Patient Access Policy

Post holder responsible for Procedural Document	Chief Operating Officer
Author of Policy	Principal Access Analyst
Division /Department responsible for Procedural Document	Operations Support Unit
Contact details:	01392 406950
Date written:	17/02/2003
Impact Assessment Performed	**Yes**/ No
Ratifying body and date ratified:	Hospital Operations Board: 18/12/2015
Review date and (frequency of further reviews):	July 2018 (every 3 years or in line with changes to national guidance if earlier)
Expiry date:	December 2018
Date document becomes live:	29/01/2016

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		**Strategic Directions – Key Milestones**	
Patient Experience		Maintain Operational Service Delivery	✓
Assurance Framework	✓	Integrated Community Pathways	
Monitor/Finance/Performance	✓	Delivery of Care Closer to Home	✓
CQC Regulations/Outcomes:12		Infection Control	
Other *(please specify)*:			
Note: This policy has been assessed for any equality, diversity or human rights implications			

Full History:		Status: Final	
Version	Date	Author (Title not name)	Reason
1	17/02/2003	Performance Manager	To meet DoH Standards and Minor amendments
2	19/06/2008	Performance Manager	To meet DoH Standards and Minor amendments
3	14/06/2010	Principal Access Analyst	To meet DoH Standards and Minor amendments
4	01/09/2012	Principal Access Analyst	To meet DoH Standards and Minor amendments
5	18/11/2015	Principal Access Analyst	To meet NHS England Standards and Minor amendments

Associated Policies:	Safeguarding Children Policy Safeguarding Vulnerable Adults Policy PAS and NHS e-Referral Training Manuals PAS User Guide and NHS e-Referral User Guide Overseas Visitor Policy Cancer Services Operational Policy
In consultation with and date: Reviewed by Access Group: 25/11/2015 Head of Operational Performance and Information, Head of Access, Cancer Performance Manager, Admin Managers and ASMs via members of the Patient Access Group following meetings held during September – November 2015 Associated SOPS reviewed by core administrative staff groups (Medical Secretaries, ASMs, Booking Supervisors, Cancer Performance Manager) September – November 2015 North, East and West Devon CCG (NEW Devon) : 24/11/2015	
Review Date *(Within 3 years)*	18 December 2018
Contact for Review:	Angela Dash, Principal Access Analyst
Executive Lead Signature:	 Pete Adey

CONTENTS

INTRODUCTION

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 hospital services provided by the NHS.

The policy fully supports the strategic aims of the Five Year Forward View and requirement of the **NHS Constitution (2015)** helping to ensure that:

Patients' rights to access services within maximum waiting times are met, or for the NHS to take all reasonable steps to offer them a range of alternative providers if this is not possible.

The numbers of patients awaiting outpatient appointment, elective treatment, imaging or any other diagnostic test and the length of time they have waited, are accurately recorded and patients informed of their anticipated wait.

The successful management of waiting times for patients is the responsibility of all NHS staff. Service Commissioners must ensure that services are commissioned with sufficient capacity to meet the needs of the population. Clinicians, managers, secretarial and clerical staff have an important role in delivering a high quality, efficient and responsive service and managing waiting lists effectively.

Failure to comply with this policy could result in disciplinary action.

2. PURPOSE

2.1 The policy applies to the management of all waiting lists, held by the Royal Devon & Exeter NHS Foundation Trust (hereafter referred to as the Trust). Northern, Eastern and Western Devon Clinical Commissioning Group (CCG) will seek to implement this policy with other commissioned providers to facilitate common approaches where patients transfer between providers.

2.1.2 The policy establishes a number of principles and definitions and defines roles and responsibilities to assist with the effective management of waiting lists relating to outpatient appointments, elective treatment, imaging and other diagnostic tests. It will be subject to regular review to incorporate revised Department of Health (DoH) rules and to include changes in practice as a result of efficiencies identified from strategic redesign work across the Trust.

2.2 National Waiting Times

2.2.1 Providers must ensure that all patients are offered appointments within the nationally guaranteed maximum waiting times. Planning for this needs to be reflected in the annual Capacity Plan and meet the rights and pledges as laid out in the NHS Constitution.

2.3 Patient Choice

2.3.1 Patients are able to choose which provider they wish to attend from a national register. Where providers have services available on the NHS e-Referral Service

(NHS e-RS) they are required to offer appointments to patients that choose the hospital as their provider, where clinically appropriate.

2.4 Transparency

2.4.1 Communication with patients will be honest, informative, clear and concise with access to scheduled care transparent to the public. The letter to patients confirming their first outpatient appointment will include information on the patient's right to treatment within 18 Week as per the NHS Constitution 2015 . The policy will be published on the Trust's website (www.rdehospital.nhs.uk)and the NHS New Devon CCG website (**www.nhs new Devon CCG)** in due course.

2.5 Waiting Times Management

2.5.1 All additions to or removals from waiting lists must be made in accordance with this policy. Wherever possible, patients with the same clinical priority will be treated in chronological order. Patients should only be added to a waiting list when they are medically fit, ready and available for their treatment or investigation.

2.6 User Training

2.6.1 An appropriate training programme will support staff with special regard given to newly recruited and temporary staff. All staff involved in the implementation of this policy and associated procedures will undertake initial training and regular updates.

3. DEFINITIONS

3.1.1 The following definitions are provided to ensure a common understanding of the terms used through this document:

3.1.2 **Active Monitoring** (also known as Watchful Wait).**:** An 18-week clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage.
An RTT clock should only stop with active monitoring where there is clear intention that the patient's condition will be monitored, either through a future outpatient appointment or via a telephone consultation.

A new 18-week clock would start when a decision to treat is made following a period of active monitoring Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to refer the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such and also stops an 18-week clock.

If a patient is subsequently referred back to a consultant-led service, then this referral starts a new 18-week clock.

3.2 **Admission:** The act of admitting a patient for a day case or inpatient procedure

3.3 **Admitted pathway:** A pathway that ends in a clock stop for admission (day case or inpatient)

3.4 **Bilateral (procedure):** A procedure that is performed on both sides of the body, at matching anatomical sites. For example, removal of cataracts from both eyes.

3.5 **Care Professional:** A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002. **www.nhs reform and health care professions act 2002.**

3.6 **Clinical decision**: A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements.

3.7 **Clinical Exception**: Where a patient's treatment has not begun within 18 weeks due to a necessary sequence of diagnostic tests that for medical reasons could not be performed within a shorter period, this would be considered a clinical exception.

3.8 **Clock Start:** The date on which the Trust receives notice of a patient's referral or the date a consultant decides the patient is ready to proceed with treatment following a period of active monitoring.

3.9 **Clock Stop:** The date on which the patient receives the start of definitive treatment. This is decided by the Consultant responsible.

3.10 **Consultant:** A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. 18 weeks excludes non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.

3.11 **Consultant-led:** A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.

3.12 **Convert(s) their Unique Booking Reference Number (UBRN)**: When an appointment has been booked via the NHS e-Referral Service, the UBRN is converted. (Please see definition of UBRN).

3.13 **Cancer Waiting Times Tracker (CWT):** The electronic system used to record data for patients on a cancer or suspected cancer pathway.

3.14 **Day Case**: Patients who require admission to hospital for treatment and will need the use of a bed, but are not expected to stay in hospital overnight.

3.15 **Devon Referral Support Services (DRSS) :** Referral Management Centre arranging outpatient appointments for patients referred to secondary care.

3.16 **DNA – Did Not Attend:** Where a patient fails to attend an appointment/admission without prior notice.

3.17 **Decision to admit:** Where a clinical decision is taken to admit the patient for either a day case or inpatient procedure.

3.18 **Decision to treat:** Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatments performed in other settings e.g. as an outpatient.

3.19 **Directory of Services:** Electronic directory held on the NHS e-Referral System (NHS e-R) of consultant led services available at the Trust, which enables GPs to refer to the appropriate service within a speciality.

3.20 **Elective Waiting List:** Patients waiting elective admission for treatment and who are currently available to be called for admission.

3.21 **First definitive treatment:** An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes First Definitive Treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.

3.22 **Fit (and ready):** A new 18 week clock should start once the patient is fit and ready for a subsequent bilateral procedure. In this context, fit and ready means that the clock should start from the date that it is clinically appropriate for the patient to undergo that procedure, and from when the patient says they are available.

3.23 **Healthcare science intervention:** See *Therapy or Healthcare science intervention*

3.24 **Incomplete Pathways:** Patients on an 18 week RTT pathway who have not yet received the start of treatment for the condition which they were referred.

3.25 **Inpatient:** Patients who require admission to hospital for treatment and are intended to remain in hospital for at least one night.

3.26 **Interface service (non consultant-led interface service):** All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care.

The 18 week target relates to hospital/consultant-led care. Therefore, the definition of the term 'interface service' within the context of 18 weeks does not apply to similar 'interface' arrangements established to deliver traditionally primary care or community provided services, outside of their traditional (practice or community based) setting.

The definition of the term does not also apply to:
• non consultant-led mental health services run by Mental Health Trusts.
• referrals to 'practitioners with a special interest' for triage, assessment and possible treatment, except where they are working as part of a wider interface service type arrangements as described above.

3.27 **Last minute cancellations:** A hospital cancellation on the day the patient was due to arrive at hospital, after they have arrived, or on the day of operation.

3.28 **NHS e-Referral System:** A national electronic referral service that gives patients a choice of place, date and time for their first consultant appointment in a hospital or clinic

3.29 **Non-admitted pathway:** A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment'.

3.30 **Non consultant-led:** Where a consultant does not take overall clinical responsibility

for the patient.

3.31 **Original Date on List:** The date of the original decision to admit a patient to a healthcare provider for a given condition which results in the patient being placed on an elective waiting list.

3.32 **Outpatient:** Patients referred by a General Practitioner or other referrer for clinical advice or treatment in an Outpatient setting.

3.33 **Planned Admissions:** Patients who are to be admitted as part of a planned sequence of treatment or investigation. The patient has been given an approximate date the procedure will take place at the time the decision to admit was made.

3.34 Reasonable offer:

A reasonable offer is an offer of a time and date three or more weeks from the time that the offer was made. Two or more reasonable offers should be made.

3.35 **Referral**: This is a request for a care service, other than a specific diagnostic investigation or procedure, to be provided for a patient.

3.36 **Referral to Treatment (RTT) Period**: The part of a patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other 18 week clock stop point.

3.37 **Referral Management or assessment Service:** Referral management or assessment services are those that do not provide treatment, but accept GP (or other) referrals and provide advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient.

Referral Management and Assessment Services should only be in place where they carry clinical support and abide by clear protocols that provide benefits to patients. They must not be devices either to delay treatment or to avoid having clinical discussions with GP practices about good referral practice.

In the context of 18 weeks, a clock only starts on referral to a referral management and assessment service where that service may onward-refer the patient to a surgical or medical consultant-led service before responsibility is transferred back to the referring health professional.

3.38 **Straight to test:** A specific type of direct access diagnostic service whereby a patient will be assessed and might, if appropriate, be treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional.

3.39 **Substantively new or different treatment:** Upon completion of an 18-week referral to treatment period, a new 18-week clock starts upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan;

It is recognised that a patient's care often extends beyond the 18-week referral to treatment period, and that there may be a number of planned treatments beyond first definitive treatment.

However, where further treatment is required that was not already planned, a new 18-week clock should start at the point the decision to treat is made.

Scenarios where this might apply include:

• Where less 'invasive/intensive' forms of treatment have been unsuccessful and more 'aggressive/intensive' treatment is required (eg where Intra Uterine Insemination (IUI) has been unsuccessful and a decision is made to refer for In Vitro Fertilisation (IVF) treatment);

• patients attending regular follow up outpatient appointments, where a decision is made to try a substantively new or different treatment. In this context, a change to the dosage of existing medication may not count as substantively new or different treatment, whereas a change to medication combined with a decision to refer the patient for therapy might.

Ultimately, the decision about whether the treatment is substantively new or different from the patients agreed care plan is one that must be made locally by a care professional in consultation with the patient.

3.40 **Therapy or Healthcare science intervention**: Where a consultant-led or interface service decides that Therapy (for example physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science (e.g. hearing aid fitting) is the best way to manage the patient's disease, condition or injury and avoid further interventions.

3.41 **Tolerance:** The waiting time standards set the proportion of RTT pathways that must be within 18 weeks. These proportions leave an operational tolerance to allow for patients for who starting treatment within 18 weeks would be inconvenient or clinically inappropriate. These circumstances can be categorised as:

- Patient choice – patients choose not to accept earliest offered appointments along their pathway or choose to delay treatments Co-operation – patients who do not attend appointments along their pathways
- Clinical exceptions – where it is not clinically appropriate to start a patient's treatment within 18 weeks

3.42 **UBRN (Unique Booking Reference Number):** The reference number that a patient receives on their appointment request letter when generated by the referrer through the NHS e-Referral Service. The UBRN is used in conjunction with the patient password to make or change an appointment.

3.43 **Watchful Waiting:** see Active Monitoring

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 Role of the Chief Executive

4.1.1 The overall and final responsibility for this policy in the Trust rests with the Chief Executive.

4.2 Role of the Executive Lead for Access (Operations Director)

4.2.1 Board level accountability for Access Standards and Waiting Times and associated service delivery.

4.2.2 Ensuring that the Key Performance Indicators related to Access Standards and Waiting Times targets are achieved.

4.2.3 Delegation of responsibilities relating to provision of Outpatient and Elective services.

4.2.4 Effective support of managerial decisions and recommendations to ensure provision of appropriate resources.

4.3 Role of the Access Group

4.3.1 To provide assurance to the Operations Director that national access targets are being monitored.

4.3.2 Ensuring effective action is taken to enable the successful operational delivery of the key access targets by reviewing divisional and trust performance, identifying common themes or trends to take forward.

4.3.3 Ensure that operational risks in relation to access targets are being actively managed.

4.3.4 Ensure that any recovery plans are understood and being delivered.

4.3.5 To ensure there is a systematic process underpinning the performance monitoring of access targets.

4.4 Role of Divisional Management teams and Cluster Managers

4.4.1 Working with clinical and administrative teams within the division to monitor capacity and demand for services and support performance in access to deliver national targets and ensure a positive patient experience.

4.4.2 Notify the Access Group if they are unable to identify and organise additional capacity when it is required and may result in breaches.

4.4.3 Chair Patient Tracking List (PTL) meetings for their area, challenging and resolving any avoidable delays as appropriate.

4.4.4 Identifying the need for additional activity required to meet the demand.

4.4.5 Liaison with the relevant teams to ensure booked dates in the future are brought forward where possible, to prevent a breach.

4.5 Role of the Central Performance Team and Information Services

4.5.1 Monitor compliance with the Access Standards and Waiting Times targets in line with the Trust's Key Performance Indicators.

4.5.2 Provide reports on high level Referral to Treatment and Access Standards performance and patient level detail on a regular basis to the relevant internal teams, including trend data to the CCG.

4.5.3 Upload the National Returns to Unify on a monthly basis in line with nationally directed deadlines.

4.5.4 Provide activity and performance forecasts to Specialties to aid capacity planning for the future.

4.6 Role of All Staff Groups

4.6.1 Admin Service Managers and Admin Line Managers are responsible for ensuring that information is recorded accurately and in a timely manner.

4.6.2 All administrative staff, but specifically Medical Secretaries, Ward Clerks, Booking staff and Receptionists, are responsible for recording information accurately and timely in accordance with this Policy.

4.6.3 Clinicians are responsible for advising on the clinical priority of each patient and for indicating this to enable the correct recording of data on the patient pathway.

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

4.7 Referrer Responsibilities – Cancer – (Cancer Services Operational Policy)

Primary Care clinicians will not refer patients who are not available for appointments within two weeks and will inform the patient that they are referring them for a diagnosis of suspected cancer. The quality of suspected cancer referrals needs to be subject to regular audit, with appropriate feedback to GPs and the relevant training put in place where required. Referrals received by the Provider will be added to and monitored via the CWT Tracker, within one working day of receipt.

4.3 Provider Responsibilities – Cancer (Cancer Services Operational Policy)

Patients who are referred to the Trust via a 2 Week Wait suspected cancer route will receive their first treatment as follows:

- no more than 62 days from receipt of referral from GP, consultant upgrade, or screening referral (31 days for leukaemia, testicular and children's cancers)
- no more than 31 days from decision to treat for first treatments
- no more than 31 days from decision/fit to treat date for subsequent treatments

- All patients with breast symptoms, where cancer is not suspected, will wait no more than two weeks from urgent GP referral to first appointment.

