

A Guide to the Law on Patient Choice¹

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1. Background to patient choice issues

- 1.1 The principle that NHS patients should be entitled to choose where they are treated has become a key part of government policy in recent years. The underlying concept is that patients should be able to choose the clinician who they want to provide them with healthcare and that the money should follow the patient. Turning this political aspiration into reality is far from straightforward but this chapter attempts to explain how the systems are supposed to operate to deliver patient choice. Whether the choices made by patients are respected in practice is, of course, an entirely different matter.

¹ The law stated in this chapter is with effect from 1 December 2016.

- 1.2 The importance of patient choice was reflected in the key “[5 year Forward View](#)” document published by NHS England which said at pages 12/13:

“We will make good on the NHS’ longstanding promise to give patients choice over where and how they receive care”

- 1.3 The importance of patient choice was also set out in the Mandate² issued by the Secretary of State for 2016/17 which said:

“We want people to be empowered to shape and manage their own health and care and make meaningful choices, particularly for maternity services, people with long term conditions and end-of-life care”

- 1.4 The 2020 goals in the Mandate included a requirement to “significantly improve patient choice”. NHS England has responded to this part of the Mandate by saying on its website³:

“NHS England is therefore committed to a major programme of work to realise the NHS’ longstanding promise to give patients choice over where and how they receive care, as highlighted in the NHS Five Year Forward View.”

- 1.5 NHS England has set up a “Patient Choice Unit” and refers to the government guidance called the “Choice Framework”. The ambit of this Guidance is considered below.

The rights under the NHS Constitution

- 1.6 The NHS Constitution was created in 2009 to be a single summary of the “rights” that NHS patients have and the rights and expectations of NHS staff. Section 2(1) of the Health Act 2009 provides that NHS bodies⁴ must, in performing [their] ... health service

² See

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/494485/NHSE_mandate_16-17_22_Jan.pdf

³ See <https://www.england.nhs.uk/about/gov/patientchoice/>

⁴ There is a list of NHS bodies which have a legal duty to have regard to the NHS Constitution. It includes NHS England, CCGs, NHS trusts, NHS Foundation Trusts and local authorities exercising NHS functions. It does not

functions, have regard to the NHS Constitution”. The duty to “have regard” to the NHS Constitution is a legal duty to consider the NHS Constitution when exercising functions. However, it is a procedural duty and does not necessarily make it unlawful for an NHS body to act in a way that contravenes the NHS Constitution. However, in order to take a lawful decision to depart from the NHS Constitution, an NHS Body would have to have very carefully considered the relevant provisions of the NHS Constitution and to have departed from it for very good reasons.

- 1.7 There are provisions of the NHS Constitution relating to patient choice in both primary care and secondary care. These provisions are referred to below.

2. Patient choice of GP

- 2.1 The NHS Constitution provides as follows concerning choice and GP services:

“You have the right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.

You have the right to express a preference for using a particular doctor within your GP practice, and for the practice to try to comply.”

This wording is a summary of the rights given to patients by the rules under which NHS GP practices operate and does not materially add to those rights.

- 2.2 Patients living in the catchment area of an NHS GP practice have the right to apply to be registered at that practice. Please see [chapter 6.7](#) of the website www.gplaw.cp.uk for details of the application process and the limited grounds on which a GP practice with an open list can refuse to register a patient.
- 2.3 Once a patient is registered at a GP practice, the rules about patient preferences for seeing a particular doctor within are set out in [regulation 22](#) of the National Health

include the Secretary of State but a like duty is imposed on the Secretary of State by section 1B of the NHS Act 2006.

Service (General Medical Services Contracts) Regulations 2015 (SI 2016/1862) (“the GMS Regulations”). These provide that every GMS contract must contain a term to the following effect:

“22.—(1) Where the contractor has accepted an application made under paragraph 18 or 20, the contractor must—

(a) give notice in writing to the person (or, in the case of a child or an adult who lacks capacity, to the person who made the application on the applicant’s behalf) of that person’s right to express a preference to receive services from a particular performer or class of performer either generally or in relation to any particular condition; and

(b) record in writing any such preference expressed by or on behalf of that person.

(2) The contractor must endeavour to comply with any reasonable preference expressed under sub-paragraph (1) but need not do so if the preferred performer—

(a) has reasonable grounds for refusing to provide services to the person who expressed the preference; or

(b) does not routinely perform the service in question within the contractor’s practice”

An identical provision is in [Regulation 21](#) of the National Health Service (Personal Medical Services Agreements) Regulations 2015.

2.4 In accordance with these Regulations, once a patient is accepted onto the list of an NHS GP practice, the contractor must inform the patient of the right to “*express a preference to receive services from a particular performer or class of performer either generally or in relation to any particular condition*” and that, if a patient expresses a preference, the practice “*must endeavour to comply with any reasonable preference*”.

2.5 Thus if a patient expresses a preference to see Dr Ahmad, the practice must operate a system which endeavours to comply with this preference. Patients can also request to be treated by a “class of performer”. This may raise some difficult issues about discrimination. This provision could be used to permit a female patient to express a preference to see a woman doctor, particularly if she needs to be treated for

gynaecological or family planning matters. Equally, a male patient may express a preference for being treated by a male doctor if he has erectile dysfunction problems. Patients for whom English is a second language may properly ask to be seen by “class” of doctors who can speak their language. However, it is almost certainly not permissible to use this part of the contract for a patient to express a preference only to be seen by a “white doctor”.

- 2.6 There are different ways that the practice can comply with this requirement in practice, including ensuring that the practice computer system informs the receptionist where a patient has expressed a preference and prompts the receptionist to offer an appointment with the patient’s preferred GP.

3. Patient choice in secondary care

- 3.1 Patient choice in secondary care is more complex than in primary care. The rules are both substantive and procedural but there is considerable ambiguity about what the rules mean and there have been attempts to cut down the ambit of the rules by “Guidance” produced by NHS England. Accordingly, the extent to which patients can exercise any meaningful choice in secondary care is somewhat unclear.

