NHS

Patient Access Policy

Policy summary
The purpose of this policy is to outline the approved processes for managing referrals to first definitive treatment or discharge.

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Version and Document Control

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1.0	Sept 2008	New Policy	[redacted]
2.0	Jan 2013	Update	[redacted]
3.1	December 2014	Draft Updated Policy with specific RTT Guidance	[redacted]
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3.3	October 2015	Update of National Guidance Update of Internal Referral Process Additional responsibilities for disseminating updated national guidance	[redacted]
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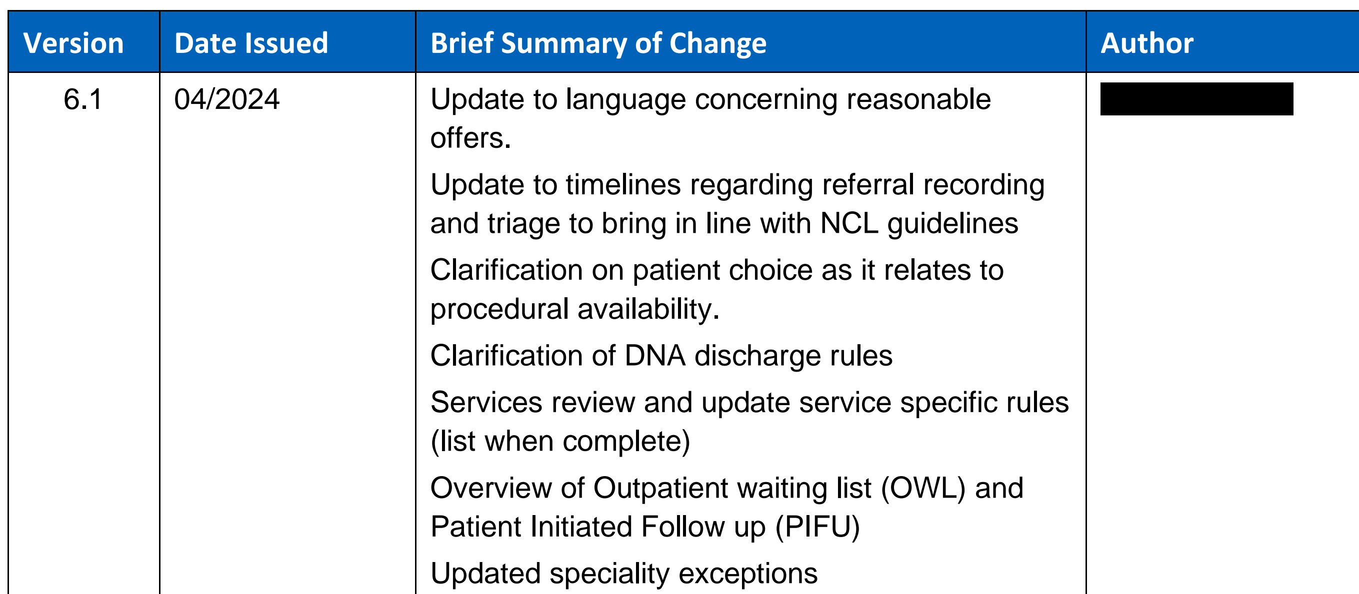
6.0	Dec 2018	Safeguarding references Bring in line with NHSE policy. Patient Responsibility within RTT Admin responsibilities clarified. Diabetic Retinal Screening Policies updated. Referrals from devolved NHS providers included. Role and responsibility of Head/ Deputy head of access performance added. Updated Chief Information Officer and Performance and Information roles. Examples of patient cancellation and DNA added. Monitoring table for compliance included. Updated format to comply with updated template	[redacted]



Version	Date Issued	Brief Summary of Change	Author
6.1	04/2024	Update to language concerning reasonable offers. Update to timelines regarding referral recording and triage to bring in line with NCL guidelines Clarification on patient choice as it relates to procedural availability. Clarification of DNA discharge rules Services review and update service specific rules (list when complete) Overview of Outpatient waiting list (OWL) and Patient Initiated Follow up (PIFU) Updated speciality exceptions	

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Document Control and Archiving

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Previously approved versions of this document will be removed from the intranet by the compliance team and archived in the policy repository. Any requests for retrieval of archived documents must be directed to the Quality and Compliance team.

Monitoring Compliance with this Policy

The Trust will use a variety of methods to monitor compliance with the processes in this document including internal audit every six months and annual external audits by Deloitte and KPMG.

This document is compliant with:	Care Quality Commission Standard 4c. Safeguarding children and child protection policy Safeguarding adults at risk policy Private patients' policy Overseas visitors' policy Annual Leave policy The Armed forces covenant. Did Not Attend (DNA): Children and Young People Policy and Procedure	
For more information on the status of this document, please contact:	Head of Access Performance	
Policy author		
Policy owner	Head of Access Performance	
Accountable director	Chief Operating Officer	
Department	Access	
Applies to (audience):	All clinical, administrati2ve and managerial staff that are responsible for managing referrals, appointments and elective admissions.	
Groups / individuals who have overseen the development of this policy	Head of Access Performance, Access Board	
Committees which were consulted and have given approval (name | date)	Access Board	24/01/2024
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Executive Summary

The purpose of this policy is to outline the approved processes for managing referrals to outpatient clinics, diagnostic procedures and elective procedures and operations, through to discharge, to allow consistent and fair care and treatment for all patients in line with the NHS Constitution measures as set out in the NHS Constitution handbook (NHS England 2013).

This policy sets out the key principles, including standardisation of administrative pathways in relation to patient access, outpatient appointments, diagnostics and admissions bookings, cancer pathways and waiting list management. The Trust aims to provide patients with a seamless service, assuring that all referrals are managed in the same way regardless of which subspecialty a patient is referred to.

"Patients have the right to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions.

And

Patients have the right to be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.

The Trust will provide fair and equitable services to all service users".

Section 1. Introduction

Moorfields Eye Hospital Foundation NHS Trust is committed to ensuring that patients receive treatment in accordance with national objectives as agreed with the Lead ICB Commissioner and in line with the eligibility of a patient's legal right to treatment on the NHS.

The Patient Access Policy sets out the Trust's local access policy and takes account of guidance from the Department of Health and NHS England. This policy is intended to support a maximum wait of 18 weeks from referral to first definitive treatment and is designed to ensure fair and equitable access to hospital services in line with the NHS constitution.

The overall aim of the policy is to provide the rules by which we aim to ensure patients are treated in a timely and effective manner, specifically to:

- Ensure that patients receive treatment according to their clinical priority and in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.
- Ensure patients are treated in accordance with agreed NHS targets.
- Reduce the number of cancelled operations for non-clinical reasons.
- Allow patients to maximise their right to patient choice in the care and treatment that they need.
- Minimising Did Not Attends, (DNA's), cancellations, and improving the patient experience.
- Ensure that the patients treatment is in line with other local and national policies including the oversees patient policy and any other relevant guidance in relation to the treatment of serving military personnel, their immediate families, war veterans and reservists as per the Armed services Covenant 05/11.
- All patients of English commissioners are included in Referral To Treatment (RTT) measurement, including personnel registered with Ministry of Defence (MoD) practices and for whom NHS England commissions their care. RTT measurement does not apply to care commissioned by MoD unless stated in commissioning agreements with providers.
- Ensure that anyone who has lived lawfully in the UK for at least 12 months immediately preceding treatment is exempt from charges and has a right to treatment on the NHS within the RTT principles, patients from overseas not meeting this criteria will be treated in line with the Overseas Patient Policy.

This policy defines roles and responsibilities and establishes the policies to be followed in the effective management of patient access to services. It describes the principles for managing referrals for outpatient appointments, diagnostic investigations and elective surgery, and instructions for the operational management of waiting lists. These processes can be found in relevant SOPs within the Trust It promotes consistency and fair treatment to all patients and aids provision of timely, accessible, high quality and safe patient centred services.

This Policy relates to the treatment of patients on active RTT pathways. However, patients who are not on an RTT pathway can expect their ongoing care to be managed within these same principles.

1.01 Scope

The Patient Access Policy sets out the Trust's local access policy and takes account of guidance from the Department of Health and NHS England. This policy is applicable to all Moorfields locations in the United Kingdom.

1.02 Purpose

To advise and inform patients, staff; clinical and administrative of the approved processes for managing patients' access to outpatient, diagnostic and elective admitted care services at Moorfields Eye Hospital NHS Foundation Trust.

Section 2. Key Principles Underpinning this Policy

- Clinical priority and clinical requirements must be the main determinant of when patients are seen as outpatients, admitted for elective procedures or undergo diagnostic investigations. Patients of equal priority will be treated in chronological order where possible.
- This policy will be applied consistently and without exception across Moorfields NHS locations unless otherwise stated in Appendix 2. This will ensure that all patients are treated equitably and according to their clinical need.
- The Health Community will work together to ensure that all patients are seen as quickly as possible and within the current maximum national guaranteed waiting times.

The Trust relies on GPs and other referrers, to ensure patients understand their responsibilities, (including providing accurate address and contact details) and potential pathway steps and timescales when being referred. This will help ensure that patients are:

- Referred under the appropriate clinical guidelines.
- Aware of the speed at which their pathway may be progressed.
- All GP referrals into a clinician led service will be through the Electronic Referral System, as GP referrals not sent in this way will be subject to rejection, as per national policy (see Section 4.02 for details)
- That any patient potentially needing an individual funding request procedure has been informed of the criteria and initial assessment where appropriate has taken place against this prior to referral.
- In the best position to accept timely appointments throughout their treatment.
- Everyone involved in patient access should have a clear understanding of his or her roles and responsibilities.
- This policy will be applied consistently and fairly across all services provided by the Trust.
- Communications with patients should be timely, informative, clear and concise. We currently communicate appt information with patients electronically via text message, email, and the patient portal The process of waiting list management should be transparent to patients.
- Nothing should be done to limit treatment for patients who have a clinical need for it (e.g. by adopting administrative practices designed to defer treatment). The Trust also has a responsibility to ensure no patient is added to a list inappropriately.
- Patients have responsibilities e.g. for keeping appointments and giving reasonable notice to the Trust if unable to attend.

Under the national RTT standards maximum wait for the whole of the patient pathway from GP referral to first definitive treatment is a maximum of 18 weeks for at least 92% of patients on incomplete pathways. This includes the various stages of outpatient consultation, diagnostics and in-patient treatment.

This is a maximum wait not a target and some patients will need to be seen in a much shorter timeframe to ensure patient safety. It is the Trust's intention to treat all patients within 18 weeks where clinically and socially appropriate to do so.

Those patients who choose to wait longer should have their wishes accommodated, without being penalised. The tolerance of 8% set for achievement of the incomplete pathway waiting time operational standard is there to take account of the following situations that might lead to a longer waiting time:

- Patients who choose to wait longer for personal or social reasons.
- Patients for whom it is clinically appropriate to wait longer (this does not include clinically complex patients who can and should start treatment within 18 weeks).
- Patients who fail to attend appointments they have agreed.

2.01 The NHS Constitution Handbook

The NHS Constitution commits the NHS to 'provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution.' The handbook states that 'from the end of December 2008, 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. Moorfields Eye Hospital NHS Foundation Trust has committed to honour the 'Universal Pledge' set out in the NHS Constitution.

As a general principle, the Trust expects that before a referral is made for treatment on an 18-week pathway the patient is both clinically fit for assessment and possible treatment of their condition, and available for appointments and diagnostic procedures from two weeks of the initial referral.

The Trust will work with the Lead ICB Commissioner, GPs and other primary care services to ensure that patients understand this before starting an 18-week pathway. Patients will only be added to, or remain on, an elective waiting list if they remain fit for surgery and will be in a position to accept dates for treatment within reasonable timeframes as defined within this policy.

Once a referral to treatment (RTT) waiting time clock has started, it continues to tick until:

- The patient starts a first definitive treatment.
- A clinical decision is made that stops the clock.

The Trust will ensure that all clock stops without treatment are made in the best clinical interest of the patient and are not influenced by the impact on incomplete pathway waiting time performance. Patients are permitted to choose their time of treatment within reasonable timeframes taking account of clinical advice where undue delay may present a risk to them.

