Trust Policy

Plymouth Hospitals NHS
NHS Trust

Access Policy For Planned Care Services

Date	Version
July 2015	**2**

Purpose
To inform staff of the key principles for managing patients on an Elective waiting List.

Who should read this document?
All Staff who deal with patients who are attending hospital for Elective care.

Key messages
It is imperative that all members of staff understand the 'rules' that govern the management of patients who are on our waiting lists. This is primarily to ensure that no patient is unnecessarily disadvantaged. It is every member of staff's responsibility to ensure that these rules are applied equitably.

Accountabilities	
Production	Head of Patient Access/Deputy Head of Performance/Commissioning Team
Review and approval	IPAM & COO (on behalf of Trust Board)
Ratification	Chief Operating Officer
Dissemination	Head of Patient Access
Compliance	Head of Patient Access

Links to other policies and procedures

Version History		
1.1	November 2013	Initial document
2	July 2015	Policy Review

Last Approval	Due for Review
October 2015	October 2016

The Trust is committed to creating a fully inclusive and accessible service. By making equality and diversity an integral part of the business, it will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on the Trust. Larger text, Braille and Audio versions can be made available upon request.

1 Introduction

The NHS Constitution, which came into effect on 1st April, 2010, establishes the principles and values of the NHS in England. It sets out the rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure the NHS operates fairly and effectively.

These duties and responsibilities are legally binding.

2 Purpose, including legal or regulatory background

There are several guiding principles which must underpin the way in which planned care patients under the care of Plymouth Hospitals NHS Trust are managed. It is the intention of this policy and the duty of every member of staff to ensure that these guiding principles are adhered to:

- All of our services must be available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief.
- Access to our services is based on clinical need.
- The planning and delivery of our services must be focused on patient experience.
- Our services must reflect the needs and preferences of patients, their families and their carers through the provision of choice wherever possible.
- The NHS works across organisational boundaries and in partnership with other organisations in the interests of patients and the wider population.
- PHNT is committed to providing the best possible value for money to deliver the most effective and fair use of finite resources.
- All services are accountable for supplying adequate and suitable capacity to meet the needs of their patients.

The NHS constitution guarantees the right for patients to receive any treatment for their condition within 18 weeks. The only exception to this is where the patient

chooses not to be treated within this time period or where it would be clinically unsuitable to do so.

This policy will be made publically available so that patients and/or their carers understand what to expect from us as we deliver our obligations under the NHS Constitution and the contracts we have with our commissioners.

It is imperative that all members of staff understand the 'rules' that govern the management of patients who are on our waiting lists. This is primarily to ensure that no patient is unnecessarily disadvantaged. It is every member of staff's responsibility to ensure that these rules are applied equitably. This policy has therefore been developed to facilitate the clinical service lines in effectively achieving the Referral to Treatment maximum waiting time.

3 Definitions

Please see glossary at Appendix B

4 Duties

All staff are responsible for ensuring that the principles of this policy are followed.

Executive accountability for the implementation of this policy lies with the Chief Operating Officer.

The Head of Patient Access will ensure that Trust staff has access to this policy and the provision of appropriate training sessions in order for the policy to be rolled out successfully.

Individual management teams are responsible for ensuring that this policy is applied in all cases and that the appropriate infrastructure is in place to enable delivery.

Clinical Commissioning Groups are responsible for facilitating effective communications with referring practitioners. However, overall accountability for the communication process lies with PHNT.

General Practitioners should ensure that they do not refer patients who are unavailable for treatment within 18 weeks and that they support patient as necessary throughout the process.

Patients are responsible for ensuring that they follow the booking procedures and protocols based on the information supplied to them via correspondence and leaflets for example by attending appointments that are booked with them.

5	Key elements (determined from guidance, templates, exemplars etc)

Which Pathways are included in RTT?

Referral to treatment waiting times only apply to services commissioned by English NHS commissioners and for those patients that English commissioners are responsible.