The gatekeeping role of the GP or other primary care professional

- 3.2 Patients make their own choices about when they visit primary care. In contrast, NHS patients can only make their own choices about the provider that delivers NHS funded secondary care where they seek care on an emergency basis or where a patient is referred for a specific secondary care procedure by their GP, community dentist or an optometrist. The vast majority of referrals are made by GPs and so this chapter will describe patient choice rights by reference to a GP. However, the same principles apply to referrals by community dentists and optometrists.
- 3.3 Patient choice is generally concerned with elective procedures as opposed to emergency procedures, and the role of the GP as “gatekeeper” in the system is

essential. Giving effect to patient choice for secondary care is not, in reality, giving effect to a choice for the patient alone. It is giving effect to joint decision making between a GP and the patient. The GP makes the decision to offer a referral and, if the patient agrees to the proposed referral, the patient has the right to be referred to any clinically appropriate provider who contracts with the NHS.

The sources of the legal right to exercise choice in secondary care

3.4 Patient choice is delivered by 2 complimentary processes, namely:

- i) Specific occasions on which a patient can establish a legal right to choose their secondary care provider in a specific case; and
- ii) General procedural duties which are imposed on NHS England and CCGs (which are only relevant where (i) does not apply).

The duty on CCGs and NHS England to make patient choice arrangements

3.5 Part 8 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012⁵ (“the 2012 Regulations sets up the system of legal rights of patients to make their own choices about which provider should provide treatment to them. Subject to the terms of the Regulations, patients have a legal right to choose the secondary care provider to whom they are referred for a first appointment by their NHS GP (and certain other NHS primary care professionals) where the GP decides that the patient requires an “elective referral”.

3.6 Regulation 38 defines the meaning of an “elective referral” as follows:

⁵ The original text of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 is at <http://www.legislation.gov.uk/ukxi/2012/2996/contents/made> but these Regulations have been amended on a number of occasions since they were made in 2012. References in this chapter are to the form of the 2012 Regulations in force in September 2016.

“elective referral” means referral by a general medical practitioner, general dental practitioner or optometrist to a health service provider for treatment that is not identified as being immediately required at the time of referral”

3.7 Hence, a patient cannot “self-refer” for secondary NHS care and claim to exercise patient choice rights in respect of that referral. The person making the referral must be a GP, community dentist or optometrist. Further the rules about choice for elective referrals do not apply to emergency procedures and so a referral by a GP for treatment that is “immediately required” does not give rise to patient choice rights.

3.8 The elective referral must be made to a “health service provider”. This term is widely defined in Regulation 2 of the 2012 Regulations to mean:

“health service provider” means a person, other than a relevant body, who has entered into a commissioning contract”

3.9 Accordingly, a health service provider can be any public body, commercial organisation or third sector body, provided it holds a “commissioning contract” with any CCG or NHS England (referred to in the Regulations as the “relevant body”). There is some controversy about what is meant by a “commissioning contract”. This term is defined in Regulation 2 as follows:

“commissioning contract” means a contract, other than a primary care contract, entered into by a relevant body in the exercise of its commissioning functions”

Hence, the Regulations appear to define the term “commissioning contract” as meaning any contract entered into by a CCG or NHS England in exercise of their commissioning functions other than a primary care contract. However NHS England Guidance suggests that a “commissioning contract” can only be an NHS Standard Contract. That does not seem to be consistent with the above definition but the issues are considered at paragraph 9.18 below.

3.10 Regulation 39 of the 2012 Regulations provides:

“(1) A relevant body must make arrangements to ensure that a person—

- (a) who requires an elective referral; and
- (b) for whom that body has responsibility,

is given the choices specified in paragraph (2).

(2) Subject to regulations 40 and 41, the choices specified for the purposes of this paragraph are the choice—

(a) in respect of a first outpatient appointment with a consultant or a member of a consultant's team, of—

(i) any clinically appropriate health service provider with whom any relevant body has a commissioning contract for the service required as a result of the referral, and

(ii) any clinically appropriate team led by a named consultant who is employed or engaged by that health service provider; and

(b) in relation to an elective referral for mental health services in respect of which the patient's first outpatient appointment is not with a consultant or a member of a consultant's team, of—

(i) any clinically appropriate health service provider with whom any relevant body has a commissioning contract for the service required as a result of the referral, and

(ii) any clinically appropriate team led by a named health care professional who is employed or engaged by that health service provider.

(3) . . .

(4) . . .

(5) The arrangements referred to in paragraph (1) must include such arrangements as are necessary to ensure that a person may make the choices specified in those paragraphs where that person—

(a) has not been offered that choice by the person making the initial referral; and

(b) notifies the relevant body who has responsibility for that person that that choice was not offered.

(6) For the purposes of this Part, a health service provider, or a team led by a consultant or a health care professional, is clinically appropriate if, in the opinion of the person making the referral, they offer services that are clinically appropriate for that person in respect of the condition for which that person is referred”

3.11 Regulation 39(1) imposes a legal duty on each CCG and NHS England to “make arrangements” to give effect to the right of patients to exercise their patient choice rights. The imposition of a legal duty “to make arrangements” is used throughout the NHS Act. It imposes a legal obligation on the CCG to operate systems which ensure that patients can access those services that are within the scope of the arrangements. In *Tandy v East Sussex CC* [1998] A.C. 714 the House of Lords was concerned with a duty to make arrangements to provide suitable education services to children in its area. Whilst emphasising that the council had a discretion to decide the form of these arrangements, Lord Browne-Wilkinson said at page 747:

“The duty is to make arrangements for what constitutes suitable education for each child. That duty will not be fulfilled unless the arrangements do in fact provide suitable education for each child”

3.12 It follows that, when making decisions as to whether to fund medical treatment for an NHS patient, regulation 39(1) requires both CCGs and NHS England to put in place a decision making processes, which asks 4 questions, namely:

- i) Is this patient a person for whom the CCG/NHS England has commissioning responsibility;
- ii) Is this patient a person who “requires” an elective referral; and
- iii) Do the patient’s circumstances come within Regulation 39(2); and
- iv) Is the patient entitled to exercise patient choice rights for this particular episode of treatment.

