Patient Access Policy

Department / Service:	All Departments
Originator:	Kayleigh Wheatley
Accountable Directors:	CEO
Approved by:	HQC and Board
Date of approval:	26 March 2019
Revision Due:	August 2021
Target Organisation(s)	Tetbury Hospital Trust
Target Departments	All Departments
Target staff categories	All Staff

Policy Overview:
This policy has been adopted and revised by Jane Jones, with the kind consent of Kayleigh Wheatley, Validation Department, Gloucestershire Hospital's NHS Foundation Trust.

Key amendments to this Document:

Date	Amendment	By:
01.09.16	Adopted and revised for Tetbury Hospital	Jane Jones
22.02.2019	Reviewed	Jane Jones

1. INTRODUCTION
This policy details how patients will be managed administratively. This policy will reflect overall expectations of the Trust and Clinical Commissioning Group, on the management of referrals and admissions within the organisation and defines the principles on which the policy is based. This policy applies to:

- Booking referrals to an outpatient episode
- New appointments
- Follow up appointments
- Booking for a diagnostic test
- Booking a pre-operative assessment
- Booking an inpatient or day case episode

This policy and its associated Standard Operating Procedure are intended to be used by anyone, both clinical and administrative, within Tetbury Hospital Trust and other organisations where secondary care activity takes place, who are responsible for:

Referring patients
- Receiving and managing referrals
- Adding and maintaining waiting list

This policy covers General Practitioner and all other referrers.
The scope of this policy covers the 18 week referral to treatment pathway, cancer referrals and private patients who transfer their care to the NHS.

2. DEFINITIONS

Word/Term	**Descriptor**
Admitted Pathway	Patient journey that ends in a clock stop for admission (day case treatment)
NHS e-Referral Service (ERS)	National electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic
DNA	Did Not Attend. Patients who have failed to attend an outpatient appointment without informing the hospital
Outpatients	Individuals referred by a General Practitioner (medical or dental) or another consultant/health professional for clinical advice or treatment
PALS	Patient Advice Liaison Service
PAS	Patient Administration System
RTT	Referral to Treatment

3. POLICY STATEMENT
Patients and/or their carers must receive good quality, timely and relevant information regarding treatment and care. Information provided must help patients to participate fully in their own healthcare decisions and support in making choices. This will be made as and when required and as

defined by the specialty through various routes, e.g. specialty specific leaflets provided before or via consultation, copies of clinic letters, copies of discharge information.

Agreed pathways must be in place for patients which optimise outcome and use of resources.

- The purpose of this document is to outline the Trust and Commissioner requirements and standards for managing patient access to secondary care services for patients from referral to treatment. The policy covers the processes for booking, notice requirements, patient choice and waiting list management for all stages of a referral to treatment pathway and replaces all previous Access Policy Documents.
- This policy should be adhered to by all staff within the Trust who are responsible for referring patients, managing referrals, adding to and maintaining waiting lists for the purpose of progressing a patient through their treatment pathway.
- This document defines the principles and philosophy of the 18 week referral to treatment (RTT) target. These statements apply to all scheduled care commissioned by all NHS commissioners..
- The policy is designed to ensure fair and equitable access to hospital services and the appropriate allocation of resources (beds, theatres, clinics etc.) Adherence to the policy will be managed regularly through the Operational Performance Board and will be reviewed on a bi-annual basis.
- The main objective in all circumstances is for the patient to receive their treatment. There will be an occasion when a situation arises that is not covered by this policy. Any concerns should be addressed to the Head of Information Technology & Administration

4. ROLES AND RESPONSIBILITIES

Post/Group	Details
Chief Executive	• Control and co-ordination of this policy • Delegation of key tasks listed below
Medical Director	• Information governance aspects of policy and procedure (as Caldicott Guardian)
Clinical staff /Administrative staff	Responsible via Medical Director for the following: • Provide clinical judgement on further management of patients following a DNA or multiple patient cancellations. • Vet and grade referrals within 5 working days • Manage waiting lists and patient waiting times in accordance with the maximum guaranteed waiting times and RTT pathway. • Ensure patients are not listed unless medically fit and ready for procedure. • Comply with the Trust Leave Policy and Study Leave - Consultants, SAS Doctors & Hospital Practitioners Policy, to ensure adequate notice and cover for absences. • Ensure discharge summaries for Day surgery are completed within 24 hours of patient discharge and shared with GP practices electronically via Docman

	• Provide outpatient clinic outcome information on the day of clinic to reception staff • Record waiting list data at point of decision and add to the PAS waiting list within 24 hours. • Provide emergency admissions notifications to GP practices • Provide ED discharge summaries to GP practices within 24 hours. • Provide Outpatient clinic letters within 5 days.
Head of Information	• Maintenance of PAS and other reporting systems on which all waiting lists are held • Ensure Systems Managers maintain data appropriately • Provide regular data quality audits of standards of data collection and recording, and the submission of central returns
Matron	• Manage non-compliance by Trust staff and escalate issues to CEO • Resolve minor issues and log incidents via Incident Form • Provide regular data quality audits of standards of data collection and recording, and the submission of central returns
Wards and departments	• Ensure that all patient movements are accurately transacted via PAS, i.e. admissions, ward transfers, hospital transfer and admitting consultant changes through to discharge • Ensure case notes are available for admission date
Theatre Manager	• Relay any changes to patients' planned procedure, (cancelled or delayed more than 24 hours) to the waiting list co-ordinator
Medical Secretaries	• Ensure outpatient clinical outcome correspondence is produced within a maximum of 5 working days of a patient event and that the letter is stored via Tetbury Administration drive - Correspondence to be shared with patient and GP unless the patient has opted out GP letters to be sent electronically via Docman • Ensure the appropriate RTT code is recorded on PAS in a timely manner. This must reflect the clinical decision, either by letter or by clinical action
Lead Receptionist/Health Records Coordinator	• Ensure requests for patients record are actioned and records are available
Managers	• Evaluate the impact of any process or services changes on RTT pathways

