

*“Choose & Book” –
Patient’s Choice of Hospital
and Booked Appointment*

**Policy Framework for Choice and
Booking at the Point of Referral**

READER INFORMATION

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1 Introduction

1. This document provides guidance to NHS organisations in their transition to a fully booked NHS, which offers patients a choice of hospital and of date and time of their appointment.
2. The document sets out the requirements to offer patients fully booked appointments from a choice of 4-5 hospitals (or suitable alternative providers) by December 2005. NHS organisations will be expected to increase the levels of choice available to patients so that:
 - from August 2004, patients waiting more than six months for elective surgery will be offered faster treatment at an alternative hospital
 - from January 2005, patients requiring cataract surgery (including those referred directly by an optometrist) are offered a choice of hospital at the time they are referred for treatment
 - from April 2005, patients who need a heart operation will be offered a choice of hospital at the time they are referred for treatment
 - by December 2005, patients who require an elective referral will be offered a choice of 4-5 hospitals (or suitable alternative providers) and a choice of time and date for their booked appointment, at the time they are referred by their GP or primary care professional.
3. This policy is a key step in achieving the standards set out in the NHS Improvement Plan.
4. The guidance within this document covers the period up to December 2005 and has been subject to significant testing with NHS clinicians and managers, which has shaped the development of the policy.
5. This document is copied to Foundation Trusts for information only.

Choice at Referral: The NHS Vision

6. By December 2005 all patients who need a referral to hospital (or a suitable alternative provider) for elective care, can expect:
 - to be offered a choice of 4-5 hospitals or suitable alternative providers
 - to be able to book their appointment with their preferred hospital/suitable alternative provider
 - information to be available locally to inform their choice
 - to be supported in making their choice by their GP or primary care professional and, where necessary, by a range of practice, PCT and community and voluntary sector based services. PCTs will provide targeted packages of support designed to ensure that all patients, including hard to reach patients and communities, can benefit from choice
 - aftercare and rehabilitation to be provided locally following any hospital treatment.
7. PCTs will be responsible for ensuring that choices are available and the necessary systems and processes are in place to offer and support choice and to enable booked appointments to be made.

8. Secondary care services will be responsible for ensuring that appointment bookings are honoured. This will involve the development of clinical governance, handover and service provision arrangements to ensure appointments booked over six weeks in advance can be made and delivered. This is essential to develop fully booked first outpatient services by December 2005.¹

1.1 Benefits for Patients

9. Offering and booking a choice of hospital and appointment will bring real improvements to patients’ experience of the NHS:
 - patients will have a greater opportunity to influence the way they are treated by the NHS
 - patients will be able to discuss their treatment options so that they experience a more personalised health service
 - patients will experience greater convenience and certainty which will reduce the stress of the referral process
 - patients will have a choice of time and place which will enable them to fit their treatment in with their life, not the other way round.

1.2 Benefits for the NHS

10. Offering and booking a choice of hospital and appointment will also bring improvements to the service.
11. Primary care will:
 - see a reduction in the number of patient enquiries regarding appointments
 - see a reduction in the amount of time spent on the paper chase and bureaucracy associated with existing referral processes.
12. Secondary care will:
 - see a reduction in the volume of Did Not Attends (DNAs) and cancellations because patients will agree their date and time
 - see a reduction in the administrative burden of chasing hospital appointments on behalf of patients
 - have a more secure referral audit trail, which may contribute to further clinical education development
 - see more consistency in the standard and format of referral letters.

¹ The standard for booking all appointments by December 2005. Patients are given the opportunity to agree a date on or within the working day of the referral or decision to admit, as defined for current reporting purposes in the current DSCN 20/2001.

2 Choice at Referral: Policy for December 2005

13. This section sets out the policy for delivering choice of hospital and booked appointments at the point of referral from primary care by December 2005.