3.13 The decision making process in the policy which constitutes the “arrangements” must provide that if the answer to all 4 questions is “yes”, the CCG or NHS England must make a decision to fund the initial consultation with the preferred secondary care clinician which is the subject of the referral. That appointment must be funded because the patient’s “legal right” to have NHS funded treatment have been established and so the CCG or NHS England ceases to have a discretion to decide whether to fund the treatment or not as part of NHS funded care. It follows that any set of legal “arrangements” must set up a decision making process that guide a decision maker to ask whether the answer to all 4 questions set out above are answered in the affirmative.

3.14 Regulation 39(6) provides that the assessment as to whether the referral is clinically appropriate is exclusively a matter for the person making the referral, not for the CCG or NHS England. Hence, the decision-making processes cannot allow the commissioner to reach their own view as to whether the referral is appropriate treatment to be funded as part of NHS care.

4 The limitation of secondary care patient choice rights to a first out-patient appointment

4.1 The right of patients to choose their secondary care provider under the Regulations is limited to a “first appointment”. On the face of it this seems a strange limitation because it suggests that a patient only has a very limited right to choose who the patient should be treated by and thereafter must accept the choice foisted on the patient by the NHS commissioner. As far as the author is aware, neither the government nor NHS England has advanced a policy reason why the right to patient choice under Part 8 of the 2012 Regulations is limited to a first out-patient appointment.

4.2 In the absence of any other explanation, it seems that the limitation of the right to a first out-patient appointment reflects a compromise between the interests of NHS commissioners and those of individual NHS patients. NHS commissioners have no

absolute duty to commission every clinically appropriate service for an NHS patient. CCGs are entitled to adopt policies to define the services that they wish to commission for the patients for whom they are responsible in order to manage their budgets: see for example *R v Cambridge Health Authority ex parte B* [1995] 1 WLR 898 and *R (AC) v Berkshire West Primary Care Trust & Anor* [2011] EWCA Civ 247. In contrast, NHS England and CCGs are not entitled to have blanket policies to refuse to fund particular treatments and have a legal duty to consider requests to commission care for a patient outside their usual policies and to make decisions whether to commission the requested treatment: see *R v North West Lancashire Health Authority ex parte A* [2000] 1 WLR 977 and Regulations 34 and 35 of the 2012 Regulations.

- 4.3 It follows the purpose of limiting the legal right of a patient to choose their provider for a first out-patient appointment appears to be designed to enable the provider of the patient's choice to have a first meeting with the patient, funded by the NHS, to discuss treatment options. Following this first appointment the patient can then request the NHS commissioner for funding to support a full course of treatment with the patient's favoured provider (either as part of an existing CCG or NHS England policy or as an individual funding request outside the policy).
- 4.4 The purpose of limiting the legal right to a first out-patient appointment appears to allow the patient to be seen by the secondary care provider of the patient's choice and for the CCG (or NHS England) to be informed by the secondary care provider what treatment that provider recommends for the patient. The CCG (or NHS England) is then in a better position to make a decision whether to commission further treatment for the patient. It is also relevant to note:
- i) When making decisions about funding further treatment, both NHS England and CCGs must comply with their general procedural duties (see below) to exercise their functions with a view to enabling patients to make choices with respect to aspects of health services provided to them; and

- ii) Each CCG must have regard to the Guidance issued by NHS England concerning whether to commission any further treatment in accordance with the patient's choice: see section 14Z8 of the NHS Act.

4.5 Accordingly, properly understood, the legal framework appears to represent a balance between the interests of the individual patient and the interests of the NHS commissioner, who acts on behalf of the general body of patients for whom the NHS commissioner is required to commission services.

5 Does NHS England have patient choice arrangements in place?

5.1 NHS England has no policy on its website which informs patients how decision makers within NHS England are required to give effect to patient choice rights when services are commissioned by NHS England. It is therefore unclear what arrangements, if any, have been put in place by NHS England to ensure that patients can exercise their choice rights when referred for care commissioned by NHS England.

5.2 The department of NHS England which regulates CCGs appears to be focused on making sure CCGs respect the patient choice rights of patients. The NHS England website⁶ says:

"Clinical commissioning groups (CCGs) have a duty to enable patients to make choices, and to promote their involvement in decisions related to their care or treatment. NHS England will work alongside CCGs to help them meet their legal responsibilities and build on their offer of choice to patients, to ensure that choices are meaningful and deliver positive improvements to patient outcomes including patient experience of the services they access and use.

The initial priorities of this programme of work are:

- Strengthening choice in outpatient services
- Enhancing the choice available in maternity services, including through a programme of Pioneers to develop and test ways of improving choice in maternity services for national replication

⁶ See <https://www.england.nhs.uk/about/gov/patientchoice/>

- Improving choice in end of life care (EOLC) (including ensuring more people are able to achieve their preferred place of care and death)
- Securing choice in the new care models that some Vanguard areas of the country are developing.

More information on these priority areas will be available via this webpage by summer 2016.

5.3 However, it is less clear how NHS England is complying with its own patient choice obligations. If NHS England does not have any “patient choice” arrangements in place then it will be acting in breach of its duty under Regulation 39 and any decisions which fail to respect patient choice rights could be challenged by way of judicial review.

6 Patient Choice arrangements by CCGs

6.1 There are some CCGs with well developed “patient choice polices”. A good example is Blackpool CCG (see <http://blackpoolccg.nhs.uk/patient-choice/>). However, there are many other CCGs that have no specific policy which explains patient choice to patients and, crucially, to decision makers within the CCG. As with NHS England, CCGs will be acting unlawfully if they do not have a policy which guides decision makers to identify and respect appropriate choices made by patients.

6.2 The legal rights given by Part 8 of the 2012 Regulations need to be seen within the overall legal structures operating in the NHS. These structures provide that that decisions about which NHS funded medical treatment should be provided to an NHS patient are primarily a matter to be decided between the patient and their treating NHS GP or other primary care clinician. This balance between the decision making power of GPs and the powers of the CCG is seen in 3 areas in particular, namely:

- i) Drugs or medical appliances prescribed for patients by a GP;
- ii) NICE recommended treatments for NHS patients (usually prescribed within secondary care); and

- iii) Patient choice rights for secondary care recommended by a GP or other primary care clinician.

