

## **Choice of Hospitals**

### **Guidance for PCTs, NHS Trusts and SHAs on offering patients choice of where they are treated**

This document sets out the next steps to deliver the NHS Plan vision for greater patient choice within the NHS. The policy guidance in this document is supported by more detailed implementation guidance issued in CD format with this document or available in web format at [www.doh.gov.uk/choice](http://www.doh.gov.uk/choice). The implementation guidance provides a step by step description of the process of offering choice alongside lessons from the pilots and good practice from the Department of Health

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## Contents:

1	Choice of Hospital: Objectives and Policy.....	3
1.1	Introduction .....	3
1.2	Why Choice? .....	3
1.3	Choice of Hospital .....	4
1.4	Benefits of Choice .....	4
2	Choice of Hospital for Patients who have waited 6 months.....	4
2.1	Objectives .....	4
2.2	What can patients expect .....	5
2.3	Which Patients will benefit.....	7
2.4	What is an appropriate alternative provider .....	8
2.5	Supporting Patients in making their choice.....	8
2.6	Commissioning for Choice for Patients waiting 6 months .....	9
2.7	Implementation.....	10
2.8	Implementation Timetable .....	10
2.9	Implementation Plan.....	11
2.10	Monitoring.....	12
3	The next stage – Choice at the Point of GP referral.....	13
3.1	Purpose of this section .....	13
3.2	Vision for Choice at the Point of GP Referral .....	13
3.3	Current thinking on implementing Choice at the point of GP referral .....	14

# **Choice of Hospitals: Guidance for PCTs, NHS Trusts and SHAs on offering patients choice of where they are treated**

## **1 Choice of Hospital: Objectives and Policy**

### **1.1 Introduction**

- 1.1.1 This document sets out the next steps to deliver the NHS Plan vision for greater patient choice within the NHS. The policy guidance in this document is supported by more detailed implementation guidance issued in CD format with this document or available in web format at [www.doh.gov.uk/choice](http://www.doh.gov.uk/choice). The implementation guidance provides a step by step description of the process of offering choice alongside lessons from the pilots and good practice from the Department of Health.
- 1.1.2 Delivering the NHS Plan sets out the requirement that patients and their GPs will be able to book appointments at both a time and place that is convenient to the patient. This might include NHS hospitals locally or elsewhere, Diagnosis and Treatment Centres, Private hospitals or even hospitals overseas.
- 1.1.3 Choice is being rolled out carefully to maximise the benefits to patients and the NHS. 9 pilot projects are already operational. This document sets out the actions needed to deliver choice to all patients waiting more than 6 months for elective surgery. It also provides initial guidance on Choice at the point of GP referral, which is to be available for all patients requiring elective surgery from December 2005.

### **1.2 Why Choice?**

- 1.2.1 Choice is central to the Government's vision for the NHS. Greater choice for all patients will help ensure all patients experience an NHS that is centred on their needs.
- 1.2.2 Choice has always been available to some people. Some have had the resources to opt out of the NHS. Others have proved informed and articulate enough to access choices within the NHS that are not routinely available to others.
- 1.2.3 The Government believes that all patients should have the advantages of choices over their healthcare. The NHS should develop as a personalised service, open to everyone.
- 1.2.4 Patients value choices. We face more and more choices in our everyday lives. People expect to be involved in, and play a key role in the decisions that effect their lives. This is as true in healthcare as in other areas.
- 1.2.5 Increases in capacity and diversity go hand in hand with patient choice. A wider range of services and providers will allow patients to choose services that best meet their needs.

### **1.3 Choice of Hospital**

- 1.3.1 This document provides guidance on choice of hospital for patients who may require elective surgery. A total of 9 pilot programmes are already offering patients who have waited 6 months for elective surgery the choice of moving to another hospital for faster treatment. Patients have found these services valuable. Nearly half the patients offered choice in the national CHD pilot have chosen to move to another hospital for faster heart surgery. In the London pilot 70% of patients waiting 6 months for cataract surgery have chosen to move hospital for faster treatment.
- 1.3.2 By next summer all patients waiting six months for elective surgery should benefit from the choice to move to an alternative provider.
- 1.3.3 In this way those waiting longest will benefit first from choice.
- 1.3.4 However all patients should have the opportunity to make choices about their hospital treatment. From December 2005 all patients requiring elective surgery will be offered the choice between 4-5 hospitals (or other appropriate providers such as DTCs and Practitioners with a specialist interest) at the point their GP (or other primary care professional) makes a referral to more specialist care. In Ophthalmology we will make faster progress, following the elimination of 3-month waiters in December 2004, choice at the point of referral will be piloted in this specialty.
- 1.3.5 Delivering choice at GP referral will require significant changes in the way the NHS commissions and provides services, and of course, in the way patients and clinicians work together. New technology and systems will also be needed. The Electronic Booking Service will underpin choice at GP referral, linking GP practices to hospital appointment systems, providing information on the choices available and enabling the patient to exercise their choice by booking with their preferred provider.