2.02 Who may commission 18-week pathways and start an 18-week RTT clock:

- General practitioners (GPs).
- General dental practitioners (GDPs).
- General practitioners (and other practitioners) with a special interest (GPSI's).
- Named Optometrists and Orthoptists.
- Emergency Department (ED).
- Genito-urinary medicine clinics (GUM).
- Prison health services.
- Consultants (or Consultant-led services).

An 18-week clock starts when any of the above healthcare professionals refers a patient to the Trust for any Consultant led elective service (other than planned care) for the patient to be assessed and, if appropriate, treated before responsibility is transferred back to primary care.

For non-GP paper referrals this is the date the Trust receives the referral.

For NHS e-referral Service referrals the clock starts on the date the patient makes an appointment, either by phone or online and converts their unique 18-week booking reference number (UBRN).

Where a patient has been seen by a clinician privately but then decides to transfer their care to the NHS, and they are transferring onto an 18-week pathway, the 18-week clock starts at the point at which the clinical responsibility for the patients' care transfers to the NHS. (I.e. the date when the Trust accepts the referral for the patient). Private patients transferring in this way will be treated in turn within the terms of this Access Policy. If a patient wishes to transfer their care to the private sector following initial referral to the Trust, the clock will stop at the time of this transfer to the private provider is notified to the Trust.

The 18-week clock stops when the patient receives the first definitive treatment (see 2.8.1 below) for the condition for which they have been referred. This may occur following a consultation, receipt of results from a diagnostic test or following surgery or other specific treatment.

The following clinical decisions stop the clock, on the date the decision is communicated to the patient and GP, and original referrer if not the GP:

- First definitive treatment.
- Decision not to treat by clinician or patient.
- Decision to embark on a period of active monitoring.
- Decision to add a patient to a transplant list for a matched transplant.
- Decision to return the patient to primary care for non-medical/surgical Consultant led treatment in primary care.

The clock also stops when the patient declines treatment, or Does Not Attend (DNAs), their first or follow-up outpatient appointments, diagnostic appointments, pre-operative assessment or inpatient date as long as the date of that appointment has been clearly communicated to the patient.

For the first DNA of the first appointment, the clock will be nullified if reappointed and the clock will be restarted with a new pathway starting on the date when the patient is reappointed. For any subsequent DNA where the clinician has indicated that the patient should be offered a further appointment then their RTT clock continues to tick. The clock will stop for any subsequent DNA if the patient is assessed by a clinician and deemed fit to be discharged back to their GP.

A patient's RTT clock cannot be stopped because a patient has rearranged an appointment. However if the patient cancels two appointments they may be referred back to their GP, following a clinical review, who can re-refer the patient when they are able to attend.

First definitive treatment is defined as a clinical intervention intended to manage a patient's disease, condition, or injury and avoid further intervention. This can include eye drops, therapy or advice, as well as medication or surgical intervention. Treatment will often continue beyond the first definitive treatment and after the clock has stopped. Medication or advice intended to manage a patient's symptoms while awaiting definitive treatment does not stop the clock.

2.03 Safeguarding

All patients within the trust, including all patients covered in this policy, are covered by the Trust Safeguarding policies. There are circumstances, outlined in the appropriate sections, whereby additional consideration of the rules and guidance laid out in the Safeguarding Policies is necessary.

If you are concerned that following an aspect of this policy would be detrimental to the patient's safety or if at any point you are concerned about the safety and wellbeing of a patient, please consult the Safeguarding Policies available on the intranet, Trust Website, or contact the Safeguarding Team.

If a patient has been identified as having a vulnerability that is likely to impact on their ability to attend appointments the Trust will make reasonable adjustments to the use of relevant policies and

processes in order to accommodate and support any special needs a patient with a vulnerability such as a learning disability or dementia may have. This may include but is not limited to, offering further appointments following patient cancellations or DNAs, allowing more time on a pathway for diagnostics and best interest meetings regarding the patient's care.

2.04 Patient Choice

Patient choice for which trust they attend is laid out in the NHS Choice webpage. Moorfields NHS Trust operates across multiple sites and there may be an instance where a patient wishes to attend a particular site but the procedure or appointment they require is not offered at that site. In such instances, the patient will be informed of this and will be redirected to the relevant site. If the patient decides to decline the appointment based on this change, they will be reviewed by a clinician, who may decide to discharge the patient to their GP, who will be informed of this.

Section 3. Duties and Responsibilities

3.01 Chief Executive

The Chief Executive is ultimately accountable to the Trust board for ensuring that effective processes are in place to manage patient care and treatment, ensuring that local, national and NHS Constitution targets and standards are met.

3.02 The Chief Operating Officer (COO)

The Chief Operating Officer has overall responsibility to develop, implement and regularly monitor the Trust's elective service access policy, and is responsible for:

- Ensuring that effective processes are in place to manage patient care and treatment to ensure local, national, and NHS Constitution targets and standards are met.
- Implementing Trust wide monitoring systems to ensure compliance against the policy and to avoid breaches of the access standards.
- Monitoring progress against achievement of the national standards and informing the Trust board of progress and any remedial action taken.
- Ensuring effective processes are in place for learning from incidents and complaints arising from breaches.
- The management, communication and dissemination of the Trust access policy.

3.03 Chief Information Officer

The Chief Information Officer is responsible for:

- The management of the hospital's computerised information systems.
- Quality assuring and producing accurate performance management data for use by Trust Managers' and for reporting data to external sources.
- Providing Data Quality reports to assist the 18-week pathway tracking.

3.04 Performance and Information Teams (P&I)

The Trust has a statutory requirement to submit a Weekly PTL position and Monthly RTT Performance to NHS England to monitor the Trust performance against current RTT performance

targets (currently 92% for Open Pathway at month end). Weekly statutory RTT submissions are signed off before by the Head of Access Performance, Deputy Head of Access Performance, COO or Deputy COO and the monthly returns are signed off by the COO or Deputy Coo and submitted by Performance and Information.

The Head of Performance and information and Head of Access Performance are responsible for keeping the Trust up to date with amendments/revision to the rules and guidance. This also includes disseminating the information to the operational and clinical teams. Additional duties include;

- Representation of P&I staff at performance meetings held by the Divisions as well as the access meetings held by the COO.
- That robust systems and processes are in place to support the achievement of the access targets and that there is accurate reporting both internally and externally.
- Early identification of anomalies with reporting or data quality
- Assist operational teams with activity and performance forecasts to aid capacity planning to meet demand.
- Contribute to development of additional reporting, as and when required, on either an ad-hoc or routine basis using recognised tools such as QlikSense, SSRS, etc.
- P&I will provide a PTL on a daily basis accurate to the previous day. Where technical issues prevent that, P&I will endeavour to provide an updated list within 24 hours.

3.01 Deputy Chief Operating Officer, Divisional Managers (DM's)

The Deputy Chief Operating Officer will monitor compliance with the Policy via the weekly Patient Tracking List (PTL) and the Access Meeting. DM's are responsible for maintaining overall RTT compliance of all services and areas under their authority. This includes:

- Ensuring the service waiting list reports are updated and maintained on the main Trust's PAS system by the
- Identifying managers responsible for reviewing each month's trends in the number of patients awaiting treatment, at what point patients are waiting on their pathway and identifying in advance potential mismatches between demand and capacity.
- Managing allocated resources to achieve access targets. This includes having staff and other resources available to operate scheduled outpatient clinics, patient treatment and operating theatre sessions and avoiding the need to cancel scheduled care, and the ability to flex these resources when necessary.
- Ensuring that the duties, responsibilities and processes within this policy are implemented within their areas and that all staff that need to operate this policy are aware and trained in its use.
- Implementing effective monitoring systems to ensure compliance with this policy and avoid breaches of the targets, escalating any actual or potential breaches to the COO.
- Day to day responsibility for ensuring this policy is adhered to at a divisional level.
- Delivering operational targets for service delivery in line with the annual business plans to include national standards for RTT and cancer waiting times and all other key access targets.
- Taking action to avoid potential breaches and working with the senior operations team on their site to manage any actual breaches.
- Monitoring site progress against achievement of the targets, escalating issues as required to the COO.
- Identifying site-specific challenges in complying with the guidance contained in this policy and working with all relevant staff to identify and implement improvements where necessary.
- 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.

3.02 Service Managers and Assistant Service Managers (SMs and ASMs)

SMs And ASM's are responsible for all direct reports, to ensure they are given access to training and are provided with support and guidance in delivering the key principles of this policy. SM's and ASM's are also responsible for monitoring the internal & external maximum waiting time standards and are responsible for monitoring RTT standards via Patient Tracking Lists (PTL's) and validation processes, reporting to the weekly PTL meeting and raising issues to DM's for the Access meeting as appropriate. SM's and ASM's are responsible for monitoring compliance and delivery of the patient pathway within their individual services and are responsible for ensuring the detailed implementation of this policy for each speciality.

This includes;

The day-to-day management of the waiting list is undertaken by the SM's and ASM's

- Ensuring that the duties, responsibilities and processes within this policy are implemented within their areas and that all staff that need to operate this policy are aware and trained in its use.
- Undertaking effective monitoring systems to ensure compliance with this policy and avoid breaches of the targets, escalating any actual or potential breaches to the Divisional manager.
- Day to day responsibility for ensuring this policy is adhered to at a site and specialty.
- Monitoring site progress against achievement of the targets, escalating issues as required to the relevant DM.
- Identifying site-specific challenges in complying with the guidance contained in this policy and working with all relevant staff to identify and implement improvements where necessary.
- 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.

3.03 Head of Access Performance/Deputy Head of Access Performance

The Head and Deputy Head of Access Performance have overall responsibility for monitoring trust adherence to RTT policies, specialist training of trust staff on RTT and Access policy issues, including medical induction. The roles are also responsible for reviewing and updating all RTT and Access policy training materials, presentations and eLearning modules used in the trust. The roles are also responsible for overseeing trust RTT validation, for both patients currently on and off active RTT pathways. The roles other duties include:

- Monitoring of whole trust 18-week position through all available reporting metrics.
- Monitoring all trust RTT Key Performance indicators
- Feeding back information, themes or exceptions found within these reports to the relevant DM, SM or ASMs as appropriate to allow for correction, staff learning opportunities or issues around patient safety.
- To oversee the day-to-day working of the validation team, feeding back information, themes or exceptions as appropriate.

3.04 Medical/Clinical Directors and Service Directors

Medical/Clinical Directors are responsible for ensuing each consultant reviews/scrutinises all patient referrals received by the outpatient appointments team. This includes allocating a clinical priority to the referral within the agreed triage timelines and ensuring leave is planned well in advance of being taken to minimise disruption to patients, but always with a minimum of eight weeks' notice, including study/professional leave.

The consultant /clinician leave form must be completed with advance notice provided to theatres, outpatients and admissions to minimise or avoid cancellations. Every effort must be taken to cover clinics and theatre lists where appropriate. Lists should not be cancelled or reduced at short notice, defined as eight weeks, for any purpose, unless there are exceptional circumstances.

Medical/clinical directors and service directors are also responsible for ensuring that there is suitable capacity made available across all sites and services in order for the national RTT standards.

3.05 Consultants/Clinical Teams

3.05(1) NHS e-referral Service

Each Consultant is responsible for the following;

- Reviewing all patient referrals whether under trust systems or ERS directly. For those accepted for an outpatient appointment, to allocate a clinical priority and to shortlist within NHS e-referral Service.
- Rejected referrals must be completed within two working days to allow the appointments staff and other relevant specialty areas to inform the GP and patient of the appointment cancellation. For rejected referrals, an automated response will be sent to the GP via the NHS e-referral Service system.
- Managing the patient's care and treatment and working with their Service Manager and Clinical Director and clinical colleagues to ensure that this is provided within the timescales laid down by local and national targets and standards.
- Managing medical staff to ensure that scheduled outpatient clinics, patient treatment and operating theatre sessions are held and avoid the need to cancel patient treatment.
- Managing waiting lists and deciding on patient admissions/treatments in line with clinical priority and order of inclusion on the waiting list.
- Working with colleagues to prevent the cancellation of patient admissions for non-clinical reasons and taking action to reschedule any patients so cancelled.
- Communicating accurate waiting time information to patients, their families and carers and dealing with any queries, problems or complaints in line with Trust policy.
- Responsible for completion of their outcome forms for their own and their junior staff.
- Ensure that they and any junior staff who are undertaking Clinics are competent in the completion of Outcome Sheets, including the 18-week rules.
- Act on clinic and surgical patients who do not attend (DNA) and cancellations on the day of appointments to ensure the administration teams can record accurate data in both the patients' records and via electronic reporting systems.
- Writing appropriate patient correspondence regarding diagnosis, treatment and clinical decisions regarding discharges.

