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Northern Lincolnshire and Goole NHS
NHS Foundation Trust

Directorate of Strategy & Planning

REFERRAL TO TREATMENT ACCESS POLICY

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1.0 Summary

1.1 This policy highlights the key principles that govern effective and reliable referral and admission management throughout the local health community. The policy is in place to ensure patients attending for elective care receive timely, equitable treatment in line with national access standards and the NHS.

1.2 The Trust operates over three hospital sites; patients will receive their care at the most appropriate site.

1.3 This Policy should be read in conjunction with the Standing Operating Procedures (SOP's) which provides the detail for managing patient access into hospital services.

2.0 Introduction / Purpose

2.1 The purpose of this document is to provide a policy framework for managing patient access into hospital services and their continuing follow up.

2.2 The processes of referral, diagnostic and admission management are transparent to the public and external organisations.

2.3 The NHS Constitution states that patients can expect to start their consultant led treatment within a maximum of 18 weeks of referral for a non-urgent condition. Patients with more urgent conditions, such as cancer or heart disease, will be seen and treated more quickly.

2.4 This policy is underpinned by the Standing Operating Procedures detailing the processes and the standards expected to ensure effective policy adherence.

2.5 The Trust will give priority to clinically urgent patients and treat everyone else in turn. War pensioners and service personnel injured in conflict must receive priority treatment if the condition is directly attributable to injuries sustained in conflict as per the Trust's Armed Forces Covenant Policy.

2.6 The policy defines the roles and responsibilities for effective management of patient's access to hospital services.

3.0 Area / Scope

3.1 This Policy reflects the overall expectations of the provider and commissioner on the management of referrals and admissions into and within the organisation, and defines the principles on which the policy is based.

3.2 This policy and the Standing Operating Procedures apply to all those individuals within the Trust and partnership organisations who are responsible for referring patients, managing referrals, coordinating and maintaining waiting lists and admissions for the purpose of organising patient access to hospital treatment.

4.0 Duties, Roles and Responsibilities

4.1 Provider Responsibilities

4.1.1 The delivery of the Access Policy is the responsibility of the Executive Team reporting to the **Trust Board.** All staff with access to and a duty to maintain, referral and waiting list information systems, are accountable for their accurate upkeep and robust delivery.

4.1.2 **Director of Strategy & Planning** is responsible for the negotiation of contracting activity and to develop and monitor the Access Policy ensuring mechanisms are in place to enable data to be collected and reported accurately and in accordance with the data manual.

4.1.3 **Chief Operating Officer** is responsible for the operational delivery of the Access Policy.

4.1.4 **Director of Performance Assurance** is responsible for the reporting of information to the Executive Team, Trust Management Board and Trust Board monitoring performance against locally or nationally agreed targets and ensuring this is fed into appropriate operational and performance forums.

4.1.5 **The Directorate of Performance Assurance** is responsible for the reporting and escalation in accordance with the Scheme of Delegation and Governance process, monitoring performance against locally or nationally agreed targets and ensuring this is fed into appropriate operational and performance forums.

4.1.6 **Information Services Manager/Data Quality** is responsible for providing regular data quality audits of standards of data collection and recording the submission of central returns produced by the Information Services Department.

4.1.7 **Clinical Staff** – All clinical staff are responsible through their Clinical Lead structure for ensuring they comply with their responsibilities as outlined in this policy.

4.1.8 **Associate Chief Operating Officers** through their Management Structures are responsible for ensuring the Patient Tracking Lists (PTL's) are managed and validated.

4.1.9 **Operational Groups** have the day to day responsibility for achieving targets within the activity levels agreed with commissioners. All staff with access to and a duty to maintain, referral and waiting list information systems, are accountable for their accurate upkeep.

4.1.10 **Speciality Admin Teams** are responsible for the day-to-day management of the referral and waiting list administrative processes and are responsible to the Service Managers with regard to compliance of all aspects of the Patient Access Policy.

4.1.11 **All Staff** – have a responsibility to follow this policy and any accompanying Standing Operational Procedures. Training programmes will support staff in managing all aspects of the patient's pathway.

4.2 GPs & Clinical Commissioning Group (CCG)

4.2.1 GPs play a pivotal role in ensuring patients are made aware during their consultation of the likely waiting times for a new outpatient consultation and of the need to be contactable and available when referred.

4.2.2 The CCG is responsible for ensuring robust communication links are in place to feedback information to GPs.

4.2.3 Referrers have a responsibility to provide accurate and complete information within referral letters, particularly in relation to demographic information.

4.2.4 Minimum demographic information includes NHS Number, Surname and Forename, DOB and Primary Contact Number. Failure to provide minimum demographic and contact information could result in a rejection of the referral.