2.1 Choice of 4-5 Providers

14. Patients will be able to choose a provider for their elective care from within a range of services commissioned by their PCT and should normally expect at least 4-5 different providers to be available to them.
15. The range of service providers available could include:
 - NHS Trusts
 - Foundation Trusts
 - NHS and Independent Sector Treatment Centres
 - Independent Sector Hospitals
 - General Practitioners with a Special Interest (GPwSI) or other extended primary care treatment services.
16. Establishing the menu of providers from which patients will be able to choose will be a key responsibility of the PCT. PCTs will discuss the options with their Patient Forums and decide which should be made available. It may also be good practice to engage the Local Authority Overview and Scrutiny Committee on these commissioning decisions.
17. For some treatments with real capacity constraints, it may not be possible to offer the full range of 4-5 choices. PCTs will need to seek SHA agreement to offering reduced menus for such treatments.
18. The full range of 4-5 choices may not be appropriate for all patients. There may be clinical reasons for limiting the number of choices, for example a patient may require access to intensive care services. Any clinical restrictions on the number of choices should be explained to the patient by the referring primary care professional.
19. Choice of hospital may not be appropriate for all services. The services that will not be required to offer a choice of 4-5 hospitals (or suitable alternative providers) by December 2005 are:
 - Services where speed of access to diagnosis and treatment are particularly important:
 - emergency attendances/admissions
 - patients attending a Rapid Access Chest Pain Clinic under the 2 week maximum waiting time
 - patients attending cancer services under the 2 week maximum waiting time

- Services where other choices are more likely to improve the patient experience:
 - maternity services
 - mental health
- 20. Some limits on choice may also be appropriate for paediatric services where it may not be possible to offer choice for all referrals, particularly for referrals requiring more specialist interventions.
- 21. In many cases NHS Trusts run services on more than one hospital site. Where services are offered on more than one site and are separately bookable, patients should be able to choose which site they attend for their appointment or treatment. However multiple site providers will still only count as one provider against the requirement to offer 4-5 different providers from which patients can choose.
- 22. Patients will choose a provider for the whole of their elective care episode. This will usually include an initial outpatient appointment and any subsequent treatment. This approach preserves the clinical continuity between assessment, diagnosis and treatment. However aftercare and rehabilitation services should normally be delivered locally, providing greater convenience for patients.
- 23. Where patients are unhappy with the care offered by their chosen provider they will be able to return to their GP in order to make another choice. This reflects current local practices for dealing with exceptions and patient complaints.
- 24. The choice options will be based on locally commissioned services. Where patients have their PCT’s agreement to attend a service outside the PCT’s commissioned services, they will be supported on an individual basis by their PCT as in present service provision arrangements.
- 25. Further work is being carried out to address the issue of cross border issues between the NHS in England and the devolved administrations in Scotland and Wales.

2.2 Decision to Refer

- 26. Choice of hospital should be offered once the relevant primary care professional has decided that a referral is appropriate. For most patients the offer of choice will follow the decision of their GP that a referral is required. Best practice for GP consultations suggests the decision to refer should be reached through mutual agreement between the GP and the patient.

2.3 Choice through Clinical Assessment Services

- 27. Clinical Assessment Services (“CAS”) involve the clinical evaluation of a patient’s condition and treatment needs. The result will be a *clinical decision* about the most appropriate care required for the patient.
- 28. This decision must be discussed with the patient prior to an onward referral being made. If this assessment identifies a clinical need for the patient to attend secondary care, the Clinical Assessment Service should offer the patient a choice of 4-5 providers and the opportunity to book their appointment.
- 29. Where a patient is referred to a Clinical Assessment Service, they should have the opportunity to book an assessment time with the CAS, at the point of their assessment with the primary care professional who makes the referral.

30. Where the assessment does not involve the patient being present, patients should still expect to be offered a booked assessment time. This should be used to inform the patient of the outcome of the assessment, either in person or over the telephone, and, if an onward referral for elective care is required, to offer the patient a choice of the hospital for their care and the opportunity to book their appointment.
31. Non clinical “Referral Management Centre” services will need to be adapted to ensure that the process of care is not inappropriately delayed and that the patient has the opportunity for a clinical discussion about their choice of hospital (or suitable alternative provider) before any referral is made.

2.4 Secondary and Tertiary Referrals

32. It is not expected that secondary and tertiary referrals will be subject to offering the patient the choice of 4-5 alternative providers by December 2005.
33. However, building on the successful CHD Choice Pilot, such a choice will be offered to patients requiring heart surgery (see section 3.10). The learning from this pilot will be used to inform the roll out of choice in other areas.