A referral from any health care professional to either a consultant led service, or an interface service e.g. ICATS will start a waiting time clock

Following is a list of example referral sources which will start a Referral to Treatment 'clock':

- General Practitioners
- General Dental Practitioners
- General Practitioners with a Specialist Interest
- Optometrists and Orthoptists
- Accident and Emergency
- Minor Injuries Units
- Walk in Centres
- Genito-urinary medicine clinics
- National Screening Programmes – for non-malignant conditions
- Specialist Nurses or Allied Health Professionals working in Primary Care where CCGs have approved these referral mechanisms
- Interface or referral management/assessment service

Key Principles for all waiting lists

Use of electronic systems for Waiting Lists

All waiting lists and activity must be recorded on an appropriate electronic clinical system. Wherever possible this should be iPM. Other systems, such as CRIS, may be used where there is appropriate waiting list management functionality, which can be interrogated to feed into the performance management process.

Manual recording of waiting lists and appointments such as diaries or 'kardex' systems are not permissible.

Waiting Lists must be managed according to clinical priority

Clinical priority must be the main determinant of when patients are seen.

Patients may only be categorised as two week wait, urgent or non-urgent (routine).

Patients of the same clinical priority will be seen in chronological order.

Directorate teams must ensure that patients are categorised in an open and reasonable way.

Pooling of Waiting Lists

Where there are no sub-specialty issues or the patient has made a specific request to see a particular clinician then patients should be placed on a pooled waiting list to enable the booking of patients on an equitable basis.

Transparency

Communication with patients will be open, informative, timely, clear and concise. The process of waiting list management should be transparent to the public.
All policies, procedures and performance information will be made widely available, including the general public this will be via Staffnet and the Hospital Internet site.
All processes must be open to monitoring, inspection and audit.

Training

An appropriate training programme should support all levels of staff on an ongoing basis, with special regard given to newly recruited staff.

All staff involved in the implementation of this policy, clinical and clerical will undertake training and regular updating.

It is the responsibility of the relevant cluster management team to ensure that all staff to attend appropriate training sessions.

Policy adherence will be part of the staff appraisal process.

Management of Capacity and Rotas

All Clinical Service Lines have a responsibility to ensure that they supply suitable and adequate capacity to match the demands of their services. It is essential that this capacity is utilised fully and effectively to provide the best possible value for money for patients.

In order to allow effective booking procedures, medical and related rotas must be completed and published to relevant staff at least six weeks in advance. As a result of this all specialties must apply the notice of annual leave policy within their areas.

No session is to be cancelled where patients have been booked unless under very exceptional circumstances, all cancellations have to be agreed with the relevant cluster manager. Every effort must be made within the specialty team to ensure any such sessions are covered to prevent hospital cancellations.

Booking guidelines for patients on a waiting list

Regardless of the type of appointment all patients must have been offered and opportunity to have had a choice of appointment. As a result of this reasonable attempts must have been made to negotiate appointment/TCI dates with the patient via a telephone or face to face conversation.

Traditional appointment letters (so those letters informing a patient when to attend hospital without an opportunity to negotiate their appointment) must only be sent under exceptional circumstances.

Please refer to APN Partial Booking of non-Choose and Book Appointments and TCI's to review the relevant timescales on booking procedures.

Patient Expectations

The NHS Constitution states that all patients have the right to seek alternative providers for their treatment if we cannot guarantee their treatment within 18 weeks.

The onus is on the patient to contact the provider in the event of them being concerned about their waiting times.

It is the responsibility of PHNT to inform the patient of their rights therefore the leaflet "About your Waiting Times" must be enclosed within the confirmation letter for the patient's first outpatient appointment.

Wherever a patient has been added to waiting list they must be sent an acknowledgement detailing what they should now expect. Any other appropriate patient information leaflets must also be included.

Use of Primary Target Lists (PTLs)

The use of a PTL is mandatory for all areas when booking patients for appointments or treatment. On no account should different systems be used when booking patients e.g. a diary or 'kardex' system.

The waiting list management view on iPM must not be used to determine when patients are to be booked.

Under no circumstances should a patient be booked past their 'see-by-date'. If it is not possible to book a patient by this date then the relevant member of the cluster management team must be notified so that sufficient capacity can be arranged.

Reasonable notice

If the anticipated length of wait is in excess of 6 weeks then the patient must have had an opportunity for this discussion at least three weeks prior to the appointment or admission date.

The only exception to this is where a traditional appointment letter needs to be sent to a patient referred under the two week wait rule. In this event this letter must be sent at least 7 calendar days prior to the anticipated appointment.

If a patient has agreed a date either in a face-to-face discussion or via a telephone conversation, then this will count as being a firm date for appointment or admission. This will be the case for all categories of patient.