3.05(2) Paper referrals:

Each Consultant is responsible for:

- Receiving the referral from the Booking Office Team electronically.
- Accepting or rejecting the referral on Trust systems.

- For referrals accepted into the service they need to provide clinical priority and pass back to the central appointments team for booking.
- For rejected referrals, dictate a letter to be sent back to the GP.

3.05(3) Consultant to Consultant Referrals

When a consultant identifies a possible routine condition in a patient other than the condition identified in the original referral, they may refer the patient to another clinician within the trust, or back to their GP if for a condition not covered by the trust.

Conditions where there is a risk of loss of vision unless the condition is assessed and treated promptly, e.g. nonvascular age-related macular degeneration or significant corneal disease including;

- Malignancy
- Ophthalmic conditions in young people and children [under 16]
- Genetic eye conditions
- Neurological conditions
- Ocular co-morbidities, which need to be managed simultaneously by two or three services: cataract surgery in patients with diabetic retinopathy.

A referral to the relevant service either internally or externally will start a new RTT pathway. The referring clinician should ensure that the new condition/RTT clock start date is clearly documented within the referral letter or email. There are local agreements between services for urgent appointments to be booked directly into the second service; it is the responsibility of the administrator to enter the new referral on Trust PAS to ensure the RTT clock start date for the new service is accurate.

3.06 Clinicians undertaking Outpatient Clinics

Each Clinician is responsible for:

- Managing clinical staff to ensure that scheduled outpatient clinics, patient treatment and operating theatre sessions are held to avoid the need to cancel patient treatment.
- Working with the admissions team by deciding on patient admissions/treatments in line with clinical priority and order of inclusion on the waiting list.
- Working with colleagues to prevent the cancellation of patient admissions for non-clinical reasons by providing surgical dates that comply with national RTT standards where possible and taking action to reschedule any patients so cancelled.
- Communicating accurate waiting time information to patients, their families and carers and dealing with any queries, problems or complaints in line with Trust policy.
- Providing patient information leaflets related to the relevant clinical condition to support the patient and careers with treatment options and decision making at the time of the appointment.
- Responsible for completion of their outcome forms for their own and oversight of their junior staff.
- Ensure that they and any junior staff who are undertaking Clinics are competent in the completion of Outcome Sheets, including the 18-week rules.
- Responsible for reviewing all those patients who did not attend and making a decision on whether the patient should be offered a further appointment. If the patient is discharged, a letter must be sent to the referring doctor and a copy to the patient.

3.07 Appointments Teams

3.07(1) Paper Referrals

- All paper referrals will come into the Trust directly to the Booking Office Team. They will ensure that the referral is date stamped, indexed and entered onto Trust systems within 1 working day
- The Booking Office Team will pass to the appropriate clinician to accept or reject the referral, which will be completed by the clinician within 2 working days for urgent and oncology referrals and 3 working days for routine referrals.
- For accepted referrals, once clinical priority is assigned, it will be passed to the Booking Office Team to contact the patient to make an outpatient appointment, ensuring wherever possible that patients are given reasonable notice and choice relating to appointment dates.
- For checking referral's referencing military personnel and ensuring the original referral date from the referring organisation is used as the referral date to accurately capture the wait any serving member of the armed forces has had before being transferred to our hospital and to prevent personnel waiting longer due to a change in provider.

3.08 Appointments Team – general responsibilities:

- To book outpatient appointments, within 5 working days of receipt of referral
- The Booking Office Team will ensure that all outpatient appointment offers are recorded on Trust PAS
- To enter full free text reasons for cancellations onto Trust PAS to support reason recorded on system.
- To ensure Trust PAS is updated correctly and timely with any patient choice decisions.
- To ensure the appropriate Referral to Treatment (RTT) status is accurately recorded on Trust PAS. This should be entered onto the system within 24 hours of the clinic.
- To refer any problems or suspected/potential breaches of policy or compliance with RTT targets to the appropriate Service Manager.
- Team Leaders are responsible for the management, communication and dissemination of the Trust Access Policy within their team.

3.09 Responsibilities of Admissions teams

- When a decision to admit has been made to enter the patient's details on the waiting list entry screen so that they show on the PTL Waiting lists, within 5 days of Decision to admit being made and to inform the patient in writing that they are on a waiting list.
- To ensure when a decision to admit is made in a clinic, the clinic attendance date is entered onto the Trust PAS waiting list entry screen as the Decision to Admit date.
- To ensure patients are given reasonable notice and choice relating to admission dates.
- Ensure that all admission offers are recorded on Trust PAS.
- To enter full free text reasons for cancellations onto Trust PAS.
- To ensure Trust PAS is updated correctly and timely, including free text reasons with any patient choice decisions.
- To ensure the appropriate Referral to Treatment (RTT) status is accurately & timely recorded on Trust PAS.

3.10 Responsibilities of Validation teams

- To regularly validate waiting lists to ensure lists are accurate as possible at all times.
- To correct and update incorrect RTT statuses when confirmed with evidence from trust systems and patient records.
- To raise themes or learning opportunities discovered within validation work to Head/Deputy Head of access performance as appropriate.
- Communicate with SM/ASMs any urgent issues that have been discovered during the course of validation work including:
    - Long waiting patients
    - Patient safety Issues
    - Unbooked referrals/appointments

3.11 Responsibilities of Secretarial Teams

- To track patients 'awaiting results', ensuring once results are received, the clinician reviews and advises on next steps. Also, confirm action taken to GP.
- To ensure that clinical documents are produced in a timely manner where appropriate.
- Ensuring that clinical documents are sent to the correct internal and external recipients where appropriate.

3.12 Outpatient and Admission Managers

Are responsible for ensuring their teams accurately monitor PTL's with specific focus on clinical urgency and the length of patient pathways. The outpatient and admissions manager must ensure the choice agenda is delivered with regards to giving adequate notice and choice of convenient dates to patients, and to ensure earliest reasonable offer dates are given and patient choice delays are recorded accurately for admitted pathways. The outpatient manager through the outpatient team leads must ensure that outcome forms are completed and filled in the patient's notes within a maximum of 72 hours.

3.13 All Trust Staff

All Trust staff are responsible for maintaining the highest standards of data quality and patient confidentiality. All staff are responsible for ensuring that any data created, edited, used or recorded on the Trust's Trust PAS system, within their area of responsibility, is accurate and recorded in accordance with this policy and other Trust policies relating to the collection, storage and use of data. All staff involved in the referral to treatment pathway will be required to adhere to the policy. They will also receive ongoing training and will be kept informed of any changes.

3.14 Responsibilities of Referrers

Referrers have a responsibility to both the patient and to the Trust in ensuring the patient is aware of the reason they are being referred to the hospital. The referrer must provide a minimum data set to the hospital to ensure patients can be contacted and offered an appointment with reasonable notice and in line with local and national standards alongside current status where the patient has been referred via other NHS providers. Clinical reasons for referrals must be clear in order for clinical scrutiny to be accurate which supports directing patients into the appropriate services and subspecialty clinics. Referrers must also ensure that the patient will be available to attend appointments in the near future when referring into the Trust.

3.15 Patient Responsibilities

We want to use our clinics, theatres and staff efficiently and effectively, and we do everything we can to ensure that all of our patients are seen within 18 weeks. The following are a few things that our patients can do that help us and in turn help other patients.

- When patients are being referred to us, please make sure that, as far as is reasonably possible, they are available within the next 18 weeks.
- If patients are unable to attend their appointment, please tell us with as much notice as possible. The more notice that is given, the easier it is for the Trust to offer that appointment to another patient who needs our help.
- It is imperative that patients arrive on time for their appointments. The trust does its best to see all our patients on time and while situations can occur that cause clinics to run behind, if our patients arrive on time for appointments this helps ensure clinics run smoothly.
- Patients tell their GP and the Trust if their address or contact details change.

Section 4. Outpatients and Diagnostics

4.01 New patient referrals via NHS e-referral Service

NHS e-referral Service is a national electronic referral service that gives patients a choice of place, date and time for their first Consultant outpatient appointment. The patient is allocated a Unique Booking Reference Number (UBRN).

The Trust will ensure that all Consultant led new patient clinics have sufficient slots available for GP's/patients to book via NHS e-referral Service Book in line with national targets.

Patients exercising choice of hospital and deciding to receive treatment at the Moorfields Eye Hospital NHS Foundation Trust Hospital will be referred in one of the following ways:

- The GP or one of their administrative staff will book an outpatient appointment by choosing one of the available clinical appointment slots accessed via the NHS e-referral Service computer system. The GP surgery will have ensured any referral criteria are adhered to and pre referral diagnostics are complete prior to undertaking the referral. Patients who do not meet the pre referral criteria will have the referral rejected as an inappropriate referral and the GP informed. The GP is responsible for informing the patient in this instance.

- For patients not wishing to book a clinic appointment immediately, or when no appointment is available on the system, they will be given a UBRN after the GP has entered the initial referral onto the NHS e-referral Service system. The patient can then subsequently access the NHS e-referral Service website themselves and book an outpatient appointment or contact the National Telephone Appointment Line to organise an appointment. Where no appointment slots are available, the patient details/UBRN will appear immediately on the Appointment Slot Issues worklist, and for the patients the RTT clock starts when the patient appears on the worklist. It is then the Trust's responsibility to contact the patient and agree an appointment.

The RTT clock starts when a patient activates their UBRN. This can be done by either the referring GP or one of their administrative staff booking an appointment using the NHS e-referral Service system. It can also be booked by the patients themselves online using the NHS e-referral Service system, or by the patient contacting the NHS e-referral Service National Call Centre. The appointment will be registered on the Trust systems and the Trust made aware as soon as the UBRN is converted by the patient or GP. This will start the 18-week clock.

Where appropriate, GPs are being encouraged by ICB's to use generic 'Dear Doctor' letters which can be allocated by the Trust to an appropriate Consultant with the shortest waiting time. GP's must retain the flexibility to refer to a named Consultant, but the Trust will offer the patient an alternative Consultant if the named Consultant would exceed the maximum waiting time target.

If the NHS e-referral Service appointment has been booked in the correct speciality, but in an incorrect clinic, it is the responsibility of the receiving clinician to "re-direct" the appointment to the appropriate clinic. The patient must be informed if the appointment is to be re-booked and given the opportunity to agree a convenient date within the agreed Trust timeframe. The 18-week clock continues ticking throughout this process.

If the NHS e-referral Service appointment has been booked in an incorrect speciality, it is the responsibility of the receiving clinician to "re-direct" the appointment to an appropriate clinic in the correct speciality rather than rejecting back to the GP. The patient must be informed if the appointment is to be re-booked and given the opportunity to agree a convenient date within the agreed Trust timeframe. The 18-week clock continues ticking throughout this process. If the Trust is unable to contact the patient after two attempts, an appointment is to be booked and confirmation sent in writing.

Referrers are asked to ensure letters are received within a maximum of three days for a routine referral and one day for an urgent referral to enable the Trust to confirm the correct booking slot and ensure that the appropriate clinical information is available for the clinician to review.

All referrals made via the NHS e-referral Service system should be reviewed by the clinician or nominated staff member within a three-working day (72 hours) period. Any referrals, which are not reviewed in this designated timeframe, will be automatically accepted by the Trust.

Veterans receive their healthcare from NHS Trusts and should receive priority treatment where it relates to a condition which results from their service in the armed forces, subject to clinical need.

Where a referral is considered clinically inappropriate, the consultant may choose not to accept the referral. If this situation arises, the decision will be communicated to the GP/Referring clinician.

The scrutinising clinician holds the responsibility of informing the GP/referring clinician of this decision whether by writing or telephone. The booking office will action electronic referrals via the reject function. The GP/Referring clinician will have the responsibility of ensuring this information is communicated to the patient.

