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1. Introduction

1.1 This policy has been produced and sets out the standards for iSIGHT Clinic, referrers and patients by which we manage our access to services. This policy also gives iSIGHT staff clear direction and expectations on all aspects of patient access in line with patient rights as set out in the NHS Constitution and Accessible Information Standard. iSIGHT Clinic will use this policy to demonstrate how rules are applied fairly and with equity in the provision of planned care. This policy should be read in conjunction with other related policies, which can be accessed from iSIGHT Clinic's shared drive F:/wordp/policiesandprocedures which are available upon request.

1.2 This policy aims to inform patients, their relatives and carers of their rights and what they can expect from iSIGHT Clinic in terms of access to services by outlining relevant rules, responsibilities and actions by which iSIGHT will manage patients through their pathways, specifically:

- The national 18-week Referral to Treatment (RTT) pathway, which is about improving patients' experience of the NHS, ensuring all patients receive high quality elective care without any unnecessary delay.

1.3 Everyone has the right (by law since 2010) to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible. This includes a right to:

- Start consultant-led treatment within a maximum of 18 weeks from referral for non- urgent conditions.

1.4. We also provide a range of patient information publications on a range of conditions, procedures and services and these are available to patients in the respective departments and via the iSIGHT's website.

2 Purpose and Outcomes

2.1 This policy sets out how iSIGHT Clinic will manage 18-week RTT pathways in line with national targets and guidance. Application of the policy will ensure that each patient's RTT clock starts and stops fairly and consistently in accordance with an agreed structured methodology. Treatment decisions will be fair and transparent and at an operational level this translates into the adoption of the following key principles:

- The management of patients will be fair, consistent and transparent and communication with patients will be clear and informative and will be consistent with the Human Rights Act 1998 and the Equality Act 2010.
- Patients seen in outpatients, diagnostics or admitted as day cases will be seen firstly according to clinical priority and then in chronological order based upon the 18-week RTT pathway.

- We will attempt wherever possible to agree appointment dates to suit patients' personal circumstances.
- In the event that, due to a lack of capacity, iSIGHT cannot expect to treat patients within the mandated timescale, patients and their GP will be notified of this. Patients will also be presented with a range of alternative providers that will be able to treat them within those timescales should they wish to take up this offer.

2.2 Consultant-to-Consultant and Consultant-to-GP referral criteria are:
a. Direct referrals will be appropriate for:

- Suspected or diagnosed cancer.
- Urgent problems for which delay would be detrimental to the patient's health. The expectation here would be that the patient needs to be seen within 2 weeks.
- Referral as part of the same clinical problem.
- Part of the recognised pathway of care for the condition or as part of a pre-operative assessment.
- Transfer of responsibility of care for an on-going condition, when it would be more convenient for the patient to be seen in a different location.

b. Referral back to GP will be appropriate for:

- Conditions that are unrelated to the presenting problems and do not require urgent referral.
- Incidental findings; conditions that can be dealt with by the Clinical Commissioning Group (CCG) or GP.
- Those patients who Did Not Attend (DNA) their appointment twice, subject to clinical agreement (it is anticipated that these cases will be reviewed in a timely manner, ideally at the end of the relevant clinic).
- Those patients who cancel their appointment twice, subject to clinical agreement (it is anticipated that these cases will be reviewed in a timely manner, ideally at the end of the relevant clinic). Staff should also satisfy themselves that the weight of cause is biased towards the patient and not for example due to the fact that iSIGHT may have cancelled the patient first and offered a new appointment that is inconvenient for the patient.

c. Referral Queries:

- If there is any doubt as to whether a patient needs to be managed by iSIGHT or whether a patient should be offered another choice of hospital, consultant or treatment option, the responsible Consultant should contact the patient's GP to discuss the case.
- Patients should only be added to a waiting list when fit and ready for treatment and in the case where a patient is unfit; they should be reviewed by a clinician or GP and added when appropriate.