Patient Non-attendance

This section applies to all waiting lists including outpatient, Inpatient, day case and diagnostic.

As long as the above rules around reasonable notice apply and the Trust can demonstrate that the appointment has clearly and reasonably communicated to the

patient, any patient who does not attend (DNA) may be returned to the care of their GP for a decision to be made on future management.

The only exceptions to this rule are where there are genuine concerns around vulnerable patients this will include either paediatrics or adults or where a clinical risk has been identified in discharging the patient e.g. 2 week waits. In these instances a further appointment can be arranged.

Please see the Paediatric and Adult Safeguarding Protocols and the Cancer Two Week Wait guidance.

In all circumstances the patient contact details must be checked to ensure that they are correct prior to a patient being referred back to Primary Care.

If a patient needs to cancel their attendance then this can be facilitated twice.

Any further requests for reschedule may result with the patient being referred back to their GP/GDP for the GP/GDP to decide whether it is appropriate to re-refer the patient back into the Trust. A clinical opinion must be sought to determine whether the patient can be referred back to Primary Care. The same caveats are applicable as for DNA patients.

Re-instating a patient on to the Waiting List

In the event of a patient requiring to be returned to the waiting list due to a clerical error then the previous waiting list entry must be reactivated rather than establishing a new entry. This must be authorised by the Directorate Management Team. Please see APN - Reinstating Waiting List Entries.

Patients who relocate

Please refer to APN - Checking Patient Details and Reception of Patients and also Checking Patient Details when adding a referral to iPM.

Tertiary Referrals to and from PHNT

Inter Provider Transfers should only be made if the patient's condition is related to the original reason for referral.

All patients being referred from another provider will be referred via the standard Inter Provider Transfer (IPT) form. All patients being referred to another provider must also have an IPT form included as part of the referral.

All IPT information must be sent using a secure e-mail system e.g. NHS net Please refer to APN - Inter Provider Transfers.

Data Quality and Waiting List Compliance Reports

The importance of Data Quality both to the patient and to the organisation cannot be overstated. Patient safety can be affected along with the organisation's ability to report an accurate waiting list and waiting time position.

Operational Managers are accountable for ensuring that data quality issues are minimised by providing effective training and support for all their staff.

A number of data quality reports are available detailing errors being made on the system. Service Lines are accountable for ensuring these reports are reviewed and acted upon in a timely manner and that appropriate follow-up action is taken with staff.

Management of Patients whose lead clinician has left their post

Where clinician has left the employ of the organisation the Service Line will be responsible for ensuring that any residual patients on a waiting list whether treated or not are moved over to the care of a suitable alternative clinician

Waiting List and Validation Review

Elective waiting lists will no longer be validated as a matter of routine however under certain circumstances it may be deemed necessary to review certain lists. This will be at the discretion of the relevant Cluster Manager and must be done in conjunction with clinical staff.

Outpatients

Management of Referrals

Where no specific specialist requirements apply then referring clinicians should refer to a service rather than an individual. This will ensure that there is an equalisation of waiting lists and the maximum waiting time for all patients is reduced. Where there is a definite sub-specialisation issue then a named clinician referral is permissible.

Methods of Referral

All referrals from Primary Care should be made via the Choose and Book system where a Choose and Book service is available.

External Referrals

Choose and Book

The RTT “clock” starts from the point at which the patient books their outpatient appointment.

Patients that have been booked under Direct Booking rules will have their referral automatically created on iPM by the Choose and Book software.

GP referrals that have been booked under Indirect Booking rules will need to have a referral added to iPM at the point at which the patient contacts the hospital to arrange their appointment. The referral received date entered onto iPM must be the date at which the patient has contacted the hospital.

Non-Choose and Book patients

The Trust will not accept non-Choose and Book referrals into services where a Choose and book option is available. Appropriate arrangements will be put in place to ensure that all postal referrals will be returned to the relevant CCG for uploading through Choose and Book.

Where it has been agreed that postal referrals are acceptable e.g. for services where there is not a Choose and Book option then, for the purposes of Waiting List management, the date on list will be the point that the referral has been received by the hospital.

Please refer to the APN Management of Referrals and Priorities for details on processes for referral management

Internal Referrals

Where a consultant has made a referral to another consultant for a second opinion or further assessment the patient wait for this second appointment will be included in the overall calculation of length of wait for the purposes of 18-week measurement.

