University Hospitals of North Midlands NHS
NHS Trust

Policy No. (G05)
Patient Access Policy

The following personnel have direct roles and responsibilities in the implementation of this policy:

- **All Trust Staff**

Version:	**10**
Ratified By:	**Quality and Safety Forum**
Date Ratified:	**March 2017**
Date of Issue via Intranet:	**March 2017**
Date of Review:	**March 2020**
Trust Contact:	**Deputy Head of Performance**
Executive Lead:	**Chief Operating Officer**

Version control schedule		
Final Version:	**Issue date:**	**Comments**
1	January 2004	
2	July 2006	
3	April 2008	
4	September 2010	
5	May 2012	
6	September 2013	
7	November 2014	
8	August 2015	Aligned with County
9	November 2015	Aligned with supporting procedural manuals for County site and Royal Stoke site
10	March 2017	Changes have been made based upon: • Changes to national RTT rules, 1st October 2015 - The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) (No.2) Regulations 2015 came into effect, removing the provision for **a patient pause** • The policy has been reviewed by the national elective Interim Support Team, in preparation for the implementation of the Medway PAS system.

University Hospitals of North Midlands NHS
NHS Trust

Statement on Trust Policies to be included in all policies

Staff Side and Trade Unions
The University Hospitals of North Midlands NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way in which we provide services to the public and the way in which we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

Equality and Diversity
The University Hospitals of North Midlands aims to promote equality and diversity and value the benefits this brings. It is our aim to ensure that all staff feel valued and have a fair and equitable quality of working life.

Equality Impact Assessment
The organisation aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Assessment tool is designed to help you consider the needs and assess the impact of your policy.

Information Governance
Any Trust policy which impacts on or involves the use and disclosure of personal information (patient or employee) must make reference to and ensure that the content of the policy is comparable with the relevant statutory or legal requirement and ethical standards

Data Protection Bill, General Data Protection Regulations (GDPR) and the NHS Code of Confidentiality
GDPR replaces the EU Data Protection Directive of 1995 and supersedes the law of member states that were developed in compliance with the Data Protection Directive 95/45/EC. Its purpose is to protect the "right and freedom" of natural persons (i.e. livening individuals) and to ensure that personal data is not processed without their knowledge, and, wherever possible, that it is processed with their consent.

Processing includes holding, obtaining, recording, using and disclosing of information and applies to all forms of media, including paper and images. It applies to confidential patient information but is far wider in its scope, e.g. it also covers personal records

Whiles GDPR applies to both patient and employee information, the Confidentiality Code of Practice (COP) applies only to patient information. The COP incorporates, the requirements of GDPR and other relevant legislations together with the recommendations of the Caldicott report and medical ethics considerations, in some cases extending statutory requirements and provides detailed specific guidance.

Freedom of Information Act 2000
The Freedom of Information Act 2000 (FOIA) is an Act which makes legal provision and creates a legal gateway and timetable for the disclosure, to the public, of the **majority** of corporate information held (but not necessarily created) by this Trust. The Trust has a legal responsibility to proactively provide a large amount of information to the public and to pro-actively respond to specific requests for information. Information will not be disclosed when the Trust can claim legal exemption. Any non-disclosure must be conveyed in writing; quoting the relevant exemption together with signposting to internal and external methods of compliant. Locally, guidance on the DPA, FOIA and COP can be obtained from the Information Governance Manager or the Caldicott Guardian.

Mental Capacity Act

Any Trust policy which may affect a person who may lack capacity should comply with the requirements of the Mental Capacity Act 2005 (MCA)

The MCA and its associated Code of Practice provides the framework for making decisions on behalf of individuals

who lack the mental capacity to do these acts or make these decisions for themselves. Everyone working with and/or caring for adults who lack capacity, whether they are dealing with everyday matters or life-changing events in the lives of people who lack capacity must comply with the Act.

In a day to day context mental capacity includes making decisions or taking actions affecting daily life – when to get up, what to wear, what to eat etc. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person lacking capacity, or for other people.

The Code provides guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack the capacity to do this for themselves. In particular, it focuses on those who will have a duty of care to a person lacking capacity and explains how the legal rules set out in the Act will work in practice.

The Health Act: Code of Practice for the Prevention and Control of Health Care Associated Infections
The purpose of the Code is to help NHS bodies plan and implement how they can prevent and control HCAI. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean, safe environment, where the risk of HCAI is kept as low as possible. Failure to observe the Code may either result in an Improvement Notice being issued by the Care Quality Commission, or in the Trust being reported for significant failings and placed on 'Special Measures'.

The Code relates to healthcare provided by all NHS bodies. Each NHS body is expected to have systems in place sufficient to comply with the relevant provisions of the Code, so as to minimise the risk of HCAI to patients, staff and visitors.
The Trust Board must have an agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks.

Effective prevention and control of HCAI must be embedded into everyday practice and applied consistently by all staff.

Human Rights
The Trust is committed to the principles contained in the Human Rights Act. We aim to ensure that our employment policies protect the rights and interests of our staff and ensure that they are treated in a fair, dignified and equitable way when employed at the Trust.

Sustainable Development
The University Hospitals of North Midlands NHS Trust (UHNM) is committed to demonstrating leadership in sustainability and has a Trust Board approved Sustainable Development Management Plan (SDMP): Our 2020 Vision: Our Sustainable Future which sets out the route to developing a world-class healthcare system that is financially, socially and environmentally sustainable.

There are three 'Key Priorities' to aim for by 2020. With the help of employees, key partners and other stakeholders the trust will embed opportunities to:

1. Reduce our environmental impact, associated carbon emissions and benefit from a healthier environment;
2. Improve the resilience of our services and built environment as a result of severe environmental and climatic changes;
3. Embed sustainable models of care and support our local community to be well-connected, healthy, resilient, independent and managing their lives in a positive way.