All Trust staff	• Report breaches of this policy

5. ROLE OF THE CLINICAL COMMISSIONING GROUP

- Ensuring robust communication links are in place to feed back any service changes made by the Trust to GP's and other referrers.
- Promoting use of agreed electronic referrals, e.g. NHS e-Referral Service (ERS) to improve patient experience and reduce waste.
- Engage in cross health community redesign of clinical pathways
- Establish service specifications

6. REFERRER PATHWAYS

General Practitioners and other referrers must ensure the following:

- That referrals are clean and contain the minimum data set required to process referrals effectively and efficiently (see Table 1 below)
- That patients are made aware of the likely waiting times for a new outpatient consultation and of the need to be contactable and available when referred
- That patients placed on a urgent care pathway are aware of the reasons and urgency of the referral
- That established referral pathways are followed to ensure that patient care is not delayed unnecessarily

ALL referrals from GP's to be sent via ERS (Electronic Referral Service). Only tertiary referrals are permitted to be sent manually.

Table 1: Minimum data set for referrals

Patient Demographics	Referral Details	Other (if required)
• Given name • Family name • NHS number • Full postal address • Contact telephone number(s) – at least one number, e.g. home, work, mobile • Title (Mr, Mrs Miss etc.) • Date of birth] • Gender • Ethnicity	• Status of referral (routine/urgent/suspicion of cancer) • Referrals detail; presenting complaint, history etc. • Any relevant test results or reports (see RCGP Good Medical Practice for GPs 2008) • Referral source, (GP, HM Prison Medical Officer etc.) • Referral source address • Referring clinician	• Patient periods of unavailability • Armed Services Veteran Status • Support needs (disability/interpreter)

7. PATIENT INPUT

The Trust also places reasonable expectations as to how patients with interact with the services that they are accessing:

- It is vital that patients must inform the hospital of any changes to their name, address, contact number or GP to ensure correspondence reaches them.

- Patients should keep their appointments, and make every effort to arrive on time.
- If the patient cannot attend, they should inform the hospital with as much notice as possible.
- Patients must inform their GP if their medical condition improves or deteriorates in any way which may affect their attendance.
- Patients who know that they will be unavailable for any period of time and therefore will not be able to attend an appointment or admission should inform the hospital with as much notice as possible.
- Patients who no longer wish to have their outpatient appointment or admission, for whatever reason, must advise either their referrer or the hospital appointment office.
- Patients are encouraged to ask staff about any aspect of their care and the steps towards their treatments.
- Patients are encouraged to feedback comments or suggestions regarding their experience of services provided by the Trust.
- Patients are encouraged to ask Clinical staff any questions they have regarding their condition, treatment or support before leaving the hospital.

8. PROCESSES

The referral process is as follow:
The booking office receive notification of an appointment booked through ERS – at this point the appointment is unconfirmed.
The appointment is triaged by the consultant for appropriateness and speed of appointment – once triaged the booking is confirmed to the patient by telephone if less than two weeks' notice, with an appointment letter following.

9. PERFORMANCE MEASURES

The following table defines the performance measures to ensure compliance, along with those responsible for achieving the measure.

Table 2: Performance measures metrics

Post/Group	Measure
Patients	• Patient satisfaction survey • Patient cancellations • Do not attend
Clinical Commissioning Group	• Increase NHS e-Referral Service compliance • Reduction in written referrals
General Practitioners	• Use of NHS e-Referral Service • No written referrals • Complete Minimum data set
Medical Director	• Waiting list management • Discharge summaries via appraisal and job planning • Vetting referrals • Clinic letters • Outcomes, exception report
Head of Information Technology & Administration	• DATIX recording • Reduction in validation • Meeting national waiting time standards
Managers	• Meeting national waiting time standards

	• Specialty level standards (To be defined locally)
Wards & Departments	• Updated admissions, discharges and transfers • Notes availability
Theatre Manager	• Cancelled operations • Theatre availability
Medical Secretaries	• Achievement of outpatient and discharge letter standards Reduction of incompletes pathways • Monitoring of data quality reports
Health Records Manager	• Availability of notes
Booking Centre Manager	• Reduction of cancellations • NHS e-Referral Service compliance • Reduction of follow-up pending list

10. TRAINING

The Trust is committed to providing training relating to the Patient Access to Treatment Policy and Procedure. The training elements will be divided into two categories:

- Relevant staff will receive the Basic Patient Access to Treatment information and presentation and access to an e-learning package.
- Patient Administration Training session - Staff will attend according to job role, including refresher training yearly or sooner if required.