Patients who require an internal referral for any reason that is related to the original referral must not be sent back the patient's GP to be re-referred back into the Trust.

Internal referrals for an unrelated condition must only be made if the condition for which the patient is being referred is deemed as urgent or for suspected cancer. This referral must be made to the most appropriate service, consideration must be given to referrals being made to services such as ICATS where such a service exists,

In this event a new episode of care will commence and a new 18-week clock will start.

Internal referrals for an unrelated non-urgent condition are not permissible. In these circumstances the patient must be referred back to the GP for a decision to be made on appropriate future care for that patient. In the event of a re-referral being required the GP must consider referral to alternative services such as ICATS, where such a service exists.

Where an internal referral is appropriate for the purposes of waiting list management the date on list must be the date that the decision was made for the onward referral. The overall patient wait from referral to treatment will be calculated via an 18-week PTL.

Low-priority or Procedures of Limited Clinical Effectiveness

Through the Clinical Policy Committee NHS NEW Devon CCG and South Devon and Torbay CCG will work together to carry out their responsibilities for making local decisions about the funding of medicines and treatments in the NHS.

Some conditions such as Cosmetic Surgery are classed as low priority treatments and **will not** be routinely funded by commissioners. These patients should not be added to the waiting list or seen in outpatients unless explicit approval has been received on a named patient basis from the commissioning CCG. Please see the Low-Priority and Procedures of Limited Clinical Effectiveness policies at http://southwest.devonformularyguidance.nhs.uk/referral-guidance/policies

The individual Funding Panel processes still operate alongside the Clinical Policy committee. Further details of the panel process for NEW Devon CCGcan be found at
http://newdevonccg.nhs.uk/partnerships/nhs-funded-patients/exceptional-individual-funding-requests-ifr.100115

Outpatient Waiting Lists

Choose and Book patients booked under the Direct Booking rules will not require an outpatient waiting list entry.

Choose and Book patients booked under the Indirect Booking rules will require an outpatient waiting list entry. The date on list will be calculated from the date that the patient contacted the hospital to book their appointment.

Non-Choose and Book patients will require a waiting list entry. The date on list will be calculated from the date the referral was received by the hospital.

Where a waiting list entry is required this must be added, fully triaged by a clinician, within two working days of either patient contacting the hospital or the receipt of the referral.

Clinical Directorates must have arrangements in place for the triaging of referrals to meet the above timescales.

Patient Unavailability

Patients that are attending an outpatient appointment must be offered at least two reasonable appointments within their anticipated waiting time. If these are declined and the patient is unavailable to attend then the patient may be suspended from the outpatient waiting list for the duration that they have indicated that they are unavailable.

For the purposes of reporting this period of suspension will not be subtracted from the patient's recorded waiting time.

Confirmation of appointments

All patients regardless of their method of booking must be sent a letter confirming the time, date and location of their appointment. Where appropriate additional information required for their appointment e.g. health questionnaires etc. should also be included at this stage. If the appointment has been arranged with the patient at less than two days notice then the patient should be asked whether they require a letter. When sending the confirmation letter please ensure that the 'About your waiting times' leaflet has been included.

Planned Outpatient Waiting Lists

The use of the planned outpatient waiting list is appropriate for patients who need an outpatient appointment outside the waiting time standard for clinical reasons. Please see APN - Outpatient, Diagnostic and Inpatient/Day case Planned Waiting Lists.

Patients who need their appointment delayed for reasons other than clinical must follow the policy rules for unavailability and patient deciding on treatment options.

The use of the planned outpatient waiting list will be reviewed on a regular basis to check that patients on this list are compliant.

Patients considering treatment options

If a patient would like time to decide on their treatment options then they must be added to a follow up waiting list with the relevant RTT code (RTT06). The maximum time period is two weeks. If the patient has failed to contact the hospital within this period of time to let the hospital know their decision then the relevant Medical

Secretary should contact the patient. Patients who wish to go ahead with treatment will then undergo pre-operative assessment. Please see APN - Patient considering treatment options

If the patient decides against treatment then a decision must be made as to whether the patient will require a further follow-up appointment or discharged from the care of the hospital. If the patient is to be discharged then they must be removed from the waiting list and their referral closed.

If in the event it is considered that patients will require longer than two weeks then a case by case discussion must be had with the relevant management team to ensure that the patient's best interests are taken into account.