The SWITCH campaign is designed to achieve these priorities. It is relevant to all departments and all members of staff. The focus is on using resources sustainably in order to provide better patient care, improve health and our working environment.

EXECUTIVE SUMMARY

The length of time a patient waits for hospital treatment is an important quality issue and is a visible and public indicator of the efficiency of the services provided by the Trust. The Trust is committed to putting patients first and ensuring that national operational performance standards are met in line with the Everyone Counts: Planning for Patients 2014/15 – 2018/19. NHS England.

https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid.pdf

The Trust is required to deliver performance against the key measures set out by our regulator the NHS Improvement (NHSI) through their accountability framework and oversight model.

The Access Policy informs patients, relatives and staff of their rights and what to expect from the Trust. It is linked to the NHS Constitution (2013) and therefore to certain legal rights. It also allows Trusts and commissioners to set out their local approach to managing and sustaining shorter waiting times, as set out in the NHS Constitution. https://www.england.nhs.uk/2013/03/nhs-constitution

Part of the NHS pledge is to put patients at the center of their care which involves making sure that the patients are diagnosed and start treatment as soon as possible, at a time that is convenient for them.

The NHS Constitution says that patients have the right to access certain services commissioned by NHS bodies within maximum waiting times. Where this is not possible and the patient requests it, the NHS will take all reasonable steps to offer a range of suitable alternative providers, unless the patient chooses to wait longer or it is clinically appropriate that you wait longer.

In addition to these standards, the following quality measures must be attained. The threshold, method of measurement and consequences of breach are also detailed.

- The Provider shall make specified information available to prospective NHS patients through the NHS Choices website, and shall in particular use NHS Choices to promote awareness of the Services among the communities it serves, ensuring the information provided is accurate and up-to-date, in accordance with the provider profile policy which can be found at http://www.nhschoices.nhs.uk
- Commissioners and Providers will provide information on patient's right to access services within the maximum waiting times. The NHS Constitution states that patients have the right to start treatment within 18 weeks from referral
- The Provider shall offer clinical advice and guidance to GPs on potential referrals through E-Referral, whether this leads to a referral being made or not
- The Provider and the Commissioners shall work together to ensure that patients are not inconvenienced by insufficient slots being made available to E-Referral. This is by means of joint robust Capacity and Demand planning monitored through the joint Local Health Economy (LHE) Planned care meetings
- Ensure that there are contingency plans in place to deal with patient bookings and the receipt of referrals should the E-Referral system be temporarily unavailable for any reason
- Have in place a system to accept referrals from The Appointments Slot Issue (ASI) where patients have attempted to book an appointment but there were no slots showing on E-Referral at the time, as detailed in the Appointment Slot Issue guidance
- Ensure that the only referrals which are rejected are those considered to be clinically inappropriate (except where local arrangements have been agreed that ensures patients' are fully informed of the choice of alternative providers)
- Provide clear feedback information in E-Referral when referrals are rejected

- The Provider shall issue the Patient's Discharge Summary to the Patient's GP: within 24 hours of the Patient's discharge from the Provider's Premises
- Following an appointment the Provider should try to notify the Service Users GP as soon as reasonably practicable (and in any event within 14 days) following an appointment

This policy defines roles and responsibilities and establishes a consistent approach to managing patient access to the Trust.

1. INTRODUCTION

The length of time a patient needs to wait for hospital treatment is an important quality and efficiency measure of the hospital services provided by the Trust. The policy details how patients will be managed administratively at all points of contact at The University Hospital of North Midlands, and should be read in conjunction with

- The UHNM *Patient Access Procedure Manual – G05a. This details the operational processes*
- *UHNM Trust Policy for Management of Cancer Operational Standards, C58*

The aim of the policy is to:

- Set out how the Trust will consistently manage access for patients who are waiting for treatment on non-admitted, diagnostic or admitted (including planned) pathways;
- Define roles and responsibilities;
- Ensure the accuracy of all related data.

The policy reflects the expectations of the Trust and Commissioners on the management of referrals and admissions into and within the organisation and defines the principles on which the policy is based, which apply to both clinical and administrative waiting list management.

The policy refers to the NHS Outcomes Framework 2015 to 2016. The NHS Outcomes Framework, alongside the Adult Social Care and Public Health Outcomes Frameworks, sits at the heart of the health and care system. The NHS Outcomes Framework:

- Provides a national overview of how well the NHS is performing;
- Is the primary accountability mechanism, in conjunction with the mandate, between the Secretary of State for Health and NHS England; and
- Improves quality throughout the NHS by encouraging a change in culture and behaviour focused on health outcomes not process.

National Operational Standards		Standard
Referral To Treatment	Patients on an incomplete pathway (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%
Diagnostic Wait Times	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%
Cancelled operations	Where a patient is cancelled on the day of admission or day of surgery (for non-clinical reasons, he/she must be rebooked within 28 days of the original admission date. Two reasonable offers must be made to the patient within 28 days of the date of cancellation. The patient may choose not to accept a date within 28 days.	Zero tolerance
Cancer Two Week Wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%
Cancer Wait 31 Day	Maximum one month wait from diagnosis to first definitive treatment for all cancers	96%
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	94%
	Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regime	98%
	Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	94%
Cancer Wait 62 Day	Maximum two-month (62 day) wait from urgent GP referral to first definitive treatment for cancer	85%
	Maximum 62 day wait from an NHS screening service to first definitive treatment for all	90%

	cancers	
	Maximum 62 day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) -	none set

NB. Some of the above targets do not apply to Welsh/Scottish patients. Separate wait time targets apply to this group of patients and the Trust adheres to the contract.