2.5 Supporting Patients and Providing Information

34. Patients are likely to need some support in making choices about the hospital they are to attend. At the least, patients and their clinicians will require better information to ensure patients are able to make an informed choice.
35. Through extensive work with patients and clinicians, it has been demonstrated that information is required in four key areas to support and inform patients’ choice of hospital:
 - waiting times
 - location and convenience of the hospital
 - patient experience
 - clinical quality.
36. National level information, building on the existing www.nhs.uk service, will be made available to support choice. PCTs will also need to consider what local level information will be needed, both for patients and to support GPs as they engage with a wider range of secondary care providers.
37. All patients can expect their GP or the referring primary care professional to introduce the choices available to them and to discuss any clinical implications of the choice. Patients should only be offered clinically appropriate choices.
38. While the majority of patients are expected to be able to make their choice with some support and advice from their GP or referring primary care professional, some patients may require additional support. Patients should expect to be able to access local support services to help them make their choice of secondary care provider. The level and targeting of support needed within individual communities will need to be considered as part of the local implementation planning and will be led by PCTs.

39. PCTs are expected to provide a range of patient support services appropriate to their local populations. The range of services PCTs should consider includes:
- direct support for choice from the GP or referring primary care professional
 - support from the practice staff
 - use of the Booking Management Service (BMS)²
 - support from the Patient Advice and Liaison Service (PALS).
40. Where PCTs identify particular challenges in securing choice for all parts of their community they should consider additional investment to support choice through:
- use of voluntary sector organisations and,
 - use of specialist Patient Care Advisors.

2.6 Choice and Waiting Times

41. Patients should expect to be offered a choice of hospitals (or suitable alternative providers) that are able to provide appointments within the maximum outpatient waiting times.
42. Secondary care service providers should provide availability of appointments up to 13 weeks in advance.
43. PCTs and Trusts will have to actively monitor referrals to ensure that patients are able to choose appointments within the maximum waiting time. Trusts that prove more popular than anticipated and receive additional referrals through choice may be able to increase activity to enable them to treat the additional patients within the maximum waiting time. PCTs should support this.
44. As a last resort, hospitals that cannot provide appointments within 13 weeks will have to be temporarily removed from choice menus. Hospitals will be restored to choice menus when appointments become available within the maximum waiting times.
45. To protect local patients’ access to local hospitals, the process of removing hospitals from choice menus should, where possible, remove the hospital from non-local menus first. This should reduce the number of referrals and ensure local patients can access their local hospital within the target time.

2.7 Aftercare

46. Patients should expect to be able to choose the same provider for their first outpatient consultation and any related follow-up treatment (i.e. their whole elective care episode). The offer of choice is made only at the point of referral, this must be clearly explained to patients before a decision is reached. Any exceptions should be managed through local processes.
47. Patients and clinicians will need to consider whether any aftercare or rehabilitation required should be delivered locally.

2 A call centre or similar that any relevant party can contact to perform an initial booking, change, cancel or query an Electronic Booking or Electronic Referral. Such a service will have to access relevant scheduling, PAS and other systems.

2.8 Transport

48. Patients who are currently eligible for free transport, either under the Hospital Travel Costs Scheme (for patients on low incomes) or through Patient Transport Services (for patients requiring transport on the basis of a medical assessment), will continue to be eligible for free transport to any of the hospitals on their PCT’s choice menu.

2.9 Cataract Choice

49. PCTs are expected to offer a choice of at least two providers for cataract surgery from January 2005 increasing to a choice of 4-5 providers by December 2005.

2.10 CHD Choice

50. Rapid Access Chest Pain Clinics offer patients a 2 week maximum waiting time for the investigation of sudden onset chest pain. Speed of access to diagnosis at this stage of the patient pathway is considered the highest priority. Choice is more appropriately offered in CHD following confirmation of diagnosis, at the point at which the patient is referred for treatment. This is at the point of referral by the cardiologist for cardiac surgery.
51. From April 2005, CHD Choice will be extended to offer all patients requiring a coronary artery bypass graft (CABG), angioplasty (PTCA) or valve repair, a choice of hospital at the point of referral by the cardiologist. The choice of hospitals offered to patients will be decided locally.
52. From April 2005 at least one alternative to the patient’s local hospital should be provided, increasing to a choice of 4-5 alternatives by December 2005. The Department of Health will issue guidance to Choice leads and CHD leads on the delivery of cardiac choice at the point of referral. Further advice and information on cardiac choice is available from kate.bowe@dh.gov.uk.