### **1.4 Benefits of Choice**

- 1.4.1 Choice will bring real benefits for patients:
  - Greater involvement and control over their treatment, so that choices reflect the patients' priorities
  - Faster treatment
  - Greater certainty over the time they will be treated
  - Reduced variation in standards of care, as more standardised care pathways are introduced and patients apply pressure for higher standards
  - Greater equality of choice for all patients

## **2 Choice of Hospital for Patients who have waited 6 months**

### **2.1 Objectives**

2.1.1 Long waits are the largest cause of dissatisfaction with the NHS. While 70% of patients are seen within 3 months, significant numbers of patients face substantially longer waits. Investment in new capacity and new approaches to managing waiting lists are tackling long waits. The NHS has plans to reduce the maximum waiting times for inpatient/daycase care to:

- 9 months from April 2004
- 6 months from Dec 2005

The longer term vision in the NHS plan is for a maximum wait of 3 months for either outpatient or inpatient/daycase appointments from 2008. Effective waiting list management will be crucial to reducing the numbers of patients experiencing long waiting times. The implementation guidance for Choice for 6 month Waiters (issued alongside this guidance or available at [www.doh.gov.uk/choice](http://www.doh.gov.uk/choice)) includes detailed advice on how to reduce waiting times.

2.1.2 Offering choice to those waiting the longest will help the NHS to meet the required reductions in waiting times. More importantly it will offer the opportunity of faster treatment to those patients currently waiting the longest.

## 2.2 What can patients expect

2.2.1 From the summer 2004 patients who will wait more than 6 months for elective surgery will be offered the choice of moving to another hospital for faster treatment.

2.2.2 The table below sets out an overview of the choice patients can expect and the key responsibilities for NHS organisations in delivering choice:

Patients will be offered	NHS responsibilities
Patients will be informed about how they will be provided with choice and the role of the Patient Care Advisor (PCA). Safeguards and security measures for confidentiality should be outlined but patients will have the opportunity to opt-out of the choice process if they have concerns about confidentiality.	PCTs to ensure that all staff who have access to confidential patient information are aware of their responsibilities and have confidentiality requirements built into their employment contracts. Guidance on confidentiality is available from DH 'Confidentiality: A Code of Practice for the NHS' and PCTs will be supported by an information governance toolkit that supports the provision of confidential services (planned for October 2003).
Patients who are expected to wait more than 6 months will be contacted at the earliest opportunity and certainly before they have waited 5½ months. Patients may need to be contacted earlier to allow an offer of faster treatment.	The originating NHS Trust will identify patients who will wait more than 6 months PCTs will be responsible for establishing a system of Patient Care Advisors who will support patients in making their choices.

	The PCT will arrange for PCA (Patient Care Advisor) to contact the patient
Patients will be contacted by a patient care advisor (PCA) who will explain the offer of choice, provide information and make the necessary arrangements if the offer is accepted. The PCA will be able to support the patient if any problems occur.	PCA will contact the patient. They will explain the offer. PCA should have the necessary information to support the patient in making their choice.
Patients will be offered the choice of at least one, normally more, alternative providers for their surgery. The alternatives could include other NHS hospitals, DTCs, or independent sector hospitals.	The PCT will identify and commission capacity to treat choice patients who choose to move provider. PCTs should be aware of the goal of providing a much wider range of choices, and should seek to provide as wide a range of alternatives as possible. The PCT should ensure that originating and receiving providers have agreed the clinical pathways needed to allow patient transfer, providing a quality assured process for patients.
The alternative offer will allow for a booked appointment, ensuring certainty for the patient.	A booking system will be needed to enable the PCA to book the patient into the alternative provider. Where possible a booked pre-operative assessment and a booked admission should be offered. At a minimum the pre operative assessment should be booked.
The alternative offer should be for faster treatment than would be possible in the original hospital. The patient must be treated before they have waited 9 months.	
Patients will be asked if they are able to travel to the alternative hospital. Those with significant transport difficulties that would prevent them from choosing the alternative should be provided with transport. In these circumstances it may also be appropriate to provide transport, and potentially to ensure the availability of affordable accommodation, for carers. Patients who would in any case qualify for help with transport (under the existing Patient Transport Scheme and Hospital Travel Cost Scheme) to their local hospital will qualify for the same	The PCT should commission an appropriate package of transport services. The Receiving Hospital will make the final arrangements for appropriate transport