4.02 New patient paper referrals

The Standard Contract for 2018/19 requires the full use of the NHS e-referral service (eRS) for all consultant-led first outpatient appointments. From 1 October 2018, providers will only be paid for activity resulting from referrals made via eRS. All referrals made outside of ERS will be returned to the referring GP practice and a request made to re-refer the patient via ERS as soon as possible so as not to delay the patient's appointment.

Referrals made to non- consultant led services (such as Optometry), Inter-provider referrals, internal referrals and referrals from non-GP sources are not affected by this guidance and will be accepted in multiple formats as previously.

Further guidance on paper switch off is provided on the NHS England website:

https://digital.nhs.uk/services/nhs-e-referral-service/the-future-of-the-nhs-e-referral-service/paper-switch-off-programme-and-documents

On receipt of a paper referral, the Trust will book the patient's appointment following the national RTT standards and send a letter confirming the date and time to the patient with instructions on how to change their appointment if this is not convenient.

All new paper-based referrals will be date stamped, scanned and registered/entered onto Trust PAS on receipt of referral and within 1 day of receipt of the referral letter. This date is entered onto the system as the first date that the referral was received by the Trust and starts the 18-week clock. If the patient has had an assessment, but no treatment in a Primary Care clinic or Referral Management Centre or any other provider then the 18-week clock start is the date that the referral was received in the Referral Management Centre. The same principle applies for referrals from other Trusts, but the clock start may differ see section 4.03.
Referrals must include full demographic details, including NHS number and telephone numbers (both day and evening, if possible) to reduce administrative time contacting the patient. It is the responsibility of the referring non-GP service to ensure that the referral letter contains accurate and up to date demographic information regarding the patient. The non-GP service will have ensured any referral criteria are adhered to and pre referral diagnostics are complete prior to undertaking the referral. Patients who do not meet the pre referral criteria will have the referral rejected and the non-GP service informed. The non-GP service is responsible for informing the patient in this instance.

Referral letters must be passed to the Consultant within 1 day of receipt to be triaged.

Referrals should be triaged on the Trust system within 3 days of receipt by the Consultant to whom the patient has been referred and then sent directly to the Outpatient Appointment Team/Booking Centre via the Trust system. Any generic 'Dear Doctor' referrals should be prioritised within the speciality to which the patient has been referred within the same timescale.

GP referrals directly to non-consultant led services (Optometry, Prosthetics etc.) can still use the paper referral processes.

4.03 Inter-provider transfers (tertiary referrals)

Where patient referrals are received from external Trusts via Inter provider Transfer (IPT) on an incomplete pathway, the RTT clock start date will be when the original referral was received in the referring Trust. This will result in the clock start date on Trust systems being backdated to the original referral date received from the referring Trust. When a patient is received on a complete pathway the RTT clock will not start until a subsequent decision to begin a significantly different treatment plan, for which the patient must wait, has been made.

Inbound and outbound requests for IPT information are the responsibility of the booking Centre on the City Road Site. The Booking Centre Manager is responsible for accurate data collection and data entry of the required IPT minimum data set.

The referring Trust is obligated to ensure that the MDS and referral letter is transferred within five working days, so as to make achievement of 18 weeks reasonable and possible. Any incurred breach of 18 weeks will be reported by the reporting organisation.

When a patient is transferred from this Trust to another for a diagnostic investigation only, the 18-week clock continues ticking and the ongoing management of the patient's pathway remains with the referring Trust.

4.04 Internal Referrals

For all other internal referrals EXCEPT Oncology referrals:

All internal referrals are sent via internal trust systems. Clinicians are responsible for initiating this process by correctly directing internal correspondence.

If the patient has been referred internally (for the same condition) by a clinician to another Consultant and is still awaiting treatment, then the 18-week clock continues to tick from the original referral date.

4.05 Oncology referrals

4.05(1) GP Referrals

All Oncology GP referrals are to be sent to the Trust via ERS, as per NHS England guidelines.

4.05(2) Internal Referrals

All internal referrals to Ocular Oncology will be sent electronically via Open Eyes.
All internal referrals must be sent via Open Eyes using the 'internal referrals' template and marked as urgent to enable swift processing. Referrals must be generated on the same day as the decision to refer is made, and should be completed by the referring clinician, not the secretariat.

4.05(3) Referrals from external organisations/other Trusts

Referrals from external trusts must include the minimum clinical data set.

4.06 Diabetic Retinal Screening Referrals

All patients referred into the acute service must be seen in line with National Screening Guidance, which can be found at http://diabeticeye.screening.nhs.uk/kpis

Patients who are screen positive (i.e. M1, R2, R3A) are referred to hospital eye service for further investigation and treatment if necessary. Referrals are received into the Trust via email to the DRS Service shared nhs.net mailbox.

4.06(1) Time between screening event and first attended consultation at hospital eye

Urgent (R3AM1 & R3AM0)
Acceptable: ≥80% within 6 weeks from the date of screening

Routine (R2M1, R1M1, R3SM1, R2M0)
Acceptable: ≥70% within 13 weeks from the date of screening
Achievable: ≥95% within 13 weeks from the date of screening

4.06(2) Trust internal timelines for DR appointment offers

NOTE: All referrals from diabetic eye screening have their clock start from the date of SCREENING and not date referral received. Patients on Trust PAS must be registered with the 'referral date' field as the screen date.

R3AM1/R3AM0 (urgent):
1st appointment to be offered within 2 weeks of screen date – if DNA/cancellation…
2nd appointment to be offered within 4 weeks of screen date – if DNA/cancellation and upon clinical review…
3rd appointment to be offered within 6 weeks of screen date – Breach post 6 weeks.

R2M1/ R1M1/ R3SM1/ R2M0 (routine):
1st appointment to be offered within 10 weeks of screen date – if DNA/cancellation…

2nd appointment to be offered within 13 weeks of screen date – Breach post 13 weeks.

DR referrals for pregnant patients (urgent):
These referrals should be booked as per urgent DR referrals i.e. within 6 weeks of screen date (see above) – Breach post 6 weeks.
Non -assessable DR (Non reportable routine referrals): To be booked into MR clinic.
1st appointment to be offered within 10 weeks of screen date – if DNA/cancellation…
2nd appointment to be offered within 13 weeks of screen date – Breach post 13 weeks.

Non-DR referrals:
Appointments to be offered and managed as per the Trust Access Policy following clinical scrutiny and/or 18-week RTT timeline – Breach post 18 weeks.

DRS patients referred into an acute setting will start an RTT pathway from the date of the patient screening visit not the date on the referral letter and must be monitored via the PTL alongside all other RTT pathways.

For further information on DRS pathways, please see the relevant appendices.

4.07 Optical Coherence Tomography (OCT) Pathway

Patients referred to the hospital eye service on an OCT pathway are not monitored under RTT guidance. However, the OCT pathways must follow DRS guidelines.

4.08 Private Patients Transferring to the NHS

Patients can choose to transfer to an NHS provider at any point during their private treatment. If a patient has been seen privately and wishes to transfer to the NHS, the patient must first obtain an electronic referral from their GP or a letter from their referring consultant. This applies no matter the location of the private treatment.

On receipt of this letter, the patient may then be treated as a new referral to outpatients or placed directly onto a waiting list for investigations or treatment. Patients will be treated according to their clinical priority. The RTT clock will start on receipt of referral to the NHS where first definitive treatment has not yet started.

Where a patient transfers to NHS care having received their first definitive treatment a new RTT clock will not start.

4.09 Referrals to Research Services

Referrals into an acute service where the clinical care and responsibility are subsequently taken over by a research service and where the first appointment takes place within the research setting must be monitored against the RTT standards.
Patients who are recruited into a research trial at any point on an open RTT pathway will continue to be monitored against the RTT standards.

4.10 Referrals to Genetics Service

Clinical genetics services are covered by RTT. The RTT clock starts on the date that the provider receives the referral. The clock stops on the date that the patient starts their first definitive treatment (which may be counselling in the case of genetics). There is no facility to delay starting a patient's clock to exclude the time required for family history gathering where this is done after receipt of referral.

4.11 Referrals from devolved NHS providers

Referrals to Moorfields from the devolved regions (request for appropriate term) must arrive at Moorfields with funding requests already approved. Patient referrals without the correct funding approval will not be accepted by the trust and will be immediately returned to the referring organisation with a request for the correct funding approval.

This includes routine urgent and paediatric referrals. This does not include Oncology/2 week wait referrals, which will be accepted, and the funding approval request sent at the same time.

Section 5. Referral Management – Booking Centre/Outpatients

5.01 Referral Scrutiny

It is the responsibility of each service to ensure that scrutiny of referrals is carried out at least once every 24 hours by a member of the clinical team. Where a service has not scrutinised their referrals within the stated timelines of 1 day for urgent or 3 days for routine, this will be escalated to the relevant SM/DM.

Clinical scrutiny must not delay the process of booking an outpatient appointment. Where it is not possible for the Booking Centre to allocate a patient to a service from the information held within the referral, the referral letter must be scrutinised by a clinician to ensure they are seen within the appropriate service and time frame.

Referrals must not be automatically directed into General Ophthalmology without agreement from the General Ophthalmology Service Lead.

Scrutiny of all referral letters must also take note of any reference contained within the referral to safeguarding children and young people or child protection concerns for example:

- Child is on a Child Protection Plan (CPP).
- Child is in Foster Care.
- Child has an allocated social worker.

GP practices must be contacted prior to the appointment date where the referral letter has not been attached within the e-referral system If a referral letter is not attached by the GP within 5 days of the appointment being made then the appointment will be cancelled in eRS and the patient and GP will be sent rejection letters.

When following scrutiny there is a request to change an appointment booked via e-referral, the Booking Centre will make every effort to contact the patient to agree a convenient date and time in the appropriate service. Where the patient is not contactable by telephone, and there is sufficient notice, confirmation of the new appointment details will be sent via letter informing the patient of the change of appointment.

5.02 Reasonable Offers

All patients offered outpatient (new and follow-up) and diagnostic appointments must be given at least three weeks' notice in line with RTT and Diagnostic rules (DMO1). Appointment letters must be sent to the patient within 24 hours of the appointment being booked. Patients are allocated appointment times in the order of clinical priority and date of their 18-week RTT clock start to ensure equity of access. Clinical priorities should be kept to the minimum i.e. urgent cancer referrals or urgent. All other referrals should be dealt with in chronological order.

If the patient accepts an offer at shorter notice via telephone and is informed that they may be discharged if they do not attend this also represents a reasonable offer in respect to subsequent cancellations of DNA's.

5.03 Refusal of Reasonable Offer

A patient may refuse the offer of a 'reasonable' appointment (at least three weeks' notice) and indicate that they still require the appointment. Moorfields Eye Hospital NHS Foundation Trust will record the date offered. These patients must be offered a further appointment when they are available, but this should not exceed 12 weeks. If the patient is unavailable for more than 12 weeks, the patient must be returned to the care of their GP and asked to re-refer when the patient is ready to be seen. All offers of appointments must be documented in PAS.

If the patient declines two reasonable offers of appointments, they will be considered for discharge and, only if clinically indicated, returned to their referring organisation. Their GP will also be notified of this discharge.

Where the patient does not respond to phone calls, i.e. teams tried with two phone calls during office hours and one out of hours call, the appointment will be booked, and an appointment letter sent to the patient. If the patient does not advise that they are unable to attend the appointment and subsequently DNA's, the standard DNA process will be followed, (as documented within this policy). This will stop the 18-week clock.

5.04 Patients who are not Medically Fit

If a patient is not medically fit for an extended period of more than six weeks, they will normally be referred back to their GP to ensure the clinical condition is monitored and they are re-referred as soon as they are fit to be treated. This is expected to be an unlikely scenario as patients who are not fit should be picked up at the pre assessment stage or earlier in the pathway when a decision on suitability for treatment would be made. This will stop the 18-week clock. Patients with short-term illnesses i.e. colds or chest infection will continue on an active RTT while they recover.

5.05 Patients who have to wait for a Diagnostic Test

If a patient has to wait for a diagnostic appointment the 18 weeks RTT clock will continue.

5.06 Appointment Notification and Reminders

All sites and services must have a procedure in place to implement a telephone or text message reminder service for a minimum of all new patient appointments at least 5 working days prior to the appointment.