Use of the Follow-up waiting list

Patients should only be added to the follow-up waiting list where there is a clear demonstrable need for a further specialist appointment. Any patient that requires a follow-up must be added to the relevant follow-up waiting list, this must include all of the relevant information so that that waiting list can be effectively managed. Please see APN - Follow-up waiting lists.

All clinical teams should agree thresholds for adding patients to the follow-up waiting list to ensure that patients are only added when necessary.

Where clinically indicated patient initiated follow ups are encouraged. Generally for patients with 'acute' surgical conditions, this will be for a maximum of three months.

For patients with long term conditions then patients can be placed on a patient initiated regime for a period of up to two years.

In all cases once this maximum period has been reached then patients should be validated to determine whether they can be discharged or whether they need to be re-listed for a further period of time.

Clinic Outcome Information

Following every outpatient attendance the relevant clinician must ensure that the outpatient outcome information is completed. This provides key information to ensure that the future care plans for patient is recorded on iPM/CRIS. All outcomes from clinic or ward attenders must be entered onto iPM on the same working day as the clinic.

This is to ensure that the next phase of the patient's pathway is not delayed and patient safety and experience is not compromised.

Inpatients and Day cases
Additions to the treatment list

The decision to treat a patient must be made by a Consultant, or under an arrangement agreed with a Consultant.

Patients who are undergoing a procedure which requires a General Anaesthetic must have a pre-operative assessment.

Where patients are undergoing a procedure under a local anaesthetic an assessment must be made on whether a pre-operative assessment on suitability for surgery is required.

Please see APN - Referring Elective Patients to Planned Care Assessment for Pre-operative Assessment.

In order to be added to the waiting list patients must be clinically and socially ready for admission on the day the decision to admit is made. Patients who require an outpatient consultation or investigation to decide if they require / wish the procedure, should not be placed on the waiting list until the consultation is complete and the results received.

Patients, who are not fit, ready and able to come in on the date the decision is made, must not be added to the waiting list. In the event of a patient being unfit for surgery they must be returned to the care of their GP to be re-referred when they are fit and ready. This referral can be made back into the pre-operative assessment service.

The date on list should be the date that the patient has confirmed their wish to undergo treatment and/or it has been determined that the patient is fit to have their surgery.

Additions to the waiting list must not be back-dated, unless as a result of a previous administrative error. In such circumstances approval from the relevant Cluster Manager must be sought.

All Inpatient and Day Case waiting lists must be coded with the appropriate OPCS and RTT code.

Management Intention

When adding a patient to the inpatient and day case waiting list then following pre-operative assessment advice, consideration needs to be given whether the patient should be listed as an inpatient or a day case. Please see appendix A for definitions. If it is possible that a patient can be admitted and discharged on the same calendar day then they must be listed as a day case. If this is not the case then they must be listed as an inpatient.

Inpatient/Day case - Patient Unavailability
Medical Unfitness for treatment

No patient should be added to the waiting list if they are unfit for their treatment at the time of adding. It is however recognised that patients may become unfit after they have been listed. In the event of this, an assessment must be made on the likely duration of the period of unavailability.

Short-term periods of unavailability (two weeks or less) must be absorbed into the overall patient waiting time. In the event of long-term periods of unavailability (over two weeks) then the patient must be discharged back to the care of their GP for re-referral into the preoperative assessment clinic. In this instance clear guidelines must be given to the GP regarding patient condition to warrant re-referral. This referral must be for the same condition for which the patient was originally referred.

Weight Loss and Smoking Cessation

Where required, Clinicians should invite patients to consider weight loss and/or smoking cessation if it is indicated it will provide a clinically better outcome for treatment.

In the event of weight loss being agreed then the patient should be referred back to the care of the GP for re-referral at the appropriate point. This re-referral may be made directly to pre-operative assessment.

Where smoking cessation has been agreed the patient's clock may be paused, using the suspension facility on iPM. The maximum period of suspension is one month. If the patient has been unable to quit smoking at this point then in agreement with the patient they may be discharged from the waiting list and referred back to the care of their GP for re-referral as appropriate. This re-referral may be made directly to pre-operative assessment.

CCG lifestyle and wellbeing resources and service details are available at http://www.plymouthcommunityhealthcare.co.uk/livewell/livwell-home-page

Patient Request Unavailability

Clock pauses can only be applied to admitted RTT pathways i.e. once a decision to admit for treatment has been made. The clock can only be paused once a patient has been offered and has declined two or more reasonable offers. These offers must have been made with three weeks notice and different dates must have been offered. The clock can be paused for the period of time between the earliest of these reasonable offer dates and the date the patient is making themselves available.