11. MONITORING OF COMPLIANCE

Do the systems or processes in this document have to be monitored in line with national, regional or Trust requirements?	**YES**

Monitoring requirements and methodology	**Monitoring requirements and methodology Frequency**	**Monitoring requirements and methodology Frequency**
KPIs will be reported via Performance dashboards and addressed via Divisional Performance Review	6-monthly	• Review by Planned Care Board, who will make any recommendations for changes to policy

Further actions Frequency Further actions Further actions

PATIENT ACCESS TO TREATMENT POLICY – DOCUMENT PROFILE DOCUMENT PROFILE

REFERENCE NUMBER	B0523
CATEGORY	Non-Clinical
VERSION	V2.2
VERSION AMENDMENTS	V2 – August 2015 V2.1 – September 2015 V2.2 – April 2016
SPONSOR	Eric Gatling, Director of Service Delivery
AUTHOR	Kayleigh Wheatley – Patient Access Manager
ISSUE DATE	08/2015
REVIEW DETAILS	08/2018 – review by Eric Gatling, Director of Service Delivery
ASSURING GROUP	Trust Policy Approval Group
APPROVING GROUP	Planned Care Board
APPROVAL DETAILS	Policy approval: Planned Care Board, July 2015 TPAG approval: e-approved August 11th 2015
EQUALITY IMPACT ASSESSMENT	
CONSULTEES	
DISSEMINATION DETAILS	Upload to Policy Site; global email; cascaded via divisions
KEYWORDS	Patient access, appointment, RTT
RELATED TRUST DOCUMENTS	Patient access to treatment procedure
OTHER RELEVANT DOCUMENTS	
EXTERNAL COMPLIANCE STANDARDS AND/OR LEGISLATION	

1. INTRODUCTION

This procedure underpins the Patient Access to Treatment Policy and will be the vehicle for ensuring the policy is adhered to. This will be supported by a series of action cards that will be used to define the training requirements.
This is the standard operating procedure for all administrative actions on the patient access to treatment pathway.

2. DEFINITIONS

Word/Term	Descriptor
Admitted Pathway	Patient journey ending in a clock stop for admission (inpatient or day case treatment)
NHS E-referral service (ERS)	National electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic
DNA	Did Not Attend (patient did not notify the hospital of non-attendance)
MDS	Minimum Data Set; required data items for processing the associated request
Outpatients	Patients referred y a GP (medical or dental) or another consultant/health professional for clinical advice or treatment
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
RTT	Referral to Treatment
TCI	To come in

3. ROLES AND RESPONSIBILITIES

See roles and responsibilities listed in the Patient Access to Treatment policy.

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4. Making referrals

All new outpatient referrals must be:

- Made to a service rather than clinician. Only where clinically required should the referral be made to a named Clinician.
- Made via NHS e-Referral Service only All other non-
  outpatient referrals must be sent directly to the relevant department.
- Referrers must ensure that referrals are clear and contain the minimum data set (MDS) required to process referrals effectively and efficiently :

Patient Demographics	Referral Details	Other (if required)
• Given name • Family name • NHS number • Full postal address • Contact telephone number(s) – At least one number e.g. home, work , mobile • Title (e.g. Mr, Ms, Miss, Mrs.) • Date of birth • Gender • Ethnicity	• Status of referral (routine/urgent/suspicion of cancer) • Referral details presenting complaint, history etc. • Any relevant test results or reports (See RCGP Good Medical Practice for GP 2008) • Referral source e.g. GP, HM Prison Medical officer etc. • Referrals source address • Referring clinician	• Patient periods of unavailability • Armed Services Veteran Status, see 4.6, War Veterans - special notes. • Any support needs (e g disability / interpreter) • Copy of any relevant imaging reports and name of provider where imaging undertaken

4.2 Validate and register referral

On receipt of the referral to the Trust (booking staff), all outpatient referrals will be date stamped by the member receiving the referral and validated within one working day for appropriateness, i.e.:

- Referral must contain minimum data set as detailed in 5.1 and be validated against information held on the hospital patient administration system. Any change must be recorded and/or updated
- Patient is willing and able to be seen within time
- Referral fits with Tetbury Hospital Trust Guidelines and Clinical Commissioning Group
- Lead healthcare professional for the patient is based on the clinical detail provided within the referral letter.
- Duplicate registrations must be escalated to the Health Records Department.
- Additional/Special notes are able to be accommodated, e.g. physical needs

4.2 Managing inter-provider transfer forms

Where patients are transferred between providers, including primary care intermediate services, the standard inter-provider form with MDS must accompany the referral. This is the responsibility of the organisation referring the patient to the Trust.
In accordance with national timescales, referrals to other provider organisations will be sent within two working days of the decision to refer being made.
Contact email address: RTT.Team@glos.nhs.uk

4.3 Consultant to Consultant referrals for same condition

The date of a consultant to consultant referral must be the date the patient was advised they would be referred, e.g. if a patient is seen in clinic on 1st June, the decision to refer date will be that date, the 1st June.

Appropriate and accepted referrals will follow the same administration pathway as outpatient referrals from the GP.

4.4 Patients transferring from non-NHS (private) patient status
Patients that have been seen, as an outpatient, in the private sector and choose to undertake their treatment Tetbury Hospital Trust Ltd are permitted to do so.
Patients, following a private outpatient appointment/consultation, who wish to change to NHS for their diagnostic imaging may do so, but this must be arranged by their GP. The GP may directly refer the patient for the test is appropriate, i.e. test is available to the GP through Direct Access. Where the test is not available to the GP, they must make an outpatient referral for the patient. On vetting the outpatient referral, the clinician can refer the patient for the test without the patient having to attend another outpatient appointment.
Private clinicians cannot refer a patient for an NHS Diagnostic test.