Where a mobile phone number is available, a text reminder will also be sent 5 working days prior to the appointment date. All messages sent by our system are logged when successfully sent. It is the patient's responsibility to check your messages and to ensure that we are informed of any changes to their contact details. The Trust will assume that the patient has received their reminders if it has been logged as successfully sent.

Please note, messages are sent out of courtesy, not necessity. It is the patient's responsibility to turn up on time for an appointment. Failure of the messaging system for any reason is not sufficient reason for failing to attend or turning up too late for treatment.

5.07 Outpatient and Diagnostic Cancellations

5.07(1) Patient Cancellations

For routine referrals, the patient can only cancel and rearrange an outpatient or diagnostic appointment once, regardless of the referral method used. New appointments must be made as close to the original appointment as possible. Patients who cancel on the same day unless unwell will be counted as a DNA. Patients who could not wait (CNW) will be counted as a DNA unless there

are clinic delays for more than 1 hour. If a patient wishes to cancel a second appointment, they will be considered for discharge by their clinician and returned to their GP in writing if appropriate.

An Example of this would be:

Patient X is referred to Cataract for an assessment. They are given an appointment for 27th January. On 15th January, the patient calls to cancel their first appointment and are offered another appointment for 23rd February. On 20th February, the patient calls to cancel this appointment. Before being offered another appointment, the clinician reviews the patient's file and determines that as the patient has cancelled twice, they will be discharged to the care of their GP. The patient will require a new referral for their Cataract.

5.07(2) Hospital cancellations

A minimum of 8 weeks' notice is required from all clinicians, in all but exceptional circumstances, to cancel or reduce any outpatient or diagnostic session for reasons of annual, study leave or on-call commitments. If it is necessary, in exceptional circumstances, to cancel or reduce any outpatient session, the Clinical Director for that specialty must discuss in person with the relevant Consultant and agree re- provision of lost capacity to ensure patients are not disadvantaged and wait times do not increase.

All short notice (less than 8 weeks), clinic cancellations must be authorised in writing by the appropriate Clinical Director and Divisional Manager and signed off by the COO. The Outpatient Teams and Outpatients staff will not action any short notice cancellations without appropriate authorisation.

If a patient's appointment has to be rescheduled due to a hospital cancellation, the patient will be contacted by telephone to arrange an alternative appointment date and time. An apology and reason for cancellation will be extended to the patient.

Appointments must be made as close to the original appointment as possible. This is particularly important when patients need to re-attend for test results, or to review medication. It is the clinician's responsibility to make adequate provision of clinic time so that new patients cancelled by hospital can be seen within the 18-week RTT pathway. The 18-week clock continues ticking during this time.

5.08 Reception Management

5.08(1) Patient Demographics

It is the responsibility of the clinic receptionist to confirm each patient's demographic details as the patient arrives at reception. Health records must be crosschecked with the Trust PAS system. Where details are inconsistent, they must be updated in both the health records and on Trust PAS. Demographic details include:

- Patients Name.
- Date of Birth.
- Address.
- Telephone Number including mobile numbers
- Email address.
- GP Details.
- Ethnic Origin.
- Next of Kin

It is essential for mobile numbers to be collected to operate a successful text reminder service.

Any issues with non-completion of outcome forms must be escalated to the Service manager in the first instance. If the issue cannot be addressed this needs to be escalated to the Divisional Manager within 2 working days.

Completed recording of patient demographics is key to our performance against Accessible Information Standards (AIS) which are monitored nationally.

5.09 Did not attend (DNA)

The Trust aims to reduce the incidence of patients failing to attend appointments and acknowledges this is best achieved by agreeing the date with the patient in advance. If a patient fails to attend their first scheduled appointment, another may be offered. If the patient fails to attend their second new appointment, they will be considered for discharge. If a patient fails to attend any subsequent follow up, diagnostic, pre assessment or surgical date, they will be considered for discharge.) All discharges are made under the condition that the appointment was clearly communicated and that the patient will be discharged and referred back to the care of the GP following a clinical review of the patient's condition to ensure this will not be to adverse clinical effect.

Both patient and GP will be notified of this in writing to ensure the referring GP is aware and can action further management of the patient if necessary. This will stop the 18-week clock.

In the extreme circumstance (see Appendix 1) that the clinician feels it would be detrimental to the patient's health if an appointment is not re-booked, of if the patient is a child, young person or vulnerable adult then the patient must first be contacted to ascertain the reasons for DNA and ensure compliance to attend a rescheduled appointment.

Where a patient DNA's a first attendance for the first time on the 18-week pathway, the RTT clock is nullified, and the activity is not reported. If the Clinician decides to re-appoint the patient, then the date that the patient is contacted, and the new appointment is agreed will start a new RTT clock.

For all subsequent DNAs on an RTT pathway, if the patient is re-appointed then the RTT clock continues, unless the patient is discharged to the care of their GP on the advice of the clinician and the clock is stopped.

Where the patient does not respond to letters or phone calls, i.e. tried for at least a week with two phone calls or have not responded to an admission letter within 10 days of the letter date, then the patient is not fulfilling their obligation to make themselves available for admission and they can be discharged back to their GP. In this instance, a letter will be sent to the patient explaining the process and that their care is being transferred back to their GP.

An Example of this would be:

Patient Y is referred to General Ophthalmology for an assessment. They are given an appointment for 13th February which they DNA. A second appointment is made for the patient on 2nd April. The patient also DNAs this appointment. Following review, the clinician decides to discharge the patient. This is communicated to the patient via letter. The patient will require a new referral for assessment.

5.09(1) NHS e-referral non-attendance

The same conditions of non-attendance, hospital or patient, apply to patients referred under the NHS E –Referrals system.

5.10 Follow up appointments

Follow-up appointments, prior to first definitive treatment, are appropriate when a patient's condition requires the continued intervention of specialist clinical expertise. In situations where there is no

evidence that a further specialist clinical intervention is required (e.g. patient no longer has symptoms or primary healthcare support is considered more appropriate) the patient should be discharged to the care of their GP. This will stop the 18-week clock.

To ensure time to process test results, follow-up appointments should be booked at an appropriate interval following the test in line with current policy diagnostic waiting times (of 6 weeks) with a maximum of five-day allowance for results to be readily available for view.

If the results of tests are negative, the requirement for a further follow up appointment may not be necessary. A suitable letter to the patient and GP may be sufficient, but this is subject to clinical judgement. The patient must be discharged and if appropriate close the patient's referral on Trust PAS. This will stop the 18-week clock.

The patient should not change follow up appointments more than once and the reason for the change and the clinician authorising the change must be recorded in PAS.

5.11 Outpatient Waiting List

Following the first outpatient appointment, the patient will be placed on an Outpatient Waiting List (OWL) for subsequent outpatient appointments. This does not affect the patient's RTT clock but allow the trust to monitor our patient's Latest Clinically Appropriate (LCAD)date.

5.12 Active monitoring

Active monitoring is defined as a 'clinical decision' (agreed with the patient) following a diagnosis that a period of active monitoring in secondary care, without clinical intervention or diagnostic procedures (for diagnosis purposes) at that stage should begin rather than treatment (i.e. a decision that there is no intention currently to treat the patient). This will stop the 18-week clock.

It is expected that at the end of the active monitoring period there will be a review during a follow up appointment at which point there should be a new decision whether or not to treat the patient. If a decision to treat is made following a period of active monitoring, then a new 18-week clock would start.

5.13 Clinic outcome Form

A clinic outcome form must be completed correctly indicating the clinic visit outcome and updating the 18-week pathway at every outpatient visit. The completed outcome form must be filed in notes. Outpatient supervisors/ Assistant service managers must ensure that outcome forms are filed in the patient notes within a maximum of 24 hours. If outcome forms have not be filed within 24 hours of attendance this must be escalated to the clinician and relevant specialty Service Manager.

5.14 External/Contact Lens

When a patient is issued a prescription for contact lenses that can only be made by Moorfields Eye Hospital, the patients have six weeks to pay for their prescription. If the six weeks passes without payment, the patients 18-week RTT clock will stop, and they will be discharged back to their referrer with a letter sent to the patient and referrer. If the prescription is paid within the 6-week period, the patient's clock will stop when the patient receives and is instructed how to use the contact lens.

5.15 Patient Initiated Follow

A patient may be placed on

Section 6. Outpatient Procedures/Day Case Procedures/ Elective Inpatients

6.01 Reasonable offers

The majority of patients are treated in an outpatient setting with injections or a laser procedure. This group of patients must be given the same reasonable offer as outlined in this section. Non-availability of more than 12 weeks and repeated refusal of reasonable offers may result in the patient being discharged back to the care of their GP.

The decision to add a patient to an elective inpatient/day case waiting list must be made by a consultant, or Consultant's representative. For patients with a decision to admit for treatment, two reasonable offers of an admission date must be offered with a minimum of three weeks' notice.

Where available, patients may be offered an earlier admission date at less than the 3 weeks minimum notice period, however patients will have the opportunity to decline without any adverse effect on their waiting times or 18-week clock. If the patient accepts a shorter notice offer date, it will be explained to the patient that this will count as a reasonable offer and that if they cancel or DNA, will be treated as such.

Consultants or Consultant's representatives who are offering patient's dates for outpatient procedures or admission must follow the Trust RTT protocol and offer the patient a date within 8 weeks of the clinic appointment. If the patient is not available for more than 12 weeks, they must be considered for discharge to the care of their GP. If it is clinically appropriate to do so, the GP or referring practitioner will be notified in writing. The GP should be asked to re-refer the patient when they are ready for treatment.

Where the patient does not respond to letters or phone calls i.e. tried for at least a week with two phone calls or have not responded to an admission letter within 10 days of the letter date. The patient is not fulfilling their obligation to make themselves available for admission and they can be taken off the waiting list and brought back to clinic, or discharged to the care of their GP if appropriate. A letter will be sent to the patient and their GP explaining why they have been taken off the waiting list.

6.02 Determining patient priority

All patients who are added to the in-patient waiting list will be treated in chronological order unless they are given a clinical priority of urgent.

6.03 Elective Planned patients

Patients who have completed their 18-week referral to treatment (RTT) pathway but still require a further planned course of treatment are added to a planned waiting list. Patients who are on the planned list are not included in any calculation of the size of the waiting list because their procedures would not be done sooner if resources were not a constraint. These patients are monitored via the PTL for elective planned patients.

Each Directorate is responsible for reviewing the planned PTL list on a weekly basis. This review will include checking that patients are being seen in accordance with their planned review dates and have been listed appropriately to the planned PTL list data definition.

When a patient on a planned list does not have their consultant - led procedure / treatment by the stated to be seen date they should be transferred to an active list and an RTT clock should start and usual RTT monitoring be followed from that date.

6.04 Thinking time

Patients requiring thinking time regarding if a treatment is suitable for them will not normally stop the clock. There is an expectation that the clinician will have discussed a suitable timeframe of not more than 3 weeks for this decision to be made, this may be shorter on cancer pathways.

Where a patient wishes to think about a non-cancer RTT treatment for longer than 3 weeks, a period of active monitoring will commence. The patient must be given an appointment for a review in 13 weeks or less. This will stop the 18-week clock.

The Trust cannot pause an 18-week pathway for clinical or social reasons.

6.05 Clinically initiated delays (or patient unfit for treatment)

Patients who are known to be medically unfit for treatment must not be added to the waiting list. Patients must either be actively monitored within an outpatient setting or discharged back to the GP/referring clinician until they are fit and available to accept and undergo treatment. Where a clinical decision is made to discharge the patient back to the care of the GP/referring clinician, the consultant in charge of the patient's care must inform the GP and patient in writing. This results in their 18-week clock being stopped. This applies to all patients who are not expected to be fit for treatment for a period of more than 3 weeks.

The Trust will start a new pathway when the patient is fit for surgery on confirmation from the GP the consultant or from a patient contact to inform of this. The patient will be added to an in- patient waiting list and if necessary be required to attend a further pre-operative assessment. This will start a new 18-week clock.

If a patient is referred to their GP to undergo and obtain tests and results not available to Moorfields Trust and this will take more than six weeks, the patient should be removed from the waiting list and their clock stopped until confirmation of the results is received. This can be either in a clinic appointment or upon receipt of the test results from the GP via post or electronically. Where tests are requested in such a manner and will take less than three weeks, the patient will remain on the waiting list on an active RTT pathway.