5. 18 WEEK REFERRAL TO TREATMENT

5.1.1 A patient's waiting time is calculated from the date of receipt of the new referral or when the Unique Booking Reference Number is converted (if appointment is booked through NHS e-RS), to start of definitive treatment, start active monitoring or discharge if no treatment is necessary. Treatment is defined as the start of the first treatment that is intended to manage the patient's disease, condition or injury (this might include a period of active monitoring). **See Appendix 1**

5.1.2 The right to treatment within 18 weeks from referral will cease to apply in circumstances where the patient may chose to wait longer or delaying the start of treatment is in the best clinical interest of the patient, for example where smoking cessation or weight management is likely to improve the outcome of the treatment. Similarly where it is to a necessary for the patient to undergo a sequence of diagnostic tests that for medical reasons could not be performed within a shorter period, this would be considered a clinical exception.

We recognise that patients not on an 18 week RTT pathway will still be managed in accordance with this policy and delays will be eliminated wherever possible.

6. WAITING TIMES AND TARGETS – see *Guide to waiting times*

6.1 The NHS Constitution 2015 brings together the principles, values, rights and pledges that underpin the NHS. It supports patients, the public and staff by clearly setting out their legal right.

6.1.1 The pledge is 'to provide convenient, easy access to services within the waiting times set out in the handbook to the NHS Constitution which states that: 'patients can expect to start their consultant – led treatment within a maximum of 18 weeks from referral for non-urgent conditions unless they choose to wait longer or it is clinically appropriate that they do so'.

6.1.2 For patients with suspected cancer, the waiting times standard is 'a maximum 2 week wait to see a specialist' from GP referral, unless the patient chooses, despite the urgency of the referral, to wait longer.

6.1.3 Patients' right to treatment within 18 weeks applies to all Consultant led services.

6.1.4 If a patient feels concerned that they will or have been waiting longer than 18 weeks, the patient should contact their local CCG who are responsible for commissioning services from the Trust.

7. DATA QUALITY

7.1.1 All targets are reliant on good quality data entry. It will be the responsibility of all staff involved in supporting the patient journey to collect and accurately record this data, i.e. clinician, medical secretary, admin and clerical staff.

7.1.2 All clinicians will be responsible for the completion of an RTT outcome on the Patient Administration System (PAS) system for all outpatient appointments, within one

working day. Where a decision is made outside a clinical event that affects a RTT clock, then the RTT outcome will need to be recorded on PAS using a generic event.

This is necessary to ensure the information is captured about the decision to treat, not to treat or active monitoring which in turn affects whether a clock has stopped or treatment is about to start.

7.1.3 Regular audits will be undertaken to assess the comprehensiveness and quality of data collected. Concerns will be raised immediately with the Cluster Manager accountable for data collection and escalated to the Divisional Business Manager if appropriate.

8. CONSULTANT/CLINICAL NURSE SPECIALIST/ALLIED HEALTH PROFESSIONAL (AHP) ANNUAL LEAVE

8.1.1 It is expected that for planned cancellations of scheduled clinical commitments at least six weeks' notice is given to provide as much notification as possible to patients and minimise the amount of re-work caused to administration staff.

8.1.2 In exceptional circumstances where it is not possible to provide six weeks' notice, leave must be authorised by the Divisional Business Manager, with the clinician and Service Lead working together to ensure appropriate re-provision of services.

9. OUTPATIENT BOOKING PROCESSES

9.1 Referrals

9.1.1 The CCG and Providers will work together to ensure that all referrals are made to the most appropriate Service.

9.1.2 Primary Care clinicians will only refer patients who are fit, ready and able to attend an appointment or treatment.

9.1.3 All referrals must include an NHS Number and full demographic details including age, gender and marital status, daytime, evening and mobile telephone numbers (where available), to ensure the patient can be contacted promptly, together with any specific requirements that may be needed. For example patients who have English as a second language, or require a sign language interpreter

9.1.4 All referrals will be entered onto Providers electronic or paper systems within one working day of receipt.

9.1.5 GP referrals will be booked through NHS e-RS via the Devon Referral Support Service (DRSS) following the guidelines below:

- Patients are requested by GPs to wait a minimum of 3 days after the date of their GP appointment before telephoning DRSS
- DRSS will ensure the referral letter is attached before booking an appointment

- If the referral letter is not attached to Choose and Book when the patient phones, DRSS will contact the practice and then contact the patient to make an appointment following the letter becoming available.

9.1.6 If the patient has specified a consultant, DRSS will honour this request where clinically appropriate.

If the patient is referred to an inappropriate service or clinician within a speciality the referral shall be redirected to an appropriate service or clinician within the same speciality if this is available. Delays to this process are to be kept to a minimum as the RTT clock continues to run from the original date of receipt of referral. Where the referral is inappropriate this will be rejected (see Rejected Referrals – Section 10.3).

9.1.7 Where it is not possible to offer an appointment at the time of receiving the referral , this will be added to the Outpatient Pending List and the patient informed they will be offered an appointment as soon as clinically appropriate.

The Trust will offer dates with 3 weeks' notice, or more. Patients will not be penalised where they are unable to accept short notice appointments.

9.2 NHS e-Referrals (NHS e-RS) Standard Operating Procedure PN07

9.2.1 NHS e-Referrals provides direct access for patients with GP referrals, to arrange their appointment direct from the GP surgery, on-line, or by telephone contact with the National Appointment Line. For Devon patients, booking will be via DRSS.

9.2.2 A Directory of Services (DoS), listing all outpatient services provided by each organisation is published and reviewed annually to provide GPs with adequate information to ensure referral to the correct service.

9.2.3 Patients should be offered an appointment with an appropriate Consultant/Clinician with the shortest wait.

9.3 Rejected Referrals Standard Operating Procedure PN06

9.3.1 If a referral has been made through CAB and the service selected does not meet the needs of the patient, the referral should be returned to Primary Care. For these rejections DRSS will receive an electronic notification to inform the patient of the rejected referral. In this circumstance, the referrer must then re-refer the patient to an appropriate service without delay.

9.3.2 Clinician to Clinician referrals are appropriate when:

- The onward care of the patient is part of a pathway for which the original referral was received.
- The patient needs to be managed under a cancer pathway (Consultant Upgrade) as delay in sending the patient back to the GP would be inappropriate.

If the patient does not fulfil either of the above criteria, the consultant should direct the patient back to their GP with the appropriate advice.

9.4 Paper Referrals Standard Operating Procedure PN09

Where paper referrals are received the Trust will monitor such patients and ensure they are allocated appointments within 5 working days of receipt. Designated administrative staff will monitor pending list patients, via IM&T Waiting Time reports, escalating concerns over timeliness of grading to the Admin Services Manager responsible for the service.

9.5 Advice and Guidance (A&G)

A&G services are currently being developed. This policy will be updated once the details have been agreed.

9.6 Clinical Assessment Services (CAS)

CAS are the route of referral for the following specialties:

- Orthopaedics – Spinal, Foot and Ankle and a joint Hand and Wrist service with Plastic Surgery
- Endocrinology
- Gastroenterology
- Respiratory
- Cardiology
- Ophthalmology – Minor Ops and Paediatrics

This allows the Consultant to review the referral letter and decide if the patient is to have an investigation or an outpatient appointment. Referral letters will be graded within 5 working days and appointments booked within 14 days. Patients will receive an appointment direct from the Trust, and an 18 week clock will start.

9.7 Grading of Referrals Standard Operating Procedure PN05

9.7.1 NHS e-Referrals will be graded online by the clinician within 5 working days. If, after 5 working days the clinician has not graded the referral, the Booking teams will accept the referral on the clinicians' behalf, into the service chosen by the referrer.

9.7.2 Adequate cover arrangements must be in place to ensure the timely grading of electronic and paper referrals by consultants or a member of their team.

9.7.3 If the first outpatient appointment is not made through e-RS, the Clinician will review the paper referral within 5 working days. The patient will be offered the first available appointment and if the patient accepts, that will be considered as a reasonable offer. If the patient is unable to accept two reasonable offer of dates the patient should be appointed for a date of their choosing and the delay recorded as 'Patient Choice' on their RTT pathway.

9.8 Outpatient Follow Up Appointments **Standard Operating Procedure PN04.PN10**

9.8.1 When requesting further outpatient appointments, clinicians should specify the clinical requirement and timescale for the patient to be seen within.

9.8.2 Best practice is to agree an appointment with the patient at the time. However where appropriate, patients offered an appointment more than six weeks ahead should be

added to a PAS Pending List.

9.8.3 Services may choose to have a partial booking system in place to reduce the number of appointment cancellations of scheduled follow up slots.

9.8.4 Wherever possible, the booking process will take into account the individual requirements for appointment times i.e. elderly patients not offered early morning slots.

9.8.5 If after discharge a patient feels they wish to be seen again, the patient should be re-referred by the GP/GDP.

9.8.6 Consultants/Clinicians will consider the clinical appropriateness before offering 'open appointments' to patients.

9.9 Slot Availability Standard Operating Procedure PN08

9.9.1 Providers should regularly review available capacity, both on the DoS for first appointments and on clinic schedules for follow up appointments to prevent appointment slot issues (ASIs) occurring.

9.9.2 e-RS patients who contact DRSS or the national booking line to arrange an appointment but find that no slot is available, are advised they will hear from the Trust within 10 working days with the offer of an appointment. The Appointments Line (TAL) or DRSS contact the Trust via the 'Defer to Provider' option on e-RS providing details of the patient and the service requested.

9.9.3 It is the responsibility of Divisions to identify a suitable slot, within 5 working days of receiving the request as the RTT clock is ticking from the date the patient attempted to arrange the appointment.

9.9.4 All other referrals where capacity is an issue will be actioned within the same timescale and process.

9.10 Patient Cancellations Standard Operating Procedure PN13**,** Cancer Services Operational Policy

9.10.1 The Trust will ensure local systems are in place to enable patients to communicate their cancellation before it becomes a DNA. This will include information on all first appointment letters, informing patients that they risk being discharged back to their GP if they cancel an appointment more than once.

9.10.2 Patients who cancel and re-book any outpatient or diagnostic appointment two or more times will be discharged and their GP/GDP informed unless it is clinically inappropriate or reasonable notice of the appointment wasn't given.

9.10.3 Where a patient with suspected cancer cancels their appointment, they should not be referred back to the GP/GDP after two or more cancellations unless this has been agreed with the the patient following discussion with the clinician to whom the patient has been referred. Clinicians must ensure that any decision to refer back to the GP/GDP is in the best interest of the patient.

9.10.4 If patients cancel with no further appointment required they will be discharged back to the referrers care with the consultant and GP/GDP being informed. The 18 Week pathway will be updated to stop the clock as the patient has declined treatment.

9.11 Hospital Outpatient Cancellations Standard Operating Procedure PN14

9.11.1 In order to maintain clinical safety the Trust will make every possible effort to ensure that outpatient appointments are not cancelled.

9.11.2 Clinicians will be expected in all but exceptional circumstances to give a minimum of 6 weeks' notice of any outpatient session to be cancelled.

9.11.3 In circumstances where short notice cancellations are unavoidable, the clinician will be expected to work with the appropriate manager to arrange cover or offer an additional clinic session within an acceptable timescale in order to maintain waiting times.

9.11.4 Where appointments do need to be cancelled or changed, the Trust will aim to provide patients with a minimum of 5 weeks' notice.

9.11.5 Patients should be re-booked as close to their original appointment date as possible as the RTT clock remains ticking.

9.11.6 When patients have chosen an appointment at a specific site and the clinic is subsequently cancelled, care must be taken to ensure patients are still treated in an acceptable timescale in order to maintain waiting times. This may require patients being seen at alternative sites as patient choice relates to the provider and not the site on which the provider holds the clinic.

9.11.7 Wherever possible, patients who have been cancelled previously should not be cancelled for a second time.

9.12 Patients Who Do Not Attend a First Outpatient Appointment Standard Operating Procedure PN11, Cancer Services Operational Policy

9.12.1 The 18 week clock rules states that if a patient DNAs their first appointment, including straight to test, after initial referral, they will have their clock nullified and the referral returned to the GP/GDP as long as the Trust can demonstrate that the appointment offer was clearly communicated to and received by the patient. A new clock starts on the date a subsequent referral is received.

9.12.2 The DNA Reminder Service reminds patients of future appointments, seven days in advance, providing them with the opportunity to change or cancel their appointment before it becomes a DNA.

9.12.3 The 18 Week rules for DNAs do not differentiate between adults and children. However, consideration should be given to allocating a second appointment, before discharging children, vulnerable adults, cases of clinical urgency, i.e. two week wait patients or others as clinically indicated. In this instance, the RTT clock will be reset to the date of the DNA. Providers need to ensure this is reflected in the Safeguarding Children and Safeguarding Vulnerable Adults policies**.**

9.12.4 The rebooking of patients who DNA on two or more occasions should be considered on a case by case basis.

9.12.5 Where a cancer patient DNAs their initial outpatient appointment, they will be offered a further appointment within two weeks of the DNA and the clock start date reset. If the patient DNAs twice in a row they will be referred back to the care of their GP/GDP. Clinicians must ensure that any decision to refer back to the GP/GDP is in the best interest of the patient.

If a cancer patient DNAs a diagnostic test appointment twice the diagnostic department will contact the patients Consultant and the cancer services team to inform them of the DNAs, the Consultant will then make contact with the patient and discuss the need for the tests before informing the GP that they have been unable to progress the pathway and need to consider their view on discharging back to the care of the general practitioner

9.13 Patients Who Do Not Attend a Follow Up Appointment Standard Operating Procedure PN11, Cancer Services Operational Policy

9.13.1 Patients who DNA a follow up appointment, will be discharged back to the care of their GP/General Dental Practitioner (GDP), provided that the Trust can demonstrate that the appointment was clearly communicated to the patient and that discharging the patient is clinically agreed. The DNA Reminder Service reminds the patient of future appointments, seven days in advance and provides them with the opportunity to change or cancel their appointment before it becomes a DNA.

Patients with cancer or suspected cancer should not be referred back to the GP/GDP after two or more cancellations unless this has been agreed with the patient following discussion with the clinician to whom the patient has been referred. Clinicians must ensure that any decision to refer back to the GP/GDP is in the best interest of the patient.

9.13.2 Clinically urgent appointments, cancer fast track patients, some vulnerable adults and paediatric patients will not be discharged but have a further appointment made. The 18 week clock will continue to tick from the original start time.

9.14 Prior Approvals Policy (NEW Devon CCG - IFR Process)

9.14.1 The CCG has a Prior Approvals Policy, incorporating its Low Priority Policy and Policy on Limited Clinical Effectiveness. This identifies treatments that may not be routinely funded and describes for each example what process to follow. Where it is clear at the point of referral that the referral is for a 'restricted' condition it is the responsibility of the referrer to follow the policy and ensure authorisation is gained prior to making a referral to secondary care.

9.14.2 DRSS will be asked to ensure this policy is followed. However any referral being received in secondary care that is clearly covered by the Prior Approval Policy should be rejected (and the 18 week clock nullified) and returned to the referrer with advice for them to follow the Prior Approval Policy.

9.14.3 In many cases it is not possible to determine whether the treatment is covered by the Prior Approval Policy until after initial assessment. The 18 week clock will continue to 'tick' during the time taken to gain funding approval. For cases referred to the Exceptional Treatments Panel they will seek to confirm within 1 week of receipt if the request, providing full supporting information has been received with the request.

Referrals going to the Restricted Treatments Panel are currently only reviewed on a monthly basis, however it is expected that these will be identified prior to referral, i.e before a clock has been started. For cases that require a significant review of evidence before a funding decision can be made it is expected that the tolerance for clinical complexity will be sufficient to ensure targets are not breached.

9.14.4 The list of procedures that requires prior approval is not a fixed list and will be added to over time as NICE recommendations and local decommissioning develop further.

It is important that clinicians and business managers periodically review the list to prevent the RD&E completing procedures that the CCG may not have commissioned or subsequently refuse to fund.

10. INPATIENT AND DAYCASE WAITING LISTS

10.1 Additions to Waiting List Standard Operating Procedure PN15

10.1.1 The decision to add a patient to a Waiting List must be made by a Consultant or appropriate clinician jointly with the patient. The date this decision is made is the "original decision to admit" date.