3 Responsibilities, Accountabilities and Duties

4. Outpatient Referrals

4.1 With the exception of cancer 2WW and urgent screening referrals, all referrals (electronic and paper) will be reviewed and prioritised within 7 working days of receipt, except for visiting

consultants, where alternative arrangements are to be agreed locally by the Business Director or Practice Manager.
4.2 Cancer 2WW and cancer screening urgent referrals must be reviewed and prioritised within 24 hours of receipt.
4.3 Processes around the use of the NHS e-Referral Service Advice & Guidance (A&G) service (designed to support GPs with referral queries) must be in accordance with contractual requirements.
4.4 If a 2WW referral is deemed inappropriate from the information provided, consultants must contact the GP to discuss the referral further. If, after that discussion, the GP agrees to downgrade the referral, the GP must re-refer the patient using a standard urgent or routine letter or pro-forma through NHS e-Referral Service. The consultant must note the date, time and outcome of the discussion on the 2WW form, which must be filed in the case notes. A new referral with a new patient pathway identifier will start a new pathway.
4.5 3 weeks (21 days) notice must be given to the patient when agreeing an appointment date. The only exceptions to this are:

- Where it is clinically urgent (e.g. 2WW referrals).
- Urgent referrals for screening appointments i.e. Age Related Macular Degeneration
- For a diagnostic test/procedure, where a reasonable offer is 10 days or more.
- Where patients make themselves available at short notice.

4.6 Referral Queries - If there is any doubt as to whether a patient needs to be managed by the hospital or whether a patient should be offered a choice of provider it will be advisable for the consultant to contact the GP to discuss the case.

5. Day Cases / Active Waiting List / Planned Waiting List
5.1 Patients must only be added to an active elective admission access plan or booked for surgery when they are ready and able 'to come in' (TCI) for their appointment/treatment.
5.2 Any conversations with patients agreeing to dates offered and declined need to be recorded and documented together with the reason(s).
5.3 Patients may choose to delay their inpatient treatment, in this case, their 18wk RTT clock will continue to tick and they must remain on an active waiting list. If this results in a breach, these patients fall into the allowed tolerance level above the RTT national target. You should however inform the clinician of any patients who have requested a delay that is longer than agreed guidelines in case this is detrimental to their condition, as well as the Practice Manager if the delay will result in a breach.
5.4 A decision to treat letter must be sent to the GP.
5.5 Patients with the same priority will be treated in chronological order in line with their RTT pathway, unless the patient has specifically chosen a later date themselves.
5.6 When selecting patients for listing, it is essential to make that selection based on clinical grounds and length of wait only.
5.7 DNAs where safeguarding issues (Adults and Children) are a factor must be alerted to the GP, the Health Visitor and Family and Children's social care as necessary.
6. NHS e-Referral Service
6.1 NHS e-Referral Service is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. The guidance states that the responsibility for the effective implementation of NHS e-Referral Service should be shared between organisations. For example:

- Providers are responsible for ensuring that services are made available on NHS e-Referral Service and that patients can book into appointments using the system

- Referrers are responsible for using NHS e-Referral Service effectively to find suitable services for their patients
- Commissioners are responsible for ensuring that services available on the system accurately represent the clinical needs of their patient population and that those referrers and providers use the system effectively for the benefit of all patients.

6.2 Until this option is formally closed as part of a paperless strategy in the future, the option for paper referrals via post or fax machine remains.

7. Referral to Treatment (RTT) Rules

7.1 The NHS Constitution confirms that all patients have the legal right to start NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate that they wait longer. The national standard for 18 week RTT is :

- Incomplete pathway whose clock is still running; 92% of those on the waiting list should not have waited more than 18 weeks.

7.2 Consultant-led treatment includes treatments where a consultant retains overall clinical responsibility for the treatment. This could include treatments provided by the service or team led by the consultant. The setting of the consultant-led treatment, whether hospital-based or in a community-based clinic, will not affect a patient's right to start treatment within 18 weeks.
7.3 If a patient cannot be seen within the maximum waiting time, the organisation that commissions and funds the treatment (CCGs or NHS England) must investigate and offer a range of suitable alternative hospitals or community clinics that would be able to see or treat the patient more quickly. The local CCG or NHS England must take all reasonable steps to meet the request.

8 RTT Measurement

8.1 **Clock Starts**. A clock start is the date that iSIGHT Clinic receives notice of the referral in to any service (consultant led, interface or assessment service) via the NHS e-Referral Service or when the 'Defer to Provider' functionality is used in the NHS e-Referral Service. Where a paper referral is sent, the clock start is the date on which the referral is received by iSIGHT Clinic or the receiving consultant for consultant-to-consultant referrals.