2. STATEMENT

The patient Access Policy throughout will be explicit in documenting the best interests of the patient are foremost and the Trust intends to ensure efficient and equitable handling of referrals in line with waiting time standards and the NHS Constitution.

3. SCOPE

The Policy applies to all staff who are involved with managing patients access to services across the admitted; non-admitted; diagnostic and cancer pathways. The policy does not include access to non-elective services.

This policy applies to the management of all patients on elective outpatients, diagnostic and inpatient waiting lists and includes all pathways; cancer, RTT and Planned. The policy should be read alongside the Patient Access Procedure Manual (G05a) which provides operational instructions on how the expectations in the policy are to be activated. The aim of the Procedure Manual is to give operational users and managers the details of the processes to be undertaken and the roles responsible. Outside the scope of this policy is ALL non-elective activity i.e. patients attending A&E.

The Policy (G05) and accompanying procedure manual (G05a)will reference the Trusts Patient Administration System (PAS); from January 2017 will be MEDWAY.

4. ROLES AND RESPONSIBILITIES

Whilst responsibility for achieving the above targets lies with the Trust Board all staff with access to and responsibility for maintaining referrals and waiting list information systems, are accountable for their accurate upkeep.

The Chief Executive and Trust Board through the Chief Operating Officer will be responsible for ensuring that this policy is implemented effectively. The Chief Operating Officer is responsible for ensuring that this document is reviewed annually or as recommended by The Compliance Steering Group.

The **Chief Operating Officer** or delegated officials has responsibility for reporting waiting list performance and through the **Divisional Performance reviews** will monitor compliance against the policy. In addition the **Chief Operating Officer** has responsibility for ensuring recommendations of internal audit are implemented once the final report is presented to the Audit Committee.

Clinical Directors and Associate Directors have responsibility within their Divisions for all access target performance including the maintenance of accurate waiting lists and the training of staff that are responsible for managing patient's access, to ensure compliance with this policy. The CDs and ADs will hold to account responsible staff through the monitoring processes at performance reviews.

Directorate Managers have responsibility for ensuring patients are provided with reasonable notice and appropriate choice and for ensuring that their practices are consistent with the policy and that the systems are in place to support effective waiting list management. Included in this is the responsibility that all staff has access to training that allows them to undertake delegated roles and apply the principles within this policy.

Individual staff members, including clinicians, are responsible for ensuring that their practices and documentation is consistent with the policy and that the systems are in place to support effective waiting list management.

It is the responsibility of **all members of operational staff** to understand patient access to elective services principles and definitions and to attend all training offered in regards to reporting and managing waiting lists.

Data quality is the responsibility of everyone in the Trust. Data capture, processing and reporting must accurately reflect any Trust policies or procedures and must be of a standard so as not to adversely affect patient care, refer to the Data Quality Strategy & Policy)C27). September 2013.

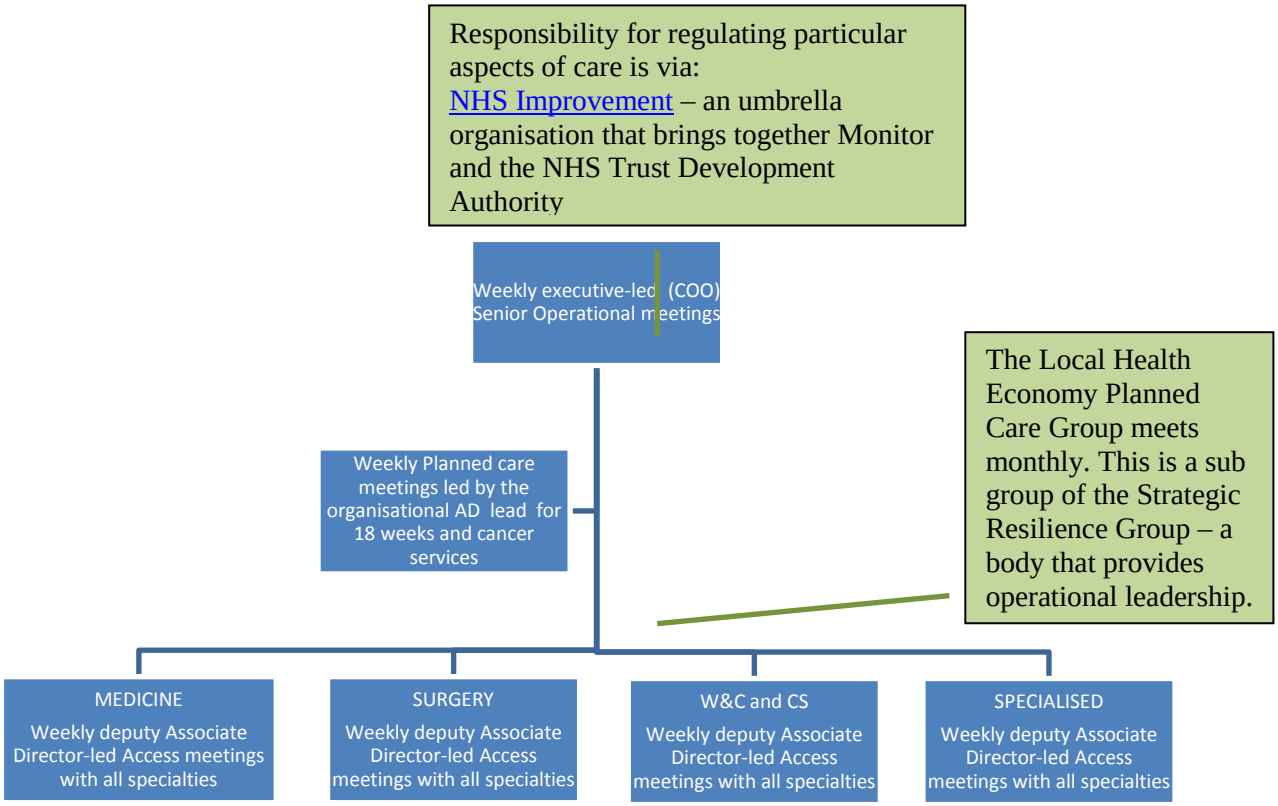
All staff who does not comply with this policy and the accompanying Procedure Manual / Policy may be subject to action under Trust disciplinary policies.