Short-term transitory illness - If the reason is transitory, such as a cold or a chest infection, then patients should contact the relevant Admissions Team and a new admission date will be agreed with the patient, normally within 3 weeks of the original date. This will allow patients with minor acute clinical reasons for delay the time needed to recover. The 18-week clock will continue to run during this time.

6.06 Bilateral procedures

Where a patient requires a bilateral procedure, and the second procedure is not undertaken at the same time as the first, a new clock starts when a patient is fit and ready for the second treatment. These patients will be managed from the active waiting list and listed directly for bilateral procedures when the patient is declared fit and ready to proceed for the second procedure by the clinician. This will start a new 18-week clock.

6.07 Patients admitted from an emergency referral via a GP or ED

Patients admitted as emergency referrals are not subject to 18-week RTT targets. If a patient was already on an RTT pathway for a treatment that is carried out during the emergency admission the existing RTT 18-week clock will stop.

6.08 Pre-operative assessment

The Trust aims for all patients to be pre-assessed on the day of Decision to Admit (DTA). The patient will move directly to the Pre-assessment Clinic (PAC) at the end of their outpatient consultation. Where this is not possible the patient will be allocated a future appointment date.

Where the pre-assessment nurse requests a clinical notes review by an anaesthetist, this must take place within two working days.

MRSA swabs should be obtained from all eligible patients when attending for pre-operative assessment, where patients are found to be colonised, they are treated immediately in line with Trust's MRSA policy. This does not stop the 18-week clock.

Patients who require a face-to-face anaesthetic review must be allocated an appointment no longer than five working days after the decision to be reviewed by an anaesthetist has been made. The 18-week clock will keep ticking during this period.

6.08(1) Patients who are not fit for Surgery

Where the Anaesthetist confirms the patient is unfit for surgery, it is the responsibility of the Anaesthetist to inform the consultant in charge of the patients care and the GP/referring clinician. Patients found to be unfit for surgery at pre-assessment or are already on a waiting list and subsequently become medically unfit for surgery for a period greater than six weeks must be actively monitored within an outpatient setting or discharged back to the referring clinician/GP. The RTT pathway will be stopped, and the patient will be removed from the waiting list. Where the clinical decision is made to discharge the patient back to the care of the GP/referring clinician, the consultant in charge of the patient's care must inform the GP and patient in writing.

6.09 Patients Who DNA Pre-assessment Appointments

All patients have a responsibility to attend their pre-assessment appointment and their surgery date (TCI). Where patients DNA their pre-assessment appointment, it is the responsibility of the pre-assessment administrator to make contact with the patient to confirm they wish to go ahead with their surgical TCI date. Where a patient confirms they will be attending their TCI, one further pre-assessment appointment will be offered prior to the TCI date already allocated. If a patient fails to attend a second pre-operative assessment appointment, they should be discharged back to the care of the GP. This will stop the 18-week clock.

Where routine patients decline a first or subsequent offer for a pre-assessment appointment the administrator will inform the admissions Coordinator to remove the patient from the waiting list. The admissions coordinator will then inform the patients' consultant of this action and the patient will be considered for discharge to their GP/Referring clinician as appropriate.
Where Urgent, cancer, paediatric or vulnerable adults decline the offer of a further pre-assessment appointment the consultant in charge of the patient's care must be informed. It is the consultant's responsibility to decide whether it is clinically safe to discharge the patient back to the care of their GP or if a further appointment should be allocated. Each case will be dealt with on an individual case-by-case basis in these circumstances.

6.10 Corneal Grafts and Transplants

Where a clinical decision is made to add a patient to the inpatient waiting list for a Corneal Graft/Transplant that does not require tissue matching, the RTT clock will continue to tick until the procedure has taken place.

Where a clinical decision is made to add a patient to a Corneal Graft waiting list that requires tissue matching, and the decision has been communicated to the patient and their GP, this will stop the

RTT clock. When matched tissue becomes available, a new clock starts and is stopped at the point at which the patient is treated.

6.11 Adding patients to the inpatient waiting list

Patients must be made aware of the waiting times if a date is not able to be agreed. They should also be asked if they are available at short notice and this information should be entered onto Trust PAS with contact telephone numbers. All patients should be advised they will receive a waiting list letter.

6.12 Best Interest Meetings

Where a patient lacks capacity to make a complex decision, it is not appropriate to list a patient for elective surgery until the Trust has held a Best Interest Meeting, however, the RTT clock will continue to run. A Decision to treat should not be made or entered onto the system until a best interest meeting has taken place in which a DTA has been made.

6.13 Individual Funding Requests (IFR's)

For patients referred by the GP to proceed with procedures listed in the lower priority procedures (LPP) thresholds or who do not have an Individual Funding Request authorised, the clock continues while commissioner approval is obtained for the LPP.

In circumstances where an IFR is declined by the IFR panel, it is essential to ensure the patient and the GP are informed as soon as possible to enable the RTT pathway to be closed. The patient and GP can be informed either in writing or via a telephone consultation.

In some individual cases, the GP may refer the patient for a specialist opinion to determine if the treatment would support an IFR. In these cases, once the decision has been made by the Consultant, the patient will be discharged back to the GP while they discuss with their patient their individual circumstance. The patient would receive a new GP referral if the specialist opinion supported an IFR.

This is in line with the IES ICB guidance on the use of IFR and the role of the Individual Funding Request Panel

6.14 Selecting patients from the inpatient waiting list

Patients should be selected in clinical priority and chronological order in terms of their 18-week RTT wait. Patients with the same clinical priority should be admitted in RTT breach date order. For those patients not monitored under RTT e.g. a planned treatment event such as a six-monthly examination under anaesthetic, should be offered a date within the period requested by their clinician.

It is the responsibility of the admissions Coordinator to escalate potential breaches to the appropriate ADM/DM/Service Manager

6.15 Patients Directly Listed for Surgery Following Receipt of Referral

Patients may be listed directly for surgery without having attended an outpatient clinic appointment. In these circumstances, the date the referral for direct listing is received is the RTT clock start date.

6.16 Booking a TCI Date

The Admissions team will aim to contact patients within 5 working days of the decision to admit offering them at least two choices of dates for surgery. Patients will be contacted directly to make offers verbally. Verbal offers must be confirmed via letter and documented in the patients' electronic records on PAS and Open Eyes. If the patient is not available for more than 12 weeks, they must be discharged to the care of their GP in writing. The GP should be asked to re-refer the patient when they are ready for treatment.

Moorfields Eye Hospital at City Road performs ophthalmic surgical procedures as day cases. There is only a limited amount of over-night in-patient beds at City Road site. In order to accommodate patients' pre- and post-surgical procedures for non-clinical reasons, there are hostel beds available on the first floor in Mackellar Ward once day care surgical activity ceases at 21:00 during weekdays and 19:30 during weekends. The hostel is staffed by a warden who is not required to have nursing or medical training.

6.17 Earliest Reasonable Offer Date (EROD)

A reasonable offer of notice for an elective admission is 'a TCI date offered with a minimum of three weeks' notice'.

If the patient declines two reasonable offers of TCIs, they will be considered for discharge and, only if clinically indicated, returned to their referring organisation. Their GP will also be notified of this discharge.

A patient may be offered a TCI date with less than three weeks' notice. In these circumstances where a patient has declined an offer of less than three weeks' notice, this must not be recorded as an EROD.

6.18 Patient Reminder Notifications

Attempts must be made to contact all surgical patients by phone to confirm their attendance five working days prior to the TCI date.

Where patients confirm they will not be attending their TCI date, the slot must be offered to another patient from the appropriate waiting list. The patient must be selected from the waiting list in clinical priority order and chronological order.

6.19 Patient Choice Delay to Receipt of first Definitive Treatment

There is no provision to pause or suspend an RTT waiting time clock on a non-admitted pathway under any circumstances. Patients can request thinking time. If this is for a period in excess of 3 weeks the patient will be put on active monitoring, this will stop the 18-week clock.

Data required to confirm a patient choice delay to receipt of first definitive treatment, for audit purposes only, must be recorded in Open Eyes and within the patient's records in the Trust PAS waiting list as follows:

- Date of discussion.
- EROD 1st reasonable offer date.
- Second reasonable offer date.
- Date the patient is available from.
- Reason why the offers were declined e.g. Abroad.
- Any other TCI dates offered (These dates are recorded to ensure we do not offer the same dates they have previously turned down).

6.20 Hospital Cancellations

The Trust objective is to have all patients on the waiting list treated within their 18-week Target. In the event that the Trust has to cancel a patient's elective procedure for a non-clinical reason, either

on the day of admission or day of surgery, the patient must be contacted within 5 days and offered an admission date that is within 28 days of the cancelled operation date, or the RTT date, whichever is sooner. The 18-week clock will continue to tick throughout until treatment is started.

Theatre and Clinic sessions should not be cancelled without a minimum of 8 weeks' notice.

All short notice cancellations must be authorised in writing by the Chief Operating Officer, following review by the appropriate Directorate Clinical Director and Divisional Manager. No action can be taken on any short notice cancellations without appropriate authorisation.

Cancellations initiated by the hospital must be kept to a minimum; every effort to cover lists must be taken prior to cancellation.

Patients that have been cancelled by the hospital on one occasion must not be cancelled a second time. The admissions Coordinator must escalate such patients to the Assistant Divisional Managers/Service Manager, who will take every action to ensure a second cancellation does not take place.

The RTT clock will continue to tick for patients on an open pathway that have their TCI cancelled and rescheduled by the hospital.

6.21 Elective Admitted Cancellations and DNA Management

6.21(1) Patient Cancellations

Routine and urgent patients (Adults) who cancel their TCI date on one occasion may be offered one further date depending on the subspecialty guidance. Subsequent cancellations will be referred to the consultant in charge of the patients care to determine whether it is clinically safe to discharge the patient back to the care of their GP. Patients who cancel on the same day unless unwell will be counted as a DNA.

Where urgent, cancer, children, young people or vulnerable adults cancel their TCI date one further offer date will be made. Subsequent cancellations will be referred to the consultant in charge of the patients care. It is the consultant's responsibility to decide whether it is clinically safe to discharge the patient back to the care of their GP or if a further surgical date should be offered.

For children, young people and vulnerable adults the consultant must send a letter to the relevant healthcare professionals e.g. GP, referrer, and/or social worker to confirm the actions taken.

Where discharge has been confirmed by the consultant for the patients in the categories above, the patient must be removed from the waiting list, their RTT pathway will close and the referral discharged on Trust PAS.

Patients who either call in to cancel an agreed date for surgery due to sickness or extreme personal circumstances or are deferred on the day of surgery due to a short and measurable medical condition will be cancelled and a new date should be agreed with the patient for a maximum of 3 weeks' time. The 18-week clock will keep ticking throughout this period.

6.22 Did not attend (DNA) inpatient/day case procedure

In line with local Trust policy, patients who fail to attend for reasons unknown for their agreed in-patient procedure date should be removed from the waiting list and referred back to their GP and the Consultant will be informed. Patients must be informed clearly in all Trust correspondence that in the event that they DNA either their pre-operative assessment appointment or in-patient procedure, that they will be referred back to their GP. This will stop the 18-week clock.

In the extreme circumstance, that the clinician feels it would be detrimental to the patient's health if an appointment is not re-booked, of if the patient is a child or vulnerable adult then the patient must first be contacted to ascertain the reasons for DNA and ensure compliance to attend a rescheduled appointment. The existing referral will continue on Trust PAS and the referral date will be the ORIGINAL date used to determine the patient's 18-week pathway.

Patients who subsequently fail to attend will be referred back to the care of their GP providing:

- The appointment was clearly agreed and communicated and discharging the patient is not contrary to their best clinical interests.
- The final decision will be made by the clinician managing the patient's care.

6.23 After the 18-week clock stops

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

Upon completion of an 18-week RTT period, a new RTT clock starts:

- When a patient becomes fit and ready for the second of a consultant-led bilateral procedure.
- Upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan and which the patient has to wait for the treatment. Changes to a patient's medication would not restart the clock for example.
- For subsequent treatment episodes for the same condition which are not planned care.
- Upon a patient being re-referred into a Consultant-led service as a new referral.
- When a decision to treat is made following a period of active monitoring.