Drugs or medical appliances prescribed for patients by a GP

6.3 The question as to whether a pharmaceutical drug should be provided to patients of a GP practice is, in the first instance, a matter exclusively for the GP. A CCG cannot impose any fixed cost limit on the pharmaceutical drugs a GP can prescribe for an NHS patient and which must be funded by a CCG as part of NHS funded care. See regulation 56 of the GMS Regulations. The only exceptions are the “black list” of drugs published by the Secretary of State that an NHS GP cannot prescribe and a “grey” list of products such as Viagra which can only be prescribed in limited circumstances. However outside these limited examples, the only restraint on GPs and other primary care clinicians on prescribing is in Regulation 64 of the GMS Regulations which provides:

“(1) The contractor must not prescribe drugs, medicines or appliances the cost or quantity of which, in relation to a patient, is, by reason of the character of the drug, medicine or appliance in question, in excess of that which was reasonably necessary for the proper treatment of the patient.

(2) In considering whether a contractor has breached its obligations under paragraph (1), the Board must seek the views of the Local Medical Committee (if any) for the area in which the contractor provides services under the contract.”

6.4 Save where GPs are prescribing branded drugs when generics are available, the requirement not to prescribe drugs where the cost or quantity is “*in excess of that which was reasonably necessary for the proper treatment of that patient*” is almost impossible to enforce because the GP must follow GMC Guidance in prescribing the most appropriate drug for the patient regardless of the cost. A drug should only be prescribed for a patient where the patient agrees to take the drug (or it is a waste of NHS resources), but a joint decision between the GP and the patient on the choice of drug binds the CCG. Once the prescription is written, the patient goes to an NHS pharmacy which dispenses the drug to the patient. The pharmacist then makes a

financial claim from the NHS Business Services Agency for payment for dispensing the drug (where the payment depends on the type of the drug). The cost of the drug eventually makes its way back to the local clinical commissioning group. CCGs can encourage GPs to limit costs when prescribing drugs but have no powers to prevent GPs exercising their clinical judgement to prescribe the drug GP considers most appropriate for the NHS patient.

NICE recommended treatments for NHS patients (usually prescribed within secondary care)

6.5 There is, in principle, no limit on the types of drugs or other treatments that a secondary care provider, such as a Hospital Trust, can provide to an NHS patient. However, the contract between a CCG (or NHS England) and a secondary care provider can place limits on the costs that a secondary care provider can recover from the CCG. Secondary care providers will usually prevent clinicians providing expensive drugs or other medical interventions for an NHS patient unless the secondary care provider can recover the costs of those drugs or interventions from the CCG.

6.6 However, CCGs are obliged to fund drugs or other treatments provided to patients where the drug or medical appliance is recommended in a Technology Appraisal Guidance (“TAG”) by the National Institute for Health and Social Care Excellence (“NICE”). A combination of section 237(8) of the Health and Social Care Act 2012 and Regulation 34 of the 2012 Regulations means that CCGs must have arrangements in place which require the CCG to fund drugs or treatments for patients with medical conditions which come within a cohort defined by a NICE TAG. Regulation 34 provides:

“(1) A relevant body must have in place arrangements for making decisions and adopting policies on whether a particular health care intervention is to be made available for persons for whom the relevant body has responsibility.

(2) Arrangements under paragraph (1) must—

- (a) ensure that the relevant body complies with relevant NICE recommendations; and
- (b) include arrangements for the determination of any request for the funding of a health care intervention for a person, where there is no relevant NICE recommendation and the relevant body's general policy is not to fund that intervention⁷

6.7 This right is repeated in the NHS Constitution⁸ which says:

“You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you”

6.8 Thus, a CCG may not lawfully adopt a policy not to reimburse a secondary care provider for providing drugs or treatments to patients with medical conditions which come within a cohort defined by a NICE TAG.

7 The requirements that must be fulfilled before a patient can establish “patient choice” rights under Part 8 of the 2012 Regulations

7.1 The wording of Part 8 of the 2012 Regulations provides that NHS patients have a legal right to have a referral funded by their CCG or NHS England for the first consultation with the clinician to whom they are referred by their GP if the following conditions are satisfied:

- i) **Condition 1:** The patient is a patient for whom the CCG has responsibility (Regulation 39(1)(b));
- ii) **Condition 2:** The patient requires an elective referral (Regulation 39(1)(a)). The wording of the regulation is that the patient requires an elective referral, not that the patient requires an elective referral for a form of treatment that the CCG considers she ought to receive. Regulation 39(6) provides that the exercise

⁷ This is the Regulation which requires a CCG and NHS England to have an Individual Funding Arrangement policy and to operate IFR panels. Where an IFR request is turned down the CCG or NHS England must give reasons: see Regulation 35.

⁸ See <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>

of clinical judgement to determine what treatment the patient requires is for the GP and not the CCG;

- iii) **Condition 3:** A referral has been made by the patient's GP⁹ to a "*clinically appropriate provider*" (Regulation 39(2)(a) and (b)). However Regulation 39(6) provides that whether a provider is clinically appropriate is solely a decision for the person making the referral;
- iv) **Condition 4:** The provider to whom the patient is referred has a commissioning contract with a "relevant body" for the service required by the referral (see Regulation 39(2)(a) and (b)). The expression "relevant body" is also defined in Regulation 2 as follows:

""relevant body" means a CCG or the Board"

Thus, this condition is satisfied if any CCG or the Board (known as NHS England) has a commissioning contract for the service required by the referral with the proposed provider. It is not necessary for the patient's own CCG to have an existing contract with the proposed provider for the proposed service;

- v) **Condition 5:** The service is not of a type listed in Regulation 40 where the choice right does not apply. The services that are exempted from patient choice rights are:
 - a. Cancer services (where a 2 week wait right arises – as to which see below);
 - b. Maternity services; and
 - c. Services for which the patient has a need for urgent care;
- vi) **Condition 6:** The patient is not a person who comes within Regulation 41 (which defines those patients who cannot exercise choice). The following patients do not have patient choice rights under Regulation 41:

⁹ Or another person who can make a referral under Regulation 38.