5. GOVERNANCE

There is a recognised process where policies that have been developed and/or reviewed are agendered at the Trusts Compliance Steering Group and once ratified the policy is available on-line.

The policy will be reviewed annually.

Patient Access is reviewed on a weekly operational basis within each Division. The Trust has a weekly AD-led Planned Care Patient Access Group. Issues regarding patient access and compliance with the access policy are escalated through these groups and then to the Senior Operational Group, led by the Chief operating Officer.



6. EDUCATION/TRAINING AND PLAN FOR IMPLEMENTATION

It is the responsibility of the Directorate Managers to ensure that staff are made aware and training is available for the policy and any revised issues. Each Directorate will have a named champion(s) whose role it is to be the first point of contact for operational staff if any queries regarding application of the policy arise.

Referral To Treatment and Patient Access training will be made available supported by e-learning packages.

GPs play a pivotal role in ensuring patients are made aware of the likely waiting times for a new outpatient consultation and the need to be contactable and available when referred. The Trust relies on all referring clinicians to the Trust to ensure that patients understand their responsibilities and potential pathway steps and timescales when being referred. This will help ensure that patients are referred under the appropriate clinical guidelines and are aware of the speed at which their pathway may be progressed and are in the best position to accept timely and appropriate appointments.

Therefore the Trust expects that, before a referral is made for treatment on an 18 week Referral to Treatment pathway, the patient is ready, willing and able to attend for an appointment and undergo any treatment that may be required.

Patients are responsible for complying with booking arrangements, attending appointments and ensuring that the Trust is informed of any relevant changes in circumstances. When patients are placed on waiting lists they have a responsibility to ensure that they are ready, fit and able to attend. The Patient Access Policy is made available to the public via the Trusts wed site.

7. MONITORING AND REVIEW ARRANGEMENTS

The policy will subject to regular monitoring against compliance:

- The policy is subject to the annual internal audit programme. As good practice this should be in partnership with local Health Economy Planned care forums
- On request, Clinical audit will be undertaken against a number of the clinical standards to audit against compliance with the policy
- Compliance against the patient access policy can be monitored through operational use of the Business Intelligence dashboards. These are monitored by Directorate Management teams and reported through the governance structures outlined above in 6.
- Compliance against the access policy can be monitored via the contractual routes specifically against specific national targets. In some instances Root Cause Analysis is undertaken and reported via the contractual arrangements.

8. KEY PRINCIPLES OF PATIENT ACCESS

At the heart of effective patient access is a Patient Administration System (PAS) that enables electronic recording of patient's records by:

- Managing the administration of patient pathways (Outpatient and inpatient waiting lists)
- Providing patient demographic and attendance details
- Interfaces to other systems : iCM / PACS / ORMIS/ CRIS / etc
- Information recorded helps us to evaluate the quality of care and monitoring waiting times, cancelled operations etc

The Patient Administration System that will be effective from 30th January 2017 is Medway which has functionality regarding the documentation of patients wait times against the Referral To Treatment (RTT) national standard.

For more detailed instructions of patient access national rules and operational application users should refer to:

- **https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/**
- **Patient Access Procedure Manual, G05a.**
- **National Cancer Waiting Times Monitoring Dataset Guidance - Version 9.0 - http://www.datadictionary.nhs.uk**
- **http://www.datadictionary.nhs.uk/data_dictionary/messages/clinical_data_sets/data_sets/national_cancer_waiting_times_monitoring_data_set_fr.asp**

8.1 Referral Guidelines

- NHS providers should accept all clinically appropriate referrals for elective consultant-led services 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. Managing to meet the demand for popular services is a shared responsibility between commissioners and providers and they need to work together to ensure that, where clinically appropriate, patients are treated at their choice of provider

- Where possible referrals should be made to a service rather than a named consultant, which can be allocated to an appropriate Consultant with the shortest waiting time using the E-Referral System (ESR) which is the preferred route of referral. However, services on E-Referral should be set in a way that allows users to book with a named consultant should they wish.

- Where an appointment slot is not available within the Trust, the national E-Referral system places the referral on an Appointments Slot Issue (ASI) work list; it is the Trust's responsibility to liaise directly with the patient to arrange their appointment. E-Referral guidance states that all patients on the ASI list to be contacted within 4 working days, and an appointment made at that time. During this time the Referral To Treatment (RTT) clock is still ticking. It is the responsibility of the GP practice to ensure the referral is attached.

- E-referrals (Choose and Book) are the preferred method of referring a patient. The NHS contract is working towards a fully established E-referral system and with effect from 1st October 2018 the Trust may reject any referrals made by GPs to Consultant-led acute outpatient Services made other than through the NHS e-Referral Service.
- Non E-referrals (Paper) should be made using the Trust standard referral form, if not the referral will be returned/rejected to the referrer.
- Patients who are referred as 'open-referrals' to a speciality will be allocated to an appropriate consultant with the shortest waiting time
- The Trust will adhere to the local Commissioning Policy on Excluded and Restricted Procedures. The purpose of this Commissioning Policy (which replaces the current Policies on Procedures of Limited Clinical Value and Low Priority Treatments, or Exclusions and Restrictions) is to clarify the commissioning intentions of the Clinical Commissioning Groups across Staffordshire, namely North Staffordshire CCG, Stoke on Trent CCG, Stafford and Surrounds CCG, Cannock Chase CCG, South East Staffordshire and Seisdon CCG and East Staffordshire CCG.

