Devlin, John Appleby, Federico Gallo, Edward Nason, Tom Ling; (Rand Europe Report prepared for Department of Health

when making an initial choice of provider, around 50% of patients would choose a non-local provider, and that 62% of patients consider length of wait to be a significant factor when choosing a hospital[4]. Whilst it is reasonable to assume that the two factors are related, we do not have information on what the dependency may be. We can therefore only present a range of options to indicate the number of the patients who are likely to approach a PCT when their waiting time standard has not been, or will not be, met. An upper bound would be 50% of the 268,000 – 402,000 who it was estimated breached the waiting time standard for reasons other than patient choice or clinical need in 2008/09. In practice, it is likely to be much lower than this, as:

- 38% of patients do not consider waiting time to be a significant factor when initially choosing a provider;
- the patients to whom this mechanism applies will already have made an initial choice of provider which it is reasonable to assume that they would prefer to stay with; and
- patients who considered length of wait to be very important in choice will already have chosen providers with short waiting times.

With these caveats, we can estimate a range of approaches as follows:

% of patients who breach waiting time standards for reasons other than choice or clinical need, and who request an alternative	Estimated number of approaches in total annually	Estimated number of approached per PCT annually
10%	26,800 – 40,200	176 – 264
20%	53,600 – 80,400	353 - 529
30%	80,400 – 120,600	529 – 793
40%	107,200 – 160,800	705 – 1058
50%	134,000 – 201,000	882 – 1322

As PCTs and providers already have systems in place to manage waiting times and general enquiries, we believe that an increase in the administration required to handle approaches such as this can accommodated within existing resources.

Travel costs

Not all patients who request an alternative when their waiting time standard is not met, or will not be met, will choose to go to an alternative provider. Individual decisions about receiving treatment by an alternative provider are likely to depend on a number of personal factors and individuals would be faced with balancing the benefits they associate with their initial choice of provider against the inconvenience of further travel and factors they may associate with treatment at an unfamiliar hospital. However, we believe that the proportion of patients accepting an offer of an alternative would be quite high as the patients would already have taken the trouble to request an alternative, although it appears very unlikely that 100% of patients would accept an offer an alternative provider. Given the uncertainties, we present a range of estimates below.

Given the number of variables involved, it is difficult to estimate the travel and accommodation costs that would be associated with supporting patients to travel to, and receive treatment by, an alternative provider. We have therefore used the nominal figure of £100 to reflect local travel costs for patients and companions and rare instances of travel over longer distances with associated accommodation costs (where this cannot be provided directly by the NHS). This

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[4] National Patient Choice Survey, March 2009

figure is also designed to reflect the fact that patients may have to travel to an alternative provider a number of times.

Estimated % of patients accepting an alternative and associated travel costs	Estimated number of approaches in total (based on 10% of eligible patients making an approach) 26,800 – 40,200	Estimated number of approaches in total (based on 50% of eligible patients making an approach) 134,000 – 201,000
25%	6,700 – 10,050 £0.67m - £1.01m	33,500 – 50,250 £3.35m - £2.03m
50%	13,400 – 20,100 £1.34m - £2.01m	67,000 – 100,500 £6.70 - £10.5m
100%	26,800 – 40,200 £2.68m - £4.02m	134,000 – 201,000 £13.4m - £20.1m

This gives a potential range of travel and accommodation costs of £0.67m - £20.1m

Specific Impact Tests: Checklist

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Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	***Results in Evidence Base?***	***Results annexed?***
Competition Assessment	No	No
Small Firms Impact Test	No	No
Legal Aid	No	No
Sustainable Development	No	No
Carbon Assessment	No	No
Other Environment	No	No
Health Impact Assessment	No	No
Race Equality	Yes	Yes
Disability Equality	Yes	Yes
Gender Equality	Yes	Yes
Human Rights	Yes	Yes
Rural Proofing	No	No

Annexes

Equality Impact Assessment

Introductory

This Equality Impact Assessment (EqIA) considers:

- the introduction of a right into the NHS Constitution: to start consultant-led treatment within a maximum of 18-weeks from referral for non-urgent conditions; for patients with suspected cancer to see a specialist within 2-weeks of referral; and for PCTs to take reasonable steps to offer a range of alternative providers when this is not possible

This EqIA should be read alongside the overall EqIA for the NHS Constitution.