4.6 Add to outpatient waiting list, prior to grading
Appropriate referrals will be added to the new outpatient waiting list:

- In chronological order, where patients have not already expressed a choice via NHS e-Referral Service.
- Within one working day of receipt.
- Clinician with the relevant specialism and the shortest wait time (therefore may not necessarily be the clinician originally requested unless a clear indication for a specific clinician is requested).

Manual or paper waiting times must be calculated from the date that the referral was received. Electronic or NHS e-Referral Service waiting times must be calculated from the date that the UBRN is converted, i.e. an appointment is either made or attempted to be made. **Overseas visitors - special notes:**

- For any overseas visitors notify the Overseas Visitors Officer.
- Separate guidance should be referred to when managing the treatment of overseas visitors, as access to the Health Service may be limited. Refer to the *GHNHST Overseas Visitors Policy*.
- Department of Heath guidance on overseas visitors may be found at: https://www.gov.uk

Private patients – special notes

- Patients may opt to transfer to NHS. Outpatient appointments will be managed the same as stated above.
- In the event that a patient requires surgery (as is known to the consultant performing the surgery) patients will not require an outpatient appointment.

War veterans – special notes

- Where the patient is content for their military status to be included, GPs are asked to clearly state this when drafting referral letters, including, in their clinical opinion, that the condition may be related to military service.
- Where secondary care clinicians agree that a veteran's condition is likely to be service-related, they are asked to prioritise veterans over other patients with the same level of clinical need.
- It remains the case that veterans should not be given priority over other Patients with more urgent clinical needs.
- Family Members should retain their relative position on any NHS waiting list if moved around the UK due to the service person being posted.

Contacts and links: DoH.ArmedForcesnetworks@nhs.net
http://www.nhs.uk/NHSEngland/Militaryhealthcare/Pages/Militaryhealthcare.aspx

4.6 Dispatch referral letter for grading
Referral letters will be distributed to the relevant Consultant within one working day of receipt. Preferably electronically and all NHS e-Referral Service referrals will be vetted online.

4.7 Vetting and grading referral letter
Clinical staff must confirm:

- Vetted for appropriateness (with the exception of cancer referrals, which will be booked without vetting).
- Graded for clinical need i.e. referral fits with most appropriate clinician
- Graded for priority outcome i.e. cancer, urgent, routine or advice only
- This must be done within 5 working days

4.9 Not appropriate referrals or request for advice only – see also action card PAP2
Referrals not considered appropriate/advice only will be managed as follows:

Referral	Action	Timescale
Does not contain minimum data set	Returned to the referring source with an explanation for rejection , if not urgent and note in comments	1 working days of receipt of letter
Does not fit with appropriateness	Returned to the referring source with an explanation for rejection and note in comments	3 working days of receipt of letter
Requires advice only	Responded to directly by the receiving Clinician to the referrer e.g. GP etc Transactions must be recorded via PAS, note in discharge comments	5 workings days of receipt of referral
Does not match need of patient e.g. if a referral has been made and the special interest of the Consultant does not match that of the patients requirements	The Consultant must cross-refer the patient to the appropriate Consultant colleague within the same specialty This is not a new pathway.	3 working days

4.9 Update outpatient waiting list entry, post grading
Booking staff must record the outcome of grading via PAS and either:

- Book referral
- Re-direct referral
- Remove referral

4.10 NHS e-Referral Service– see also action card PAP3 for non NHS e-Referral Service
The Trust will ensure sufficient provision of slots available through NHS e-Referral Service to enable patients to choose between at least two appointments for their appropriate service within the polling range.

To comply with the operating framework the trust will list their services on NHS e-Referral Service in such a way that allows users to book appointments with consultant led teams.
Where it has been agreed that a referral proforma is the preferred method of referral these should be attached by the GP to NHS e-Referral Service, for urgent and cancer referral this must be within 24 hours, other referrals 3 days.

Appointments unable to be booked via NHS e-Referral Service due to insufficient capacity are booked into appointments following discussion with the patients

5. MANAGING OUTPATIENT APPOINTMENTS, AMENDMENTS AND CANCELLATIONS

Amendments will be transacted via NHS e-Referral Service and PAS, and managed according to the reason for change.

Note: Action card PAP3 describes the process for any paper referrals, i.e. those not using NHS e-Referral Service.

5.1 Booking an appointment

Patients must be:

- Booked as per clinical need, i.e. routine, urgent or cancer
- Booked in chronological order
- Booked from the outpatient waiting list.
- Given 3 weeks' notice and a choice of 2 appointments

5.2 Cancellation of an outpatient appointment: patient initiated - see also action card PAP4

- Patients are allowed **one** cancellation of a previously negotiated appointment. Upon a second cancellation the patient will be discharged and returned to the care of the care of their referrer.
- A letter must be sent to both the referrer, e.g. GP, and the patient
- Patients must be clearly advised about the cancellation policy

Appointment still required - Special notes

If at a later date, the appointment is still required, the patients GP must re-refer the patient This must be treated as a new referral as per the date of the re-referral whether received in writing or by telephone call. Consideration must be given to vulnerable patients and in exceptional circumstances it may not be necessary to instigate a re-referral.