Clocks can only be paused for social reasons. Pauses are not acceptable for medical reasons e.g. if the patient becomes unfit for surgery or if the patient is requesting treatment by a specific surgeon.

There is no minimum or maximum period for this pausing.

If a patient is requesting a clock pause then the relevant clinician should be contacted so that a clinical review can be undertaken to see if the pause is in the best clinical interests of the patient. If the clinician is happy with the pause then this may be added to iPM using the suspension functionality.

If the clinician feels that the proposed pause is not in the best clinical interests of the patient then the patient should be contacted by the clinical team so that they may be advised of the risks in not receiving treatment in a timely way.

If the patient persists in making themselves unavailable then they should be returned to the care of their GP.

For the purposes of reporting this period of suspension will not be subtracted from the patient's recorded waiting time.

Criteria for adding patients to planned lists

Patients should only be added to a planned list where clinically they need to wait for a period of time. This includes planned diagnostic tests or treatments, or a series of procedures carried out as part of a treatment plan, which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.

Examples may be patients who need to undergo 1st treatment but will also need subsequent treatment carried out on a second side (e.g. bilaterally). Or patients who need a clinical delay due to age related surgery, surveillance patients or the removal of metalwork post Trauma.

The planned waiting list must not be used where there are delays as a result of administrative or resource problems or where alternative assessments are being sought e.g. anaesthetic or renal opinion prior to surgery.

Please see APN - Outpatient, Diagnostic and Inpatient/ Day case Planned Waiting Lists for the process to follow for the use of planned waiting lists

Information to the Patient

Every patient will be sent a letter confirming that he or she has been put on a waiting list, along with a waiting list policy information sheet. If a leaflet is available for the intended procedure, this should be given to the patient in clinic or included in the letter.

Managing an Inpatient or Day Case Waiting List

Waiting lists must be kept up to date by staff using data received from various sources. Patients must be listed promptly; within 24 hours of the decision to admit.
All elective admissions should be booked and admitted through the iPM waiting list. It is only **emergency** admissions that are not required to be placed on a waiting list.

TCI Cancellations
Hospital Cancellations

Whenever the hospital cancels an operation or procedure for non-medical reasons, either on the day of admission or on the day of surgery, the patient should be given a re-arranged date within 28 days of their original TCI date or within the see by date according to the Referral to Treatment pathway (whichever is sooner).

No patient should be cancelled twice for their surgery.

Patients no longer requiring treatment

If, whilst on the waiting list, the patient decides that they no longer require treatment then the relevant consultant should be notified. The patient must be removed from the waiting list and the related referral closed down with notification sent to the patients GP/GDP.

Access to Health Services for Military Veterans
Treatment of Military Veterans

All veterans should receive priority access to NHS secondary care services for any conditions that are likely to be associated to their service.
For examination or treatment that relates to the Military Veterans examination or treatment, both as an outpatient and inpatient for which they received a pension or have received a gratuity for should be given priority. If another case, or emergency, demands a more urgent clinical priority then this will override the Military Veterans priority.

It is for the clinician to determine whether it is likely that the condition the Military Veteran is being seen for is service related.

6 Overall Responsibility for the Document

The Head of Patient Access has overall responsibility for the co-ordination, dissemination and implementation and review of this document.

7 Consultation and Ratification

The Trust Board at PHNT and our commissioners have both signed off this document as being fit for purpose.

After approval and publication the Clinical Administration Training Team will run and co-ordinate mandatory training sessions, to familiarise staff with the policy. The sessions will also enable staff to ask questions about the use of the policy.

This document is published on the Trust Wide Public Folders. The Head of Patient Access is responsible for holding and maintaining a master file containing a register and a signed copy of the policy, and the corresponding Equality Impact Assessment. The Head of Patient Access will ensure that old versions of the policy are archived in the archive master files. Access to archived documents will be through the Document Controller.

The Document Controller will issue the policy numbers and maintain an index that will include the document's title, policy number and issue, owner, issue date and next review date.

The approvals are indicated by the front sheet of the document as is the version (i.e. issue) control.