- A decision to add to an outpatient, diagnostic or elective waiting list must be recorded on the Trusts Patient Administration System (PAS) within two working days of receipt regardless of where in the Trust the referral is received
- All non E-Referrals referrals (paper) to be registered scanned into the Electronic Document Management System (EDMS or EDRM)/ Clinical Information System (CIS) within 48 hours of receipt.
- Clinical review of all referrals, including e-referrals, is essential to ensure the patient is seen in clinical priority, in the appropriate clinic by the appropriate consultant. The aim is for triage to be undertaken in an optimum time to ensure compliance against national wait time standards
- Tertiary Referrals - Consultants referring patients to other providers are required to use the mandatory referral template (Inter Provider Transfer Minimum Data Set - IPTMDS) to ensure that all relevant Referral To treatment information is communicated.
- Consultant to Consultant Internal Referrals are accepted when it relates to the original condition/pathway for which the patient was originally referred or for urgent conditions. Consultant to Consultant referrals that are accepted should be sent by the Consultant to the Outpatients Department Appointment Team, via methods: electronic, fax or hand delivered, to be processed.

- Other routine referrals and conditions of low clinical priority, not related to the original condition referred for, should be communicated back to the GP for them to discuss choice options with the patient.

- If a consultant deems a referral to be clinically inappropriate, it must be sent back to the referring GP with an explanation of why and the RTT clock stopped.

- If a referral has been made and the special interest of the Consultant does not match the needs of the patient, the Consultant should cross-refer the patient to the appropriate colleague where such a service is provided by the Trust and the referral amended on the PAS.

- Referrals to Advice and guidance will be operational and follow the contract agreement for 2017/18 and 2018/19

- Veterans receive their healthcare from the NHS and should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical needs. Reference: The Armed Forces Covenant - https://www.gov.uk/government/publications/the-armed-forces-covenant. Last updates 15 April 2013.

8.2 Waiting lists

- Patients are only added to waiting lists when they are 'ready, fit and available' to attend. GP's have a responsibility to discuss with patients the importance of being available to accept the next available appointment/ TCI.
- Patients may wish to choose to wait longer than 18 weeks, as is their constitutional right. However, in some cases the request for a longer wait may not be in the patient's best clinical interests. In these instances the patient's records should be reviewed by the Consultant to make a decision on the appropriate clinical management. The Trust will have in place processes to ensure this happens.
- The Trust will ensure that a patient waiting to access elective care are recorded accurately on the Trusts agreed electronic PAS (EPR). Paper based systems will not be used
- The Trust will monitor the Referral to Treatment (RTT) pathway by using Patient Tracking Lists (PTL) measuring the length of wait from referrals to new outpatient appointment, diagnostic test and elective admission.
- Waiting lists are derived in line with national guidance regarding 18 week RTT, diagnostics and cancer wait times

8.3 Making appointments / admission dates

- Indirect referrals (paper) should have a provisional appointment made within 5 working days.
- For all types of appointments/admission the Trust will give priority to clinically urgent patients. All other routine patients, of the same clinical priority, will be seen in chronological order from date referral received. If, when allocating appointments/ TCIs for routine patients a military person or veteran is made known these patients should be given priority for service-related conditions.
- The Trust will, whenever possible, negotiate appointment and admission dates and times with patients.
- Communication with patients will be informative, clear and concise and a summary recorded in the Trusts PAS. Appointments will be confirmed in writing
- Appointments will be confirmed in writing. For some patients they may have agreed an appointment before leaving clinic. Prior to all appointments a text-reminder system is in place, therefore it is essential that patient's contact numbers are kept up to date.

- The Trust aims to ensure fair and equal access to services for all patients and will show no discrimination against any patients on the grounds of ethnic origin, disability, gender, gender reassignment, marital status, age, sexual orientation, and trade union activity, political or religious beliefs
- Where a patient has failed to respond to a request to confirm an appointment/ TCI OR has DNA'd, the trust will attempt to contact the patient at a time outside that of normal working hours and ensure that they have the latest information regarding the patients address and contact number. This may include checking with the GP or cross referencing on the National Spine.
- Where the Trust is unable to contact a patient (following a DNA or alteration of several appointments/ TCIs) the clinician responsible will review their referral and/or clinical records to determine the best course of action which is in the patients best clinical interest i.e. remain on the waiting list with an appointment sent via the mail system or return to the care of their general Practitioner. Where a patient is discharged back to the care of the GP a letter will be dictated and typed to be sent to both the patient and the GP.
- Urgent follow up appointments will be arranged prior to a patient leaving clinic. Routine follow up appointments will be arranged in line with the appropriate 'appointment due by' date.
- It is **essential** that all patients who are **not discharged** back to their GP and are awaiting a follow up or review for any reason **are placed on the follow up partial booking waiting list.** For patients awaiting tests results n appointment by date will be set at 9 weeks maximum.
- If a patient has their tests results reviewed by the consultant outside of clinic and it is the clinical decision to discharge the patient, a discharge letter should be typed and sent to the patient and GP clearly informing that an appointment is no longer required. The medical secretary will ensure that letters are typed and sent to the patient and GP and all relevant waiting list entries removed and referral closed.

8.4 Reasonable Notice

- Reasonable notice for non-cancer patients is at least 2 appointments offers with at least 3 weeks' notice from the time of the offer being made
- Reasonable notice for cancer patients is classed as any offered appointment between the start and end point of 14, 31 or 62 day standards. However, patients may still wish to delay their appointment/ TCi as is their constitutional right.