This proposed new right reflect existing Government policies.

Prior consultation

Extensive consultation was undertaken to inform the development of the NHS Constitution[5]. The learning from this consultation has informed the development of the current proposals.

Following the publication of the draft NHS Constitution for Consultation on June 30th 2008, a ‘Constitutional Advisory Forum’ (CAF) was established to advise the Department of Health on how to engage effectively with staff, patients and the public, particularly those groups less likely to get involved without proactive engagement.

Since publication of the Constitution in January 2009, a ‘State of Readiness Group’ comprising key stakeholders have been working to guide the embedding of the Constitution within the NHS. The group has recognised the potential the Constitution has for reinforcing important messages and taking action on promoting equality and reducing health inequalities and have noted that *“the Constitution could be a powerful even revelatory document for those who have not previously been aware of their rights”*.

As described in the EqIA that supported the NHS Constitution on publication[6], a principle benefit of setting out patient, public and staff rights, pledges and responsibilities is that everyone has the same information in appropriate formats and languages about what they can expect from the NHS, rather than just those who feel most empowered. The introduction of new rights into the Constitution will not change this.

Overview of Equality Impact

Reflecting existing Government policies as rights in the NHS Constitution

It is unlikely that there will be any significant positive or negative change in terms of equality by converting the policies on waiting times into a right in the NHS Constitution. They are already part of Government policy and already have been fully operationalised and the policies have been assessed for their equality impact individually.

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[5] *http://www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm*
[6] *http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_093427*

An assessment of the equality impact of the 18-week referral to treatment operational standard concluded that there is no strong evidence that the policy has had an adverse impact on equality. It concluded that the policy *"has potential to reduce barriers and inequalities that currently exist through further transforming patient pathways to ensure the patient is at the centre of the process and improving data completeness which has been implemented to ensure accurate 18 week monitoring"*. NHS organisations will monitor unnecessary waits to ensure that no particular group is adversely affected, and good practice guidance has been issued to support them in doing this. The 18 week standard applies to all patients referred for treatment in consultant-led services – including those referred to a consultant for diagnosis and treatment for a long term condition. Therefore we do not believe that the creation of the new right will disadvantage any patients.

The 2-week waiting time standard for suspected cancer diagnoses was assessed as part of the EqIA for the Cancer Reform Strategy[7]. The strategy acknowledged that inequalities existed in cancer outcomes experienced by a range of different groups, and made recommendations to address the situation including investigating opportunities for new screening programmes, raising public awareness of the signs and symptoms of early cancer, and encouraging people to seek help earlier, especially among groups where this awareness is particularly low. The strategy also established the National Cancer Equality Initiative, bringing together key stakeholders from the professions, voluntary sector and academia to develop research proposals on cancer inequalities, test interventions and advise on the development of wider policy.

Constitution Champion

The Constitution Champion role is being introduced precisely so that the benefits of the NHS Constitution will not be restricted to those that are already the most empowered, but should be felt throughout the NHS and the public at large. The precise make-up of the role will be determined locally so that it can reflect the particular needs of the local population, including addressing any particular aspects of equality, diversity and human rights that exist in the local context.

One of the core roles of the Constitution Champion will be to provide advocacy for patients, their families, and their carers, and to support those who are already providing this. It is proposed that this role is developed locally and is closely integrated with the work of Patient Advocacy and Liaison Services (PALS). The role of 'Constitution Champion' in every PCT could have a strategic role in ensuring that the right systems and processes are in place so that the commitments in the NHS Constitution are being lived up to, or could have a role in making people aware of their rights, and providing information on the NHS Constitution consider carefully the needs of their populations across the equality strands.