8.2 **Clock Continues** The clock continues while tests and investigations are taking place.
8.3 A clock does not automatically stop when a patient DNAs a follow-up appointment.
8.4 The clock does not stop when a patient gives more than 24 hours' notice that they are unable to attend an appointment.
8.5 An out-patient for a diagnostic procedure only will not necessarily stop an 18-week clock; the decision on whether it does rests with the Consultant if it is felt that Watchful Wait/Active Monitoring is appropriate or there is no decision to treat and the patient is being discharged.

8.6 **Clock Stops** The 18-week clock stops when first definitive treatment is given surgically or non-surgically, for example advice or medication. The clock may also stop for non-treatment provided communication is given, without undue delay, to the patient and their GP and/or other referring practitioner. These clock stops could be:

- A clinical decision is made to start a period of active monitoring/watchful wait.
- A patient declines treatment having been offered it.

- A clinical decision is made not to treat.
- A patient DNAs their first new appointment in their RTT pathway following the initial referral that started their 18-week clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient.
- A patient DNAs any other appointment twice and is subsequently discharged by a clinician back to the care of their GP provided that:
    - iSIGHT Clinic can demonstrate that the appointment was clearly communicated to the patient.
    - Discharging the patient is not contrary to their best clinical interests.
    - Discharging the patient is carried out according to local, publicly available, policies on DNAs, which is as described in this policy

- If there is a delay in booking a further follow-up appointment because the patient preference makes it "impossible or unreasonable" for 18 weeks to be achieved for that patient, they will be discharged back to their GP. iSIGHT Clinic measures 4 weeks from the original offer as unreasonable.

8.7 **Managing Delays**

Patients are entitled to wait longer for their treatment if they wish. Patients must be allowed to plan their treatment around their personal circumstances. Delays as a result of patient choice are taken account of in the tolerance of 8% set for achievement of the incomplete pathway waiting time operational standard. This means that a patient wishing to delay their treatment must not be removed from the waiting list or have their RTT clock stopped.

There is no blanket rule within iSIGHT Clinic that allows a maximum length to patient-initiated delays to be applied for personal circumstances. Clinicians should provide waiting list staff with guidelines as to how long (in general) patients should be allowed to defer their treatment without further clinical review.

Patients requesting a delay longer than the general guideline should have a clinical/notes review to decide if this delay is appropriate. If the clinician is satisfied that the proposed delay is acceptable then iSIGHT Clinic should allow the delay, regardless of the length of wait. An approximate timescale for a 'TCI' must be documented within the patient's electronic record

If the clinician is not satisfied that the proposed delay is appropriate then the clinical risks should be clearly communicated to the patient and a clinically appropriate TCI date be agreed.

If the patient refuses to accept the advice of the clinician then the responsible clinician must act in the best interest of the patient. In this case the clinician may feel that it is in the best clinical interest of the patient to discharge the patient back to the care of their GP and inform them that treatment is not progressing. This must also be made clear to the patient. This must be a clinical decision, taking the healthcare needs of each individual patient into account. In this scenario the patient would be removed from the waiting list and the RTT clock must be stopped.

It is not acceptable to refer patients back to their GP simply because they wish to delay their appointment or treatment. However, it would be acceptable where referring patients back to their GP is in their best clinical interests. Such decisions should be made by the treating clinician on a case by case basis.

Clinician Initiated (Patient not fit for Treatment). If a patient is listed for surgery is deemed unfit for the procedure, the decision on whether or not to delay and/or stop the clock is a clinical one, regardless of whether it is the patient self-reporting as unfit or through a clinical review. The nature

and duration of the clinical issue should be ascertained, if the patient is expected to be fit for the procedure within 4 weeks the patient must remain on the waiting list and the RTT clock should continue to tick. If the clinical decision is that the patient is not expected to be fit within 4 weeks, then the patient should be removed from the waiting list and the RTT clock stopped. It may be that a period of monitoring will follow in which case a clock stop for active monitoring is appropriate, however where treatment is no longer a viable option and the patient is best managed through primary care, then a decision not to treat should be recorded. The GP and patient should be kept informed of any decision made.