8.5 Clinic Cancellations

- A minimum of six weeks' notice is required for cancellation of clinics.
- Clinic cancellation with less than six weeks' notice can only be authorised by the Directorate manager and Clinical Director for the relevant specialty
- It is the responsibility of the relevant clinician to arrange suitable clinical cover if a short notice clinic cancellation is necessary and has been approved, as above
- It is the responsibility of the clinician, in conjunction with the Directorate management team, to manage the waiting list when clinic cancellations or reductions in clinic capacity result in follow-up patients exceeding their appointment due by date
- In exceptional circumstances if a clinic is cancelled at short notice patients should be contacted by telephone and offered the choice of an alternative appointment within 14 days of the original appointment

- A patient should not be cancelled on more than two occasions
- The DM and CD will be held to account at the Divisional Performance reviews where the above principles have not been applied

8.6 Patients who do not wish to attend

- Patients who decide that they no longer wish to attend any appointment offers will be brought to the attention of the consultant. Where a patient is insistent they no longer wish to be seen they will be discharged back to their GP and the referral closed. A letter will be sent to the patient and copied to their GP.
- If the patient was referred on a 2ww the referral bureau will telephone the GP to ensure that they are aware that the patient has decided not to attend. In addition the consultant will be informed who will decide on the most appropriate action that is in the patients best clinical interests.

8.7 Patients who wish to cancel/ alter their appointment

- The patients can routinely be offered up to 3 reasonable offers
- If after the third offer, a patient wishes to alter an appointment again they will be informed that the consultant will review the referral and/or clinical records and make a decision on the appropriate course of action that is in the patients best clinical interest i.e. refer the patient back to the GP to be re-referred when they are able to attend or keep the patient on the waiting list and be offered a further appointment. For some patients it may be in their best clinical interest to be referred back to the care of their GP.
- Patients normally choose to alter their appointment for short periods e.g. when away on holiday for 2 – 3 weeks. On occasions patient will request a significant period to lapse before attending an appointment. On these occasions the patients records should be reviewed by the clinician who will make a decision on what is the appropriate clinical action i.e. refer the patient back to the GP to be re-referred when they are able to attend the reasonable notice offers or keep the patient on the waiting list and be offered a further appointment if the clinician feels it is in their best clinical interests.
- Patients can, however, choose to delay their treatment whether they are on the non-admitted or admitted stage of the pathway and the RTT clock will continue unless the patient is placed on active monitoring or referred back to the GP.
- All offers of appointments and TCIs should be recorded on PAS to be able to demonstrate that the patient chose to delay

8.8 Did Not Attend (DNA)

- Patients DNA for all sorts of reasons and the Trust must assure itself that the patient received reasonable notification before any decisions are made regarding a patient who has not attended.
- There are some groups of patients who may automatically be given a second outpatient appointment or TCI if they DNA – these include patients identified as vulnerable adults; obstetric patients; patients referred on a cancer 2 week wait referral and paediatrics (see appendix 1). This list is not exclusive and the decision should be clinically-led.
- Patients on a 2 week wait referral will, after a second DNA, be reviewed by the consultant and contacted to arrange a further appointment if the consultant determines this to be in the patients best clinical interest.

- A process should be put in place so that ALL ROUTINE patients can be reviewed by the clinician who will make a judgment on the appropriate course of action and what is in the patients best clinical interests i.e. refer the patient back to the GP or offer another appointment

- Where the DNA has been for a first new outpatient appointment and another is offered a new 18 week RTT pathway commences. For all other DNA's, if another appointment is offered the RTT pathway continues.

8.9 Management of Outpatient Clinics

- Any changes to clinic templates/ booking rules must be authorised by the Directorate Manager for that service, giving at least 6 weeks' notice.
- Changes to clinic templates i.e. permanent changes should only be submitted yearly in line with commissioning and kept to a minimum unless in exceptional circumstances. In this event 6 weeks' notice will need to be given.
- Requests to set up a new clinic must be authorised by the Directorate Manager for that service and this will need to include clinic coding and give at least 6 weeks' notice

8.10 Clinic typing

Where, in the course of delivering an outpatient Service to a Service User, the Provider becomes aware of any matter or requirement pertinent to that Service User's on-going care and treatment which would necessitate the Service User's GP taking prompt action, the Provider must communicate this by issue of a Clinic Letter to the Service User's GP. The Provider must send the Clinic Letter as soon as reasonably practicable and in any event within 10 days (with effect from 1 April 2018, within 7 days) following the Service User's outpatient attendance. With effect from 1 October 2018, the Provider must issue such Clinic Letters using an applicable Delivery Method.

9.0 KEY PRINCIPLES – CANCER STANDARDS

9.1 - 2 week wait

All patients referred from GP/GDP as suspected cancer will be seen within 14 days of receipt of referral
All patients referred with breast symptoms irrespective of whether cancer is suspected or not, will be seen within 14 days of receipt of referral.

As a general principle, the Trust expects that before a referral is made on a cancer pathway
the patient is both clinically fit for assessment and possible treatment of their condition, and ready to start their pathway within two weeks of the initial referral.

The 2 weeks wait clock stops when a patient is first seen in outpatients.

9.2 - 31 day

- All patients diagnosed as a new cancer will receive treatment within 31 days of the decision to treat irrespective of treatment.
- All patients that are having a subsequent treatment for cancer will receive treatment within 31 days of the decision to treat / ECAD (Earliest Clinically Appropriate Date).