10.1.2 A patient should only be placed on a waiting list for surgery once they have accepted the advice of the Consultant/Clinician to have treatment and are fit, willing and able to proceed with surgery.

10.1.3 Accurate data recording is essential to ensure that waiting list entries are linked to the correct RTT pathway to enable the effective monitoring of patients.

10.1.4 Patients who are considered as short-term medically unfit for surgery, e.g. patient has a cold but expects to be medically fit within 14 days, will be added to a waiting list and booked at a time when they are likely to be fit. The RTT clock will remain ticking.

10.1.5 Long term medically unfit patients are those suffering from a condition which prevents the continuation of treatment and unlikely to be resolved in less than 14 days. If deemed appropriate by the Consultant/clinician, the patient will be discharged back to Primary Care and re-referred when clinically ready. A new RTT clock would start at the point of re-referral.

10.1.6 If a patient is undecided whether to proceed with treatment, they are given up to 14 days to make that decision during which time the RTT clock will still tick. If after 14 days the patient has not decided whether to proceed with treatment this starts a period of patient initiated active monitoring, which is a clock stop event.
Patients on active monitoring will be reviewed within 3 months when the decision will be made on whether they are to proceed with treatment. Dependent upon the clinical circumstances of the individual patient they may be discharged to GP/GDP care.

10.2.1 **Reasonable Offer of Notice for Admission** Standard Operating Procedure PN16,
Cancer Services Operational Policy

10.2.2 A reasonable offer is defined to be an offer of a time and date 3 or more weeks from the time that the offer was made Two dates should be offered to the patient with any appointment agreed between the Trust and the patient within this definition automatically considered to be reasonable.

10.2.3 If the patient declines the offer of two reasonable dates, with three weeks' notice, but they are able to accept a TCI within six weeks of contact, the patient is to be dated at that time. If the patient is near to their 18 week Treat By Date, this may result in them becoming a breach, which the Trust will need to accept.

10.2.4 If the patient is not willing to accept any dates and declines any further treatment they will be discharged on clinical grounds and their GP/GDP informed. However they may wish to delay their treatment and may be transferred to a deferred list (see 10.3) The RTT clock will stop as the patient has declined treatment.

10.2.5 Patients may be offered and choose to accept dates earlier than the 3 week reasonable offer notice period.

10.2.6 The notice of admission date will be shorter for cancer patients to ensure they are treated in a timely manner. If the patient does not accept the first reasonable choice of date the clock will be suspended during the period of patients' unavailability and restarted again when the patient becomes available. For patients under the 31 day or 62 day standard, 'reasonable' is classed as any offered appointment between the start and end point of 31 or 62 day standards.

10.3 Patient initiated Delays Standard Operating Procedure PN17

10.3.1 Many patients will choose to be seen at the earliest opportunity. However, 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.

10.3.2 If the patient wishes to delay surgery, i.e. school teacher, the patient is transferred if clinically appropriate and in their best interest from the elective waiting list to the deferred waiting list and not returned to their GP/GDP. The period of delay may differ from patient to patient but in choosing the length of delay, the patient is in effect initiating their own active monitoring against their condition. There is no blanket rule against the length of delay, but good practice and clinical decision will guide how long the patient can remain on a deferred list.

10.3.3 Deferred waiting lists must be monitored in conjunction with active waiting lists to ensure that patients are not inappropriately de-listed and are not unjustly penalised for wishing to defer treatment. These patients would need to be dated as close to their available date as possible.

10.4 Planned Waiting Lists Standard Operating Procedure PN18

10.4.1 Patients should only be included on planned waiting lists if there are clinical reasons why they cannot have the procedure or treatment until a specified time. In these cases a personal treatment plan should be agreed between the clinician and patient.

10.4.2 This includes patients who are waiting for a planned diagnostic test or treatment or a series of procedures as part of their treatment plan and which for clinical reasons are to be carried out at a specific time or repeated at a specific frequency.

10.4.3 Patients on a Planned waiting list will be treated in the planned month as agreed in their personal treatment plan. Where it isn't possible for the patient to be seen within the planned month, it will be raised with the clinician responsible, who will review the patient history and where clinically appropriate he/she may decide to revise the date of the planned procedure. The GP and patient will be notified of the clinical decision to alter the date of the planned procedure. If the GP has concerns over the revised date, this will be discussed with the clinician and a consensus reached.

10.4.4 These patients are outside the scope of 18 weeks.

10.5 Multiple Procedures Standard Operating Procedure PN19

10.5.1 Patients who require bilateral procedures relating to the same reason for referral, i.e. two cataracts should be offered a date for the second procedure at follow up or when clinically appropriate (when they are fit and ready) and a new 18 week pathway will commence.

10.5.2 If the need for the second treatment is identified separately from the first, a new 18 week clock starts for the second.

10.6 Hospital Cancelled Operations Standard Operating Procedure PN20

10.6.1 The hospital will only cancel a patient's admission when it is not possible to carry out the procedure with particular consideration being given to patients who have been previously cancelled.

10.6.2 Where a patient needs to be cancelled for a second occasion this must be authorised by a Divisional Business Manager. Cancellations for a third occasion must be authorised by Chief Executive or designated Director.

10.6.3 Patients cancelled on the day of their operation for non-medical reasons must be given a new TCI date within 28 days of cancellation. PAS is to be updated at the time of the patient being notified of the cancellation and not at a later date. The patient will normally be given a new admission date on the day of cancellation or breach date, whichever is sooner. Where this is not possible, patients should be contacted within three working days of their cancellation date to agree a further suitable date.

10.6.4 If the dates offered are not within 28 days, the patient will have the choice of having treatment elsewhere, including an independent sector provider but may choose to remain with the local Trust. In such cases, the responsibility remains with the Trust to offer a new date, within 28 days. The Trust must comply with the patient's wish as the 18 week clock remains ticking.

10.7 Patient Cancellations Standard Operating Procedure PN21

10.7.1 If a patient has previously agreed to a reasonable offer date for admission for treatment which they subsequently cancel, this should be managed in the same way as patient choice and not regarded as a cancellation.

10.7.2 Patients who cancel two agreed admission dates will be removed from the waiting list and their GP/GDP informed, provided that reasonable offer of admission date was agreed with the patient and not detrimental to the patients care. The 18 week pathway will be updated to stop the clock as the patient has declined treatment.

10.8 Patients Who Do Not Attend (DNA) Standard Operating Procedure PN22, Cancer Services Operational Policy

10.8.1 All patients should be offered 2 reasonable dates with a minimum of 3 weeks' notice. Patients who fail to attend on the day of admission will be referred back to the GP/GDP and removed from the waiting list provided the date was clearly communicated to and received by the patient. The notice of admission date will be shorter for cancer patients to ensure they are treated in a timely manner.

10.8.2 The 18 week pathway will be updated to stop the clock as the patient has declined treatment. The 18 Week rules for DNAs do not differentiate between adults and children. However, consideration should be given to allocating a second date, before discharging children, some vulnerable adults, and cases of clinical urgency. In this circumstance the 18 week clock will still be ticking. Providers need to ensure this is reflected in the Vulnerable Adults and Safeguarding Children policies. If it is deemed appropriate to offer a second admission date and the patient again fails to attend, they will be removed from the waiting list and no further dates offered. The GP/GDP will be informed and the 18 week RTT clock will stop as the patient has declined treatment. The reason for allocating a further admission date must be recorded. The rebooking of patients that DNA on two or more occasions should be considered on a case by case basis.

10.8.3 Where a cancer patient DNAs their admission, they will be offered a further date within two weeks of the DNA. If the patient DNAs an admission twice in a row they will be referred back to the care of their GP/GDP

11. PATIENTS WITH SUSPECTED CANCER Cancer Services Operational Policy

Please refer to the RD&E Cancer Services Operational Policy for definitions and additional information to support the Standard Operating Procedures on how the Trust manages access to its services to ensure fair treatment for all patients with a suspected or confirmed diagnosis of cancer. Further detail of the cancer guidance supporting these documents can be found in Cancer Waiting Times a Guide (version 9.0).

11.1 Cancer Waiting Time

The current national standards relating to cancer are as follows:

- 2 weeks from urgent General Practitioner or Dental Practitioner (GP/GDP) referral for suspected cancer to first outpatient attendance.
- 2 weeks from symptomatic breast referral (cancer not suspected) to first outpatient attendance. 31 days from decision to treat to first definitive treatment for cancer

- 31 days from decision to treat or earliest clinically appropriate date to subsequent treatment (surgery, drug or radiotherapy) for all cancer patients including those with a recurrence.
- 62 days from urgent GP referral for suspected cancer to first definitive treatment for cancer (31 days for suspected Children's cancers, Testicular cancer, and Acute Leukaemia).
- 62 days from referral from NHS Cancer Screening Programmes (Breast, Cervical and Bowel) to first treatment for cancer.
- 62 days from a Consultant's decision to upgrade the urgency of a patient (e.g. following a non- urgent referral) to first treatment for cancer.

Commitment (As specified in published National Statistics data – where applicable)	**Operational Standard**
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	85%
62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	90%
62-Day Wait For First Treatment From Consultant Upgrade : All Cancers	85%
31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	96%
31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	98%
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	94%
All Cancer Two Week Wait	93%
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	93%

12. PRIVATE PATIENTS Standard Operating Procedure PN12

12.1.1 The DH Code of Conduct for Private Practice (Jan 2004) states that:

- Any patient seen privately is entitled to subsequently change his or her status and seek treatment as a NHS patient;
- Any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status;
- Patients referred for an NHS service following consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service;
- Their priority on the waiting list should be determined by the same criteria applied to other NHS patients

12.1.2 An RTT clock will start on the day the provider of NHS care accepts clinical responsibility for the patientPaper referrals are to be date stamped with the date of receipt, as this is the date the RTT clock commences. When this transfer takes place between providers the referral letter should be accompanied by an Inter Provider Transfer. When the transfer takes place within a provider (a provider who provides both NHS and private care) the date of the transfer needs to be clearly documented in the patient's medical record, both hard copy and electronic.

12.1.3 Patients who have been seen privately and subsequently transfer to the NHS for inpatient/daycase treatment will have their 18 week clock start at the point at which clinical responsibility for the patient's care transfers to the NHS.

12.1.4 The date of decision to admit is recorded as the date the letter is received and date stamped on receipt, from the private rooms. An Inter-Provider Transfer form should be received with the referral letter.

13. OVERSEAS VISITORS (Overseas Visitors Policy)

13.1.1 The National Health Service (NHS) provides healthcare free of charge to people, who are ordinarily resident in the United Kingdom (UK). People who do not usually live in the UK are not automatically entitled to use the NHS free of charge. Residency is therefore the main qualifying criterion, applicable regardless of nationality, ethnicity or whether the person holds a British passport, or has lived and paid taxes or National Insurance contributions in the UK in the past.

13.1.2 The charging regulations place a legal obligation on NHS Trusts in England to establish if people to whom they are providing NHS hospital services are not normally resident in the UK. If they are found not to be ordinarily resident in the UK then charges may be applicable for the NHS services provided. In these cases the Trust must charge the person liable (usually the patient) for the cost of NHS services.

14. INTER PROVIDER TRANSFERS Standard Operating Procedure PN02

14.1.1 All referring organisations must provide a minimum dataset to the receiving organisation to allow the monitoring of a patient's progress along an 18 weeks pathway where care has been transferred between providers.

14.1.2 An inter-provider form is to be completed and sent with the referral letter via an NHS.net account, to the receiving organisation within 2 working days of decision to refer.

14.1.3 When an inter-provider transfer is received into an organisation, the RTT clock is updated to the date that the original Trust received the referral. Data must be provided between organisations and recorded on the relevant electronic systems as the clock remains ticking until such time as the start of definitive treatment.

14.1.4 Transfers to alternative providers, in order to meet waiting times requirements, must always be with the consent of the patient. The original date of referral is passed to the receiving provider as the clock remains ticking until such time as the start of definitive treatment.

14.1.5 If the patient does not wish to be transferred to another provider, the Trust must ensure the patient is admitted for treatment in compliance with their 18 Week pathway. If the organisation does not provide the treatment required and the patient doesn't wish to be transferred, the patient is referred back to the care of their GP/GDP.

14.1.6 For suspected cancer patients on the 31 or 62 day pathway the referral letter should be faxed (highlighted '2 week wait' where appropriate, and the breach date given) to the receiving clinician. The inter-trust referral should be notified using the cancer referral protocol dataset to the nhs.net address at the Trust.

15. ARMED FORCES COMMUNITY Standard Operating Procedure PN23, Armed Forces Covenant

15.1.1 In line with the Armed Forces Covenant, the Trust will ensure that members of the Armed Forces Community (including those serving, reservists, their families and veterans) are supported, treated equally and receive the same standard of and access to healthcare as any other UK citizen in the area they live.

15.1.2 Referrers should make it clear that the patient is a member of the Armed Forces Community.

15.1.3 Armed Forces Community should retain their relative position on any NHS waiting list, if moved around the UK due to the Service person being posted, however they should not be given priority over other patients with more urgent clinical needs.

15.1.4 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 need.

16. ARCHIVING ARRANGEMENTS

The original of this policy will remain with the author, Principal Access Analyst, Operations Support Unit. An electronic copy will be maintained on the Trust Intranet (A-Z), Trust Policies – A – Access Policy. Archived copies will be stored on the Trust's archived policies shared drive and will be held for 10 years.

17. PROCESS FOR MONITORING COMPLIANCE AND ACCOUNTABILITY AND THE EFFECTIVENESS OF THE POLICY

17.1.1 The Trust will maintain effective performance monitoring systems to ensure implementation of the policy.

17.1.2 It is expected that each service will develop internal monitoring to ensure that the policy is adhered to. This will include the monitoring of waiting times for follow up appointments.

17.1.3 In order to manage Key Performance Indicators, the Information Department will provide Clinical Divisions with regular reports including Patient Tracking Lists, Incomplete Pathways, Cancer Performance Dashboard and Diagnostic Waits. In addition, compliance monitoring reports will be provided for the following areas:

- Outpatient DNAs, for both new and follow-up appointments, where further appointments have been allocated
- Clinic appointments where the outcome has been left as 'Open'
- Outpatient cancellations, both patient and hospital where further appointments have been offered
- Inpatient DNAs where further TCI (To Come In) dates have been allocated

17.1.4 Data Quality i.e. missing RTT Status, and Unknown to Follow Up reports are provided to the Patient Access meeting and via Pivot tables and Business Intelligence (BI) Reports. Further reports may be required, as agreed with the Information Manager, to assist Clinical Divisions in achieving the required standards of this Policy.

17.1.5 The Information Department will be responsible for providing timely, consistent and relevant information to manage effective waiting lists and highlight any concerns about waiting times directly with the nominated contact for each service.

17.1.6 Divisions are expected to review and act upon the information provided to ensure that patients are treated in order of clinical priority and then in chronological order.

17.1.7 Accountability for ensuring waiting times are met is the responsibility of the Divisional Business Manager.

17.1.8 Monthly validation of incomplete pathways, i.e. where a clock has started and the patient has not yet received treatment, will be undertaken. The accurate recording of data within a pathway will support this and enable the Trust to provide assurance that, where clinically appropriate, all patients receive treatment within national waiting time standards.

17.1.9 The Information Department provide a daily report of potential Unknown to Follow Up patients for validation by Divisions to provide assurance that patients receive the appropriate follow up care at the right time.

17.1.10 The Trust will ensure governance processes are in place to enable continued delivery of Waiting Times Standards.

17.1.11 In order to monitor compliance with this policy, the auditable standards will be monitored as follows:

No	Minimum Requirements	Evidenced by
1.	Outpatient pathways with 2 or more new DNAs	Daily Business Intelligence Reports
2.	Outpatient pathways with 2 or more follow up DNAs	
3.	Outpatient pathways resulting in 'Open' outcome	
4.	Outpatient hospital cancellations	
5.	Outpatient patient cancellations	
6.	Inpatient admissions resulting in DNAs	
7.	KPIs against NHS Access Targets, i.e. Cancer, Referral to Treatment and Diagnostic waits	Weekly reports

8.	Monthly sample audits of completed RTT and cancer pathways, to include accuracy of clock start and stops, pauses and cancellations. This will be timetabled in advance and initially aimed at high priority specialties.	Peer review of casenotes with report produced by the Information Department, shared with the DM and fortnightly RTT Access and Cancer Group meeting
9.	Data Completeness and Timeliness	RTT Dashboard and taken to fortnightly RTT Access and Cancer Group meeting
10.	Length of time taken by clinician to triage referral letters on NHS e-Referral Service	NHS e-R Monthly report
11.	Specialty Patient Tracking List weekly meetings	Improvement in access targets performance
12.	Fortnightly RTT Access and Cancer Group meeting	Action Notes
13.	Information and measures	Reported via Performance Assurance Framework report and meetings
14	Unknown to Follow Up patients	Daily Business Intelligence Report

17.2 Frequency
As above.

17.3 Dissemination of Results
Access Meeting, Hospital Operations Board, Divisional PTL meetings, RTT Dashboard and BI reports

17.4 Recommendations/ Action Plans
Implementation of the recommendations and action plans will be monitored by the Patient Access meeting, which meets fortnightly.