5.3 Amendment to booked appointment: with same Consultant: hospital initiated

The Trust aspires to ensure that no patient will have their appointment cancelled and seeks to only cancel appointments in exceptional circumstances (e.g. consultant sickness etc). In the event of hospital initiated cancellation the following principles apply:

Patients will be:

- Notified as soon as possible
- Offered an alternative appointment, which must be booked within 2 weeks using the original clock start date

5.4 Amendment to booked appointment: hospital administrator error – appointment booked on incorrect episode

In the event that the patient has been added to the incorrect waiting list the entry must be:

- Deleted via PAS
- Ensure correct administration process is applied if applicable

5.5 Amendment to booked appointment: with different consultant (same specialty), hospital initiated

Patients must be removed from appointed waiting list via PAS, and:

- New entry made, using the original referral date

- Record transfer details in comments

5.6 Amendment to booked appointment: required, i.e. with different consultant (different specialty), hospital initiated
In the event that patients cannot be dated within the access target patients must be found an alternative date this may be with a different consultant within the same specialty but a shorter waiting time.

6. MANAGING AND MAINTAINING OUTPATIENT WAITING LIST
6.1 Clinic template set up, alterations and cancellations
- Outpatient clinic start and finish times will reflect achievable clinic session for the clinical staff via their job plans.
- New slots will be a maximum of 30 minutes and follow up slots will be a maximum of 15 minutes.
- As much notice as possible must be given for any changes/alterations to clinic templates and the minimum notice is set at 6 weeks.
- Changes or cancellation with less than 8 weeks' notice will be monitored and reported on.
- General Managers or equivalent are authorised to make changes in conjunction with Booking Services

6.2 Validation guidance and checklist
Outpatient waiting lists must be maintained, this will require regular validation to ensure entries are timely and accurate, i.e errors must be corrected as soon as they are discovered. Errors that are discovered after the event and affect patient care or patient data must be escalated to the Patient Access Manager, and relevant General Manager. Log an incident report using DATIX Web.

6.3 Pathway flow
Pathways for patient care will differ within specialties and dependant on the patient needs and complexity of services. Directorates must ensure that they work collaboratively with external and internal staff to provide the most direct access to treatment for patients' and that provides that most effective and efficient service.
For further information relating to specific pathways flows refer to National guidance, e.g.
- Chest pain
- Allied Health Professionals: www.gov.uk/government/publications/allied-health-professional-referral-to-treatment-revised-guide-2011

6.4 Inadequate clinic capacity
Every effort must be made by the Trust to ensure capacity matches demand. In the event of inadequate clinic capacity booking staff must escalate to the General Manager within 24 working hours.

6.5 Potential breach patients
Every effort must be made to ensure patients are seen within target. In the event that a patient potentially cannot be appointed within target booking staff must escalate to the General Manager within 24 working hours.
General Manager must use the Trust Business Intelligence (BI) tool to ensure patients are not breaching their target date.

6.6 18 week breach reporting
- Before a breach is declared, carry out a full validation to rule out any points that may alter the situation, e.g. has the patient been administered correctly, has the patient been treated elsewhere.

- Escalate any potential breaches to the Patient Access Manager for full investigation within 24 working hours.
- The Patient Access Manager must verify the outcome and escalate to the Divisional Director within 24 working hours.
- All breaches must be verified by the Divisional Director before they are submitted to Information Department and the director of Service Delivery within 24 hours.

7. MANAGING CLINIC OUTCOME FOLLOWING OUTPATIENT APPOINTMENT

- Consultants/clinical staff must complete the clinic outcome, i.e. RTT pathway and any procedure codes on day of clinic. Action any clinical needs outcomes on day or within 24 working hours, e.g. order test results, complete add to waiting list request form.
- Dictate outcome letter on day of clinic or within 24 working hours so that the letter can be made available to the patient's GP or referring clinician within 5 working days from the clinic date.
- Nursing staff must assist the reception staff to ensure outcomes are detailed to the reception staff on day of clinic.
- Reception staff must record RTT pathway and any procedure codes via PAS on day of clinic or within 24 working hours of clinic.
- Medical secretaries/support secretaries must produce a clinic summary letter ready for Consultant verification within 72 working hours of receipt of dictation.
- Ensure the outpatient clinic letter is sent to the patient and their GP unless the patient has opted out within 5 working days from the date of the outpatient appointment.

7.1 Patient non-attendance (DNA) – see also action cards PAP7 and PAP8

- Patients who fail to attend their new appointment without notifying the Trust, and no further appointment is indicated following clinical review, will be discharged back to the GP.
- Patients who fail to attend their follow-up appointment without notifying the Trust, and no further appointment is indicated following clinical review, will be discharged back to the GP.
- The GP and patient will be informed, by means of a standard letter that the patient failed to attend their outpatient appointment and has been discharged back to the care of the GP – this will be recorded as a treatment status of "discharge". In the event that additional clinical information is required to be communicated to the GP, the Clinician must communicate this at point of discharge by way of a non-standard discharge summary (containing any special instructions). **The discharge letter must state that the patient can re-book a new appointment if discharged. The patient will need to contact the Trust. Patients will have a new clock start date from the date the Trust is contacted by the patient.**
- If rebooking of a (first) new patient appointment is required, another appointment will be made as a default and a new 18 week pathway clock will start.
- If rebooking of a follow-up appointment is required, another appointment will be made as a default and the 18 week clock will continue.

Paediatric – special notes
New and follow up appointments – Special notes

• The consultant or relevant health practitioner will make a decision as to whether the appointment needs rescheduling (urgently or routinely) or if the patient can safely be discharged back to the care of the GP.
• Particular attention must be paid to those children who are known to be in receipt of a child protection plan, who are children in need or looked after children. The consultant or relevant health practitioner will record the

actions in the notes, will write informing the GP of the actions taken and will communicate with any social worker or other health professional as necessary. Repeated DNA's must be followed up with the GP.