8.8 Active Monitoring will commence when a decision is made (and agreed with the patient) that it is clinically appropriate to start a period of monitoring, possibly whilst the patient receives symptomatic support, but without any specific or significant clinical intervention at this stage. Active Monitoring may be initiated by either a care professional or a patient and stops the RTT pathway. When patient initiated the Active Monitoring/Watchful Waiting, this must still be agreed by a clinician. During Active Monitoring the patient will remain under the care of a consultant or NHS Allied Health Professional Service although the GP will be updated with the progress of their patient. If a decision to treat is made during Active Monitoring, this will end the Active Monitoring and will start a new RTT period.

9. Patients Not Applicable to the 18-week RTT

- Patients on planned waiting list or undergoing planned care.
- Private patients.
- Direct GP referrals to non-consultant led services.

10. Refusal of Referrals

10.1 NHS guidance states that providers should accept all clinically appropriate referrals made to them. Patients choosing a particular NHS provider must be treated by that provider as long as this is clinically appropriate and in accordance with the patient's wishes.

11. Patients who DNA and Cancellations by the Hospital and the Patient

11.1 If iSIGHT Clinic cancels a Patient's operation on the day for non-clinical reasons, a new date should be offered and this date should be within 28 days of the date the operation was originally booked for.

11.2 This 28-day standard covers all planned and booked hospital operations, including day surgery, but does not cover minor operations carried out at outpatient appointments or clinics.

11.3 If a patient DNAs two appointments, they should be referred back to their referrer, unless the clinician deems it clinically necessary to offer another appointment. A letter confirming their discharge must be sent to the patient and their GP/referrer. At the end of clinic all DNA records will be collected together and reviewed by each Consultant for their clinic or by a nominated consultant for all clinics. The default position is to discharge after 2 DNAs unless otherwise clinically indicated. If a patient cannot make an appointment, they should contact the clinic as soon as possible to ensure timely rebooking and this may also allow the appointment to be offered to somebody else. It helps if referrers outline to patients prior to referral the patient's own responsibilities to attend appointments and how cancelling or not attending appointments can affect their right to have treatment within 18 weeks of referral.

11.4 With regard to measurement of RTT times, the national guidance states that:

For first appointments on an RTT pathway

- If the patient DNAs, their RTT clock can be stopped and nullified on the date of the DNA appointment.

- If the patient DNAs but iSIGHT Clinic chooses to rebook the patient, then their original RTT clock would be stopped on the date of the DNA appointment and a new clock will start (at zero) on the date that the Trust rebooks the patient.

For subsequent appointments on an RTT pathway:

- If the patient DNAs twice and the clinician feels it not detrimental to return the patient back to primary care, please see paragraph 12.6 below. Their RTT clock would stop on the date of the second DNA appointment.
- If the patient DNAs but iSIGHT chooses to rebook the patient, then their existing RTT clock would continue to tick.

11.5 If a patient cancels their appointment in advance, even with less than 24 hours' notice, this is not a DNA so has no effect on the RTT time; the RTT clock will continue to tick.
11.6 If a patient DNAs their appointment twice, subject to clinical agreement, the following will occur:

- Adults - where there are no safeguarding issues, the patient will be discharged back to their GP. Where there are potential safeguarding issues, the patient should be offered another appointment.

11.7 For patients with a series of planned appointments, DNA's will need to be considered on a case-by-case basis by the responsible clinician.
11.8 If a patient DNA's where a face-to-face interpreter has been booked, clinic administration staff are authorised to use that interpreter to attempt to make contact with the patient in order to establish a reason why and to offer a new appointment where that is appropriate in order to maximise the use of the translator resource.
11.9 In the event that an interpreter DNAs a pre-booked appointment, clinics are encouraged to continue with the appointment utilising other methods of communication, including attempting to resource interpretation services via the telephone service. Only if it is deemed clinically unsafe to continue with an appointment should a patient's appointment be cancelled and rescheduled.

12. Records Management

12.1 All staff who handle patient case notes are responsible for ensuring that each time a set is transferred from one location to another, the PAS is updated. It is imperative that this action is carried out accurately and in a timely fashion to reduce the incidence of case notes not being able to be located for appointments and the need to create temporary case notes.