4.2.5 If the provider cannot see the patient within the maximum waiting time, the CCG and NHS England must offer a range of suitable alternative hospitals or community clinics that would be able to see or treat the patient more quickly.

4.3 Patient Responsibilities

4.3.1 Patients must be ready, willing and available to attend an initial appointment within 6 weeks of referral.

4.3.2 Patients must inform the Trust of any change to their name, GP, address or contact number(s).

4.3.3 Patients should keep their appointment, make every effort to arrive on time and inform the Trust, with as much notices as possible, if they cannot keep their appointment.

4.3.4 Where a parent/guardian/carer is supporting the patient, they should undertake to ensure that the patient fulfils their responsibilities.

4.3.5 If patients cannot be seen within the maximum waiting time the organisation that commissions and funds your treatment (CCGs or NHS England) must investigate and offer you a range of suitable alternative hospitals or community clinics that would be able to see or treat you more quickly. The patient will need to contact the original hospital, clinic or commissioner first before alternatives can be investigated.

5.0 Referrals

5.1 General Information on Referrals

5.1.1 Referrals should, in the majority of cases, be addressed on a specialty or sub specialty basis and only in particular circumstances to named consultants (e.g. where a patient wishes to see a female gynaecologist, or for continuity of care, or patient choice). This is to ensure that the delivery of the 18 week RTT is not compromised.

5.1.2 Electronic booking via the Choose & Book system for Consultant outpatient appointments or DART for Diagnostic appointments is the expected method for referral for two week wait; urgent and routine appointments. Other referrals received must be registered on the Patient Administration system within 24 hours. Clinical review must take place within three working days of receipt of referral. Any inappropriate referrals received will be rejected and the referrer will be notified.

5.2 General Principles for Booking

5.2.1 All patients must be seen in order of clinical priority and length of wait. Three attempts should be made to contact the patient by telephone offering 2 reasonable dates patients have an opportunity to negotiate their appointment time and date. A decision to add to an outpatient, diagnostic or elective waiting list entry must be recorded on an approved information system within one working day.

5.2.2 Receptionists and ward clerks should not make appointments unless instructed to do so by the Associate Chief Operating Officer.

5.3 Tertiary / Inter-Provider Referrals

A completed Inter-provider Administrative Minimum Data Set (IPTAMDS) pro forma must accompany all inter-provider transfers both into and out of the Trust. The SOP provides the Inter-Provider Referral processes to follow.

5.4 Reasonable Offer

A reasonable verbal offer for an appointment date is a minimum of 4 working days; appointment sent in the post is 7 days' notice. Patients will be offered a minimum of two reasonable dates, if two reasonable offers are declined patient will be discharged to their GP. Patients may accept a verbal date with less notice which will count as mutually agreed.

5.5 Suspected Cancer & Rapid Access Chest Pain

All patients with suspected cancer or new onset of chest pain must be seen in outpatients within 2 weeks of referral received.

5.6 Overseas Visitors

Patients who are identified as overseas visitors must be referred to the Overseas Visitors and Private Patients Department for clarification of status regarding entitlement to NHS treatment prior to receiving non-urgent care.

5.7 Clinic Cancellation or Reduction

5.7.1 A minimum of six weeks' notice of annual or study leave is required for clinic cancellation or reduction. Clinic cancellation with less than six weeks' notice can only be authorised by the appropriate Associate Chief Operating Officer or Deputy. This will be monitored and fed through the performance process.

5.7.2 If the hospital needs to cancel an appointment, all cancellations are undertaken with appropriate clinical input to support re-prioritisation.

5.8 Could Not Attend (CNA)

Patients are able to cancel their outpatient appointment before their agreed date and time without penalty. When rescheduling a date the current waiting time targets must be considered along with clinical requirements. Where a patient becomes a potential waiting time breach following a clinic cancellation, this must be escalated to the line manager or nominated deputy.

5.9 Did Not Attend (DNA)

5.9.1 Patients (with the exception of paediatrics, vulnerable adults, or where the clinician requests further appointment) who do not attend their first outpatient appointment following referral, will be discharged back to the referrer after one DNA. The appointment must have been reasonable or mutually agreed. The clinician must always be consulted to check that it is safe to discharge the patient following failure to attend, but the general expectation will be that failure to attend will result in discharge.

5.9.2 A patient who DNAs a follow up appointment will be referred back to the care of their GP unless the clinician reviewing the notes specifies that a further appointment should be offered on clinical grounds.

6.0 Management of Diagnostic Appointments and Admissions

6.1 Patients Referred for Diagnostics

6.1.1 All Access policy rules apply equally to diagnostics appointments and admissions.

6.1.2 Referring clinicians are responsible for informing patients of the likely waiting time for diagnostic tests.

6.1.3 Where treatment has not been given, subsequent appointments must be given within in the RTT breach date.

6.2 DNA Diagnostic Appointments

Patients who DNA a first diagnostic appointment referred from a GP are referred back to the GP. Patients who DNA a first diagnostic appointment referred from within the Trust are offered a second appointment and booked within 2 weeks if urgent or on a 2 week wait cancer pathway. All routine diagnostic referrals that have been mutually agreed or given reasonable notice will be sent back to the referrer.