7.2 Patient attended: not seen

If a patient attends their appointment but subsequently leaves due to a delay in being seen i.e. clinic running late, providing they inform the receptionist of their intention this must be:

- Recorded as a patient attendance without an outcome/left before being seen.
- A new date must be rebooked as soon as possible.

Failure to inform receptionists of their intention to leave will result in a DNA being recorded and the patient must be discharged and returned back to the care of their GP

7.3 Patient attended: seen and no further appointment (including transfer to inter-provider)

Patient completing their treatment or no longer require treatment will be:

- Discharged back to the care of their GP, with letter to GP.
- Notified in writing by the Clinician of the discharge.
- Discharge will be transacted via PAS

7.4 Patient attended: follow up requested (more than 6 weeks) - Add patient to partial booking waiting

All patients with a clinical need for a follow-up appointment must have one. Where clinically possible, patients can be referred back to the GP for care in the community. Clinicians will be responsible for ensuring good use of resources and that patients are not brought back unnecessarily. Where clinical need for a follow up, patients must:

- Be added to the relevant follow up waiting list.
- Be booked in chronological order.
- Be booked in order of clinical need.
- Be notified of the trusts intentions, e.g. by being sent a letter when added to the follow up waiting list.
- Instructed to contact the Trust in the event of change in condition (e.g. no longer require appointment).
- Instructed to contact the Trust where the date of expected follow up appointment has passed.

7.5 Patient attended: follow up requested (less than 6 weeks) - Book appointment

Patients must be booked in order of clinical need.

7.6 Patient attended: seen, further treatment required i.e. add to a day case or inpatient waiting list – see also action card PAP9

Patients must be added:

- To a waiting list at the time that the clinician agrees with the patient that the elective intervention is required. This will normally be at an outpatient appointment and that clinic attendance date will then be the original date on list.
- Only if they are fit, willing and able.

Patients must not be added if they wish to defer their treatment, i.e. for up to **SIX** months (for example to take time to consider whether this is the right course of action for them).

Funding approval - Special notes

• Patients must only be listed for agreed procedures.

• In the event that a procedure is requested and falls under the criteria for Referral and Treatment Criteria (RaTC) i.e. those that would not be routinely funded must be escalated to the General Manager and identified to the relevant CCG in line with the RaTC criteria.

• If no response to accept or reject has been made within 14 workings days escalate via the Patient Access Manager. The Patient must be kept informed.
• Only when approval from relevant CCG is received can the active waiting time commence. Timeframe for decision making must be kept to a minimum.
• This will still start from when the original decision to add patient was made.

7.7 Patient attendance: outcome unknown

Outpatient staff, including consultants, nursing and reception staff, must ensure clinic outcomes are collected and transacted via PAS in real time.

7.8 Patient attendance: outcome not completed

- In the event of a delay in actioning outcome, i.e. patient not added to follow up list or treatment waiting list within six months of last episode, the patient will be issued with an outpatient appointment urgently and recorded as a follow up.
- An investigation must take place to determine reason for the outcome not being completed. This must be escalated to the Divisional Director, and logged via DATIX, the trust incident system.

8. MANAGING DIAGNOSTICS – see also action card PAP10

Diagnostic tests can be in the form of Imaging, Endoscopy, Audiology, Cardiology, Neurophysiology, Respiratory and Urodynamics etc. Patients referred for a diagnostic test must be:

- Seen within 6 weeks of referral with the exception of a suspected cancer referral, breast pain, rapid chest pain or urgent. These will need to be seen sooner i.e. within 0-2 weeks.
- DNA's and cancellations will be managed the same as outpatient referrals.

Diagnostic tests can form part of the RTT pathway. A patient's wait for a diagnostic test begins when the request for the diagnostic is made, and ends when the patient undergoes the test.

Six week target exceptions – special notes

• Patients waiting for a diagnostic procedure as part of a screening programme e.g. routine repeat smear test
• Expectant mothers booked for confinement.
• Patients currently admitted to a hospital bed and are waiting for an emergency or unscheduled diagnostic as part of their inpatient treatment. Where it would be clinically inappropriate to proceed with the procedure or have had the procedure as part of their admission.

9. MANAGING PRE-OPERATIVE ASSESSMENT

Following a decision to treat patients must be referred for a pre-operative assessment. There may be some cases where this is not clinically required.

Pre-operative assessment criterion for tests - Special notes

• Bloods and swabs tests are valid for 18 weeks prior to surgery
• Where there is a gap of more than 18 weeks between the pre-operative assessment and surgery bloods and swabs will need to be repeated.
• All other pre-operative assessments are valid for 18 weeks prior to surgery
• Where there is a gap of more than 18 weeks between the pre-operative assessment and surgery a further pre-operative assessment will be required.
• Should group and save be required this is only valid for 3-5 days.

9.1 Book pre-operative assessments - Health Screening Questionnaire

- All patients added to the elective waiting list will complete a health screening questionnaire as part of the process to determine fitness for surgery. Assessments must be made within a reasonable time frame. Repeat assessments must be avoided.
- Patient will attend pre-operative assessment or undergo a telephone fitness assessment.
- Patients who attend pre-assessment, if surgery is required and the patient is fit the patient will be offered a procedure date as soon as possible.