17.4.1 Any barriers to implementation will be risk assessed and added to the risk register.

17.4.2 Any changes in practice will be highlighted to Trust staff via the Governance Managers' cascade system.

18. REFERENCES

Cancer Waiting Times A Guide (V9)

www.nhs plan 2000

www.nhs constitution 2015

www.rdehospital.nhs.uk

www.nhsnewdevonccg

www.nhs reform & health care professions act 2002

Guide to NHS Waiting Times

DH Code of Conduct for Private+ Practice (Jan 2004)

Armed Forces Covenant

19. ASSOCIATED TRUST POLICIES

Safeguarding Children Policy

Safeguarding Vulnerable Adults Policy

PAS User Guide

NHS e-Referral User Guide

Overseas Policy

Cancer Services Operational Policy

APPENDIX 1: Department of Health -18 Week Rules Suite (Revised October 2015)

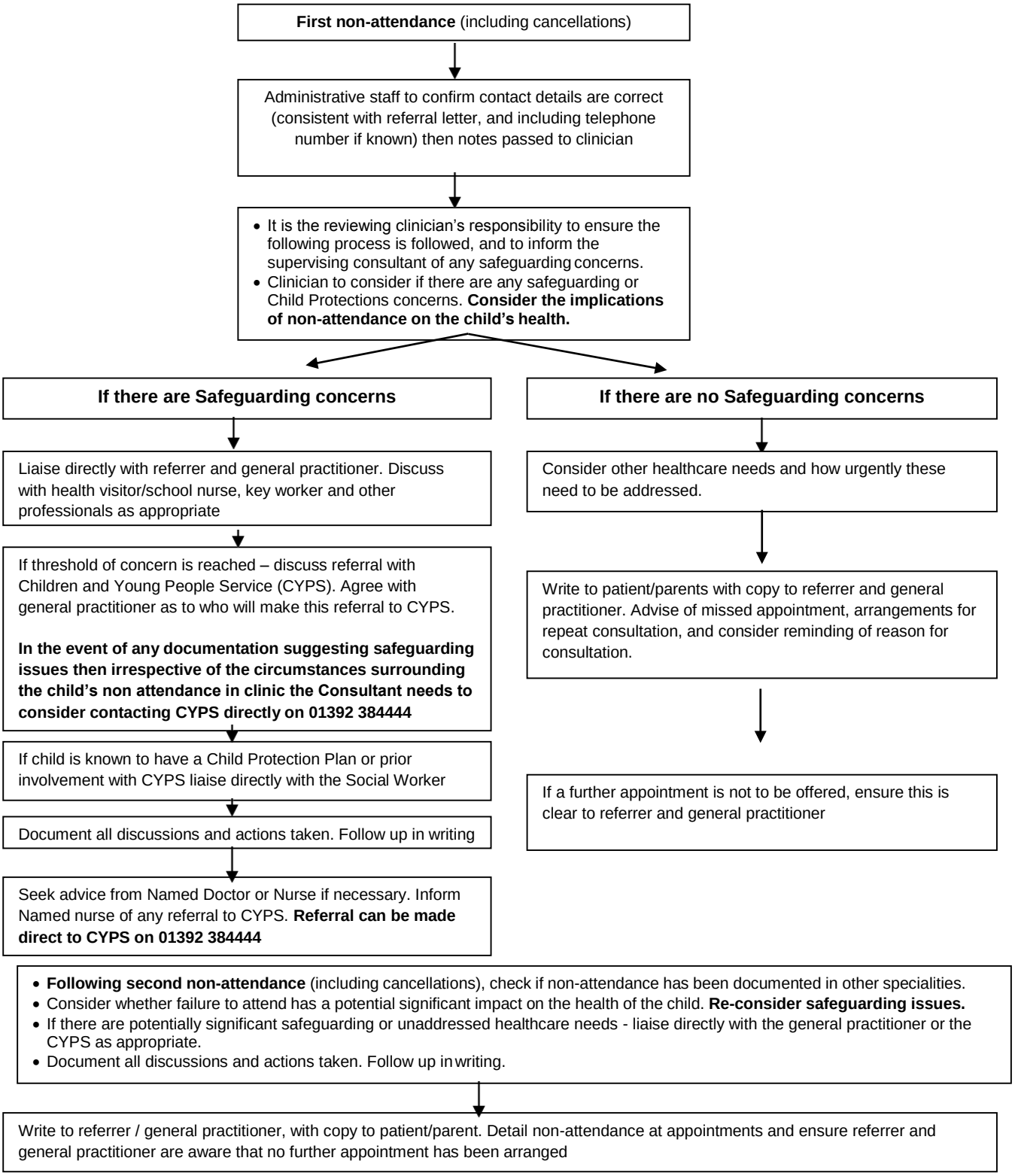
Consultant Led Referral to Treatment waiting Times Guidance and FAQs

Or

Recording and Reporting Guidance

https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting-RTT-guidance-v24-2-PDF-703K.pdf

APPENDIX 2: Actions to take when a child does not attend a new or follow-up appointment. (0-18years)



APPENDIX 3 SOP PN01 Clinician Leave – process for Booking Staff

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE: PN01

Clinician Leave – process for Booking Staff

1. RELEVANT TO:

Clinical Staff

Clinical Service Managers

Appointment Clerks

Medical Secretaries

Slot Managers/Administrative Service Managers

2. PURPOSE OF PROCEDURE:

To ensure that clinicians give at least 6 weeks notice of leave to minimise patient cancellations.

3. LINKED DOCUMENTS:

PAS Training Manuals – PAS level 3 Outpatients User Guides

Standard Operating Procedure – PN14 Hospital Cancellations

Standard Operating Procedure – PN10 Administration of Pending Lists

4. PROCEDURE:

4.1 It is expected that any cancellations of scheduled clinics should be within a minimum of six weeks notice to provide as much notice as possible to patients and minimise the amount of re-work caused to administrative staff.

4.2 In exceptional circumstances where it is not possible to provide six weeks notice, leave must be authorised by the Service Manager with the clinicians and Service Leads working together to ensure appropriate re-provision of services.

4.2 Leave approval to be sent from Directorate Office/CSM to Directorate Slot Manager/ASM.

4.3 Slot Manager/ASM to check consultant clinic commitments/timetable and complete clinic cancellation form, this must stipulate why the clinic is to be cancelled i.e. study leave, annual leave.

4.4 Slot Manager to head up clinics with session message advising of change/cancellation and reserve any vacant slots to avoid patients being booked.

4.5 Slot Manager to email clinic cancellation form to Appointment Clerk who will cancel/change clinic in line with instructions.

4.6 If leave under 6 weeks Slot Manager to advise on re-provision of clinic capacity i.e. cover for clinic, extra clinic, open up firebreaks.

4.7 For management of patients Refer to PN14 – Hospital Cancellations and/or PN10 Administration of Pending Lists.

5. MONITORING AND AUDITS:

5.1 The Information Department will produce a report of any clinics cancelled under 6 weeks by the hospital.

5.2 Divisions are expected to review and act upon the report.

5.3 To meet Monitor requirements, NHS Foundation Trusts are required to produce Quality Reports. In line with this, the Information Team carry out an audit of patients. A report is produced and shared with Divisions, providing an opportunity to improve data recording where necessary.

.

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN 02

Inter- Provider Transfers

1. RELEVANT TO:

Inter – Provider Transfer Co-ordinator

Booking Clerks

Medical Secretaries

2. PURPOSE OF PROCEDURE:

To ensure RTT data is accurately recorded for patients who transfer between organisations enabling them to receive the start of treatment within 18 weeks.

3. LINKED DOCUMENTS:

DSCN 44/2007

PAS Training Manuals – PAS level 3 Outpatients & PAS Referral to Treatment

User Guides

4. PROCEDURE:

4.1 All organisations are required as per DSCN 44/2007 to have a dedicated nhs.net email account set up to receive inter-provider transfer (IPT) forms within two working days of the decision to refer the patient to another organisation.

4.2 Where organisations have no dedicated email account, an IPT is received attached to a paper referral letter. All referrals, paper or printed from an email, must be date stamped upon receipt. Make sure that the patient letter and IPT relate to the same patient, by checking name, NHS No, date of birth etc.

4.3 An IPT provides the receiving Trust with a minimum data set, i.e. patient demographics, NHS number, RTT pathway ID, RTT clock start date, and whether the patient has received the start of treatment.

4.4 Where a paper referral is received the IPT should be sent in the internal post to the IPT Co-ordinator, based in Room 320, Noy Scott House.

4.5 If the patient is not registered on PAS, the letter should be sent to the Booking Clerk for them to register the patient and either make an out-patient appointment or add the patient to a pending list. The appointment or pending list entry must be linked to an RTT pathway.

4.6 Where a pathway ID has been created by the referring organisation, this should be used. If a pathway ID is not provided one should be created as follows:

- The Pathway should always be 12 digits, the first three are the referring organisation code (NACS code) and the remaining 9 digits are numbers. NACS codes can be found on IaN.
- Use the last 5 digits from the Local Patient Identifier (hospital number at other organisation), this can be found on the referral letter or the IPT, and then use the American date system ie. 5th November would translate to 1105. For example, an IPT received from North Devon Healthcare Trust on 5th November 2010 with a Local Patient Identifier No. 7854695 would be **RBZ546951105**
- Occasionally trusts use only 10 or 11 digit pathways, in this instance enter "0" after the NACS code to make the pathway up to 12 digits. Similarly if the issuing trust have more than 12 digits take away the relevant amount of digits after the NACS code to reduce the pathway to 12 digits.

4.7 Once the pathway has been created by the Booking Clerk, the IPT co-ordinator will create a generic event to capture the IPT data. Complete IPT's are entered on PAS with a generic event code 'AB'. Incomplete IPT's are recorded with a generic event code of 'AD'. This is necessary to allow the Information Department to produce stats if required to establish which hospitals refer to the Trust without the IPT minimum data set.

4.8 Once recorded on PAS the IPT should be sent to the Booking Clerk to be attached to the referral letter or to the relevant secretary, if the letter has already left the Booking Clerk. The IPT should be filed in the patient notes as this is proof of the patient clock start date.

4.9 Where a referral is received by the Booking Clerk from another hospital without an IPT, a copy of the referral is forwarded to the IPT Co-ordinator who will request the missing information via the nhs.net secure account. Once received, this will be recorded on PAS as above.

4.10 Where an incorrect pathway ID has been allocated, a new pathway should be created as per 4.6 above with the incorrect pathway being deleted.

4.11 **Referrals to other providers** - The medical secretary will be aware of patients being referred to other Trusts when typing the referral letter. The secretary will create a generic event with code 'AC' on the RTT pathway.

4.12 The referral letter together with a printed copy of the IPT is forwarded to the IPT Co-ordinator within 2 working days of the decision to refer.

4.13 The IPT Co-ordinator will scan and e-mailed the referral letter and IPT through the secure e-mail account to the receiving Trust.

4.14 There are occasions when the referral letter is sent without an IPT in error. The receiving Trust contacts the IPT Co-ordinator who will chase this up with the medical secretary who is expected to update PAS accordingly.

Cancer Referrals

There is a slightly different process in place for Cancer Tertiary Referrals, as agreed with the Peninsular Cancer Network. Referrals are received into the Cancer Services secure nhs.net email account.

The MDT Co-ordinator will print the referral letter and move the Tertiary Referral Minimum Data Set form into a separate folder for the IPT Co-ordinator to access. The IPT Co-ordinator will follow the above process for capturing the information on PAS.

5. MONITORING AND AUDITS:

5.1 To meet Monitor requirements, NHS Foundation Trusts are required to produce Quality Reports. In line with this, the Information Team carry out an audit of patients with a report produced and shared with Divisions, providing an opportunity to improve data recording where necessary.

5.2 The IPT Co-ordinator will escalate to ASM's where clerical staff/medical secretaries are unsure how to record an IPT

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE: PN03

Completion and Recording of Clinic Outcome Form

1. RELEVANT TO:

Clinical Staff
Outpatient Receptionists
Medical Secretaries
Slot Managers

2. PURPOSE OF PROCEDURE:

To ensure all staff responsible for the completion and recording of an outcome adopt a consistent approach to the timely recording of outpatient attendances on the appropriate electronic system.

To ensure patient care is not compromised by the incorrect recording of data leading to inaccurate clock stop dates.

To support contract and billing processes

3. LINKED DOCUMENTS:

PAS Training Manuals – PAS Level 3 Outpatients User Guides

Standard Operating Procedure – PN10 Administration of Pending Lists

Standard Operating Procedure – PN11 DNA first & Subsequent OP appointments

4. PROCEDURE:

4.1 The Clinician or in agreement with him/her, the nominated nurse, completes the Clinic Outcome Form including RTT Status and Multi Consultant fields.

4.2 Outcomes are to be recorded on PAS within the same working day or within twenty four hours maximum of the appointment having taken place, i.e. morning clinics to have outcomes recorded before the start of afternoon sessions and afternoon

sessions to be outcomed by the start of the following morning session. CCG Devon is able to withhold payment if the Attend/Did Not Attend field is left blank.

4.3 Where a patient has been seen, in the same attendance by more than one consultant from different national main specialities, it is essential the Multi Consultant field together with the additional Consultants initials are recorded as evidence of the activity the Trust has undertaken.

4.4 Short term follow up appointments, i.e. within 6 weeks are to be booked and agreed with the patient before they leave the clinical area.

4.5 Long term follow up appointments, i.e. longer than 6 weeks are not booked at the time. The patient is added to the appropriate consultant Follow-Up Pending List and advised that they will receive an appointment nearer to the time.

4.6 DNA's should be recorded immediately as CCG Devon is able to withhold payment if the Attend/DNA field is left blank.
Casenotes are returned to the consultant for review and decision on allocating a further appointment. If the patient is to be allocated a further appointment, the outcome is returned to the receptionist to book an appointment as per the consultant request. Further New appointments must be booked into a New slot and not a follow-up slot as this will result in a loss of income for the Trust.
If the appointment is for a further follow-up, the outcome is returned to the Appointment Clerk for allocating.

4.7 Where no slot is available for re-booking a follow-up appointment within the timeframe stated by the clinician, the patient should be added to the appropriate consultant Follow-Up Pending List. Further New appointments following a DNA are to be booked at the time and not added to the New Referral Pending List.

4.8 It is the responsibility of Appointment Clerk to review the Follow-Up Pending List on a regular basis to ensure patients are being allocated further appointments according to priority. Where there are issues with slot availability this is be escalated to the relevant Directorate Slot Manager who is expected to respond within 1 working day of the request.

5. MONITORING AND AUDITS:

5.1 The Information Department provide a daily Incomplete Outpatient Data Pivot informing Divisions of the % completeness for their specialties.

5.2 Directorates are expected to review the report and update the outcomes within a further 5 working days.

5.3 Failure to complete outcomes in a timely manner will result in valuable time spent by senior staff validating pathways to meet RTT targets and potential loss of income for the Trust

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE: PN04

Partial Booking for New & Follow Up Appointments

1. RELEVANT TO:

Clinical Staff
Appointment Clerks
Slot Managers

2. PURPOSE OF PROCEDURE:

Where directorates are using partial booking to ensure all patients entered onto a pending list and are booked through partial booking and wherever possible the patient agrees their appointment date and time to reduce cancellations and DNA's.

3. LINKED DOCUMENTS:

PAS Training Manuals – PAS Level 3 Outpatients User Guides

Standard Operating Procedure – PN10 Administration of Pending Lists

4. PROCEDURE:

4.1 All follow up appointments >6 weeks will have been entered on a pending list – see PN10 Administration of Pending Lists.