13. General Outpatient Booking and Referral Management Principles

13.1 If the patient was discharged more than 6 months ago, GPs will have to re-refer if an appointment is required for the same condition.
13.2 Open appointments may however, in certain circumstances, still be given by iSIGHT Clinic, but the length of time granted for these varies across specialties and is dependent upon the nature of the service/conditions treated.
13.3 Review of referrals must be completed within 7 working days, except for visiting consultants. this does not include urgent referrals
13.4 Referrals are not expected to be routinely rejected. The Practice Manager will audit rejected referrals on a regular basis and advise on solutions to the issues. iSIGHT Clinic can only reject a

referral that hasn't been accepted (to be seen) in the NHS e-Referral Service. The rejection process sends the patient back onto a work list at their GP surgery and the appointment is automatically

cancelled on the PAS and NHS e-Referral Service. It is then the GP's responsibility to notify the patient of their appointment cancellation. As a safeguard, clinics also send out an appointment cancellation letter to the patient advising them to contact their GP. If the clinic area deals with the inappropriate and more appropriate service they will change the service and book a further appointment (in NHS e-Referral Service) and notify the patient. If they do not deal with the more appropriate service they will reject it back to the GP for them to re-direct. All inappropriate referrals will be referred back to the GP for them to review the choice of provider prior to the referral being re-directed.

13.5 Outpatient clinic staff will redirect referrals as instructed to the correct service/clinic.

13.6 The 'Date Request Received' in the PAS constitutes a clock start for those patients on an active 18-Week RTT pathway. This is the date an attempt was made to convert a Unique Booking Reference Number into a booking for NHS e-Referral Service patients and the date the referral letter was received into iSIGHT Clinic for paper referrals.

13.7 Internal consultant-to-consultant referral criteria are:

Direct referrals will be appropriate for:

- Urgent problems for which delay would be detrimental to the patient's health. The expectation here would be that the patient needs to be seen within 2 weeks.
- Referral as part of the same clinical problem.
- Part of the recognised pathway of care for the condition or as part of a pre-operative assessment.
- Transfer of responsibility of care for an on-going condition when it would be more convenient for the patient to be seen in a different location.
- Advice communicated back to the referrer will be appropriate for:
    - Conditions that are unrelated to the presenting problems and do not require urgent referral.
    - Incidental findings, except cancer.

If there is any doubt as to whether a patient needs to be managed by the hospital or whether a patient should be offered a choice of other provider or treatment, the consultant should contact the GP to discuss the case.

13.8 Agreeing the dates of appointments/admissions with patients rather than notifying them of an appointment is the preferred option in order to avoid the risk of patient cancellations or DNAs.

14. Summary of Guidelines for Managing New Referrals

14.1 A new referral will be required for:

- A new condition, even if within the same specialty.
- Same condition where previous referral was discharged over 6 months ago.

14.2 An assessment should have been undertaken by the referring clinician to determine any need for special considerations at the next level of care and this should then be recorded on the PAS to alert staff. If any new or changed requirements are identified during any treatment episode, then this information should be captured and the PAS updated.

15. Follow-up Appointments

15.1 Patients will only be followed up where there is a specific clinical need following the specialty protocol.

16. Changing/Cancelling Appointments at Patient's Request – New and Follow-up

16.1 Patients have an option to cancel and change their outpatient appointment by calling iSIGHT's administration telephone line 01704 552217

16.2 In the event a patient cancels a 2WW appointment, a further appointment must be given within

14 days of the original date request received/UBRN conversion. If this is not possible and the new appointment is over 14 days, this must be escalated to the Practice Manager
16.3 If patient requests a rearrangement or cancellation within 24 hours of the appointment time it must be recorded as a patient cancellation and the 18-Week RTT clock will continue ticking and the reason for cancelation must be recorded.
16.4 If a patient cancels their appointment they should be advised that this may have a detrimental effect on their health and thus should attempt whenever possible to keep their appointment. In the event that this is not possible, a new appointment should be given as soon as possible and the responsible clinician should be made aware as they may wish to review the patient to confirm any resultant risk.
16.5 All patient cancellations must be dealt with immediately to ensure they are not recorded as a DNA.
16.6 If a patient has to leave a clinic prior to being seen (clinic over-running or other circumstance), their appointment must be changed to ensure that they are not penalised in the 18-week cycle as the clock will continue ticking.