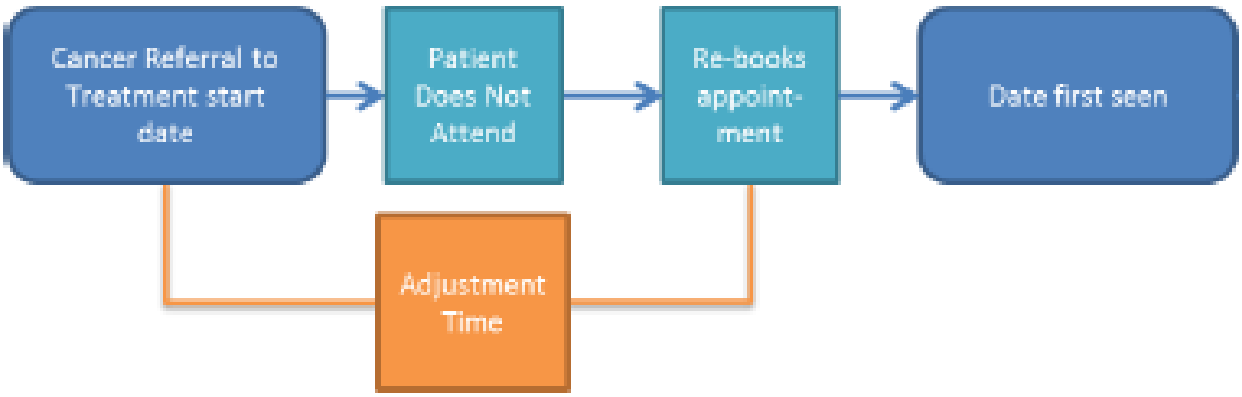
9.3 - 62 day

- All patients referred by their GP/GDP as suspected cancer or breast symptomatic, who are subsequently diagnosed with cancer, will commence treatment within 62 days of receipt of referral.
- All patients referred from screening programmes (bowel, breast, cervical) as suspected cancer who are subsequently diagnosed with cancer, will commence treatment within 62 days of receipt of referral.
- All patients that are upgraded by Consultants as suspected cancer will commence treatment within 62 days of the date of upgrade.

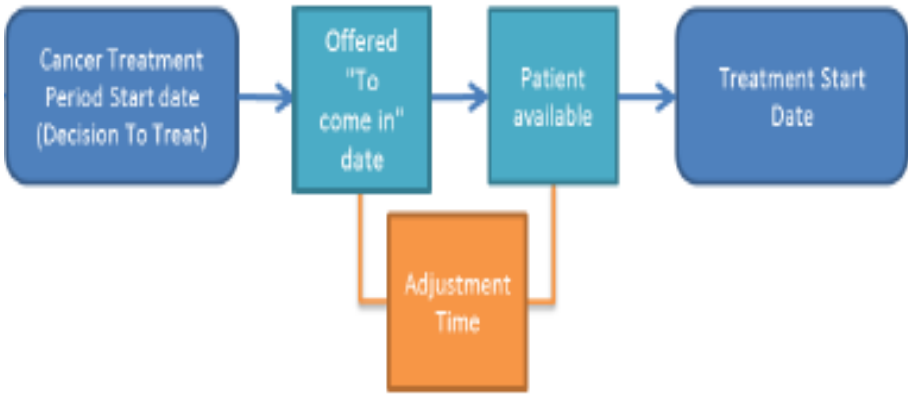
The 62 or 31 day clock stops when the patient receives the first definitive treatment or subsequent treatment as required by the Multi-Disciplinary Team (MDT) plan for the treatment of their cancer. First Definitive Treatment is defined as the treatment aimed at removing or eradicating the cancer completely or at reducing tumour bulk.

9.4 Patient wait time adjustments are allowed in two places:

- If a patient DNAs the initial out-patient appointment/diagnostic clinic



- If a patient declines a ‘<u>reasonable</u>’ offer of admission for treatment in an admitted care setting.



10.0 MANAGEMENT OF DIAGNOSTIC APPOINTMENTS

10.1 Diagnostic Referrals

- All Access Policy rules equally apply to diagnostic appointments
- The preferred method of requesting diagnostic tests is via Order-comms.
- All paper request cards will be logged on to the Radiology Information System upon receipt within one working day
- Clinical review and protocol of all requests must take place within 2 working days

10.2 Arranging Diagnostic Appointments

- Reasonable notice for non-cancer patients requiring a diagnostic test is at least 2 weeks' notice from the time of the offer being made.
- Due to short wait times for some tests the minimum reasonable notice is at least 1 weeks' notice from the time of the offer being made. Patients on a cancer pathway are likely to be requested and will accept earlier offers.
- If a patient does not accept a first offer of a diagnostic test, a second offer should be made. If a patient is unable to accept a first offer at less than two weeks' notice, the second offer should be up to a maximum of three weeks' notice.
- A patient's appointment will be arranged within 5 working days of protocolling, and appointments will be confirmed in writing.

10.3 Can Not Attend/DNA Diagnostic Appointments

The referrer will be notified and a decision is made on further management based upon what is in the best clinical interests for the patient.

10.4 Reporting of Results

- Results must be reported in sufficient time to allow progress through all stages of the RTT pathway and in line with internal targets.

11.0 MANAGEMENT OF ELECTIVE ADMISSIONS

11.1 Adding Patients to Elective Waiting Lists

- The decision to add patients to the waiting list must be made by the consultant or designate
- Additions to the PAS must be completed in a timely manner and the date of adding to the list must equal the decision date
- If a patient becomes medically unfit either once they have been added or during the course of being added to the waiting list; the following should happen:
    - If it is a short term minor ailment requiring no active optimisation, the RTT clock continues.
    - If a serious co-morbidity is found requiring longer term optimisation, the patient should be actively monitored by the Trust or discharged back to GP until fit. All clinical management will be agreed with the patient.