8 Monitoring Compliance and Effectiveness

- After approval and publication the Clinical Administration Training Team will run and co-ordinate mandatory training sessions, to familiarise staff with the policy. The sessions will also enable staff to ask questions about the use of the policy.

- The process of tracking compliance will be monitored by monthly Data Quality and waiting list compliance reports.

9 References and Associated Documentation

NHS Constitution
Staffnet – Trust Documents – APN's

Dissemination Plan | Appendix 1

Core Information	
Document Title	**Access Policy for Planned Care Services**
Date Finalised	July 2015
Dissemination Lead	Head of Patient Access
Previous Documents	
Previous document in use?	Yes
Action to retrieve old copies.	Will recall all old copies

Dissemination Plan

Recipient(s)	When	How	Responsibility	Progress update
All staff	On publication	Email	Document Control	
All staff	ongoing	Training sessions	Head of Patient Access	Commenced

Review and Approval Checklist — Appendix 2

Review		
Title	Is the title clear and unambiguous?	Y
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Y
	Does the style & format comply?	Y
Rationale	Are reasons for development of the document stated?	Y
Development Process	Is the method described in brief?	Y
	Are people involved in the development identified?	Y
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Y
	Is there evidence of consultation with stakeholders and users?	Y
Content	Is the objective of the document clear?	Y
	Is the target population clear and unambiguous?	Y
	Are the intended outcomes described?	Y
	Are the statements clear and unambiguous?	Y
Evidence Base	Is the type of evidence to support the document identified explicitly?	Y
	Are key references cited and in full?	Y
	Are supporting documents referenced?	Y
Approval	Does the document identify which committee/group will review it?	Y
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A
	Does the document identify which Executive Director will ratify it?	Y
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Y
	Does the plan include the necessary training/support to ensure compliance?	Y
Document Control	Does the document identify where it will be held?	Y
	Have archiving arrangements for superseded documents been addressed?	Y
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Y
	Is there a plan to review or audit compliance with the document?	Y

Review Date	Is the review date identified?	Y
	Is the frequency of review identified? If so is it acceptable?	Y
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Y

Equalities and Human Rights Impact Assessment | Appendix 3

Core Information	
Manager	Samantha Sheridan
Directorate	Operations
Date	July 2015
Title	Elective Access Policy
What are the aims, objectives & projected outcomes?	The purpose of this policy is to ensure that: • All of our services must be available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief. • Access to our services is based on clinical need. • The planning and delivery of our services must be focused on patient experience. • Our services must reflect the needs and preferences of patients, their families and their carers through the provision of choice wherever possible. • The NHS works across organisational boundaries and in partnership with other organisations in the interests of patients and the wider population. • PHNT is committed to providing the best possible value for money to deliver the most effective and fair use of finite resources. • All services are accountable for supplying adequate and suitable capacity to meet the needs of their patients.

Scope of the assessment
This assessment covers the impact the project will have on the workforce (clinicians, admin staff and others) and patients

Collecting data	
Race	There is no evidence to suggest there is a disproportionate impact on race. However, data collection of those affected by the policy will be monitored via workforce data, untoward incidents and complaints on Datix and feedback via other routes such as surveys.

Religion	There is no evidence to suggest there is a disproportionate impact on religion. However, data collection of those affected by the policy will be monitored via workforce data, untoward incidents and complaints on Datix and feedback via other routes such as surveys.
Disability	There is no evidence to suggest there is a disproportionate impact on disability. However, data collection of those affected by the policy will be monitored via workforce data, untoward incidents and complaints on Datix and feedback via other routes such as surveys. Reasonable adjustments for training, equipment and information will be made available upon request.
Sex	There is no evidence to suggest there is a disproportionate impact on sex. However, data collection of those affected by the policy will be monitored via workforce data, untoward incidents and complaints on Datix and feedback via other routes such as surveys.
Gender Identity	There is currently no data collected for this area; however, will be monitored via workforce data, untoward incidents and complaints on Datix and feedback via other routes such as surveys.
Sexual Orientation	There is no evidence to suggest there is a disproportionate impact on sexual orientation. However, data collection of those affected by the policy will be monitored via workforce data, untoward incidents and complaints on Datix and feedback via other routes such as surveys.
Age	There is no evidence to suggest there is a disproportionate impact on age. However, data collection of those affected by the policy will be monitored via workforce data, untoward incidents and complaints on Datix and feedback via other routes such as surveys
Socio-Economic	There is currently no data collected for this area; However, data collection of those affected by the project will be monitored via workforce data, untoward incidents and complaints on Datix and feedback via other routes such as surveys
Human Rights	There is no evidence to suggest that there is a disproportionate impact on human rights regarding this policy. However, data collection of those affected by the project will be monitored via workforce data, untoward incidents and complaints on Datix and feedback via other routes such as surveys
What are the overall trends/patterns in the above data?	No trends or patterns have been identified at this stage
Specific issues and data gaps that may need to be addressed through consultation or further research	There is no data currently collected for gender identity or socio-economic
Involving and consulting stakeholders	
Internal involvement and consultation	Consultation has been undertaken with relevant staff groups and commissioners.
External involvement and consultation	Full consultation with commissioners has occurred. A patient stakeholder event is being organised to inform on application of this policy.
Impact Assessment	
Overall assessment and analysis of the evidence	Reasonable adjustments for training, equipment and information will be made available upon request. Consideration will be given to those staff that have special requirements during the implementation of the system