9.2 Managing non-attendance DNA
DNA's will be managed the same way as those for an outpatient.

10. MANAGING THE BOOKING OF PATIENTS FOR DAYCASE AND INPATIENT TREATMENT
Patients must be managed, fairly, timely, accurately and according to clinical priority. They must also be recorded on the PAS waiting list, no manual records to be kept.

10.1 Patients on an active waiting list - see also action card PAP11

Patient must be:
- Given reasonable notice, i.e. contacted by phone to agree an admission date. Where contact cannot be made, patients will be sent an offer of admission letter, with a minimum of three weeks' notice of the intended admission date.
- Booked in chronological order
- Booked in order of clinical need, i.e. urgent before routine
- Patients must be informed of the rules of the waiting list policy with regard to the consequences of not attending on the agreed date for their surgery.
- Offered dates on any of the hospital sites (the trust will aim to appoint at the closest site to patient address. If a patient particularly requests to be treated in one hospital but an earlier date is available at another, the original date offered must be transacted via PAS as a TCI offer made and refused by the patient).

If the patient cannot agree a date within their pathway or wishes to wait longer, whether it's for treatment at a particular site, or with a particular clinician then this information must be recorded and a decision will be taken by the Directorate General Manager & Patient Access Manager regarding the options available – i.e. whether the patient will be removed from the waiting list, pending a self-referral within six months.

10.2 Patients on planned waiting list
Patients must only be included on planned waiting lists if there are clinical reasons why the patient cannot have the procedure or treatment until a specified time, i.e.
- **More than one stage operation** e.g. sequences, or skin grafting/breast/plastic reconstruction, or removal of metal work when the decision to remove is made at the time of fitting.
- **Medication intervention/work-up** e.g. Patient requiring chemotherapy, change of drug regime (this excludes patients on warfarin), or hormones.
- **Surveillance endoscopies** e.g. follow up or repeat procedure
- **Anatomy cycles** e.g. female patients requiring specific gynaecological surgery which have to be timed within their menstrual cycle.

(N.B. Above is not a finite list).
Do not add patients to the planned admission list if:
1. They will require another procedure but it is unknown when this will occur, e.g. bilateral joint replacements will require the new procedure to take place and the patient to become fit again before the second can occur.

2. The second admission is not related to the initial admission
3. The course of treatment is uncertain
4. The procedure is due to a new issue

Patients on planned waiting list will have an RTT clock status of 'treatment already commenced or on-going' or 'watchful wait/active monitoring'.

Patients on planned waiting lists are not included in RTT measurement, but must have a to be booked date.

10.3 Patients requiring more than one procedure

- Patient must be only added to one list, i.e. the consultant's list for the primary procedure.
- Patients requiring more than one procedure, i.e. bilateral (e.g. operation to both eyes) or non-bilateral (e.g. knee and eyes) to be performed on separate occasions with same or different consultant - Special notes:
- Patient must be added to the active waiting list for the first procedure.
- Once the patient has undergone the first procedure and is declared fit, willing and able they must be added to the active list for subsequent procedure
- Patients cannot be listed (on an active list) for more than one identical procedure at any one time

10.4 Patients referred for excluded procedures

There are restrictions that apply to certain procedures. Where the Trust does not have agreement with the local Clinical Commissioning Groups (CCG) patients must NEVER be listed, unless agreement has been sought from the Director of Service Delivery. For further information refer to the Gloucestershire Referral and Treatment Criteria: Individual Funding Requests

10.5 Patients referring from non-NHS (private) patient to NHS

- A patient who chooses to be treated privately is entitled to NHS services on exactly the same basis of clinical need as any other patient.
- Any patient seen privately is entitled to change his or her status subsequently and to seek treatment as an NHS patient.
- Any patient changing their status after using private services must not be treated differently from other NHS patients.
- Any patients referred to an NHS service following a private consultation or private treatment should join an NHS waiting list at the same point as if the consultation or treatment had been an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients. Patients will be listed in line with this policy, i.e. dated in chronological order and clinical priority.
- If a patient admitted to an NHS hospital as a private inpatient subsequently decides to change to NHS status before receiving treatment, there should be an assessment to determine that patient's priority for NHS care.

Joining the waiting list:

Following any private consultation or private treatment, a patient will join the waiting list as if the consultation or treatment was an NHS service. Therefore, the patient should not be referred back to general practice for a decision about onward referral unless the patient wishes to take this course of action, or the onward referral is for diagnostic imaging.
In the event that the referring clinician has not seen the patient prior to treatment patients must be given an outpatient appointment, in line with this policy prior to treatment. However, those patients

that may have already seen the excepting clinician in the private sector may not require an outpatient appointment before an inpatient, day case or diagnostic procedure.

11. MANAGING AMENDMENTS AND CANCELLATIONS TO DAY CASES OR INPATIENTS
Changes to planned treatment must be transacted via PAS and managed in accordance with guidance as stated below.

11.1 Cancellation
Appointment no longer required, patient initiated
Patient must be:
- Discharged back to the care of their GP, with letter to GP.
- Notified in writing by the clinician of the discharge.
- Discharge transacted via PAS with appropriate RTT code recorded.

11.2 Cancellation and re-date patient initiated
In the event of a patient cancellation, patients may rearrange another mutually convenient date. This date must be within their access target and may be prior to the original admission offer.