- A patient should only be placed on an active waiting list for surgery if:
  - There is a sound clinical indication for surgery
  - The patient is clinically ***ready, fit and available*** to undergo surgery
  - There is a real expectation of performing the operation within a reasonable time in relation to the patent's clinical priority
  - Patients will be added to the waiting list only when they have accepted the advice of the healthcare profession responsible for their care

11.2 Use of Planned Waiting Lists

- Patients should only be added to a planned list where clinically they need to wait a period of time for their treatment/ test (a good example are patients undergoing surveillance)
- Patients on planned lists should have a TCI arranged at the stipulated clinically appropriate time and due dates should be recorded on the PAS
- Patients on a planned list will not be classified as being on an 18 week pathway
- If the patient reaches their 'due date' and has not been admitted and treated the patient should be transferred to the active elective waiting list and a new RTT pathway commenced. This would include patients with a TCI and those without
- The records should be reviewed by the clinician.

11.3 Booking Principles

- All patients must be admitted on the day of their operation, unless the pre-assessment team/clinician clearly identifies a clinical need to dictate otherwise
- Where it is not possible to offer treatment of patients within the maximum waiting times, the Trust will work in partnership with the Local CCG's to operate a transfer process to ensure patient rights under the NHS Constitution are met
- Elective admissions will be confirmed in writing and patients will be requested to confirm their acceptance of the TCI

11.4 Reasonable Notice

- Reasonable notice for non-cancer patients is at least 2 elective admission offers with at least 3 weeks' notice from the time of the offer being made. Many patients on a cancer pathway will be offered admissions much sooner and any offer for an appointment/ admission between the start and end point of the 31 or 62 day period can be made

11.5 Pre-Operative Service

- Patients for elective surgery under general anaesthetic will undergo pre-operative assessment
- Patients admitted for elective surgery will undergo MRSA screening prior to admission
- The Pre-Operative Assessment Service aims to see patients on the day of decision to treat, but for some patients it will be clinically appropriate to offer a telephone assessment or an appointment at a later date

11.6 Can Not Attend Elective Admission

- Patients can decline or alter their elective admission on one occasion. In the event the patient wishes to alter their TCI for a second time the patients records will be reviewed by the clinician who will make a judgment on the appropriate course of action and what is in the patients best clinical interests i.e. returning the patient to the care of their GP; remaining on the Trusts waiting list to be given another TCI; see again as a follow up

Under NO circumstances can a patient's wait time be paused/ suspended.

11.7 DNA of Elective Admission

- Patients, with the exception of vulnerable adults, paediatrics (see appendix 2), urgent patients and patients on a cancer pathway, who do not attend their elective admission, will have their records reviewed by the clinician who will make a judgment on the appropriate course of action and what is in the patients best clinical interest i.e. to be discharged to the GP/ referrer or remain on the waiting list to be offered a further TCI

11.8 Elective Admissions Cancelled by the Trust

- All patients who have operations cancelled, on or after the day of admission (including day of surgery), for non-clinical reasons have the right to be offered another binding date within 28 days of the cancellation and within their RTT breach date
- No urgent operation should be cancelled for a second or subsequent time

12.0 MANAGEMENT WAITING LISTS

12.1 Responsibilities

To ensure that all patient details are kept up to date on the PAS system, all staff that have direct or indirect contact with the patient or their carers should ask the relevant questions that would ensure the latest contact details/ address and GP are recorded.

- It is the responsibility of clinicians and management teams to undertake regular review of all waiting lists to ensure that patient safety standards of care are not compromised, patients are managed in line with national waiting time standards, Trust data quality is of the required standard and that patients meet the criteria for being on the waiting list.
- Management teams are supported in this with access to Business Intelligence tools; up to date lists of patients waiting

12.2 Validation

Validation is the term applied to the systematic cleansing and review of waiting lists and has importance with regard to delivering the RTT standard which is one of the key national targets. The objective is to:

- Ensure that there has been the correct application of the RTT rules.

-
- To identify recurrent themes in poor data quality/entry
- To identify key individuals who consistently make errors when adding patients to the waiting lists, book appointments
- Provide support to one off projects around data quality

In addition, validation includes the process of checking to see that the patients who are due to have outpatient or inpatient appointments still require them e.g.

- Have they moved away?
- Has their condition improved so they no longer require the appointment?

This validation can be undertaken in two ways:

Administratively - by sending letters to or telephoning the patients.

Clinically - where the patient's clinical condition is reviewed, through a review of their clinical notes.

The patient Access Procedure Manual (G05a) describes the process that operational staff should follow and a standardised template letter to be sent to patients.

13.0 REFERENCES

National Operational Performance Standards for England in line with NHS Improvement – Everyone Counts: Planning for Patients 2014/15 – 2018/19. NHS England.

14.0 GLOSSARY

Admitted pathways	Patients whose 18 week pathway ends with an elective inpatient admission
ERS	Electronic referral system
Consultant to Consultant referrals	Referrals from one consultant to another either within the Trust or from one organisation to another.
DBS	Direct Booking Service (appointments made electronically via E-Referral).
DNA	Patients who “do not attend” an outpatient appointment or an admission to hospital without giving prior notice, however small.
IBS	Indirect Booking Service (paper referrals).
Inpatients	Patients who require elective admission to hospital for treatment or diagnostics and are intended to remain in hospital for at least one night.
PAS	Patient Administration System
Non-admitted pathways	All patients referred to the Trust to a consultant led service will commence on a non-admitted patient pathway.
Reasonable offer	A reasonable offer is an offer of two dates three or more weeks from the time that the offer was made.
RTT	Referral to Treatment –the period measured from the point a referral is received (paper based referrals) or the URBN is converted (E Referrals) to the time of first definitive treatment.
Tertiary referrals	Tertiary referrals received from a primary or secondary health professional, usually from outside of the local catchment area.
IPTMDS	Inter Provider Transfer Minimum Data Set