6.3 Results Reporting

Reporting of results must be made available in time to allow progress through all likely stages of the RTT pathway.

7.0 Management of Elective Admissions

7.1 Adding Patients to an Inpatient Waiting List

7.1.1 The decision to add patients to the waiting list must be made by the consultant or designate. The patient must have accepted the clinician's advice on elective treatment prior to being added to the waiting list. Additions to the waiting list on PAS must be within one working day of the decision to admit.

7.1.2 Patients must not be added if:

- They are unfit for procedure
- Further investigations are required first
- Not ready for the surgical phase of treatment
- They need to lose weight
- There is no funding available for the intended treatment. (Refer to Prior Approval Process)

7.2 Use of Planned Waiting List

Patients should only be included on planned waiting lists if there are clinical reasons why the patient cannot have the procedure or treatment until a specified time.

7.3 Selecting Patients for Admission

Clinically urgent patients will be prioritised according to need under clinical guidance. All routine elective patients must be managed chronologically in order of RTT waiting time. War pensioners and service personnel injured in conflict must receive priority treatment if the condition is directly attributable to injuries sustained in conflict.

7.4 Contacting Patients to Arrange a Date for Elective Admission

Three attempts should be made to contact the patient by telephone offering 2 reasonable dates. Patients have an opportunity to negotiate their admission date and time. Where patients cannot be contacted they will be sent a reasonable date in the post requesting them to confirm.

7.5 Reasonable Offer

7.5.1 A reasonable verbal offer for an admission date is a minimum of 21 days; admission date offers sent in the post requires 24 days' notice. Patients will be offered a minimum of two reasonable dates. Patients may accept a verbal date with less notice which will count as mutually agreed.

7.5.2 If the patient is unwilling to accept a date within 12 weeks, clinical advice must be sought as to:

- discharge
- clinical review in outpatients

7.6 Patients Medically Unfit for Treatment

Patients medically unfit at the time of decision to admit should not be added to an elective list. For patients on an elective waiting list, if the patient is identified as not fit for their surgery, they must be removed from elective waiting list. Patients cannot be suspended for medical reasons.

7.7 Did Not Attend (DNA)

Patients (with the exception of paediatrics, vulnerable adults, and clinical need) who do not attend their date for elective admission will be discharged back to the referrer. The clinician must always be consulted to check the notes to advice.

7.8 Cancellations on Day of Surgery

Following a "last minute cancellation" (on the day of surgery, day of admission or following admission), patients must be offered a new date for treatment that is both within 28 days (or sooner if clinically advised) of the cancellation and within their RTT breach date.

8.0 Monitoring Compliance and Effectiveness

8.1 Good practice determines that a clear distinction is drawn between the roles of staff responsible for meeting targets, and those responsible for reporting on performance (Audit Commission, 2003). Having in place up to date policies and procedures, reliable, valid data collection systems and appropriate training for key staff is essential to the accuracy of referrals and waiting list information and management. Monitoring compliance with the policy will be through the Operational Admin and Data Quality Group.

8.2 The Trust Board and Sub-Committee Structure monitors' Clinical performance against patient access targets on a monthly basis.

8.3 The Executive Team receives regular reports on performance against patient access targets and identifies and monitors where action is required to address underperformance.

8.4 Performance Assurance – The Head of Performance and Operational Groups receive weekly reports on a range of indicators at Group and speciality level including:

- Outpatient data quality (unconfirmed attenders)
- Diagnostics waits (breaches within 6 weeks)
- Inpatient data quality (expired TCIs, suspensions from waiting lists)
- Cancelled operations
- 18 week admitted and non-admitted pathways

8.5 The Operational Groups meet their teams weekly to review 18 week positions and Data Quality performance. The Head of Performance and General Managers meet weekly to go through the position and exceptions.

8.6 A weekly Data Quality and 18 week report is sent to the Executive Team.

8.7 The Operational Admin and Data Quality Group identify issues of non-compliance against access and data quality targets and agree and monitor actions to address this.

9.0 Education and Training

All grades of staff that use Patient Administration System (PAS) as part of their daily work requirements will undergo education and training in the use of PAS, dependant on role based access. All staff will be required to undertake 18 week Mandatory training.

10.0 Associated Documents

10.1 Standing Operating Procedures for administrative processes.

10.2 Northern Lincolnshire and Goole NHS Foundation Trust Safeguarding Policy for Adult and Children.

10.3 Northern Lincolnshire and Goole NHS Foundation Trust Management of Non-Attendance (DNA) in Children and Young People's Outpatient Clinics.