support if they choose to move to the alternative provider.	
The patient will chose whether to remain with their existing hospital, or move to one of the alternatives offered to them.	The PCT should define the time available for the Patient to make their decision. This needs to be reasonable for the patient, and allow the effective use of capacity (e.g. the delay doesn't involve the under-utilisation of pre booked capacity)
If the patient chooses to move provider, the PCA will agree a booked appointment with them.	A booking system will be required to allow PCAs to book into the receiving provider. Pre operative assessment must be booked. Operative schedules should be agreed locally that ensure patients are treated within the required time.
If the patient chooses to stay with their original provider they should be treated within the 9 month maximum wait.	The original NHS Trust must then treat the patient before the 9-month maximum waiting time. It will not be appropriate to offer the chance to move provider as part of a separate waiting time initiative to a patient who has already chosen to stay with a particular provider.

### 2.3 Which Patients will benefit

- 2.3.1 Choice of hospital should apply to all patients who will wait for more than 6 months for elective surgery.
- 2.3.2 We anticipate that some 600,000 patients will wait for more than 6 months between April 2004 and December 2005. We estimate that some 150,000 of these patients will exercise the choice to move to an alternative hospital to secure faster treatment.
- 2.3.3 Some patients waiting over 6 months will not be offered choice. These patients will fall into one of three groups:
- Patients with a "firm To Come In date" ensuring they will be treated before they have waited 7 months. It is unlikely that an alternative provider could offer faster treatment to these patients. Choice will not therefore be routinely offered. This should be made clear to patients when they are offered the TCI date, and patients should be given the opportunity to enter the choice process if they wish to do so.
  - Clinical exclusions. There may be clinical reasons for excluding some patients from choice of hospital. Co-morbidity may be an example of a reason for a clinical exclusion. The Department of Health does not believe there is

any justification for the blanket exclusion of any category of patient. Clinical exclusions should be decided on an individual case basis. The reasons for the exclusion should be documented and explained to the patient. Clinical exclusions should be minimal. SHAs will want to satisfy themselves that choice is being offered appropriately in cases where there are significant clinical exclusions.

- Exceptionally, patients in highly capacity constrained sub-specialties where there are no practical alternatives to the existing provider

## **2.4 What is an appropriate alternative provider**

- 2.4.1 PCTs will need to identify and commission the alternative providers that will be offered to any of their patients that wait more than 6 months.
- 2.4.2 Alternative providers could include different NHS Trusts, DTCs and independent hospitals. In some capacity constrained specialties it may be appropriate to offer a choice of overseas hospitals. It is expected that the alternatives offered to patients will be different organisations. However there are circumstances in which separately managed units within the same NHS Trust could count as separate choices, these are:
- A DTC that is formally part of an NHS Trust
  - A single NHS Trust covering two (or more) separately managed hospitals serving different communities in different locations
- 2.4.3 Normally patients should be offered more than one choice. In some capacity constrained specialties and localities this may not be possible, but at least one alternative must be on offer.
- 2.4.4 PCTs should seek to provide alternatives to patients as locally as possible. Where a local alternative is not available PCTs should provide transport for patients who would not otherwise be able to choose the alternative provider. It may also be appropriate to provide transport for relatives and carers in such circumstances.
- 2.4.5 Patients should be offered a booked appointment with the alternative provider that offers faster treatment than would be possible with their original Trust.