- a. Patients detained under the Mental Health Act 1983;
- b. Patients who are detained in or on temporary release from prison, in an immigration removal centre, secure training centre or detained other accommodation described in regulation 10(2) of the 2012 Regulations; or
- c. Patients who are serving as a member of the armed forces.

7.2 Mental Health services were excluded from patient choice rights when the 2012 Regulations were originally made. However, mental health services were removed from the list of excluded services with effect from 1 April 2014 by the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013. It follows that, from 1 April 2014, mental health patients gained the same legal rights to choose a secondary care provider from that date as other NHS patients.

8 The Guidance on patient choice published by the Department of Health

8.1 The Department of Health has published Guidance concerning the 2015/16 Choice Framework¹⁰. This suggests that the only occasions where a patient does not get the legal right to access treatment following a GP referral to a secondary care provider are those set out in the Regulations. An example of the exercise of patient rights is given in the recent Guidance from the Secretary of State as follows:

“Fatima is suffering from a mental health condition and visits her GP to be referred for treatment. She would like to exercise her entitlement to choose a named health care professional, whose team will then be responsible for her care. She has heard of a particular consultant that she would like to go to for her treatment and discusses this with her GP. He uses the NHS e-Referral Service to search for this named consultant and show Fatima the list of organisations and locations where the consultant works. Her GP creates a shortlist from these options and gives her log-in details for the NHS e-Referral service so she can do some research at home before deciding which one she would like to choose for her first outpatient appointment.

¹⁰ See <https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs>

Fatima uses NHS Choices to research each organisation before choosing one that is close to where she lives and has a number of convenient available appointments. A close friend of hers has also received treatment at this organisation and tells her that the quality of care is good. Fatima logs into the NHS e-Referral Service, selects her chosen organisation and books an appointment. She will be treated by her chosen health care specialist or a member of their team”

- 8.2 There is no suggestion in the Secretary of State’s Guidance (or in the example above) that the legal right to choose is constrained by whether the patient’s chosen provider holds a “Standard NHS Contract” or whether the treatment for which the patient is referred is treatment that is routinely commissioned by the patient’s CCG.

9 NHS England’s Guidance concerning patient choice rights

- 9.1 NHS England takes a substantially different approach to the conditions which must be satisfied before patient choice rights arise. Despite the many statements made by NHS England in support of the concept of patient choice and the existence of a team within NHS England which promotes patient choice, the Guidance issued by NHS England seeks to place additional restrictions on the ability of all NHS patients to exercise patient choice rights. This Guidance was issued after mental health patients came within the patient choice rights framework and appears to be an attempt to restrain the rights of all patients to exercise patient choice rights.

- 9.2 NHS England published interim Guidance on patient choice in mental health services in May 2014¹¹ and then published final guidance in December 2014. The December 2014 NHS England Guidance suggests that, in addition to the qualifying criteria set out in the 2012 Regulations, there are 2 further restrictions on patient choice rights, namely:

- i) The referral must be for treatment which is of a type which the patient’s own CCG routinely commissions; and

¹¹ See <https://www.england.nhs.uk/wp-content/uploads/2014/05/guid-choice-prov-health.pdf>

- ii) The “commissioning contract” held by the provider must be in the form of an NHS Standard Contract and not any other form of contract.

9.3 However, the Regulations must apply equally to patient choice for physical and mental health conditions because they are both governed by the same regulatory structure. It follows that the additional restrictions on patients’ rights to exercise their Part 8 choice rights suggested by NHS England must either apply to both physical and mental health services or not apply to any NHS services. For the reasons set out below, the latter appears likely.

Are the additional NHS England restrictions on patient choice part of the law?

9.4 A conventional approach to statutory construction would suggest that a patient who could show that he or she satisfied each of the 6 conditions laid down by the 2012 Regulations would have a legal right to require the CCG to fund a referral made by his or her GP. There must, at the very least, be serious questions as to whether NHS England has acted lawfully in publishing guidance suggesting there are additional conditions that a patient must meet before a patient choice right arose. There would also be serious issues about the legality of any CCG refusing to recognise a patient choice had been established where the patient satisfied the 6 conditions set out in the 2012 Regulations but was denied the right to exercise patient choice based on the NHS England additional restrictions. The legality of the additional restrictions would have been tested in the courts in the case of *R (AA) v Haringey CCG* comes to court in December 2016, but the CCG decided to resolve the case by providing the requested treatment shortly before the case came to trial.

The suggestion in NHS England Guidance that the referral must be for treatment which is of a type which the patient’s own CCG routinely commissions

9.5 The NHS England Interim Guidance provided at pages 4/5:

“Since 1 April 2013, people with mental health conditions who have been referred for a first outpatient appointment have had a right to choose who treats them within the organisation providing their care and treatment. This means having a right to choose which team, led by a named healthcare professional, delivers their care and treatment. Until April 2014, this right was limited to a mental health provider with which the patient’s clinical commissioning group (CCG) or NHS England had contracted.