11.0 References

11.1 Health and Social Care Information Centre (HSCIC) National Data Set for Referral to Treatment Consultant-Led Waiting Times Measurement.

11.2 NHS Constitution (2013) Department of Health.

11.3 Everyone counts: Planning Guidance as applicable.

11.4 The Mandate A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015 (2012) Department of Health.

11.5 Referral to treatment consultant led waiting times – Rules Suite (2014) Department of Health.

11.6 Operational guidance to the NHS: Extending Patient Choice of Provider (2011) Department of Health.

11.7 Standard NHS Contract as applicable.

11.8 Maximum Waiting Times – Guidance for Commissioners (2013) NHS England.

11.9 Commissioning Policy: Defining the boundaries between NHS and Private Healthcare Reference: NHSCB/CP/12 (2013) NHS Commissioning Board.

11.10 HSG (97) 31 Priority Treatment for War Pensioners.

11.11 Recording and Reporting Referral to Treatment waiting times for Consultant-led Elective Care (October 2015) NHS England.uk.

12.0 Definitions

12.1 **Active Monitoring** (Also known as 'watchful waiting') – An 18 week clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures. A new 18 week clock would start when a decision to treat is made following a period of active monitoring.

12.2 **Active Waiting List** – Patients awaiting elective admission for treatment and are currently available to be called for admission.

12.3 **Can Not Attend (CNA)** – Patients who, on receipt of reasonable offer(s) of admission, notify the hospital that they are unable to attend.

12.4 **Choose and Book** (e referrals) – national electronically booking system to book the patient into the hospital of their choice.

12.5 **Date Referral Received (DRR)** – The date on which a hospital receives a referral letter from a GP. The waiting time for outpatients should be calculated from this date.

12.6 **Day Cases** – Patients who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.

12.7 **Decision to Admit date (DTA)** – the date on which a consultant decides a patient needs to be admitted for an operation. This date should be recorded in the case-notes and used to calculate the total waiting time.

12.8 **Did Not Attend (DNA)** – Patients who have been informed of their date of admission or pre-assessment (inpatients/day cases) or appointment date (outpatients) and who without notifying the hospital did not attend for admission/ pre-assessment or OP appointment.

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

12.10 **Indirectly Bookable Services** – Some provider services are not directly bookable through Choose and Book so patients cannot book directly into clinics from a GP practice. Instead they contact the hospital by phone and choose an appointment date.

12.11 **Inpatients** – Patients who require admission to hospital for treatment and are intended to remain in hospital for at least one night.

12.12 **Outpatients** – Patients referred by a General Practitioner or another health care professional for clinical advice or treatment.

12.13 **Primary Targeting List or Patient Tracking List (PTL)** – The PTL is a list of patients (both inpatients and outpatients) whose waiting time is approaching the guarantee date, who should be offered an admission/appointment before the guarantee date is reached

12.14 **Reasonable Offer** – For an offer of an appointment to a patient to be deemed reasonable, the patient must be offered the choice of dates within the timescales referred to for outpatients, diagnostics and in patients.

12.15 **Referral to Treatment (RTT)** – Instead of focusing upon a single stage of treatment (such as outpatients, diagnostic or inpatients) the 18 week pathway addresses the whole patient pathway from referral to the start of treatment.

12.16 **TCI (To Come In) date** – the offer of admission, or TCI date, is a formal offer in writing of a date of admission. A telephone offer of admission should not normally be recorded as a formal offer. Usually telephoned offers are confirmed by a formal written offer.

13.0 Consultation

Trust Executive Team.

14.0 Dissemination

14.1 Trust Management Board.

14.2 Directorate of the Chief Operating Officer for dissemination across Operational Groups.

14.3 Clinical Commissioning Groups through the Contracting Monitoring Board.

14.4 Trust Governance & Assurance Committee.

15.0 Implementation

15.1 Implementation of the Access Policy will be embedded within staff training schedules and sign off for the Standing Operating Procedures.

15.2 The Access Policy will be rolled out across all administration teams.

15.3 The Access Policy will be kept under active review and updated annually through Trust Management Board and the Directorate of the Chief Operating Officer.

16.0 Equality Act (2010)

16.1 In accordance with the Equality Act (2010), the Trust will make reasonable adjustments to the workplace so that an employee with a disability, as covered under the Act, should not be at any substantial disadvantage. The Trust will endeavour to develop an environment within which individuals feel able to disclose any disability or condition which may have a long term and substantial effect on their ability to carry out their normal day to day activities.

16.2 The Trust will wherever practical make adjustments as deemed reasonable in light of an employee's specific circumstances and the Trust's available resources paying particular attention to the Disability Discrimination requirements and the Equality Act (2010).