17. iSIGHT Clinic Cancellations – New and Follow-up Appointments
17.1 New appointments can be changed by clinic administrative staff providing there is no breach to the waiting time targets. Potential breaches must be brought to the attention of the Business Director and Practice Manager for advice and resolution before they become a breach.
17.2 Appointments will be re-booked with the patient's agreement as close to their original appointment date as possible. Only in exceptional circumstances will a patient be cancelled twice.

18. Communication
18.1 Under the Human Rights Act, the Equal Opportunities Acts and anti-discrimination legislation, the iSIGHT Clinic has a duty to provide interpreters for appointments when requested and to ensure reasonable adjustments are made for those patients and their families. Additionally, a legal requirement has been identified as part of the NHS Accessible Information Standard that directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. This information must now be recorded onto our Patient Administration system and it is the responsibility of any member of staff who is in receipt of this information to record this directly onto the patient's record o or ensure the information is given to a PAS/EPR user to record. This will allow us to be able to better anticipate the needs of those affected patients.
18.2 Interpretation can be managed via the telephone interpretation service or face-to-face with an interpreter present.
18.3 British Sign Language can be accessed via iSIGHT's Practice Manager who will co-ordinate and book a suitable date and time.
18.4 Where the patient has a learning disability, the consultant should contact the Learning Disability Liaison Nurse to support the team and the patient with reasonable adjustments or other requirements

19. Ambulance Transport
19.1 A patient is only eligible for provision of transport (including escort) if considered necessary by a Health Care Professional.
20. **Patient Transport Service**
20.1 Patients who qualify and require non-emergency transport to attend a hospital appointment

are to arrange it themselves through the provider that serves their General Practitioner.

21. Diagnostics and Imaging

21.1 In accordance with national maximum waiting time guidance, imaging appointments will be booked within 6 weeks.

21.2 The diagnostic waiting time starts when the request for a diagnostic test or procedure is made. For referrals via the NHS e-referral service, this is the time that the UBRN is converted, i.e. when the patient has accepted an appointment

21.3 The diagnostic waiting time stops when the patient receives the diagnostic test/procedure but the RTT clock could still be running.

21.4 'If a patient cancels or DNA's an appointment for a diagnostic test/procedure, then the diagnostic waiting time for that test/procedure is set to zero and the waiting time starts again from the date of the appointment that the patient cancelled/missed, if the offer is deemed as Reasonable. A Reasonable Offer in relation to this scenario is anything over ten days. This does not mean that an offer cannot be offered with less than ten days-notice.

22. Transfers from/to Private Providers

22.1 A patient may choose to change their out- patient or day case at iSIGHT to private care. In this case, this means transferring them with a new private referral so that the patient can be switched to an RTT Not Monitored pathway. Many private hospitals see both private and NHS patients; therefore either of these patient groups may be transferred/referred to iSIGHT. These transfers will be either:

- Private to NHS - this will constitute a new clock start with an auto allocated pathway ID. If the referral is for follow up, a clock start must still be recorded. The clock will then be stopped at the outcome of the appointment with either treatment not required or active monitoring. Where requests are received for previously treated private patients to have a long-term follow up appointment with a timescale greater than 18 weeks, these must be added to a review list, booked as a follow up and excluded from 18-weeks.
- NHS (from a private provider) to NHS (NHS provider) – 18-week details must be used when entering the patient activity on PAS. If no 18-week details are sent with the referral the referring provider must be contacted.
- Private-to-Private - these patients are excluded from the 18-week RTT. A Pathway ID must still be auto allocated with a treatment status of 98 for as long as they remain a private patient.

23. Inter Provider Referrals

23.1 A transfer of clinical care to an alternative provider will be initiated using a letter from a Consultant to the other provider.

23.2 If a patient transfer request is received by any other method, then contact must be made with the sender to inform them of the correct NHS net address. This is managed by the Referral Process Office in our patient administration office.

24. Overseas Visitors

24.1 Before patients can access any of iSIGHT's services or community services, they must have registered with a GP and so will have satisfied eligibility for free NHS care at that time. If not eligible for free NHS care, the GP will initiate a cost recovery process.