Section 7. 2 week wait Referrals

Patients referred under a 2 week wait oncology pathway still come under 18-week guidelines and are processed using the same standards, excepting in the circumstances outlined in the exceptions section of this policy (Appendix 1)

For full details on 2 week wait standards and practices, please see the Cancer Access Policy.

Section 8. Training and Education

All new staff within the Divisions (including all clinical staff) involved in the implementation of this policy will complete an e-learning module on the 18 week rule suite and complete PAS technical training undertaken by Learning & Development on Trust PAS which will include specific reference to the requirements relating to Referral to Treatment (RTT).

In addition, all new staff within the Divisions (including all clinical staff) involved in the implementation of this policy will undertake initial training as part of their local induction arrangements.

NHS e-referral Service training is also required for any user prior to being given access and available as refresher training to all users.

All new staff employed within the management area of the Chief Information Office will receive induction and on-going training in line with their responsibilities for implementation of this policy. On-going training will be identified as part of Individual Performance Reviews and from the results of audits.

All new staff in the Clinical Administration Teams will undertake initial training as part of their local induction arrangements. This will include training undertaken on NHS e-referral Service (Where relevant) and Trust PAS, which will include specific reference to the requirements relating to Referral to Treatment (RTT) prior to being given access to the systems.

RTT training will be a standing agenda item on all Medical Induction Programmes.

Section 9. Development, Compliance and Effectiveness

The Access Board will routinely monitor the appropriate application of this policy for RTT pathways. Where issues arise with any member of staff in complying with the policy, the issue will be resolved between the Directorate Management and the individual concerned.

Compliance with national and local targets and standards will be monitored as part of the Trust's Performance Management Framework.

Reporting will include the weekly PTL reports available to the directorate teams, weekly and monthly summaries of RTT performance by speciality distributed to all management staff involved in the management of RTT pathways. Breach reporting is undertaken across the month and is overseen for compliance by the information team.

9.01 The mechanisms for monitoring all waiting times/data quality

- Daily PTL reports.
- Weekly PTL meeting.
- Weekly Access Board meeting.
- Monthly Directorate Performance Monitoring Reports.
- Trust Board Reports.

The main operational mechanism for monitoring progress and adherence to the Access Policy by specific KPI's will be the weekly Access Board meeting, chaired by the Chief Operating Officer or a nominated deputy.

9.02 Stakeholder Engagement and Communication

The policy is circulated to all ADMs, Service Managers, DMs, Clinical Directors, Service Directors, Chief Operating Officer, Deputy Chief Operating Officer Medical Director, Clinical Director for Quality and Safety, Lead ICB and CSU. The policy will be on the Trust Intranet. A printed copy can be requested by any relevant external stakeholder.

9.03 Approval and Ratification

Approval of this policy was gained by the Chief Operating Officer as the Lead Director by completing the policy checklist with the policy presented to the Policy and procedural Review Group and Clinical Quality Review Group.

Ratification of this policy was gained by the Chief Operating Officer as the Lead Director. The policy checklist was completed and presented to the Management Executive Group

9.04 Dissemination and Implementation

Staff will be notified of this revision of the policy by a broadcast e-mail. It will replace the current policy on the Intranet.

Appropriate information on the waiting lists and expected waits will be published by the Information Team. This will be available routinely to Service Managers, ADM's and DM's and other staff as appropriate.

Summary speciality and clinician waiting times information will be presented to the Trust Executive and Board and Commissioner regularly. Information on waiting times is routinely shared with the Commissioner with an expectation that patients should be advised on the wait time at the point of referral. This policy will be embedded through training and the divisional management structure.

9.05 Document control and archiving

The current and approved version of this document can be found on the Trust's intranet site. Should this not be the case, please contact the Quality and Compliance team.

Previously approved versions of this document will be removed from the intranet by the compliance team and archived in the policy repository. Any requests for retrieval of archived documents must be directed to the Quality and Compliance team.

9.06 Monitoring Compliance with this Policy

The Trust will use a variety of methods to monitor compliance with the processes in this document including the following methods;

Measurable policy objective	Monitoring/ audit method	Frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to which groups/ committees, inc responsibility for reviewing action plans
The Policy will be reviewed by the Head of Access Performance at least annually to ensure that they remain valid and in date	Compliance audit of sample of policy (including review history)	Annual	Head of Access Policy	Access Board
Internal Audit of Patients	Compliance and data quality audit of patients within the trust.	Annual	KPMG (or similar audit providers)	Access Board/Executive Board/
External Audit of Patients	Compliance and data quality audit of patients	Annual	Deloitte (or similar audit providers)	Access Board/Executive Board/

	within the trust.			
Maintenance of accurately recorded clock altering events and patient pathways	Monitoring and validation of patient tracking lists and Key Performance Indicators	Daily	Validation Teams Service admin staff	Access Board

Section 10. Definitions

The following section sets out the definitions issued by the Department of Health that have been used in this policy.

18-week referral to treatment (RTT period)	The part of the patient's care following initial referral which initiates a clock start, leading up to the start of the first definitive treatment or other 18-week clock stop point.
Active Monitoring (previously known as 'Watchful Waiting')	Where it is clinically decided to start a period of monitoring in secondary care without clinical intervention, or diagnostic procedures at that stage.
Active Waiting List (Waiting list types: Elective Waiting Elective Planned)	The list of elective patients who are fit and able to be treated at that given point in time. The active waiting list is also the list used to report national waiting times statistics.
ASI's	Appointment Slot Issues
Admitted Pathway	A pathway that ends in a clock stop for admission (day case or inpatient)
Cancelled Operations/procedures	If the Trust cancels a patient admission on the day of the admission/procedure for a non-clinical reason (e.g. lack of theatre time) – the Trust is required to rearrange a new operation/procedure date within 28 days of the cancelled date, or within target wait time, whichever is the soonest. The offer must be made within 5 days of the cancellation.
Admissions Coordinator	Admissions administrator who schedules operation dates directly with patients.
NHS e-referral Service	NHS e-Referral Service is a national electronic referral service that gives patients a choice of place, date and time for their first Consultant outpatient appointment. This replaced Choose and Book.
Chronological Order (in-turn)	This is a general principle that applies to patients categorised as requiring routine treatment (as opposed to urgent treatment). All these patients should be seen or treated in the order they were initially referred for treatment (Clock Start).

Clock Start/Stop	Refers to number of days/weeks in a patient pathway, which is a maximum of 18 weeks. Refer to http://www.england.nhs.uk/statistics/RTT-waiting-times/RTT-guidance/ for full details of pathway measurement. A patient may have more than one clock running at the same time either in the same or different specialities.
COF	Clinic Outcome Form
Consultant-Led Service.	An administrative arrangement enabling patients to see a consultant, the consultant's staff and the associated health professionals. The holding of a clinic provides the opportunity for consultation, investigation and treatment. Patients normally attend by prior appointment. Although a consultant is in overall charge, the consultant may not be present on all occasions that the clinic is held. However, a member of the consultants' team or locum for such a member must always be present. An individual consultant may run more than one clinic in the same or different locations. This also includes clinics run by GP's acting as consultants.
Convert(s) their UBRN	When an appointment has been booked through NHS e-referral Service, the UBRN is converted.
Day Case	Patient who requires admission for treatment but who is not expected to stay overnight.
Decision to admit	Where a clinical decision is taken to admit the patient for either a day case or inpatient treatment.
Decision to treat	Where a clinical decision is taken to treat a patient as an inpatient, day case and / or performed in other settings e.g. outpatients
Did not Attend (DNA)	Patients, who have been informed of their date of admission or pre-assessment (in-patients/day case), diagnostics or appointment date (outpatients) and who, without notifying the hospital, did not attend
DoH	Department of Health.
Elective admission / elective patients	In-patients are classified into two groups, emergency and elective. Elective patients are so called because the Trust can 'elect' when to treat them.
Elective Planned	Patients who are to be admitted as part of a planned sequence of treatment or investigation.
Elective Waiting	Patients awaiting elective admission who have yet to be given an admission date.
E-Referral (previously choose and book)	An electronic -booking software application designed to enable patients needing an outpatient appointment to choose which hospital they are referred to by their General Practitioner (GP) and to book a convenient date and time for their appointment.
Entitlement to use the NHS	Entitlement to use the National Health Service free of charge is based on where a person

	normally lives regardless of their nationality or whether they hold a British passport or have lived and paid National Insurance contributions and taxes in this country in the past. Anyone who has lived lawfully in the UK for at least 12 months immediately preceding treatment is exempt from charges.
EROD	Earliest reasonable offer date
Fast track	Special arrangements that are made for a patient who has been unable to continue on a pathway as they are medically unfit or unavailable for care. Fast tracking the patient back into the service starts a new clock but it not expected that a patient would have to wait a maximum of 18 weeks for their first definitive treatment.
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 of clinical judgement in consultation with others as appropriate, including the patient
Follow-up	Attendance Within a consultant outpatient episode are all subsequent attendances to see the same consultant following a first attendance.
Inter-Provider Transfer	A patient pathway managed between more than one organisation. Patients may receive more than one definitive treatment in a 'tertiary centre' – that specialises in their condition.
Low Priority Procedures	Procedures as detailed in the list maintained and controlled by the ICB that require specific referral criteria to be adhered to and specific agreement go procedure from the ICB
Latest Clinically Appropriate Date	The date determined by the clinician to be the latest date that the patient should be followed up to satisfy clinical safety (This does not infer that the patient is in immediate danger following this date)
MDS	Minimum Data Set: specific information about a patient that must be completed and sent with the letter of referral when transferring a patient's care between providers.
Medically Unfit	A patient who has a condition that prevents them from continuing along their current pathway of care. Special arrangements must be made for these patients to address their medical condition either in primary or secondary care and to fast track those back into the service if appropriate when they are fit and able to restart a pathway of care (note a new clock will start for these patients).
Non-Admitted Pathway	A pathway that takes place in a non-admitted/outpatient setting that does not result in an admission or for treatment.

Non-GP service	For purposes of determining which referrals will only be paid for by NHSE when submitted through ERS, this denotes referrals outside of this restriction. This includes but is not limited to; • Optometrists • Opticians • Other Tertiary providers • National Screening Programmes
Outpatients	Patients referred by a General Practitioner (medical or dental) or another Consultant / health professional for clinical advice or treatment
Outpatient Waiting List (OWL)	A method for tracking patients that require a follow up appointment. This does not affect patient's RTT status.
Pre-Assessment	A system that assesses patient's health before they are admitted to hospital to ensure that they are fit to undergo the procedure/treatment
Reasonable Offer	Refers to the notice given to a patient by the hospital for a forthcoming appointment or admission. For an offer to be reasonable two dates with at least 3 weeks' notice must be given to a patient undergoing surgery. For outpatients good practice guidance suggests notice of at least 2 weeks' notice. Exceptions to this are those patients that are referred on the suspected cancer referral pathway.
Referral Received	The waiting time for a first outpatient appointment is calculated from the date the paper referral request is received in the Trust, which must be date stamped immediately upon receipt. For e-referrals the waiting time commences upon conversion of the UBRN into an appointment booking.
RTT	Referral to Treatment, the time between referral and treatment.
TCI	To come in. A date and time for a day case/inpatient appointment
Vulnerable Adult	Someone who is or may be in need of community care services by reasons of mental health or other disability, age or illness' and 'is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation including an individual who is unable to make an informed decision or consent to treatment etc.
URBN	Unique booking reference number use for NHS e-Referral Service The patient is notified of this on their appointment request letter when generated by the referrer through NHS e-referral Service. The UBRN is used in conjunction with the patient password to make or change an appointment
Military Veteran	Anyone who has served 1 day or more in HM armed forces whether as a regular or reservist

Section 11. Supporting References / Evidence Base

Referral to treatment consultant-led waiting times Rules Suite

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464956/_Rules_Suite_October_2015.pdf

Recording and reporting referral to treatment waiting times for consultant-led elective care

http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting--guidance-v24-PDF-573K.pdf

Recording and reporting referral to treatment waiting times for consultant-led elective care: Frequently Asked Questions

https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Accompanying-FAQs-v7.2.pdf

National Guidance for managing screen positive diabetic patients within hospital eye services.

https://www.gov.uk/government/collections/nhs-screening-programmes-national-data-reporting