4.2 Appointment Clerk to send patients a letter approximately 6 weeks before they are due to be seen, asking them to contact the hospital to book a date for their consultation.

4.3 If there has been no response from the patient after 2 weeks the Appointment Clerk will confirm/update address with the patients GP surgery and send a second contact letter.

4.4 Patients not responding after 2 attempted contacts will be removed from the pending list and a letter sent to the GP if the clinician feels it is appropriate to do so, e.g. safeguarding children.

4.5 Patients who do not wish to be seen will be removed from the pending list and a generic event entered on the patient pathway to indicate the patients' decision.

4.6 If a patient is not available to be seen at the follow up time requested a 'ZA Patient Choice' generic event is to be entered to indicate that the patient has been offered and turned down an appointment.

4.7 Wherever possible the booking process will take into account the individual requirements for appointment times.

4.8 Directorates will be responsible for ensuring there are adequate slots to accommodate the follow up patients.

5. MONITORING AND AUDITS:

5.1 The Information Department will circulate a pivot of when appointments were due and when patient were seen.

5.3 It will be the responsibility of each Slot Manager/ASM to be aware of their pending lists and arrange for capacity to be made available to ensure patients are given an appointment within RTT waiting times.

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN05

Referrals Triaged Online

1. RELEVANT TO:

Appointment Clerk
Clinicians
Clinical Service Managers
Administrative Service Managers
Slot Manager
Central Support Team

2. PURPOSE OF PROCEDURE:

Providers to work towards Choose & Book referrals being triaged on line by the clinician within 5 working days.

3. LINKED DOCUMENTS:

NHS e-Referral Service – Service Provider Clinician User Guides
Standard Operating Procedure – PN06 Rejected/Redirected Referrals
Standard Operating Procedure – PN07 Management of Referrals through NHS e- Referrals Service

4. PROCEDURE:

4.1 Directorates to be responsible for ensuring consultants are issued smartcards to be able to access NHS e-Referrals.

4.2 Central Support Team to be responsible for ensuring consultants are added to appropriate worklists and clinics linked on PAS.

4.3 Consultants to grade their referrals online within 5 working days of an outpatient appointment being booked through NHS e-Referrals. Consultants to highlight to teams any patients that require consultant only appointments for Appointment Clerks to check appointment is with correct grade of clinician.

4.4 If required clinicians have the option to change grading of referral on NHS e-Referrals from routine to urgent or vice versa. Consultants should change grading and Appointment Clerk will rebook appointment.

4.5 Clinicians/Medical Secretaries to request any investigations and inform Appointment Clerk if outpatient appointment needs re-arranging.

.

4.6 Adequate cover arrangements must be in place to ensure the timely triage of referrals by consultants or a member of their team for sickness/study/annual leave.

4.7 All Clinical Assessment Services (CAS) referral letters must be graded within 5 working days and the appropriate appointment(s) booked on PAS within 14 days of receipt of the referral.

4.8 The Central Support Team will highlight any Clinical Assessment Services referrals not graded within 5 days and any not booked within 14 days of receipt to the relevant Admin Service Managers and Cluster Managers.

4.9 Adequate cover arrangements must be in place to ensure the timely triage of referrals by consultants or a member of their team for sickness/study/annual leave.

4.10 The Central Support Team will accept any referrals on behalf of the clinician not processed online within 6 days of the outpatient appointment being booked.

4.11 Appointment Clerk will be responsible for monitoring any Choose & Book worklists on a daily basis.

5. MONITORING AND AUDITS:

5.1 The Appointment Clerk will monitor those consultants who are not accepting online and or/not accepting their referrals within the agreed timeframe and inform Cluster Managers/ Admin Service Manager and Slot Manager.

5.2 Divisions are expected to review and act upon this information, working with the clinician where necessary

5.3 To meet Monitor requirements, NHS Foundation Trusts are required to produce Quality Reports. In line with this, the Information Team carry out an audit of patients. A report is produced and shared with Divisions, providing an opportunity to improve data recording where necessary.

APPENDIX 8 SOP PN06 Rejected and Redirected Referrals

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN06

Rejected and Redirected Referrals

1. RELEVANT TO:

Devon Referral Support Services (DRSS)
Medical Secretaries
Appointment Clerk
Clinicians
Senior Managers
Central Support Team

2. PURPOSE OF PROCEDURE:

To ensure appropriate referrals are rejected or redirected with a consistent approach.
To ensure patients are not disadvantaged and there is a minimal delay to their pathway

4. LINKED DOCUMENTS:

PAS and NHS e-Referral Service Training Manuals – PAS Level 3 Outpatients and Service Provider Clinician Admin User Guides
Standard Operating Procedure – PN05 Referrals Triaged On-Line
Standard Operating Procedure – PN10 Administration of Pending Lists
Standard Operating Procedure – PN09 Management of Paper Referrals

5. PROCEDURE: - Rejected Appointments

4.12 If a referral has been made through NHS e-Referrals and the service selected does not meet the clinical needs of the patients, the referral needs to be returned (rejected) to Primary Care.

4.13 For electronic referrals the consultant will reject online and type in the rejection reason. Once submitted this rejection goes directly back to the referring GP surgery/DRSS.

4.3 For paper referrals the consultant needs to write to the referring GP giving a clear explanation of the rejection reason within 5 working days with notification to the Appointment
Clerk.

5. Patient Notification

5.1 For DRSS user practices - DRSS will action any rejections daily, contacting the patient by telephone and advising them that the appointment is cancelled and the rejection reason.

5.2 For Non DRSS user practices it is the responsibility of the referring GP surgery to inform the patient that their appointment has been cancelled and the reason.

5.3 For paper referrals the Appointment Clerk will contact the patient, either by telephone or in writing to advise of the rejection advising the patient to contact their referring GP.

6. PROCEDURE: - Redirections

6.1 If a clinician decides the referral has been booked into the incorrect service the clinician needs to select the new service either on NHS e-Referrals or indicate on the paper referral and the Appointment Clerk will cancel the original appointment and rebook to the appropriate service ensuring it is linked to the correct RTT pathway.

6.2 Delays to process are to be kept to a minimum as the RTT clock continues to run from the original date of receipt of referral.

6.3 If there are no appointments available in the redirected service the Appointment Clerk will enter the patient onto the appropriate pending list with the original clock start date.

6.4 The Appointment Clerk will notify the patient that their original appointment has been cancelled and inform/agree their new appointment.

7. MONITORING AND AUDITS:

7.1 The Appointment Clerk will be responsible for monitoring any NHS e-Referral worklists attached to this process.

7.2 DRSS will monitor redirections that have been booked incorrectly and rejections picking up any referral training issues with GP Practices or DRSS staff.

7.3 To meet Monitor requirements, NHS Foundation Trusts are required to produce Quality Reports. In line with this, the Information Team carry out an audit of patients. A report is produced and shared with Divisions, providing an opportunity to improve data recording where necessary.

Royal Devon and Exeter NHS
NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN07

Management of Referrals through NHS e-Referrals Service

1. RELEVANT TO:

Devon Referral Support Service (DRSS)
Appointment Clerks
Clinicians
Admin Managers/Slot Managers
Senior Managers
Central Support Team

2. PURPOSE OF PROCEDURE:

To ensure referrals processed through NHS e-Referrals Service. To ensure patients are not disadvantaged and there is minimal delay to their pathway.

6. LINKED DOCUMENTS:

PAS and CAB Training Manuals – PAS Level 3 Outpatients and Service Provider Clinician Admin User Guides
Standard Operating Procedure – PN05 Referrals Triaged On-Line
Standard Operating Procedure – PN10 Administration of Pending Lists
Standard Operating Procedure – PN08 Slot Availability Issues
Standard Operating Procedure – PN15 Additions to a Planned Waiting List

7. PROCEDURE:

4.1 NHS e-Referrals provides direct access for patients with GP referrals to arrange their appointment direct from the GP surgery, online or by telephone contact with the National Appointments Line.

4.2 Primary Care clinicians will only refer patients who are ready, willing and able to attend an appointment or treatment within the current government target (18w).

4.3 The Directory of Services should be reviewed regularly by Directorates in conjunction with the Central Support Team to provide DRSS/GP's with adequate information to ensure referral to the correct service

4.4 Referrals received through NHS e-Referrals will automatically update the Trust Patient Administration System (PAS) with patient demographics for any directly bookable services. For indirectly bookable services and Clinical Assessment Services the Appointment Clerk will update the patient demographics on PAS.

5. DRSS referrals

5.1 GP administration staff will book a dummy appointment via NHS E-Referral Service into DRSS PAS system.

5.2 DRSS will open the referral letter and will undertake an administrative triage of the referral and will shortlist possible locations the patient can choose from.

5.3 DRSS will ensure the referral letter is attached. If the referral letter is not attached DRSS will contact the GP surgery to chase letter.

5.4 Patients are requested by GP's to wait a minimum of 3 days after the date of their GP appointment to phone DRSS.

5.5 When the appointment is booked a Provider appointment letter will be automatically generated in PAS, this is spooled centrally and sent to Synertec to print and envelope.

5.6 DRSS will ensure the Prior Approvals Policy is followed. However any referral being received in secondary care that is clearly covered by the Prior Approval Policy should be rejected and returned to the referrer with advice for them to follow Prior Approval Policy.

5.7 Referral will now appear in Clinicians work list on NHS e-Referrals – see PN05 Referrals Triaged On-Line

5.8 If there are no slots available on the selected service DRSS will add the referral to the appropriate ASI service – see PN08 Appointment Slot Issues and PN10 Administration of Pending Lists.

5.9 Appointment Clerks will be responsible for managing the Appointment Slot Issue (ASI) worklists.

6. Non-DRSS referrals

6.1 GP administration staff will enter an appointment request referral on NHS e-Referrals select the appropriate service on NHS e-Referrals and give patients their Appointment Request Letter.

6.2 Patients can book their appointment through a local referral management centre, the national line or via the internet.

6.3 Patients will be offered the provider and date/time of their choice into the pre-selected service.

6.4 When appointment is booked a provider appointment letter will be automatically generated in PAS, this is spooled this is spooled centrally and sent to Synertec to print and envelope.

6.5 Referrals will now appear in Clinicians work list on NHS e-Referrals– see PN05 Referrals Triaged On-Line

6.6 It there are no slots available MHS e-Referrals will defer referral to provider – see PN08 Appointment Slot Issues and PN10 Administration of Pending Lists.

6.7 Appointment Clerks are responsible for monitoring the Appointment Slot Issues worklist

7. Clinical Assessment Services

7.1 When DRSS are booking a service that runs as a Clinical Service Assessment at the RD&E, they will enter a dummy date of 3 months ahead and the time of 00.01.

7.2 For these services clinicians will not accept online, the Appointment Clerk will print the referral letter, check and register the patients, added to the appropriate pending list and passed to consultants to grade.

7.3 Once graded Appointment Clerk will book outpatient appointments as per grading instructions or add to graded pending lists and complete on NHS e-Referrals. Any referrals that require tests or to be added to a pending list should be passed to appropriate secretary to book.

8. Rapid Referral Review Services

8.1 GP Administration staff will book via NHS e-Referral Service into an RDE service named DRSS-Eastern -****-NEW Devon D+CCG

8.2 RDE Consultants will log into NHS E-Referral Service and will triage each referral by recording the assessment and entering the triage outcome within 48hours of receipt.

8.3 These referrals will then appear on DRSS NHS E-Referral Service and DRSS will await the patient to call in to book the appointment.

8.4 DRSS will book the patient according to the RDE Triage, this referral will then be accepted by the RDE without having to be re-graded by another consultant.

8.5 If the RDE Consultant decides to upgrade the patient to 2WW the referral will be dealt with internally by the RDE and the patient will be contacted by the RDE 2WW Booking Team

9. MONITORING AND AUDITS:

9.1 Appointment Clerks will monitor ASI worklists on a daily basis and process referrals.

9.2 To meet Monitor requirements, NHS Foundation Trusts are required to produce Quality Reports. In line with this, the Information Team carry out an audit of patients. A report is produced and shared with Directorates, providing an opportunity to improve data recording where necessary.

9.3 Central Support Team will monitor the ASI worklist and highlight any issues to the relevant Slot Manager/ALM/Access Manager

9.4 Central Support Team will monitor the Rapid Referral Review Services daily to ensure Consultants are triaging daily and will highlight any issues to the relevant ALM/ASM/Cluster Manager/Access Manager.

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE: PN08

Appointment Slot Issues

1. RELEVANT TO:

Clinical Staff
Appointment Clerks
Slot Managers
Cluster Managers
Central Support Team

2. PURPOSE OF PROCEDURE:

To ensure patients who are unable to book an appointment are not disadvantaged and booked in chronological order with directly booked patients and paper referrals.

3. LINKED DOCUMENTS:

PAS and NHS E-Referral Service Training Manuals – PAS Level 3 Outpatients and NHS E-Referral Service- Service Provider Clinician Admin User Guides
Standard Operating Procedure – PN07 Management of NHS E-Referral Service referrals
Standard Operating Procedure – PN10 Administration of Pending Lists
Standard Operating Procedure – PN09 Paper Referrals

4. PROCEDURE:

NEW:

4.1 Providers should make available sufficient capacity, both on NHS e-Refferal Service for first appointments and on clinic schedules for follow up appointment to prevent Appointment Slot Issues occurring.

4.2 NHS e-Referral Service patients who contact DRSS or the national booking line to arrange an appointment but find that no slot is available, are advised they will hear from the Provider within 10 working days with the offer of an appointment.

4.3 On receiving an ASI request the Appointment Clerk will try to book the patient into the required service. If a slot is available the Appointment Clerk will contact the patient with the appointment details – see PN07 Management of NHS e-Referrals referrals.

4.4 If there are still no slots available the Appointment Clerk will contact the Slot Manager for a slot to be made available which will be booked by the Appointment Clerk the following day through NHS e-Referrals.

4.5 Appointment Clerk will inform Slot Managers of capacity needed on a daily basis. It is the responsibility of the directorates to identify a suitable slot within 5 working days of receiving the request as the RTT clock is started from the date the patient attempted to arrange the appointment.

4.6 Once slots have been made available the Appointments Clerk/Slot Manager will email the Central support Team who will poll the relevant NHS e-Refferal Service so the Appointment Clerk can book the ASI the same day.

FOLLOW UP PATIENTS:

4.8 All follow up requests >6 weeks will be added to a follow up pending list. These will be partially booked – see PN04 – Partial Booking

4.9 The Information Department will send a follow up pivot to Directorates weekly highlighting those patients who have not been seen in their due month.

4.10 It is the responsibility of the Cluster Manager/ASM/Slot Manager to arrange extra capacity to accommodate these patients within 5 working days of receiving the request.

5. MONITORING AND AUDITS:

5.1 The Information Department provide a daily 18 week pivot to Divisions informing them of patients on their 18 week pathway, patients on follow up pending lists with no appointments will be included on this.

5.2 The Central Support Team email 3 times a week to areas with ASI patients, this report will detail the number of patients for each service.

5.3 The NHS e-Referral Service Performance and Development Manager will also report any issues to the monthly Data & Information Group meeting.

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE: PN09

PAPER REFERRALS

1. RELEVANT TO:

Clinical staff
Appointment Clerk
Medical Secretaries
Administrative Services Managers/Slot Managers
Admin Line Managers
Central Support Team

2. PURPOSE OF PROCEDURE:

To ensure all paper referrals are recorded as soon as they reach the hospital to aid 18 week RTT target. To ensure that paper referrals are booked as chronologically as possible in line with NHS e-Referral Service directly booked referrals.

3. PAS Training Manuals – PAS Level 3 Outpatients User Guides
Standard Operating Procedure – PN10 Administration of Pending Lists
Standard Operating Procedure – PN02 Inter Provider Transfer Forms

4. PROCEDURE:

4.1 Primary Care clinicians will only refer patients who are ready, willing and able to attend an appointment or treatment.

4.2 All referrals must include NHS number and full demographic details including daytime, evening and mobile telephone numbers (where available), to ensure the patient can be contacted promptly together with any specific requirements that may be needed, i.e. interpreter.

4.3 On receipt of the paper referral the patient's demographic details are checked, registered if necessary and the patient added to an ungraded pending list within one working day of receipt. If the referral has an Inter Provider Transfer form attached the Appointment Clerk will use the information to start the patient's pathway on PAS.