## **2.5 Supporting Patients in making their choice**

- 2.5.1 PCTs will be responsible for offering choice of hospital to patients, and supporting patients in making their choices.
- 2.5.2 The pilot programmes have developed a number of approaches to supporting patients. All involve dedicated staff acting as Patient Care Advisors (PCAs). The PCA is responsible for contacting the patient and explaining their choices to them. The PCA is then able to book the patient into the alternative provider (if the



patient chooses this option) and continues to provide a point of contact for the patient as they move towards completing their treatment.

2.5.3 The PCA will be crucial to the roll out of choice for 6 month waiters. PCTs will be responsible for establishing a PCA service to cover their patients.

2.5.4 PCAs will need to provide information to support patients in making their choices. This should include:

- The likely time to treatment and certainty of the estimate in the existing Trust
- The time to a booked appointment with the alternative provider
- Details of the alternative provider

2.5.5 The approach taken to PCAs will be dependent on the numbers of patients expected to be offered choice.

- In areas with very few 6-month waiters, existing staff, in the originating Trust may be able to act as PCA for those patients who will be offered choice. PCTs will want to assure themselves that the PCAs are able to support patients in reaching their choice, and offer objective advice, and are not impeded in this task by organisational constraints. In these circumstances PCTs should audit patient experiences to ensure that a real choice has been offered, and patients have received an impartial service.
- Dedicated PCAs in PCTs may be more appropriate for areas with greater numbers of 6 month waiters.
- In areas with significant numbers of 6 month waiters dedicated PCAs will be required, possibly attached to call centres to make contact with patients and help them navigate their choices.

2.5.6 An independent helpline to help patients with any concerns or queries they may have will be provided by the College of Health. This service has been commissioned on a time limited basis by the Department of Health to support the introduction of patient choice across the NHS.

## **2.6 Commissioning for Choice for Patients waiting 6 months**

2.6.1 PCTs will be expected to fund and commission choice.

2.6.2 To do this PCTs will have to develop their commissioning plans and SLAs for 2004/05 so that they take account of the fact that patients who wait for 6 months will be able to choose to have their treatment in an alternative hospital.

2.6.3 This will mean commissioning activity in both the originating providers (the providers that GPs refer to) and receiving providers (the alternative providers that patients waiting 6 months can choose to transfer too to secure faster treatment.)

- 2.6.4 To do this successfully PCTs will need to forecast the numbers of over 6 month waiters and the numbers of these patients that are likely to choose to transfer to the alternative provider. SLAs can then be drawn up to meet the expected activity.
- 2.6.5 SLAs will need to be flexible enough to allow patients to exercise choice. Variations in the planned numbers of patients choosing to transfer to alternative providers should be accounted for by varying the value of the SLA by the tariff value for the choice activity above or below plan. For example additional (beyond plan) patients choosing to move to an alternative provider should lead to the SLA for the originating provider being reduced by the national tariff rate for additional choice patients moving away from the provider. While the SLA for the receiving provider should be increased by the national tariff for the additional choice patients they treat.
- 2.6.6 The aim of the choice programme is to improve the patient experience of the NHS. Cancellations of appointments following an offer of choice (or indeed following firm TCI date that removes the need to offer choice) should therefore be avoided. PCTs may wish to consider including financial incentives in their SLAs to reduce cancellations.
- 2.6.7 The Choice Implementation Guidance provides further information on planning and modeling for choice for 6 month waiters. The Department of Health has also circulated a model to all SHAs, which could be used to support planning and estimating numbers of choice patients.
- 2.6.8 The Department of Health is also working on a Model Contract for 2004/05. This will take into account the additional complexity of commissioning under choice and will provide further guidance on the risk sharing arrangements that are likely to be required.

## **2.7 Implementation**

- 2.7.1 All patients waiting 6 months for elective surgery are to be offered choice by the summer of 2004. A phased implementation will be adopted between April and August to reduce risk, reflecting the different capacity position in different specialties. Phasing will also smooth the workload on both clinical and administrative staff.
- 2.7.2 This section sets out the detailed timetable for the roll out of choice for 6 month waiters and delivery assurance mechanisms required by the Department to track implementation.
- 2.7.3 Detailed implementation guidance is being made available on CD and on the DH website at [www.doh.gov.uk/choice](http://www.doh.gov.uk/choice). The implementation guidance sets out the detailed process behind the offer of choice and practical experience from the pilot programme.