3 Next Steps for Implementation

53. Further guidance on implementation will be issued in the form of a Delivery Framework which will explain the process for SHA state of readiness in October 2004.
54. Local implementation plans should address:
 - the roll out of choice, when will choice be offered at the point of referral by specialty and by PCT
 - how communities are planning to achieve full booking and any phasing
 - any phasing on the number of choices
 - the integration with plans for delivering appropriate technology infrastructure
 - the arrangements to support patients and to ensure equality of access to choice
 - the approach to commissioning a wider range of services to facilitate choice and to the effective involvement of patients and the public in developing appropriate choice options and,
 - the expected impact of choice on referral patterns within the local health economy.

Annex A: Key Research Findings

Choice is at the heart of the NHS reform programme:

- when asked which proposed reform would have the greatest impact over the next five years 39% of Chief Executives said patient choice¹.

It responds to patients' desire for choice:

- 71% of the public thought it was important for them to be able to choose which hospital to go to²
- 76% of the public and health professionals think that the main priority in health care is involving patients in decisions about their condition/illness or treatment³
- 61% of people think that choice over public services such as health would give them a lot of some more control over their life⁴.

and to health professionals' desire to offer patients choice:

- 71% of GPs agreed that the NHS would benefit if GPs could offer patients a choice⁵.

Choice is seen as acting as a driver for improving services:

- 44% of people thought that standards would rise in hospitals if patients were given more choice over which hospital treated them⁶.

Patients will choose which hospital to go to based on a number of factors including waiting time for treatment:

- 89% of those surveyed by the College of Health would accept an earlier date for treatment at an alternative hospital⁷.
- factors which influenced choices were said to be: waiting times (47% of patients), ease of access (68%), reputation of the hospital (59%) and information on the quality of care. (54%)⁸.

Where choice is already being offered, patients react positively:

- 86% of patients who were involved in the Patient Choice Initiative for Heart Surgery would recommend it to other patients who were waiting for treatment⁹
- take up of choice in the Patient Choice Initiative for Heart Surgery was 50.4%¹⁰
- the London Patient Choice scheme offered choice to 18,427 patients with an overall take up rate of 66%¹¹
- six pilot schemes running in Greater Manchester, West Yorkshire, Trent, Surrey & Sussex, Berkshire and Dorset & Somerset have seen take up of choice of between 57% and 90%.

In addition to choice of hospital, patients want to be able to exercise a number of other choices¹²:

- 42% would like to be able to choose appointment dates and times
- 46% of patients would like to be offered choice in the treatment they receive
- 31% would like to be offered choice in the service they can use
- 31% would like choice of hospital
- 31% would like choice of doctor
- 5% would like choice of opting for alternative medicine.

1 MORI poll for the NHS Confederation of Chief Executives, June 2003.

2 Rigge M (2001) ‘Headlines from qualitative and quantitative analysis of replies to College of Health telephone survey on patient choice in the NHS’.

3 MORI (Oct-Nov 2003) ‘Choice, Responsiveness and Equity National Consultation. Research Study conducted for the Department of Health.’

4 Economist/YouGov (April 2004) ‘Choosing to Choose’.

5 Dr Foster (April 2003) ‘Implementing Patient Choice’.

6 Economist/YouGov (April 2004) ‘Choosing to Choose’.

7 Rigge M (2001) ‘Headlines from qualitative and quantitative analysis of replies to College of Health telephone survey on patient choice in the NHS’.

8 Dr Foster and University of Nottingham (March 2004) ‘Implications of offering ‘Patient Choice’ for routine adult surgical referrals’.

9 Picker Institute (Sept 2003) Patient Evaluation of CHD Choice Scheme.

10 Picker Institute (Sept 2003) Patient Evaluation of CHD Choice Scheme.

11 Picker Institute (March 2004) Interim Report ‘Hospital Choices: Patients’ Experience of the London Patient Choice Project’.

12 MORI (Oct-Nov 2003) ‘Choice, Responsiveness and Equity National Consultation. Research Study conducted for the Department of Health.’



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