4.4 The patient's Hospital Number will be written on the referral letter and the date of receipt recorded on the letter.

4.5 If the Inter Provider Transfer form is incomplete or missing the Appointment Clerk will copy the referral and pass to the IPT Co-ordinator to chase.

4.6 The referral will then be delivered by the Appointment Clerk to the department within one working day of being added to the pending list for the consultant to grade.

4.7 Any paper referrals not received initially by the Appointment Clerk (i.e. sent directly to clinician) must be forwarded to the Appointment Clerk within one working day of receipt to enable entry onto a pending list before grading.

4.8 Consultants will grade all referrals within 5 working days.

4.9 Any graded referrals will be collected daily by the Appointment Clerk.

4.10 The patient should be offered the first available appointment and if they accept that will be considered a reasonable offer. If the patient is unable to accept two reasonable offer of dates within 3 weeks of an appointment they should be appointed for a date of their choice and recorded as 'Patient Choice' on PAS.

4.11 If patients are not willing to accept a date within 10 weeks of receipt of referral, including rebooking appointments at short notice, they will be discharged and returned to the care of the GP/GDP.

4.12 Providers will offer dates with less than 3 weeks' notice, where capacity allows, however, patients will not be penalised where they are unable to accept short notice appointments.

4.15 If the Appointment Clerk receives a paper referral for a low value procedure, a Consultant to Consultant referral for a differing condition or for a service not available at the Royal Devon & Exeter Hospital, the Appointment Clerk will return the referral to the original referrer with explanation.

5. MONITORING AND AUDITS:

5.1 Paper referrals will be monitored by DRSS, who will contact GP surgeries that are still making paper referrals to identify any training needs.

5.2 The Appointment Clerk will circulate to each ASM/Slot Manager any outstanding patients on the ungraded referral pending list. ASM/Slot Manager are expected to chase these letters within their department and ensure letter returned to Appointment Clerks within 2 working days.

5.3 Failure to complete grading timely will impact on patient 18 week pathway.

5.4 Failure to complete this timely will result in Appointment Clerk telephoning referrers for copy letters for re-grading.

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE: PN10

Administration of Pending Lists – New and Follow Up

1. RELEVANT TO:

Clinical Staff
Outpatient Receptionists
Appointment Clerks
Medical Secretaries
Slot Managers

2. PURPOSE OF PROCEDURE:

To ensure all new patients are entered onto a pending list as appropriate to allow the Trust to monitor patients waiting for appointments and react to demand versus capacity.
To ensure the correct clock start date is entered to accurately monitor 18 week referral to treatment target.

3. LINKED DOCUMENTS:

PAS Training Manuals – PAS Level 3 Outpatients User Guides
Standard Operating Procedure – PN11 DNA First & Subsequent Appointments
Standard Operating Procedure – PN09 Paper Referrals
Standard Operating Procedure – PN08 Slot Availability
Standard Operating Procedure – Pno3 Clinic Outcome form

4. PROCEDURE:

NEW:

4.1 All outpatient referrals not booked directly through NHS e-Referral Service, i.e paper referrals, Appointment Slot Issues (ASI), Clinical Assessment Service (CAS) patients, must be date stamped and entered on to an ungraded generic/consultant pending list within one working day of receipt into the hospital.

4.2 Clinical Assessment Service – Patients booked onto a CAS will have their referral letters printed daily, patient demographics checked, registered if necessary and entered onto an ungraded pending list. Referral letters will be delivered to consultants' secretary the same day. The Appointment Clerk will create the RTT pathway using the UBRN on NHS e-Referral Service.

4.3 When the Appointment Clerks receive referrals back from the consultant after being graded they will transfer patients onto a generic/consultant graded pending list depending on service.

4.4 All outpatient appointments are to be booked from pending lists wherever possible and linked to the correct RTT pathway. Every endeavour will be made to book patients chronologically but NHS e-Referral Service direct bookings, special clinic stipulations or named clinicians may prevent this from happening. If Appointment Clerks contact patients directly to book appointments they will call patients chronologically. If they are not able to make contact they must move to the next patient on the pending list. NHS e-Referral worklists are to be updated where relevant.

4.5 If a patient is added to a waiting list or listed for admission the consultant secretary is to remove the patient from the outpatient pending list and inform the Appointment Clerk to complete on NHS e-Referral Service.

4.6 If consultant requires a patient to be redirected to another service, the referral letter, with instructions are to be sent back to Appointment Clerk for them to remove from pending list and pass to relevant department.

4.7 If consultant does not think patient needs to be seen, consultant to write to GP. Secretary to notify the Appointment Clerk to complete rejection process on NHS e-Referral Service , pending list and close pathway.

4.8 New patients who DNA their first appointment - if consultant requests a further appointment due to clinical need, reception will complete outcome on PAS and send outcome form to Appointment Clerk to either book further appointment or add to graded pending list if no appointments available within breach date.

4.9 Further new appointments after change of an appointment are to be booked at the time and not added to the New Pending List where possible.

4.10 It is the responsibility of Appointment Clerk to review the New Pending Lists on a weekly basis to ensure referrals are graded and appointments allocated in a timely manner. Where there are issues with slot availability for graded patients and timeliness of grading this is be escalated to the relevant Directorate Slot Manager who is expected to respond within 2 working days of the request.

FOLLOW UP PATIENTS:

4.11 Short term follow up appointments, i.e. within 6 weeks are to be booked and agreed with the patient before they leave the clinical area where possible.

4.12 Where no slot is available for re-booking a follow-up appointment under 6 weeks, the patient should be added to the appropriate consultant Follow-Up Pending List.

4.13 Long term follow up appointments, i.e. longer than 6 weeks are not booked at the time. The patient is added to the appropriate consultant Follow-Up Pending List and

advised that they will receive an appointment nearer to the time. The clinician must enter clear instructions on the outcome form to enable the patient to be booked into the correct clinic in the future.

4.14 All outcomes are to be passed to the Appointment Clerk in a timely manner to ensure they are booked within the original timescale.

4.15 It is the responsibility of Appointment Clerks to review the Follow-Up Pending List on a regular basis to ensure patients are being allocated further appointments according to priority. Where there are issues with slot availability this is be escalated to the relevant Directorate Slot Manager/ ALM who is expected to respond within 2 working day of the request.

5. MONITORING AND AUDITS:

5.1 The Information Department provide a daily 18 week pivot to Directorates informing them of patients on their 18 week pathway, patients on pending lists with no appointments will be included on this.

5.3 The Appointment Clerk will circulate to each ALM/Slot Manager any outstanding patients on the ungraded referral pending list. ALM/Slot Manager are expected to chase these letters within their department and ensure letter returned to Appointment Clerk within 2 working days.

5.4 It will be the responsibility of each Slot Manager/ALM to be aware of their pending lists and arrange for capacity to be made available to ensure patients are given an appointment within each departments' referral to outpatient appointment timescale.

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN11

DNA First and Subsequent Outpatient Appointments

1. RELEVANT TO:

Medical Secretaries
Outpatient Receptionists
Appointment Clerks
Clinicians
Senior Managers

2. PURPOSE OF PROCEDURE:

To ensure all patients that do not attend either the new or follow up outpatient appointment are dealt with in line with National and Trust Policy. The 18 week clock rules states that if the patient DNA'd their first appointment, including straight to test, after initial referral, they will have their clock nullified and the referral returned to the GP/GDP as long as the Trust can demonstrate that the appointment offer was clearly communicated to and agreed by the patient.

3. LINKED DOCUMENTS:

PAS Training Manuals – PAS Level 3 Outpatients User Guides

Standard Operating Procedure – PN03 Completion of Clinic Outcome forms

Standard Operating Procedure – PN10 Administration of Pending Lists

4. PROCEDURE: - Patients Who Do Not Attend a New Appointment

4.1 Clinic outcomes forms will be returned to the Receptionist for action.

4.2 Receptionist to record DNA within 24 hours.

4.3 If no further appointment to be booked Reception staff to discharge patients on PAS, clinician to write to GP to inform of DNA.

4.17 If clinician requests another appointment Reception staff to send outcome form to Appointment Clerk or re-book the appointment.

4.5 Appointment Clerk will telephone the patient and agree another new appointment restarting the RTT clock on the DNA date.

4.6 If the patient no longer wishes to be seen the Appointment Clerk/Receptionist will close the pathway entering the appropriate generic event.

4.7 If there is no slot available the Appointment Clerk are to enter the patient on the appropriate pending list with DNA in the comments.

4.8 The Appointment Clerk will monitor the Appointments for Booking Worklist weekly and complete the DNA process for any flagged patients. This will automatically inform the GP of the DNA.

4.9 The rebooking of patients who DNA on two or more occasions should be considered on a case by case basis.

5. PROCEDURE: - Patients Who do not attend a follow up appointment

5.1 Patients who DNA a follow up appointment will be discharged back to the care of their GP/GDP, provided the Trust can demonstrate that the appointment was clearly communicated to the patient and that discharging the patient is clinically agreed.

5.2 Clinically urgent appointments, cancer fast patients, some vulnerable adults and paediatric patients will not be discharged and a further appointment made. If not treated the 18 week clock will continue to tick from the original start time.

5.3 If no further appointment to be booked Reception staff to discharge patients on PAS, clinician to write to GP to inform of DNA.

5.4 If clinician requests another appointment Reception staff to book appointment as per clinicians instructions and send patient appointment letter.

6. PROCEDURE: - Patients with suspected cancer

6.1 If a patient DNA's their original appointment the reception desk will email the 2WW office the same day and the patient will be contacted by phone and offered a further appointment within two weeks of the DNA and a clock pause will be applied from the date of receipt to the date the patient rebooks their appointment.

6.2 If a patient DNA's an appointment at a 'one stop' clinic a pause can be used but not if the clinic would be after this point ie. Following an outpatient appointment with the consultant.

6.3 If the patient DNA's twice in a row they will be referred back to the care of the GP/GDP and removed from the 2 week wait pathway. Clinicians must ensure that any decision to refer back to the GP/GDP is in the best interest of the patient.

7. MONITORING AND AUDITS:

7.1 The Information Department will produce pivots that show DNA's.

7.2 To meet Monitor requirements, NHS Foundation Trusts are required to produce Quality Reports. In line with this, the Information Team carry out an audit of patients. A report is produced and shared with Directorates, providing an opportunity to improve data recording where necessary.

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN12

Private Patients

1. RELEVANT TO:

Clinical Staff
Appointment Clerks
Admission Clerks
Medical Secretaries

2. PURPOSE OF PROCEDURE:

To provide guidance for staff when recording Private Patients attending an outpatient appointment or for admission, onto the Trust electronic systems, i.e. PAS
To ensure staff follow the correct procedure for managing patients referred for private treatment and patients who transfer from private to NHS status
A private patient is defined as a patient who funds the cost of their own treatment

3. LINKED DOCUMENTS:

PAS Training Manuals – PAS Level 3 Outpatients and PAS Level 3 Waiting Lists

User Guides

DoH Code of Conduct for Private Practice (Jan 2004)

PROCEDURE:

4.1 The consultant will review the letter and decide on the appropriate grading for the referral, Urgent or Routine. This is to be captured on PAS with the appropriate appointment being allocated.

4.2 The correct status must be chosen when booking an outpatient appointment, N (NHS) or P (Private). This is essential to ensure the patient is invoiced for their appointment/treatment.

4.3 Any difficulties in scheduling urgent appointments within the agreed time scale must be escalated immediately to the relevant Consultant/Clinician and to the Administrative Services Manager responsible for that area.

4.4 Priority on the waiting list for private patients should be determined by the same criteria applied to NHS patients.

4.5 If a patient transfers from Private to NHS, the RTT clock will start on the date the Trust accepts clinical responsibility for the patient.

4.6 If a patient is being added to a waiting list, without first being seen as an outpatient, the date of decision to admit is recorded as the date the letter is received from the private rooms.

5. MONITORING AND AUDITS:

5.1 The Information Department will conduct random audits on patients recorded with a private status checking that clock starts are captured accurately.

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN13

Patient Changes and Cancellations - Outpatients

1. RELEVANT TO:

Medical Secretaries
Outpatient Receptionists
Appointment Clerks
Clinicians
Senior Managers
Health Records

2. PURPOSE OF PROCEDURE:

To ensure all staff responsible for managing outpatient appointments adopt a consistent approach to ensure that patients who cancel an outpatient appointment are offered one further date or removed from the outpatient list where they cancel for a second time.

3. LINKED DOCUMENTS:

PAS Training Manuals – PAS Level 3 Outpatients User Guides
Patient Access Policy
Standard Operating Procedure – PN10 Administration of Pending Lists

4. PROCEDURE: - Change of appointment

4.1 Communication of outpatient appointment dates should include information telling patients that they risk being discharged back to their GP if they change a new or follow up appointment more than once.

4.2 Patients who are wishing to change a new appointment must be rebooked as close to their original appointment as possible, as the 18 week clock will be ticking. If a patient has been booked through NHS e-Referral Service we should attempt to rebook the patient through NHS e-Referrals. A generic event (ZA – Patient Choice) must be created on PAS to reflect this and update Trust pivot tables. The date entered on the generic event must be the date of the rebooked appointment.

4.3 If this is the first cancellation, the patient is to be booked into an alternative appointment but should be advised that if they cancel for a second time, they could be discharged back to their GP.

4.4 Patients who change and re-book any outpatient or diagnostic appointment two or more times will be discharged and their GP/GDP informed unless it is clinically inappropriate to do so or in the case of vulnerable adults, children or it is felt detrimental to the patients' care, the clinician may request that the patient be given another appointment. A different rule applies to Cancer patients.

4.5 If the patient contacts someone other than the Appointment Clerk to change an outpatient appointment it is the responsibility of the person receiving the telephone call to inform the Appointment Clerk.

4.6 If a short notice cancellation is received, it is the responsibility of the Appointment Clerk to try to fill the empty slot by either bringing patients forward or filling from the pending list.

4.7 Patients who don't fall into the above category and cancel two agreed outpatient or diagnostic appointment dates may be discharged on clinical decision back to their GP.

4.8 If patients are not willing to accept a date within 10 weeks of receipt of referral, including rebooking at short notice, they will be discharged and returned to the care of their GP/GDP.

4.9 Consultants/Clinicians should not advise patients to make a follow up appointment and then cancel if not required. In these circumstances patients should be discharged back to the GP/GDP.

4.10 The Central Support Team will ensure a report is set up to run daily for patients who have expressed a wish to cancel or rearrange their appointment when contacted by the Appointment Reminder Service. It is the responsibility of the Appointment Clerk to rearrange/cancel this appointment.

5. PROCEDURE: - Cancel appointment with no further appointment

5.1 Patients who cancel their appointment and wish no future appointment to be arranged should have their appointment cancelled with the appropriate reason entered. If the patient was booked through NHS e-Referral Service the cancellation should be done in NHS e-Referral Service.

5.2 For patients on an 18 week untreated pathway a generic event (J – Decision not to treat/be treated) needs to be entered to stop the RTT clock, using the date the patient called and enter the reason the patient has cancelled. This is for all patients that are either cancelled on PAS or NHS e-Referral Service.

CANCER PATIENTS

6.1 Patients should not be referred back to the GP/GDP after two or more cancellations unless this has been agreed with the patient following discussion with the clinician to

whom the patient has been referred. Clinicians must ensure that any decision to refer back to the GP/GDP is in the best interest of the patient.

6.2 If a patient changes an appointment and chooses to wait longer than 2 weeks for a further appointment this is to be recorded as ‘Patient Choice” on the Cancer Tracking database and RTT pathway.

7. MONITORING AND AUDITS:

7.1 The Information Department provide daily reports identifying consultants who have allocated further appointments following patient cancellations on more than two occasions.

7.2 To meet Monitor requirements, NHS Foundation Trusts are required to produce Quality Reports. In line with this, the Information Team carry out an audit of patients. A report is produced and shared with Divisions, providing an opportunity to improve data recording where necessary.

Royal Devon and Exeter NHS
NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN14

Hospital Changes and Cancellations - Outpatients

1. RELEVANT TO:

Medical Secretaries
Appointment Clerks
Clinicians
Cluster Manager
Senior Managers

2. PURPOSE OF PROCEDURE:

To ensure all staff responsible managing outpatient appointments adopt a consistent approach to ensure minimal disruption to patient

3. LINKED DOCUMENTS:

PAS Training Manuals
Standard Operating Procedure – PN10 Administration of Pending Lists
Standard Operating Procedure – PN06 Rejected Referrals
Standard Operating Procedure – PN01 Consultant Leave

4. PROCEDURE: - Change appointment

4.1 It is expected that any cancellations of scheduled outpatient clinics should be within a minimum of six weeks' notice to provide as much notice as possible to patients and minimise the amount of re-work caused to administrative staff.