## **2.8 Implementation Timetable**

- 2.8.1 Choice for patients waiting for 6 months should be phased in from April 2004 to August 2004. The implementation may be phased by specialty, but the local

implementation plan should set out how the proposed phasing will meet the minimum phasing requirements set out below.

2.8.2 The Department's recommended phasing is as follows

- By 30<sup>th</sup> April: Choice offered in all specialties other than ENT and Orthopaedics
- By 30<sup>th</sup> June: Choice offered in ENT
- By 31<sup>st</sup> August: Choice offered in Orthopaedics

2.8.3 It is recognised that some SHAs may wish to adopt an alternative phasing strategy to better meet local concerns and priorities. Where a local health economy decides to adopt an alternative phasing approach the minimum phasing expected by the Department of Health is:

- By 30<sup>th</sup> April: 30% of then current eligible 6 month waiters offered choice
- By 30<sup>th</sup> June: 60% of then current eligible 6 months waiters offered choice
- By 31<sup>st</sup> August: 100% of eligible 6 month waiters offered choice

## 2.9 Implementation Plan

2.9.1 SHAs are asked to prepare an implementation plan for Choice for patients waiting 6 months. This should be a consolidated set of PCT level plans setting out how choice will be introduced locally. Plans should cover the areas set out in the textbox below.

### **Proposed SHA Choice Implementation Plan**

- Consolidated set of PCT plans at StHA level covering:
- Governance structure
  - Single point of contact on Choice between StHA and DoH
  - Structure for coordination of planning and implementation of Choice @ 6m within StHA
  - Integrated governance structure with the Booking Programme
- Forecast of patients affected by Choice @ 6 months and of those accepting choice
- Strategy for delivery
  - Vision for implementing choice for 6 month waiters in the context of the goal of providing choice at the point of GP referral
  - Waiting List validation and management strategies

- Roll-out strategy and timescale
- Commissioning and ring-fencing capacity for Choice @ 6 months
- Implications on SLAs
- Infrastructure and systems
- Setting up the clinical pathways and quality assurance process for the pathways
- Patient care advisor role and information processes (including dealing with the Caldicott rules on patient confidentiality)
- Project management
- Communications
- Dependencies - out of area issues and other programmes
- Key milestones
  - i. Implementation plan published
  - ii. Commissioning in place by all PCTs in StHA
  - iii. Clinical pathways agreed
  - iv. Infrastructure set up - including PCAs, call centres, patient records transfer and patient tracking processes
  - v. Communications events held (as defined in the plan)
  - vi. 30% of then current eligible 6 month waiters offered choice
  - vii. 60% of then current eligible 6 months waiters offered choice
  - viii. 100% of eligible 6 month waiters offered choice
- Risk management plan
- Cost plan
- Communications plan – getting the clinical buy-in
- Resourcing plan

2.9.2 The Department is looking for sufficient information to assure delivery on a national level. Preparation of each SHA plan will form the first milestone in the Delivery Assurance process to be adopted by the Department of Health. Reflecting the new ways of working the Department will vary its approach to SHA plans, taking a light touch approach for those SHAs with relatively few 6 month waiters, but seeking more reassurance from those facing bigger challenges.

2.9.3 All SHA plans should reach the Department of Health by the end of September 2003. The Department of Health will agree plans by the end of October. To make it easier to return plans we have a set up a dedicated mailbox at [choice@doh.gsi.gov.uk](mailto:choice@doh.gsi.gov.uk). to allow electronic submission.

## 2.10 Monitoring

2.10.1 PCTs should monitor the roll out and take up of choice. The key data PCTs and SHAs will need, to monitor the introduction of choice will be:

- The numbers offered choice

- The numbers accepting choice
- The reasons for accepting/rejecting choice
- The numbers excluded from choice
- Number of operations cancelled after an offer of choice, or acceptance of TCI date after 6 months waiting that precludes the offer of choice.

2.10.2 The Department of Health will discuss with SHAs and agree by October whether any new central monitoring requirements will be needed from April 2004 to support the introduction of choice. This could include systems to support the collection of some of the information identified above, and potentially the Patient Survey which could provide useful material on the patient experience of choice.

2.10.3 Experience of the Pilot sites has raised some issues about how we record Choice patients in the national waiting times returns. The Department is working to clarify these issues and a DSCN will be issued in September.