The right to choice is no longer limited to mental health providers that have a contract with the CCG responsible for that patient, but is extended to other providers with a contract with any CCG, in the same way there is a right to choice of provider in physical health. This is an important step both towards establishing ‘parity of esteem’, or equal status, between mental and physical health services in the NHS and towards improving access, personalising and improving both the quality of care that people receive and, ultimately, their health outcomes”

- 9.6 That part of the Interim Guidance appears to be correct. However the Interim Guidance goes on to say:

“These changes mean that a patient who requires an elective referral for mental health services has a right from 1 April 2014 to choose any clinically appropriate health service provider (whether an NHS mental health trust, a Foundation Trust or a mental health provider in the independent or third sector) for their first outpatient appointment **as long as the provider has a contract with any CCG or with NHS England for the service required, and that the service or treatment is routinely commissioned by the patient’s CCG or NHS England, or is approved by the relevant Independent Funding Review Panel.** This brings mental health services a step closer towards ‘parity of esteem’, or equal status, with physical health services in the NHS” [*Emphasis added*]

- 9.7 This Guidance thus suggested patient choice rights were restricted to services that are already “routinely commissioned” by a CCG or where a specific commissioning decision was made by a CCG to support the commissioning of the service. This proposed restriction is repeated in the next part of the Interim Guidance which says:

“Consistent with the operation of choice in physical health care, patients cannot generally choose services or treatments which are not routinely commissioned by their local CCG or NHS England. Patients wishing to access services not commissioned by their CCG or (where relevant) NHS England, may seek to demonstrate exceptionality

and so access funding for the treatment through the commissioner's Independent Funding Review Panel. Patients should discuss their options with their GP who is required to support such an application"

9.8 In December 2014, NHS England published guidance on "Choice in Mental Health Care"¹². In the introduction the NHS England Medical Director, Prof Sir Bruce Keogh states:

"The changes in law that have given patients with mental health conditions the same legal rights as they have in physical health services are a significant step towards parity. They are part of the more significant shift to increase the direct control patients have over their care and every one of us working in mental health has a part to play to help implement these rights and make them work well for patients"

9.9 This guidance provides at page 4:

"This guidance seeks to interpret these regulations and set out the principles for how these legal rights to choice should operate. It is important to note that the right choice does not mean that a patient only has their first outpatient appointment with their chosen provider: consistent with physical health care, once a patient has chosen a provider, that provider will normally treat the patient for their entire episode of care unless the patient's diagnosis changes significantly"

9.10 However the NHS England Guidance departs from the terms of the Regulations in suggesting that a patient's legal right to choose a provider was limited as follows:

"As is the case in physical health, the legal rights to choose in mental health do not give a legal right to choose their treatment. It is for commissioners to decide which services to secure in order to meet the needs of their local population. Where commissioners routinely commissioned particular mental health services, eligible patients may choose any provider team, in line with the description above, to access those services. Where patients, with the support of their GP, wish to access services that are not routinely commissioned by their responsible commission, they may apply through the Commissioner's Individual Funding Request ("IFR") process or if in receipt of a personal health budget through the care planning process"

¹² See <https://www.england.nhs.uk/wp-content/uploads/2014/12/choice-mhc-14.pdf>

- 9.11 This wording follows the Interim Guidance, but it appears to confuse 2 different matters namely (a) whether patients can choose which NHS medical services they wish to access without the support of their GP and (b) whether the clinical decision maker should be the patient's referring clinician or the CCG. Neither the 2009 Choice Directions which preceded Part 8 of the 2012 Regulations nor Part 8 of the 2012 Regulations gives the patient a "choice of treatment" which is not supported by the patient's clinician. However, neither the 2009 Choice Directions nor Part 8 of the 2012 Regulations contain any wording which suggest that the CCG has the right to restrict the choices agreed between the patient and the patient's referring GP.
- 9.12 If it were to have been the Secretary of State's intention that patient choice rights should be restricted to services that are routinely commissioned by the patient's CCG or approved by way of that CCG's IFR panel, it is surprising that this important restriction is not referred to in either the Regulations or in the Department of Health Guidance. These Regulations were, after all, made by the Secretary of State and not by NHS England.
- 9.13 The duty on a CCG under Regulation 39(1) is to make arrangements to fund a first appointment for patients who "require" an elective referral. The use of the word "require" appears to echo the duty on the CCG under section 3(1) of the National Health Service Act 2006 ("the NHS Act"), namely that:
- "A clinical commissioning group must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility ..."
- 9.14 However, the 2012 Regulations were made by the Secretary of State in exercise of his powers under section 6E of the NHS Act which provides that the Secretary of State may make Regulations which direct CCGs how they are required to exercise their commissioning responsibilities. There are wide powers in section 6E(2) to make Regulations directing CCGs as follows:

“The regulations may, in relation to the commissioning functions of the Board or clinical commissioning groups, make provision—

- (a) requiring the Board or clinical commissioning groups to arrange for specified treatments or other specified services to be provided or to be provided in a specified manner or within a specified period;
- (b) as to the arrangements that the Board or clinical commissioning groups must make for the purpose of making decisions as to—
 - (i) the treatments or other services that are to be provided;
 - (ii) the manner in which or period within which specified treatments or other specified services are to be provided;
 - (iii) the persons to whom specified treatments or other specified services are to be provided;
- (c) as to the arrangements that the Board or clinical commissioning groups must make for enabling persons to whom specified treatments or other specified services are to be provided to make choices with respect to specified aspects of them”

9.15 These powers add to the commissioning responsibilities under section 3(1) and thus the limitation suggested by the NHS England Guidance does not appear to be consistent with these extensive powers. Further Regulation 39(1) appears reasonably clear that the decision-maker as to whether a patient “requires” a secondary care referral is the patient’s GP as opposed to the CCG.

9.16 The ambit of the right is also important. It is a right for a first consultation and the strict legal right does not extend beyond the first consultation. Hence, a right to a first consultation with a secondary care clinician in an area of treatment that the CCG would not routinely fund does not necessarily lead to the CCG having any further extended liability for treatment. It follows that this part of the NHS England Guidance appears to be legally incorrect mainly because a limitation to a referral for treatment that the CCG routinely commissions is not a limitation which is set out in the 2012 Regulations.

9.17 The author thus expresses the view that, as a matter of law, a patient who is referred by his or her GP for a first appointment with a secondary care clinician who has a contract with another CCG or NHS England but seeks a type of care which the patients CCG does not routinely commission can establish a legal right to an NHS funded first appointment under Part 8 of the 2012 Regulations.

The observations in the NHS England Guidance about the need for the provider to have an NHS Standard Contract.