.

4.2 In exceptional circumstances where it is not possible to provide 6 weeks' notice, clinic cancellations must be authorised by the Cluster Manager and the Clinician and Service Leads to ensure appropriate re-provision of services.

4.3 It is the responsibility of the Cluster Manager/Slot Manager to advise the Appointment Clerk of any cancellations/changes to clinics by using the appropriate template.

4.4 Ideally patients should not experience more than one hospital appointment cancellation per pathway.

4.5 For all cancellations/changes less than a week the Appointment Clerk will telephone the patient to advise of the cancellation and agree a new appointment. If the patient is uncontactable a change of appointment letter should be sent 1st class.

4.6 For new appointments these should be booked as near to the original appointment as soon as possible as the 18 week clock will be ticking. If a patient has been booked through NHS e-Referral Service, the appointment should be changed via NHS e-Referral Service and the patient telephoned to explain the change of appointment and to ensure the new appointment is suitable for the patient.

4.7 If there are no appointments available to move the patient the Appointment Clerk will place the patient back on the pending list with the original clock start date and notify the slot manager for capacity.

5. PROCEDURE: - Cancel appointment with no further appointment

5.3 Patients who have their outpatient appointment cancelled by a clinician with no further appointment to be arranged must be contacted in writing by the clinician with explanation and copied to GP.

5.4 Appointment Clerk to be notified of cancellation to complete cancellation on PAS and in NHS e-Referral Service..

5.5 For patients on an 18 week untreated pathway a generic event (J – Decision not to treat/be treated) needs to be entered to stop the RTT clock, using the date the patient called and enter the reason the patient has cancelled. This is for all patients that are either cancelled on PAS

5.6 If there are no appointments available to move the patient into, the Appointment Clerk will place the patient on the follow up pending list.

5.7 For rejections please see PN06 – rejected referrals.

6. MONITORING AND AUDITS:

6.1 The Information Department produce daily reports identifying patients where the hospital has cancelled an outpatient appointment on more than two occasions.

6.2 To meet Monitor requirements, NHS Foundation Trusts are required to produce Quality Reports. In line with this, the Information Team carry out an audit of patients. A report is produced and shared with Divisions, providing an opportunity to improve data recording where necessary.

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN15

Adding Patients to a Waiting List

1. RELEVANT TO:

Clinicians
Medical Secretaries
Waiting List Co-ordinators

2. PURPOSE OF PROCEDURE:

To ensure all staff responsible for adding patients to waiting lists adopt a consistent approach enabling patients to be treated in chronological order according to clinical priority and within national waiting times.
Patients should only be placed on a waiting list for surgery once they have accepted the advice of the Consultant/Clinician to have treatment and are fit, willing and able to proceed with surgery

3. LINKED DOCUMENTS:

PAS Training Manual – PAS Level 3 Waiting Lists and Referral to Treatment User Guides
Standard Operating Procedure – PN16 Reasonable Offer of Notice
Standard Operating Procedure – PN19 Multiple Procedures
Standard Operating Procedure – PN20 Hospital Cancellations
Standard Operating Procedure – PN21 Patient Cancellations
Standard Operating Procedure – PN22 Patient DNA Admission

4. PROCEDURE:

4.1 Patients should only be added to a waiting list once they have accepted the advice of the Clinician and are fit, willing and able to proceed with surgery.

4.2 Patients should be added to the waiting list within 5 working days of the decision to admit.

4.3 The date of decision to admit is the original decision to admit date, i.e. date of outpatient clinic, and not the date the clinic letters are typed.

4.4 The waiting list entry must be linked to the appropriate RTT pathway with care being taken to ensure it is linked to the correct pathway. Failure to link the episode may

result in the Trust failing to meet RTT targets and giving patients the opportunity to be treated at a provider of their choice at the expense of the Trust, as per their rights within the NHS Constitution. Failure to track patients may result in a clinical risk.

4.5 Where a clock stop has already occurred within a pathway, i.e cataract patients being added to a waiting list requiring surgery for second eye, the clock will re-set to zero when the waiting list episode is added to the pathway.

4.6 Patients who are short term medically unfit (up to 14 days) will be added to a waiting list and offered dates when they are likely to be fit.

4.7 Patients who are long term medically unfit (longer than 14 days) with a condition that prevents the continuation of treatment are to be discharged back to Primary Care and re-referred when fit to proceed. The medical secretary is responsible for updating the RTT pathway with a generic event to stop the clock at the point of removal from the waiting list.

4.8 Patients should not be added to a waiting list whilst they are on Active Monitoring or awaiting results as they are not available to attend for surgery.

4.9 Where a patient is undecided if they wish to proceed with treatment, they should not be added to a waiting list. If after 14 days the patient is still undecided, a generic event should be added to the pathway, patient initiated active monitoring, stopping the clock.

4.10 Where patients are removed from a waiting list on clinical advice i.e. no treatment required or the patient informs the secretary they no longer wish to proceed, i.e. treated elsewhere, the Medical Secretary / Waiting List Co-ordinator is responsible for creating a generic event on the pathway to stop the RTT clock. It is good practice to create a letter on CDM, sending a copy to the patient and GP.

4.11 Patients cancelled on the day of their operation for non medical reasons must be given a new TCI within 28 days of cancellation. A further date should be given to the patient at the time of cancellation but where this is not possible, patients should be contacted within 3 working days of the cancellation date to agree a further date.

5. MONITORING AND AUDITS:

5.1 The Information Department produce the following reports to support Directorate staff in managing patients on waiting lists:

- PTL Report – produced daily identifying patients not yet dated and approaching breach
- RTT Predictor Report – produced daily identifying patients already treated within the current month, both within and over 18 weeks, together with those that will breach if not dated within the current month

5.2 Divisions are expected to review and act upon the reports, allocating dates where appropriate.

5.3 Any concern over patients appearing on reports incorrectly are to be raised with the individual Information Analyst responsible for generating the report

5.4 Waiting List Pivot tables are also available providing regularly updated information

5.5 To meet Monitor requirements, NHS Foundation Trusts are required to produce Quality Reports. In line with this, the Information Team carry out an audit of patients with an RTT Clock Stop for admitted treatment during the previous month. A report is produced and shared with Divisions, providing an opportunity to improve data recording where necessary.

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN16

Reasonable Offer of Notice

1. RELEVANT TO:

Medical Secretaries
Waiting List Co-ordinators

2. PURPOSE OF PROCEDURE:

To ensure that a consistent approach is applied by all staff to patients on a waiting list for Daycase / Inpatient surgical or diagnostic procedure and that TCI dates are offered with reasonable notice.

3. LINKED DOCUMENTS:

PAS Training Manual – Level 3 Waiting Lists and Referral to Treatment (RTT) User Guides
Standard Operating Procedure – PN15 Adding Patients to a Waiting List
Standard Operating Procedure – PN19 Multiple Procedures

4. PROCEDURE:

4.1 Patients on a waiting list will be offered TCI dates in chronological order according to clinical priority

4.2 A reasonable offer is defined to be an offer of 2 or more dates with a minimum of 3 weeks' notice.

4.3 Ideally, the offer of a date should be given to the patient at the time of listing i.e. by the clinician when seeing the patient in outpatients.

4.4 Where patients are not offered a TCI date at clinic, the secretary / waiting list co-ordinator will contact the patient either by telephone or letter allocating a date at least 3 weeks ahead. It is good practice to agree the date with the patient over the telephone, where possible.

4.4 Where patients are offered a date by letter, the patient should be asked to confirm that they will attend on the date allocated to reduce the number of potential DNA's.

4.6 If the patient is unable to accept the first date, they will be offered a further date.

4.7 If the patient is unable to accept either of the 2 dates offered, they should be appointed for a date of their choice and the reason for the delay recorded within the waiting list comments field. This will not stop the RTT clock

4.8 Any admission agreed between the patient and the Trust within this definition is automatically considered to be reasonable.

4.9 If the patient is not willing to accept any dates at the time of contact, the secretary will remove them from the waiting list and discharge the patient back to the care of their GP.

4.9.1 The secretary needs to create a generic event on the RTT pathway to stop the clock as the patient has declined treatment

4.9.2 Where there is an urgent clinical need, patients may be offered and choose to accept dates without 3 weeks notice. Similarly if a cancellation has taken place and the patient has previously advised that they will accept a short notice cancellation.

5. MONITORING AND AUDITS:

5.1 The Information Department produce the following reports to support Divisional staff in managing patients on waiting lists:

- Waiting List Queries – produced twice weekly identifying patients not yet dated and approaching breach
- RTT Predictor Report – produced daily identifying patients already treated within the current month, both within and over 18 weeks, together with those that will breach if not dated within the current month

5.2 Divisions are expected to review and act upon the reports, allocating dates where appropriate.

5.3 Any concern over patients appearing on reports incorrectly are to be raised with the individual Information Analyst responsible for generating the report

5.4 Waiting List Pivot tables are also available providing regularly updated information

5.5 To meet Monitor requirements, NHS Foundation Trusts are required to produce Quality Reports. In line with this, the Information Team carry out an audit of patients with an RTT Clock Stop for admitted treatment during the previous month. A report is produced and shared with Divisions, providing an opportunity to improve data recording where necessary.

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN17

Elective Patients – Choice of Date

1. RELEVANT TO:

Medical Secretaries
Waiting List Co-ordinators

2. PURPOSE OF PROCEDURE:

To ensure all staff responsible for managing elective waiting lists adopt a consistent approach to managing patients that were offered a reasonable TCI date within 18 weeks of referral but choose to wait longer for personal or social reasons.

There is no blanket rule against the length of delay, but good practice and clinical decision will guide how long the patient can remain on a deferred list, protecting patients who may come to harm by choosing to delay their treatment.

3. LINKED DOCUMENTS:

PAS Training Manual – Level 3 Waiting Lists and Referral to Treatment (RTT) User Guides

4. PROCEDURE:

4.1 Following a consultation between the patient and clinician, the patient is added to an elective waiting list.

4.2 If the patient declines the offer of two reasonable dates, with three weeks' notice, but they are able to accept a TCI within six weeks of contact, the patient is to be dated at that time. If the patient is near to their 18 week Treat by Date, this may result in them becoming a breach, which the Trust will need to accept.

4.3 If the patient wishes to delay surgery for longer than six weeks and up to three months, i.e. school teacher, the patient is transferred from the elective waiting list to the deferred waiting list. The date of adding to the list is to be changed to the date of adding to the Deferred List. The urgency date, i.e. month the patient wishes to be seen, must be updated. A comment indicating which waiting list the patient was originally on, i.e. General I/P, should be recorded in the comments field, to assist when moving the patient back to an elective list.

4.4 An automated generic event (K - Patient Initiated Active Monitoring) will be created on the pathway, stopping the RTT clock at the date the patient advises they wish to delay their treatment date for longer than six weeks. The patient is to be informed that their RTT clock will be stopped at this point with a new 18 week clock starting when they are available to accept a TCI date.

4.5 In exceptional circumstances where the patient wishes to delay their admission for longer than 3 months the patient is removed from the deferred waiting list and discharged back to the referrer. A generic event, 'J – Decision Not to Treat', is to be created on the pathway, as the patient has been discharged. The patient is advised they will need to be re-referred when they are ready and able to attend for treatment and a new 18 week pathway will commence at that point.

4.6 If the patient decides they no longer wish to proceed with surgery at all, the patient is removed from the waiting list and a generic event, 'J – Decision Not to Treat', is to be created on the pathway.

4.7 When the patient has reached the time they have said they will be available, they are moved from the deferred list to an elective waiting list. The date of adding the patient back to the elective list is to be entered (not the original date on list). A new RTT 18 week clock will start automatically, on the existing RTT pathway. The K generic event will remain on the pathway as an indicator that the patient had previously deferred their admission.

4.8 It is the responsibility of the medical secretary/waiting list co-ordinator to manage patients on the deferred waiting list, in the same way as those on an elective list, i.e. via pivot tables and the PTL report. All patients are to be treated in chronological and order of priority, irrespective of which list they are on. Patients are to be given three weeks' notice of the TCI date they are being offered.

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN18

Adding Patients to a Planned Waiting List v2

1. RELEVANT TO:

Clinicians
Medical Secretaries
Waiting List Co-ordinators

2. PURPOSE OF PROCEDURE:

To ensure all staff responsible for adding patients to planned waiting lists adopt a consistent approach enabling patients to be treated at the appropriate time.

Patients should only be added to a planned list when it is clinically appropriate for them to wait for a period of time. This includes patients waiting for a planned diagnostic test or treatment or a series of procedures carried out as part of a treatment plan which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.

These patients are outside the scope of 18 weeks. However, any waits beyond the planned month should be agreed by the consultant and monitored.

3. LINKED DOCUMENTS:

PAS Training Manual – PAS Level 3 Waiting Lists and Referral to Treatment User Guides
DoH 28 Day Cancellation Standard (See Standard Operating Procedure PN20)
Standard Operating Procedure – PN15 Adding Patients to a Waiting List
Standard Operating Procedure – PN16 Reasonable Offer of Notice

4. PROCEDURE:

4.1 Patients should only be added to a planned waiting list once they have accepted the advice of the clinician and agreed a personal treatment plan

4.2 Patients should be added to the planned waiting list within 5 working days of the decision to treat them in an agreed month

4.3 The date of decision to admit is the original decision to admit date, i.e. date of outpatient clinic or following the result of tests, and not the date clinic letters are typed.

4.4 It is the medical secretary or Waiting List Co-ordinator's responsibility to maintain the planned waiting list and allocate TCI dates within the planned month. Lack of capacity issues are to be raised with the Line Manager responsible for the service.

4.5 Where it isn't possible to allocate a TCI date within the planned month, the medical secretary will raise this immediately with the Clinician responsible for the patient care. The Clinician will review the patient history and where clinically appropriate he/she may decide to revise the date of the planned procedure.

4.6 The medical secretary will update the waiting list entry with the revised month for the planned procedure to take place. A 'ZZ' generic event, for information only, will be added to the RTT pathway, including Clinicians initials, date reviewed and the planned date changed from and to. A clinical note will be recorded on CDM providing evidence as to the reasons for the change to the planned clinical procedure.

4.7 The GP and patient will be notified of the clinical decision to alter the date of the planned procedure. Where the GP has concerns over the revised date, they should contact the consultant to discuss further and reach a consensus. Where it is agreed that the patient needs to retain the original planned month for admission, the medical secretary will move the patient to an elective waiting list and a diagnostic waiting time clock will commence and be reported. The RTT pathway will be updated with a further 'ZZ' generic event indicating the reason the patient has been moved to an elective list.

4.8 A reasonable offer is defined to be an offer of a time and date 3 or more weeks from the time that the offer was made. Any appointment agreed between the Trust and the patient within this definition is automatically considered to be reasonable. (See SoP PN16)

4.9 Patients cancelled on the day of their operation for non medical reasons must be given a new TCI within 28 days of cancellation. A further date should be given to the patient at the time of cancellation but where this is not possible patients should be contacted within 3 working days of the cancellation date to agree a further date. (See SoP PN20)

5. MONITORING AND AUDITS:

5.1 The Information Department produce weekly waiting list reports which include patients on planned lists. This information is also available on the daily PTL.

5.2 Divisions are expected to review and act upon the reports, allocating dates where appropriate.

5.3 Any concern over patients appearing on reports incorrectly are to be raised with the individual Information Analyst responsible for generating the report

5.6 Waiting List Pivot tables are also available providing regularly updated information

5.7 To meet Monitor requirements, NHS Foundation Trusts are required to produce Quality Reports. In line with this, the Information Team carry out an audit of patients with an RTT Clock Stop for admitted treatment during the previous month. A report is produced and shared with Divisions, providing an opportunity to improve data recording where necessary.

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN19

RTT Pathway Process for Multiple Procedure Patients

1. RELEVANT TO:

Clinicians
Medical Secretaries
Waiting List Co-ordinators

2. PURPOSE OF PROCEDURE:

To ensure all staff responsible for adding patients requiring multiple or bilateral procedures, i.e. cataracts, to a waiting list do so in a consistent way and in line with DoH rules enabling the Trust to meet RTT targets.