### **3 The next stage – Choice at the Point of GP referral**

#### **3.1 Purpose of this section**

3.1.1 The aim in this document is to set out the vision for choice at the point of referral, so that Choice for 6 month waiters may be implemented with this knowledge. Implementing Choice for 6 month waiters will allow NHS bodies to improve their understanding of how patients respond to choice and the support they need in making choices.

#### **3.2 Vision for Choice at the Point of GP Referral**

3.2.1 Delivering the NHS Plan sets out the vision that patients and their GPs will be able to book appointments at both a time and place that is convenient to the patient. Our eventual aim is, using the new fixed NHS tariff, to allow NHS patients to exercise choice of provider from within the NHS, be it treatment at an NHS or independent sector provider.

3.2.2 By December 2005 the aim is to offer all patients who require elective surgery a carefully structured choice of 4-5 hospitals (or other appropriate providers) at the point their GP makes the referral.

3.2.3 This will be a very substantial extension of choice within the NHS with some 9 million patients benefiting each year.

3.2.4 Choice at the point of GP referral will also require significant cultural and behavioural change in the NHS. The Choice Pilot programme is already introducing choice at the point of referral in some areas and some specialties. The learning from these pilots will underpin the development of our detailed planning for the implementation of Choice at GP Referral. A programme of further work with the NHS will inform detailed guidance on Choice at GP Referral to be issued next summer.

### **3.3 Current thinking on implementing Choice at the point of GP referral**

3.3.1 Choice at the point of GP referral will ensure all patients requiring elective surgery are offered a choice over the hospital (or other appropriate provider) they are treated in.

3.3.2 From December 2005 patients will be offered a choice of 4-5 hospitals (or other appropriate providers) once the GP has decided that a referral is required. These providers could include NHS Trusts, Foundation Trusts, DTCs, Private Hospitals and Practitioners with a special interest operating within primary care. The Patient will be supported in their choice by a combination of the GP, Primary Care Team, Practice Staff and the Booking Management Service.

3.3.3 The menu of choices the patient is able to choose from will be decided by the PCT. The PCT will commission services from a wider range of providers to ensure the required level of choice is made available to patients. In this way the PCT will continue to play a commissioning role and will be able to use its commissioning strategy to respond to the choices taken by patients – both dynamically in year, changing the volumes purchased from individual providers and strategically in planning future service developments. PCTs may need to consider collaborative commissioning arrangements to help manage the volume risk on their SLAs.

3.3.4 The process of offering choice at GP referral will be underpinned by the roll out of the Electronic Booking Service, which will:

- provide the means for the GP and patient to identify the choices available (the booking system will select the 4-5 providers the PCT has commissioned for a particular specialty)
- enable the patient to exercise their choice by booking with their preferred provider
- electronic booking will be accessible to GPs and the Primary Care Team through their clinical management systems or through the call centre based Booking Management Service
- Once they have seen their GP, patients will be able to access the system through the internet and eventually through Digital TV. The Booking Management Service will also be directly available to patients over the telephone.

These options will accommodate a wide range of patient preferences for accessing information, choosing where to have their treatment and in booking their treatment.

3.3.5 It is recognised that not all patients will want to make their choice and book immediately. Some will want to take time to consider the options, or talk to family and friends about their choices. It is expected that a unique booking reference number, “a referral prescription”, will allow these patients to make their booking directly with the Booking management service or over the internet after they reach their decision.

- 3.3.6 Patients and their GPs will need information to support patient's choice. nhs.uk is being developed to support patient's choice. Work with the Pilot projects and patient and GP focus groups indicates that information will be needed in four areas:
- Waiting times
  - Convenience
  - Patient Experience
  - Clinical Quality/Reputation
- 3.3.7 The nhs.uk website already provides information on waiting times and location and transport links for hospitals and other providers. To support choice further information will be added on the clinical quality and patient experiences of each health provider.
- 3.3.8 The Department of Health will work intensively with patients, the public, NHS staff and other NHS stakeholders more generally to flesh out the details of the model for choice at the point of GP referral. This work will build on the learning from the Choice Pilot Schemes, some of which are already offering choice at the point of referral. The results of this work will be shared with the NHS and the public in the autumn, with detailed implementation guidance on Choice at GP referral to follow in summer 2004. An Implementation Plan for the Electronic Booking Service, providing more details of the roll out of electronic booking will be published shortly.