11.3 Thinking time or defer treatment: patient initiated
On occasion, a patient may be given a choice of treatment options and asked to think about these. This is referred to as 'thinking time' and is limited to a maximum of two week. This must be recorded by the clinician in the clinic outcome letter. During this period the clock will continue to tick.
There may be occasions when patients request time beyond thinking time to consider their options and to see how their condition progresses. In these circumstances the clock will stop (treatment declined). However, this will require a period of active monitoring. Only when the patient and the clinician agree that treatment is the best option then a new clock will start (for example at a follow up appointment).

If a patient fails to make a decision, and where there is not risk to patient safety, the patient must notified in writing and a letter sent discharging them back to their GP.

11.4 Amendment on day of treatment, hospital initiated – see also action card PAP13
No patient should have his or her admission cancelled for non-clinical reasons. However there will be occasions when operational pressures require changes to the day's planned activity.
Any potential on-the-day cancellations must be escalated in advance of the decision to cancel to the relevant Divisional Director.
In the event of cancellation by hospital the patient must be:
- Contacted with an explanation given for their reason for cancellation
- Offered another admission date within their access target and within 28 days of the cancelled operation date.
- Transacted via PAS.
- If a date cannot be found within 28 days this must be escalated to the relevant Divisional Director.

11.5 Amendment in advance of treatment, hospital initiated.
A cancellation that occurs on the day before the planned TCI date does not constitute a reportable cancellation, although every effort will still be made to rebook the TCI date as quickly as possible.
In the event of cancellation by hospital the patient must be:
- Contacted with an explanation given for the cancellation
- Further choices of a TCI date discussed and agreed
- Transacted via PAS

11.6 Patients clinically identified as unfit, with long-term illness or requiring clinical intervention and where patient is NOT expected to recover within two weeks

Following pre-operative assessment appointment, the pre-operative assessment team will confirm whether a clock stop is required. Any decision which does not require guidance from the clinician must be made by the pre-operative team within TWO working days to the booking team.
Patients who require simple diagnostics e.g. echocardiogram or anaesthetic assessment must have appointment within two weeks. The locally agreed process within the specialty will be followed.
Patients who require multiple diagnostics or other specialist review will be removed. If the reason is that the patient has a condition that itself requires active treatment or monitoring for a period of more than two weeks the patients will be removed from the waiting list and discharged back to the care of their GP or actively monitored by their Trust Clinician (via outpatients). Either action results in the patients 18 week clock being stopped. Re-referrals from the GP or a subsequent decision by the clinician to attempt treatment again will initiate a new clock start and pathway.
Patients can self-refer for up to six months. Pathway will start from the date of the new referral.
When patients are unfit for more than two weeks will be managed as follows:
Patients that do not require clinical decision to remove:

- Pre-operative assessment team will instruct the relevant divisional team to send a letter to the GP with copy to the consultant detailing reason for removal from list
- Booking Services to send a letter to the patient and remove the patient from the waiting list

In the event that a patient is removed and the clinician decides that the patient does require treatment then the patient must be re-instated via PAS, and the clock will continue to tick.
Patients that require clinical decision to remove i.e. patients on cancer pathway, urgent, children and vulnerable adults or any patient that the pre-operative team deems necessary to:

- Pre-operative assessment team to notify the consultant detailing reason for potential removal. Notify booking team.
- Booking team to add new entry onto tracker list to await consultant 'removal approval'
- Consultant to make decision within five working days. Consultant to notify booking team
- Booking team to action outcome, e.g. letter to GP and patient and remove from list, book OPA for monitoring, remain on list.

11.7 Patients clinically identified as unfit, with short-term illness and where patient is expected to recover within two weeks from decision

- If the patient is unfit due to minor acute clinical condition e.g. cold or cough, they remain on waiting list and are allowed time, i.e. maximum two weeks to recover.
- Patients must be re-dated within their access target. Where this is not possible patients must be re-dated as soon as possible and no more than a maximum of four weeks from date of recovery.

11.8 Patient that does not attend (DNA)

Where a patient fails to attend, or attends too late to be treated, without prior notice then their admission offer outcome must be recorded as DNA. The Trust must ensure that the appointment was clearly communicated to the patient before they are regarded as a DNA.
Patients who DNA will be:

- Removed from the waiting list.
- Discharged back to GP.
- Patient and GP to be notified.

Exceptions to this rule are children, vulnerable adults and cancer pathway referrals.

12. TRAINING

All staff involved in patient bookings must have an awareness of this procedure.

13. MONITORING OF COMPLIANCE

Do the systems or processes in this document have to be monitored in line with national, regional or Trust requirements?

YES

Supporting POLICY Document 1 Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay, bisexual and transgender people	No	
	• Age	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	NA	
4.	**Is the impact of the policy/guidance likely to be negative?**	NA	
5.	**If so can the impact be avoided?**	NA	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	NA	
7.	**Can we reduce the impact by taking different action?**	NA	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	**Yes/No**
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	No

Supporting Document 3 – Privacy Impact Assessment Tool

Please review the question below: Answering ‘yes’ to any of these questions is an indication that a PIA is required

	Title of document:	Yes/No
1.	Will the policy involve the collection of new information about individuals?	N
2.	Will the policy compel individuals to provide information about themselves?	N
3.	Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	N
4.	Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used for?	N
5.	Does the policy involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition	N
6.	Will the policy result in you making decisions or taking action against individuals in ways which can have a significant impact on them?	N
7.	Is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For example, health records, criminal records or other information that people would consider to be particularly private?	N
8.	Will the project require you to contact individuals in ways which they may find intrusive?	N
	Comments:	