The Constitution Champion role is generally designed to support patients, their families and carers, and it is envisoned that this role would have most impact on those who feel least empowered. This role is therefore likely to play a role in countering certain aspects of inequality, such as:

- **gender-based** differences in access to health services, where complex patterns are known to exist[8]
- possible stigmatisation of **transgender** people.[9]

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[7] *The Cancer Reform Strategy, and its accompanying EqIA are available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006*

[8] *The Gender and Access to Health Services Study (December 2008);*

- the differential response to health care messages that may be given by people who follow a particular **religion or belief**[10] or that are typically given by people of differing **sexual orientation**[11]

Introducing a right to the NHS taking reasonable steps to offer a range of alternative providers to individuals when it is not possible for them to access services within the 18-week / 2-week waiting times

It is unlikely that the new right will have a negative effect on any particular group, but it is also possible that the positive benefits will not be felt in a uniform way across them. This EqIA considers which groups might be affected in different ways, and how this might be mitigated through improved communications and effective use of patient support services.

The mechanism requires patients to come forward if their appointment breaches the 18-week or 2-week waiting time standards and it is more likely that patients who feel the most empowered, and are the best informed, will come forward to seek alternatives. This could potentially have a negative effect on equality as there is evidence to suggest that:

- **younger Caribbean and African men** and **older Black African women** may be less likely to be aware of their rights unless GPs provide specific information about patient choice.[12]
- **older Bangladeshi and Pakistani patients** and **younger recent immigrants from these communities** are more dependant on the quality of communication to them via their GP or family members[13].
- communication support and advocacy is particularly important for those with **sensory impairments**[14]
- **older people** have difficulty accessing certain information, for instance evidence indicates that they have reduced access to the internet[15]

It is therefore proposed that mitigation will be available to address both issues of information provision and empowerment.

Information provision

A ‘treatment planner’ covering 18-weeks is already available in a variety of languages, and will be made available in braille and audio-formats on request. The Constitution itself is also available in a variety of formats and languages, including an easy-read version. The consultation on new patient rights explored the important role that better information on waiting times would play in enabling the introduction of the new rights to make a difference. It proposed that every patient will be given information to promote their awareness of what their rights are and what to do when their expectations are not met and this will include the provision of

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[9] *The Gender and Access to Health Services Study (December 2008);*

[10] *A Practical Guide on Religion and Belief for the NHS* *http://www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights/Religionandbelief/index.htm.*

[11] *Sexual Orientation: A Practical Guide for the NHS* *http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_095634*.

[12] *Attitudes of Ethnic Minority Communities to Patient Choice – Report for DH by COI Nov 08*

[13] *Attitudes of Ethnic Minority Communities to Patient Choice – Report for DH by COI Nov 08*

[14] *Equality Impact Assessment ‘ A right to information in the NHS Constitution’.*

[15] *‘Internet access, Households and Individuals’ (ONS (2007))*

information in appropriate languages and formats, including easy-read versions where appropriate. This information provision will be carried out proactively, in a way that best suits the individual patient. The Constitution Champion will also play an important role in promoting awareness of rights generally, providing advocacy to patients, and ensuring that people know what to do when their expectations are not met.

It is also important to note that the mechanism will not be applied to patients who are unfamiliar with their right to choose a provider. All patients to whom this mechanism applies will have already made an initial choice of provider and have been given information to support that choice.

Empowerment

The **Patient Advice and Liaison Service**, known as PALS, has been specifically introduced to ensure that the NHS listens to patients, their relatives, carers and friends, and answers their questions and resolves their concerns as quickly as possible. The core functions of PALs (From “Supporting the implementation of Patient Advice and Liaison Services: A resource pack”. Department of Health, 2002) include to:

- Be identifiable and accessible to patients, their carers, friends and families
- Act as a gateway to appropriate independent advice and advocacy support from local and national sources.
- Provide accurate information to patients, carers and families, about theTrust’s services, and about other health related issues

PALS will therefore be able to support and empower patients in exploring alternatives when they do not receive treatment within waiting times. The role of Constitution Champion will support and enhance this further.