3. LINKED DOCUMENTS:

PAS Training Manual – Level 3 Waiting Lists and Referral to Treatment (RTT)
User Guides
DoH RTT Rules
Standard Operating Procedure – PN15 Adding Patients to a Waiting List
Standard Operating Procedure – PN16 Reasonable Offer of Notice

4. PROCEDURE:

4.1 Patients will be added to a waiting list only when they have accepted the advice of the clinician and are fit, willing and able to proceed with surgery for the first of bilateral procedures.

4.2 The waiting list episode must be linked to the relevant RTT pathway that will have been created on receipt of initial referral

4.3 Following treatment for the first procedure, the patient should not be added to the waiting list for the second part of surgery, i.e. second eye, until such time as they would be fit willing and able to proceed. It is not appropriate to add patients to the waiting list on the day of the original surgical procedure as the patient would not be fit to undergo further surgery at that point.

4.4 The Clinician will advise the secretary at what point the patient is to be added to the waiting list for the second procedure based on the recovery time from the original procedure.

4.5 The secretary will add the patient to the waiting list linking the episode to the existing RTT pathway. The RTT clock will re-set to the date of the new waiting list entry provided the clinical coding of the first procedure has been recorded. This provides a further 18 weeks in which the patient should expect to receive treatment.

4.6 If the need for second treatment is identified separately, i.e patient is referred for one cataract, treated, discharged and then re-referred some time later for the second cataract, a new 18 Week pathway must be created.

5. MONITORING AND AUDITS:

5.1 Medical Secretaries will have a process in place ensuring those who have received part one of bilateral procedures are discussed with their clinician as to what point the patient can be added to the waiting list for the second procedure

5.2 To meet Monitor requirements, NHS Foundation Trusts are required to produce quality Reports. In line with this, the Information Team carry out regular specialty based audits on patients with an RTT clock stop during a previous specific month. A report is produced and shared with Divisions, providing an opportunity to improve data recording where necessary.

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN20

Hospital Cancelled Operations/28 Day Cancellations

1. RELEVANT TO:

Medical Secretaries
Waiting List Co-ordinators
Clinicians
Cluster Manager
Senior Managers

2. PURPOSE OF PROCEDURE:

To ensure all staff responsible for managing waiting lists adopt a consistent approach to ensure patients who are cancelled on the day of their surgery are allocated a further TCI date within 28 days. The hospital will only cancel a patient's admission when it is not possible to carry out the procedure. In exceptional circumstances where clinicians have been unable to provide sufficient notice of leave, it is the responsibility of the Service Leads working with the clinicians to ensure appropriate re-provision of services to prevent late cancellations.

3. LINKED DOCUMENTS:

PAS Training Manual – Waiting Lists
PAS Training Manual – Referral to Treatment (RTT)
DoH 28 Day Cancellation Standard
SoP – PN15 Adding Patients to a Waiting List

4. PROCEDURE:

4.1 In exceptional circumstances where clinicians have been unable to provide sufficient notice of leave, it is the responsibility of the Service Leads working with the clinicians to ensure the appropriate re-provision of services to prevent late cancellations. However where cover isn't possible the medical secretary or waiting list co-ordinator must be informed as soon as possible to ensure they cancel the list and contact the patients prior to the day of treatment to avoid a 28 Day Cancellation.

4.2 When on the day cancellations for non-medical reasons occur it is the responsibility of whoever decides to cancel the admission, i.e. Clinician, Bed Manager, Cluster Manager to inform the medical secretary or Waiting List Co-ordinator within 24 hours

of the decision to cancel to enable them to update PAS and place the patient back on the waiting list

4.3 If the decision is made to cancel a patient for medical reasons, i.e. clinician, anaesthetist or at the preparation for surgery review, it is the responsibility of that individual to inform the medical secretary or waiting list co-ordinator immediately.

4.4 The medical secretary or waiting list co-ordinator is to update PAS and RTT pathway within 24 hours of being notified of the first cancellation.

4.5 Patients should not be cancelled for a second occasion, however where this happens it must be authorised by a senior manager. It is the responsibility of the medical secretary or waiting list co-ordinator to ensure the second cancellation has been authorised and make note of this in the comments field on the waiting list entry

4.6 Cancellations for a third occasion must be authorised by the On-Call Director or designated Director. It is the responsibility of the medical secretary or waiting list co-ordinator to ensure the third cancellation has been appropriately authorised and make note of this in the comments field on the waiting list entry.

4.7 Where a second hospital cancellation takes place within 28 days of the original cancellation, the patient must be offered a further TCI within 28 days of the original cancellation and not 28 days of the second cancellation. Where it is not possible to allocate a further date due to lack of capacity, the medical secretary or waiting list co-ordinator is to inform the Cluster Manager or Service Lead.

4.8 Cluster Manager, ASM or Medical Secretary is to inform the Information Analyst who manages the 28 Day Cancellation reporting where a patient has been cancelled and it is not possible to rebook within 28 days. The Information Analyst records this as a confirmed breach on the report.

5. MONITORING AND AUDITS:

5.1 The Information Department produce a weekly report showing same day cancellations not yet treated. It is the responsibility of the CSM or nominated person to confirm that this is a same day cancellation and to inform the Information Analyst when a TCI has been arranged and the patient treated.

5.2 Divisions are expected to review and act upon the reports, allocating dates where appropriate.

5.3 Any concern over patients appearing on reports incorrectly are to be raised with the individual Information Analyst responsible for generating the report

5.4 Waiting List Pivot tables are also available providing regularly updated information

5.8 To meet Monitor requirements, NHS Foundation Trusts are required to produce Quality Reports. In line with this, the Information Team carry out an audit of patients with an RTT Clock Stop for admitted treatment during the previous month. A report is produced and shared with Divisions, providing an opportunity to improve data recording where necessary.

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN21

Patient Cancellations - Admissions

1. RELEVANT TO:

Medical Secretaries
Waiting List Co-ordinators
Clinicians
Senior Managers

2. PURPOSE OF PROCEDURE:

To ensure all staff responsible for managing waiting lists adopt a consistent approach ensuring that patients who cancel admission dates are offered one further date or removed from the waiting list where they cancel for a second time.

3. LINKED DOCUMENTS:

PAS Training Manuals – Level 3 Waiting Lists and Referral to Treatment (RTT) User Guides
Standard Operating Procedure – PN15 Adding Patients to a Waiting List
Standard Operating Procedure – PN17 Elective Patients – Choice of Date

4. PROCEDURE:

4.1 All patients should be offered 2 reasonable dates with a minimum of 3 weeks notice.

4.2 Communication of TCI dates to patients should include contact details for the Medical Secretary/Waiting List Co-ordinator enabling the patient to inform the hospital in a timely manner where they are unable to accept the date offered.

4.3 If the patient contacts someone other than the Medical Secretary/Waiting List Co-ordinator to cancel an admission it is the responsibility of the person receiving the telephone call to inform the Medical Secretary/Waiting List Co-ordinator

4.4 If a short notice cancellation is received, i.e. within 24 hours, it is the responsibility of the person receiving the call to inform other relevant parties, i.e. the medical secretary or waiting list co-ordinator.

4.5 The Medical Secretary will update PAS with the cancellation, including the reason.

4.6 If this is the first cancellation, the patient is to be added back onto the waiting list but should be advised that if they cancel for a second time, they could be removed from the list.

4.7 If the patient has cancelled a previous admission date for the procedure, the individual case should be discussed with the clinician responsible for the patients care. In the case of vulnerable adults, children or it is felt detrimental to the patients' care, the clinician may request that the patient remain on the waiting list.

4.8 Patients who don't fall into the above category and cancel two agreed admission dates will be removed from the waiting list and their GP informed. The Medical Secretary is responsible for informing the GP and patient.

5. MONITORING AND AUDITS:

5.1 The Information Department will produce monthly reports identifying patients who have cancelled an admission date on more than one occasion and who still remain on the waiting list.

5.2 Divisions are expected to review and act upon the report, discussing specific cases with the clinician where necessary

5.3 To meet Monitor requirements, NHS Foundation Trusts are required to produce Quality Reports. In line with this, the Information Team carry out an audit of patients with an RTT Clock Stop for admitted treatment during the previous month. A report is produced and shared with Divisions, providing an opportunity to improve data recording where necessary.

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN22

Patient DNA - Admissions

1. RELEVANT TO:

Medical Secretaries
Waiting List Co-ordinators
Ward Clerks
Ward Administrators
Clinicians
Pre-op Nurse
Senior Managers

2. PURPOSE OF PROCEDURE:

To ensure all staff responsible for managing waiting lists adopt a consistent approach to managing patients who do not attend an agreed admission date, discharging them back to the GP/GDP and removing them from the waiting list

3. LINKED DOCUMENTS:

PAS Training Manual – Level 3 Waiting Lists and Referral to Treatment (RTT)
User Guides
Standard Operating Procedure – PN15 Adding Patients to a Waiting List

4. PROCEDURE:

4.1 All patients should be offered 2 reasonable dates with a minimum of 3 weeks notice

4.2 Communication of TCI dates to patients must include contact details for the Medical Secretary/Waiting List Co-ordinator enabling the patient to inform the hospital in a timely manner where they are unable to accept the date offered.

4.3 If the patient contacts someone other than the Medical Secretary/Waiting List Co-ordinator to cancel an admission date at short notice, it is the responsibility of the person receiving the telephone call to inform the relevant staff, (Medical Secretary, Waiting List Co-ordinator) including the ward where the patient is expected, in order for the cancellation to be recorded on PAS before it becomes a DNA.

4.4 If the patient fails to attend a pre-op appointment, the pre-op nurse will inform the Medical Secretary

4.5 The secretary will contact the patient to establish if the patient still wishes to proceed with surgery. If surgery is still required, a further pre-op date is arranged. If surgery is no longer required, the secretary will remove the patient from the waiting list. If the patient wishes to defer the operation for up to a period of 3 months, they will be moved to a Deferred Waiting List (See SoP PN17 – Elective Patients – Choice of Date). If following contact with the secretary, the patient wishes to be seen in outpatients to discuss treatment further with the consultant, the patient is removed from the waiting list (on clinical decision), pending an outpatient appointment.

4.6 If the patient fails to attend on the day of expected admission, a nurse from the admissions team will check with the secretary that the patient hasn't cancelled their TCI. The nurse, secretary or waiting list co-ordinator will contact the patient to see why they have not arrived and advise the medical secretary accordingly.

4.7 If there is no contact with the patient on the day of expected admission, it is the responsibility of the Ward Clerk to update PAS with the DNA. If a DNA occurs over a weekend or Bank Holiday, it is the responsibility of Ward Support to update PAS.

4.8 The RTT clock will stop at this point as the patient has declined treatment.

4.9 The Ward Clerk will send or deliver the patient hospital notes to the medical secretary advising that the patient failed to attend as soon as possible.

4.10 The secretary will endeavour to contact the patient and understand why the patient failed to attend. If the patient is able to provide an acceptable reason for the DNA, the secretary will update PAS, replacing the patient on the waiting list after discussing with the consultant responsible for the patients care.

4.11 Consideration must always be given to children, vulnerable adults and clinically urgent cases who DNA a first admission before discharging them. Where the patient is to be allocated a further admission date, they are added to the waiting list on the original date of decision to admit with the RTT clock still ticking.

4.12 If the secretary is unable to contact the patient and it is noted that they also failed to attend a pre-op appointment, the patient will not be re-instated on the waiting list. In this instance, the consultant will write to the patient, copying the GP, advising that they have been removed from the waiting list and if further treatment is required they will need to contact their GP and be re-referred.

4.13 The reason for re-instating the patient on the waiting list following a DNA must be recorded in the comments field on the waiting list module.

4.14 Patients who DNA for a second time will be automatically discharged back to the care of their GP. The secretary will write to the patient, copying the GP, advising that they have been removed from the waiting list and if further treatment is required they will need to contact their GP and be re-referred.

5. MONITORING AND AUDITS:

5.1 The Information Department will produce daily reports identifying patients who have DNA'd an agreed admission date on more than one occasion and who still remain on the waiting list.

5.2 Divisions are expected to review and act upon the report, discussing specific cases with the clinician where necessary. At this point and following discussion with the clinician, the patient may be removed from the waiting list and advised accordingly.

5.3 To meet Monitor requirements, NHS Foundation Trusts are required to produce Quality Reports. In line with this, the Information Team carry out an audit on patients with an RTT Clock Stop for admitted treatment during the previous month. A report is produced and shared with Divisions, providing an opportunity to improve data recording where necessary

Royal Devon and Exeter NHS Foundation Trust

PATIENT ACCESS POLICY

STANDARD OPERATING PROCEDURE : PN23

Armed Forces Community

1. RELEVANT TO:

Clinicians
Outpatient Appointment Clerks
Medical Secretaries
Waiting List Co-ordinators

2. PURPOSE OF PROCEDURE:

To ensure that members of the Armed Forces Community (including those serving, reservists, their families and veterans) are supported, treated equally and receive the same standard of and access to healthcare as any other UK citizen in the area they live. A veteran is defined as someone who has served at least one day in the UK armed forces.

3. LINKED DOCUMENTS:

Armed Forces Covenant

4. PROCEDURE:

4.1 It is the responsibility of the referrer when referring a patient that they know to be a veteran for a condition that in their clinical opinion may be related to their military service, to make this clear in the referral as long as the patient wishes the referral to mention they are a veteran

4.2 On grading / triaging referral letters the clinician must prioritise the referral over other patients with the same level of clinical need.

4.3 Veterans should not be given priority over other patients with more urgent clinical needs

4.4 It is for the clinician to determine whether it is likely that a condition is related to service

4.5 Family members should retain their relative position on any NHS waiting list, if moved around the UK due to the Service person being posted. To enable this, Inter-provider Transfer details should accompany the referral.

5. MONITORING AND AUDITS:

5.1 The Information Team carry out regular audits of patients with an RTT clock stop during a previous month. Where it is clearly indicated on the original referral that the patient is a veteran the member of staff undertaking the audit will check to see whether the patient received any priority. This will be noted as part of the audit report and fed back to the Directorate responsible for the service

APPENDIX 26: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Access Policy
Division/Directorate and service area	Operations Support Unit
Name, job title and contact details of person completing the assessment	Angela Dash, Principal Access Analyst Tel. 01392 406950
Date completed:	30/11/2015

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

This document has been put in place to establish a consistent approach to the management of waiting times across the organisation as well as defining roles and responsibilities and clarifying procedures relating to access on a Trust-wide basis.

2. **Who does it mainly affect?** *(Please insert an "x" as appropriate:)*

Carers ☐ Staff ☒ Patients ☒ Other (please specify)

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an "x" in the appropriate box *(x)*

Protected characteristic	Relevant	Not relevant
Age	☐	☒
Disability	☒	☐
Sex - *including: Transgender, and Pregnancy / Maternity*	☐	☒
Race	☐	☒
Religion / belief	☐	☒
Sexual orientation – *including: Marriage / Civil Partnership*	☐	☒

4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to… (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

This policy relates to those with disability related communication issues and may also affect those that are homeless (lack of a fixed address) or not speaking/reading English.

5. Do you think the document meets our human rights obligations? ☒

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:

- ***Fairness –*** *how have you made sure it treats everyone justly?*
- ***Respect –*** *how have you made sure it respects everyone as a person?*
- ***Equality –*** *how does it give everyone an equal chance to get whatever it is offering?*
- ***Dignity –*** *have you made sure it treats everyone with dignity?*
- ***Autonomy –*** *Does it enable people to make decisions for themselves?*

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

While creating this document, key parties have been provided oversight and the opportunity to comment on the processes and wording of the policy. All feedback has been collated in an inclusive manner.

This Policy continues to recognise the potential for those making referrals to advise the Trust that the patient needs an interpreter and will be updated during 2016 to reflect new accessible information standards.

Section 10.3 – patients must be allowed to plan their treatment around their personal circumstances.

7. If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

"Protected characteristic":	Disability
Issue:	Whilst the policy is legally compliant at present, it does not appear to be adequately robust (as currently written) to meet the March 2016 requirements of the accessible information standard SCC I 1605- requiring all health and social care providers to communicate with each other regarding disability related communication needs.
How is this going to be monitored/ addressed in the future:	The policy will be reviewed in consultation with parties that can enable such referral improvements to be made.

Group that will be responsible for ensuring this carried out:	Access Group