9.18 The NHS England Guidance suggests that a provider will only qualify for patient choice rights if the provider holds a Standard NHS Contract for the service in question and that any other type of contracting arrangement will not suffice to give rise to patient choice rights. This additional requirement is not in the Department of Health Guidance and appears to be even more problematic than the suggestion that the service is limited to a service that the CCG routinely commissions.

9.19 This suggested limitation was not included in the May 2014 Interim Guidance but was set out in the December 2014 NHS Guidance. This says at page 6¹³:

“Routinely commissioned services are the types of treatments that commissioners secure for their populations on an ongoing basis, through the award of NHS Standard Contracts. These treatments exclude spot contracts between a commissioner and a provider on a one-off basis for the treatment of a specific patient”

9.20 Thus, the Guidance suggests that if a CCG enters into a “spot contract” with a provider to treat a specific patient, that contract cannot be relied on by other patients in order to establish a right to be referred to that provider. There are 2 major problems with this suggested limitation. First, in entering into these contracts, CCGs are discharging commissioning functions in relation to particular patients under section 3(1) of the NHS Act. Accordingly, these contracts constitute “commissioning contracts” within the definition of that term in Regulation 2 of the 2012 Regulations. There is a full definition of the term “commissioning contract” in Regulation 2 of the 2012 Regulations as follows:

¹³ See <https://www.england.nhs.uk/wp-content/uploads/2014/12/choice-mhc-14.pdf>

““commissioning contract” means a contract, other than a primary care contract, entered into by a relevant body in the exercise of its commissioning functions”

9.21 The attempt in the NHS England Guidance to restrict the meaning of the term “commissioning contract” to a contract which was concluded using the NHS Standard Contract is thus not contained within the wording of the 2012 Regulations. If it were the definition would read:

““commissioning contract” means a contract, other than a primary care contract, entered into by a relevant body in the exercise of its commissioning functions which, if entered into by a CCG, is in a form that complies with any obligations on a CCG under Part 5 of these Regulations and if entered into by the Board is in a like form”

9.22 However, this is not what the 2012 Regulations provide. It follows that the Guidance is attempting to introduce limitations which do not appear in the Regulations. Guidance which attempts to impose obligations on a statutory scheme or to re-interpret the form of the statutory scheme is unlawful: see for example *R (Simpson) v Police Medical Appeal Board & Ors* [2012] EWHC 808 (Admin).

9.23 The second difficulty in suggesting that a “*commissioning contract*” should mean “*a commissioning contract in the form of an NHS Standard Contract and not in any other form*” is that a CCG that entered into a commissioning contract in any form other than the NHS Standard Contract would be acting in breach of NHS England’s own rules. Hence, a CCG would not be acting lawfully in entering into a “spot contract” with a provider for the delivery of NHS services to a patient in any form other than the NHS Standard Contract.

9.24 The requirement on CCGs to use the NHS Standard Contract when commissioning all NHS services is set out in Part 5 of the 2012 Regulations which is headed “Standing rules: commissioning contract terms”. Regulation 16 provides :

“(1) The Board must draft—

- (a) terms and conditions making provision for the matters specified in regulation 16; and
- (b) such other terms and conditions as the Board considers are, or might be, appropriate for inclusion in commissioning contracts entered into by a relevant body.

(2) The Board may draft model commissioning contracts which reflect the terms and conditions it has drafted pursuant to paragraph (1).

(3) A relevant body must incorporate the terms and conditions drafted by virtue of paragraph (1)(a) in commissioning contracts entered into by it.

(4) The Board may require CCGs to incorporate the terms and conditions it has drafted pursuant to paragraph (1)(b) in commissioning contracts that a CCG enters into.

(5) If a CCG is required by the Board to incorporate terms and conditions pursuant to paragraph (4), it must do so”

9.25 NHS England has complied with this obligation by publishing the NHS Standard Contract¹⁴, which is revised on annual basis. NHS England has also exercised the power under Regulation 17(4) to require CCGs to use the NHS Standard Contract. The NHS England website says:

“The NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care”

9.26 NHS England also produces “Technical Guidance” each year concerning the legal obligations on NHS bodies to use the NHS Standard Contract. Although these documents describes themselves as being “Guidance”, the documents set out the rules set by NHS England exercising its powers under Regulation 17 of the 2012 Regulations. Accordingly, CCGs have a legal duty to follow the rules set out in the Technical Guidance document as opposed to merely having a duty to have regard to them. Para 5.2 of the 2015/16 Technical Guidance¹⁵ provides:

¹⁴ See <https://www.england.nhs.uk/nhs-standard-contract/>

¹⁵ See <https://www.england.nhs.uk/wp-content/uploads/2015/03/7-nhs-contrct-tech-guid-fin.pdf>

5.2 The NHS Standard Contract must be used by CCGs and by NHS England where they wish to contract for NHS-funded healthcare services (including acute, ambulance, patient transport, continuing healthcare services, community-based, high-secure, mental health and learning disability services). The Contract must be used regardless of the proposed duration or value of a contract (so it should be used for a small-scale short-term pilots as well as for long-term or high-value services). Where a single contract includes both healthcare and non-healthcare services, the NHS Standard Contract must be used.

5.3 The only exceptions are:

- primary care services commissioned by NHS England, where the relevant primary care contract should be used; and
- any primary care improvement schemes agreed by CCGs with GP practices (with contractual arrangements, involving a variation or supplement to existing general practice contract, agreed between local NHS England teams and CCGs). Such Local Improvement Schemes involve payments for improving the quality of services provided under an existing GP contract, not the commissioning of additional services [*Emphasis added*]

9.27 The compulsory nature of the obligations set out in these paragraphs is shown by the use of the word “must” in the first line of paragraph 5.2. It follows that, at least until April 2016, CCGs were under a legal obligation to use the NHS Standard Contract whenever they were commissioning “NHS funded healthcare services” unless the services were exempted because they came within the type of services set out in paragraph 5.2. CCGs may now use an approved form of “NHS Contract light” but cannot enter into commissioning contracts in any other form.