NHS Diabetic Eye Screening Programme Pathway standards

https://www.gov.uk/government/publications/diabetic-eye-screening-standards-and-performance-objectives

NHSE guidance and information on Paper Switch Off

https://digital.nhs.uk/services/nhs-e-referral-service/the-future-of-the-nhs-e-referral-service/paper-switch-off-programme-and-documents

Policy for patients who require appointments for assessment, review and/or treatment - use of planned (pending or review) lists.

http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Planned-Patients-Guidance.pdf

IES ICB guidance on the use of IFR and the role of the Individual Funding Request Panel

https://www.england.nhs.uk/wp-content/uploads/2017/11/ifr-patient-guide.pdf

National Cancer Waiting Times Monitoring Data Set:

http://www.datadictionary.nhs.uk/data_dictionary/messages/clinical_data_sets/data_sets/national_cancer_waiting_times_monitoring_data_set_fr.asp?shownav=1

Waiting times for tests and treatment after cancer diagnosis

http://www.cancerresearchuk.org/about-cancer/cancers-in-general/cancer-questions/waiting-times-for-tests-and-treatment-after-cancer-diagnosis

Safeguarding Children & Young People Policy

http://mehhome/resources/safeguarding-children-and-young-people-(0-18-years)/

Was Not Brought/Did Not Attend/Could Not Attend/ Policy

http://mehhome/_uploads/documents/policy-documents/paediatric-wnb-dna-cna-v2.pdf

Safeguarding Adult Policy

http://mehhome/resources/safeguarding-adults/

Going Further on Cancer Waits (GFOCW):

https://www.england.nhs.uk/wp-content/uploads/2015/03/going-further-cancer-waits.pdf

Section 12. Appendices

12.01 Appendix 1 Exceptional Circumstances Preventing Patient Discharge from Service

12.01(1) Vulnerable patients

When considering a patient for discharge following cancellation or DNA, any risks associated with the patient's vulnerability must be assessed and factored into the decision, with additional contact with the patient/carers made as appropriate. This includes patient with learning disabilities, Dementia and any other vulnerability that is likely to impact on their ability to attend appointments. For further information on the treatment of Vulnerable patients, please consult the Safeguarding Adult policy and the Safeguarding Children & Young People Policy

12.01(2) 2 week wait patients

Patients who do not attend

Whenever a patient referred to the Trust under suspicion of cancer does not attend a new outpatient appointment, a clinician must write to the referrer and GP to inform them on the day the patient failed to attend. They will be offered another appointment.

Should a patient fail to attend for a second time, a clinician should review the patient's notes at the end of the clinic and instruct that the patient is discharged unless it would not be clinically appropriate to do so. Further re-booking will be at the discretion of the clinician. The same process is followed where patients fail to attend a follow-up patient.

12.01(3) Cancellations

If a patient cancels their first new outpatient appointment, the Booking Centre must agree a date for another appointment with the patient at the time of cancellation. Where a patient requests to rearrange their appointment, the alternative appointment offered must be within 14 days of the referral date where possible. In the event a replacement appointment cannot be offered before the

breach date, this should be escalated to the Assistant Service Manager/Service Manager immediately.

If a patient cancels a subsequent appointment, the Consultant must review the notes to decide the appropriate action and a member of the clinical team should consider contacting the patient to discuss their non-attendance. Where a patient has cancelled or not attended their first outpatient appointment on two or more occasions, they should be discharged back to the referrer unless it would not be clinically appropriate to do so. If a decision is made to discharge, both the patient and the GP should be notified via clinical letter. The same process should be followed if patients cancel a follow-up appointment.

12.01(4) Adnexal Service

The Adnexal service sees more patients with conditions that may resolve and also more possible tumour patients where failure to attend and repeated offers of re-attendance may carry significant risk. Therefore, in the Adnexal service, patients who DNA their first appointment will be discharged. At the discretion off the scrutinising clinician, high-risk patients including paediatric cases and possible tumours will be telephoned to enquire whether there were extenuating circumstances, or a message of cancellation was *not* actioned and, if so, a further appointment may be offered. Patients, who fail to attend a follow up appointment, will be discharged.
However, for high-risk patients (e.g. thyroid eye disease patients, tumour patients, further follow up appointments may be offered, or a telephone enquiry made, at the discretion of the senior clinician. Immediate post-operative patients who do not attend must be contacted by telephone if they do not attend to rearrange the appointment.

12.01(5) DRS Patients

Patients referred for Diabetic Retinal Screening may be offered further appointments in addition to the standard appointments depending on the severity of the referring condition, particularly patients referred on an urgent basis with proliferative diabetic retinopathy (R3A).

12.01(6) Children and Young People Services

Children and Young People are dependent on parents or carers to attend appointments and special consideration should be given to their case before discharge. For paediatric DNAs, could not attend (CNAs) in any service, the consultant or senior clinician in charge of the patient should assess the medical records and referral and make an individual decision in line with the guidance above.

Patients with conditions such as watery eyes or cysts are not to be routinely offered another appointment. If the child is subject to a Child Protection/Child in Need/Looked After plan, the allocated social worker must also be contacted to inform them of the outcome of the contact with the family and whether another appointment has been booked.

12.01(7) Cancellation of Appointments / Could Not Attend (CNA) in Children

In the case of an appointment cancellation the member of staff receiving the communication must record the following information:

- name of person making the request
- their relationship to the child

- reason for cancellation (if known)
- Whether another appointment is required and if so whether there are any specific requests relating to such an appointment.

This information should be recorded on Trust PAS and be made available to the consultant responsible for the child/young person's appointment to inform their decision about further appointments.

All children and young people known to be on a child protection plan or child in need plan must have their cancelled appointment shared directly with their allocated social worker.

The MEH Child Protection Named Professionals can be contacted for advice.

12.01(8) Did Not Attend / Was Not Brought (DNA / WNB) in Children

The Consultant or designated deputy is responsible for reviewing the medical record of all children and young people who fail to attend a hospital outpatient's appointment.

All children and young people known to be on a child protection plan or child in need plan must have their non-attendance shared with their allocated social worker.

The MEH Child Protection Named Professionals can be contacted for advice. Non-attendance must be recorded in the child's healthcare records along with any reason they did not arrive, and actions taken.

For all child DNAs regardless of service, consideration should be given to the possible need to follow safeguarding or child protection pathways. Staff should follow the Children and Young People Non-Attendance at Moorfields OPA Procedure Flowchart contained in the policy below [include link to existing policy here] and if in doubt consult with the Trust safeguarding children professionals.

If the child is subject to a Child Protection/Child in Need/Looked After plan, the allocated social worker must be notified of the defaulted appointment.

12.01(9) External disease, cornea and cataract

Exceptions to the DNA policy apply to patients who are on immunosuppression or who have had a corneal transplant. This is at the discretion of the scrutinising clinician for each clinic.

12.01(10) Glaucoma

Exceptions to the DNA policy apply to patients with uveitic glaucoma at the discretion of the scrutinising clinician for each glaucoma clinic. Patients within 12 weeks of glaucoma surgery are also an exclusion to the DNA policy and administrative teams will telephone patients to understand reasons for non-attendance so that timely follow up can be organised.

12.01(11) Medical Retina

The exceptions that apply for the Medical Retinal service with regards to DNA policy are patients on immunosuppression or patients referred from the diabetic screening service. It is especially important for the booking clerks of the diabetic clinics to ensure that the details for the diabetic screening patients are correct in the notes and the Trust PAS system.

Diabetic screening patients who fail to attend for their appointments are currently sent back to their local diabetic screening service which will potentially delay the treatment of their ocular condition. Therefore, at the discretion of the scrutinising clinician, diabetic screening patients may be offered further follow up appointments.

12.01(12) Uveitis

Transfer of care to local eye hospital services (Via GP:
· Chronic anterior uveitis on minimal therapy (except those with chronic anterior uveitis of childhood onset)
· Posterior uveitis, with no systemic disease, on no therapy or minimal local stable therapy (maintenance) for 6 months
· Intermediate uveitis on no therapy or minimal local therapy for 6 months

Discharge to optometrist (recommend yearly)
· Fuchs Uveitis Syndrome: good vision, normal IOP

Plain Discharge:
· Resolved simple AAU
· Resolved toxoplasmic retinitis
· Resolved episcleritis/scleritis
· Patients with posterior/intermediate uveitis off therapy for 1 year

1.01(13) Neuro-ophthalmology

Neuro-emergency clinic DNAs ideally should be called within 24 hours by a clinical member of staff to discuss their non-attendance and to decide on possible re-booking.

12.02 Appendix 2 Policy Applicability to Trust Sites

This document applies to all premises occupied by Trust staff/activities, unless explicitly stated otherwise.

For any sites that are excluded from the policy, the policy must list those sites together with a brief explanation as to why the site is excluded and name the local/host policy and any other documents that are used in its place.

Excluded sites	Reason for exclusion	Host policy and any other documents used in its place
Bedford Hospital	Bedford service complies with Bedford Hospital RTT Access Policy and performance is monitored via Bedford Hospital.	Bedford Hospital Access Policy
Homerton Hospital	Homerton service complies with Homerton Hospital RTT Access Policy and performance is monitored via Homerton Hospital.	Homerton Hospital Access Policy

Where the list indicates that the policy does not apply, this implies that the Trust will adhere to the policy of the host. Where a query exists then this must be referred, in the first instance, to either the:

- Divisional Manager /Head of Nursing
- Policy owner
- Accountable director
- Service director.

Moorfields Dubai will adhere to their own local policies and procedures and Trust-wide documents will not apply, unless explicitly stated otherwise.

Appendix 3 Equality Impact Assessment

The equality impact assessment is used to ensure we do not inadvertently discriminate as a service provider or as an employer.

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Comments / Evidence
1	Which groups is the policy/guidance intended for? Who will benefit from the policy/guidance? (refer to appropriate data)	All patients referred to Moorfields sites. Service users and commissioners.
	• Race	
	• Gender (or sex)	
	• Gender Reassignment	
	• Pregnancy and maternity	
	• Marriage and civil partnership	
	• Religion or belief	
	• Sexual orientation including lesbian, gay and bisexual people	
	• Age	
	• Disability (e.g., physical, sensory or learning)	
2	What issues need to be considered to ensure these groups are not disadvantaged by your proposal/guidance?	N/A
3	What evidence exists already that suggests that some groups are affected differently? (identify the evidence you refer to)	N/A
4	How will you avoid or mitigate against the difference or disadvantage.	N/A

5	What is your justification for the difference or disadvantage if you cannot avoid or mitigate against it, and you cannot stop the proposal or guidance?	N/A

If you have identified a potential discriminatory impact of this procedural document, please refer it to the director of Quality and safety, or the human resources department, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the director of Quality and safety (ext. 6564)

Please ensure that the completed EIA is appended to the final version of the document, so that it is available for consultation when the document is being approved and ratified, and subsequently published.

12.03 Appendix 4 Checklist for the Review and Approval of Documents

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

Title of the document: Patient Access Policy

Policy (document) Author Head of Access Performance

Policy (document) Owner: Head of Access Performance

		Yes/No/ Unsure/NA	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Scope/Purpose**		
	Is the target population clear and unambiguous?	Yes	
	Is the purpose of the document clear?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
3.	**Development Process**		
	Is there evidence of engagement with stakeholders and users?	Yes	
	Who was engaged in a review of the document (list committees/ individuals)?	Yes	
	Has the policy template been followed (i.e. is the format correct)?	Yes	
4.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
5.	**Approval**		
	Does the document identify which committee/group will approve/ratify it?	Yes	

		Yes/No/ Unsure/NA	Comments
	If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?	N/A	
6.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
7.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes	This policy is monitored internally by internal audit and externally by KPMG and Deloittes on an annual basis as well as regular internal validation and monitoring
8.	**Review Date**		
	Is the review date identified and is this acceptable?	Yes	
9.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Yes	
10.	**Equality Impact Assessment (EIA)**		
	Has a suitable EIA been completed?	Yes	

Committee approval (Policy and Procedure Review Group)			
If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner			
Name of Chair	[redacted]	Date	22/05/2024
Ratification by trust management committee or management executive			
If the [Trust Management Board or Management Executive] is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner			
Date: 27th September 2016			