9.28 Three points appear to emerge from the 2015/16 rules concerning the extent of the legal obligations on CCGs to use the NHS Standard Contract which are relevant to the issue of patient choice, namely:

- i) There is no exemption from the legal duty where the proposed contract is of low value. The legal duty to use the NHS Standard Contract arises regardless of the value of the contract;
-

- ii) There is no exemption from the mandated duty to use the NHS Standard Contract where the commissioning decision has been made by an IFR panel. The Technical Guidance shows that the fact that the commissioning decision has been made through an IFR process as opposed to be made by any other process does not exempt a CCG from using a Standard NHS Contract when putting the IFR commissioning decision into effect; and
- iii) There is no exemption from the duty to use the NHS Standard Contract where services are being commissioned by a CCG for a single patient as opposed to being commissioned for cohorts of patients. This is clear from the rules in paragraph 5.2 which provides that the only exceptions to the mandated rule under paragraph 5.1 others exemption set out in paragraph 5.2. Further the use of the NHS Standard Contract is emphasised at paragraph 12.1 of the Technical Guidance.

9.29 It follows that every CCG is under a public law legal obligation to use an NHS Standard Contract when placing a contract with a chosen provider following an IFR decision for an individual patient. It is therefore difficult to see that this part of the NHS England Guidance can possibly be correct because it fails to give effect to NHS England's own rules on the type of contracts that must be used by CCGs. The view is therefore put forward that the attempt by the NHS England Guidance to limit the type of contracts that count as "commissioning contracts" for establishing patient rights under Part 8 of the 2012 Regulations is wrong as a matter of law.

10 The general duties on CCGs and NHS England to commission services in accordance with preferences expressed by patients

10.1 Section 13I of the NHS Act provides:

"The Board must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them"

10.2 A like provision is imposed on CCGs by section 14V of the NHS Act 2006 which provides:

“Each clinical commissioning group must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them”

10.3 This general duty is clearly not relevant where a patient seeks to establish a right to exercise patient choice under Part 8 of the 2012 Regulations. However, this duty is relevant to categories of patients who are outside the patient choice rights under Part 8 of the 2012 Regulations and to any request for funding for treatment that goes beyond an initial consultation.

10.4 Sections 13I and 14V impose procedural duties which require NHS England and each CCG to act at all times “with a view” to enabling patients to make their own choices about inter alia their selected healthcare provider. It is thus a general duty which applies to all commissioning decision-making processes by NHS England and every CCG. It therefore applies to CCGs when formulating general policies as well as when they are considering Individual Funding Requests.

10.5 A CCG has a legal duty to have regard to NHS England Guidance when making commissioning decisions in accordance with this duty. This duty is set out in section 14Z8 of the NHS Act which provides:

“(1) The Board must publish guidance for clinical commissioning groups on the discharge of their commissioning functions.

(2) Each clinical commissioning group must have regard to guidance under this section.

(3) The Board must consult the Healthwatch England committee of the Care Quality Commission—

(a) before it first publishes guidance under this section, and

(b) before it publishes any revised guidance containing changes that are, in the opinion of the Board, significant”

10.6 The December 2014 NHS England Guidance to CCGs provides at page 4:

“It is important to note that the right to choice does not mean that the patient only has their first outpatient appointment with their chosen provider: consistent with physical health care, once the patient has chosen a provider, that provider will normally treat the patient for their entire episode of care unless the patient’s diagnosis changes significantly”

10.7 This is statutory guidance that each CCG must follow unless it has a good reason to depart from the Guidance. The courts scrutinise those “good reasons” carefully and they need to be very good reasons: see *R (Fisher) v North Derbyshire Health Authority* [1997] EWHC Admin 675 and *R (Rose) v Thanet Clinical Commissioning Group* [2014] EWHC 1182 (Admin). NHS England has no specific statutory duty to follow its own guidance but may well be acting irrationally if it has identical legal duties and yet fails to follow guidance it issues to CCGs about how the duties under the section are to be discharged.

10.8 However, sections 13I and 14V only impose procedural duties. It follows that there can be countervailing factors on which a CCG or NHS England could rely upon to reach a final decision which does not enable a patient to make choices with respect to aspects of health services provided to them. That raises the interesting question as to how a CCG or NHS England should approach a request for a provider to fund treatment which the CCG or NHS England has made a specific decision not to commission. The factors would have to be balanced in the decision-making but it is probably lawful to override the patient’s preference and to apply the general policy. It is not, however probably permissible to adopt a general policy not to fund any medical treatments where no specific decision has been taken to fund the form of treatment.

11 These legal structures probably mean that NHS England and CCGs can only discharge the duty by adopting a starting point that it should enable a patient to make choices with respect to aspects of health services provided to them, and then depart from that

position if driven to do so by other factors. Some helpful guidance on the meaning of the section 14V duty can be drawn from the observations of Aitkens LJ in *R (Brown) v Secretary of State for Work and Pensions* [2008] EWHC 3158 (Admin) which was concerned with the similarly worded “due regard” duty under section 149 of the Equality Act 2010. It follows that, in order to act lawfully:

- i) Decision makers in a CCG and NHS England must record their awareness of the duty when making decisions. A CCG or NHS England decision maker will be in difficulties in asserting that he or she complied with this legal obligations in making a commissioning decision if the person who made the decision was not aware of the legal duty and/or made no reference to the legal duty in the decision making process;
- ii) The mind of the decision maker must be focused on the duty during each stage of the commissioning decision making processes. Decision makers must have a “*conscious approach and state of mind*” which is focused upon the legal obligation when they are taking commissioning decisions;
- iii) The legal duty must be exercised in substance, with rigour and with an open mind;
- iv) The duty is a non–delegable duty;
- v) The duty is a continuing duty throughout the commissioning process;
- vi) It is good practice for those exercising public functions in public authorities to keep an adequate record showing that they had actually considered this duty and pondered relevant questions.

Summary

- 12** Patient choice rights are powerful rights for patients to exercise a measure of control over the services they wish to receive. However, these rights are complex, are not generally well understood and are rarely exercised in practice. However, these legal

rights are likely to become more important as NHS resources become tighter and patients are therefore increasingly denied treatment that they seek in order to balance the books.

David Lock QC

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