Action Plan				
Action	**Owner**	**Risks**	**Completion Date**	**Progress update**
Monitoring of systems for feedback of impacts	Head of Patient Access		Ongoing	

Appendix A
CLASSIFICATION OF ADMISSIONS OR APPOINTMENTS

Patients who undergo treatment/procedures currently categorised, as Day case may be re-categorised as outpatients. Often these procedures are undertaken in an outpatient setting, but have historically been classified as day cases. Alternatively, for convenience, treatment has been provided in the day case unit but in reality patients only receive outpatient treatment. It is required that each Clinical Directorate reviews the classification of procedures locally. Changes in year may affect recorded activity and the Purchaser Efficiency Index. If changes are planned they should be agreed in advance.

Definitions:
The definition of Day case is as follows:
Patients admitted electively to a hospital bed during the course of a day with the intention of receiving care of treatment that can be completed in a few hours so that they do not require to remain in hospital overnight and who are discharged as scheduled.

The definition of a Day case procedure:

1) Are patients admitted electively?
2) Are patients admitted to a hospital bed?
3) Do patients receive care or treatment?
4) Is treatment completed within a few hours?
5) Is the patient discharged during the same day?

If the answer is yes to all of the above, the patient may be categorised as a day case patient. The patients must be placed on a day case waiting list.

The definition of an outpatient procedure:

1) Are patients treated electively?
2) Can patients be treated in a non-theatre environment?
3) Is treatment and discharge completed within 3 hours?
4) Patients do not require a recovery period greater than 20 minutes prior to discharge?
5) Patients do not require recovery in a nursed bed?

If the answer is 'yes' to all of the above, the patient may be categorised as an outpatient procedure. The patients who need to see the clinician again must be placed on a follow-up treatment list.

Definition of diagnostic admissions:

1) Is the patient admitted electively?
2) Is the patient's admission intended purely for investigation or tests?
3) Is the purpose of the admission to diagnose then plan any required treatment?
   If the answer is yes to all of the above, then the patient may be categorised as a diagnostic admission. The patient must be placed on the appropriate diagnostic waiting list and a follow up waiting list for review of results of diagnostic tests or to discuss treatment options.

Definition of diagnostic outpatients:

1) Is the patient's appointment intended purely for investigations or test?
2) Is the purpose of the appointment to diagnose then plan any required treatment?

Definition of a Ward Attender:

1) Patients who have appointments for an attendance on the ward with a nurse or technician.

Appendix B

GLOSSARY

TERM	DEFINITION
Referral	"A referral is when a request is made for a patient to be seen for advice, examination, consultation, investigation or treatment."
External Referral	External referrals are used to record a new referral from outside the Trust. This will include all other NHS Trusts, Private Sector, Primary Care, Social and Educational Services, ED and newborn babies. All referrals received from other providers must have an Inter Provider Transfer (IPT) sent with the referral.
Internal Referral	Internal referrals are used for any referral internal to the Trust. This is primarily used when patients require specialist treatment in another specialty or by another clinician within the same specialty.
Outpatient	Patients referred by a GP or another consultant for clinical advice, examination or treatment.
Outpatient Waiting list	An Outpatient Waiting list is a record of patients waiting for a new outpatient appointment.
Pre-Booking Fully Booked	The patient is given the choice of when to attend. For full booking the patient is given the opportunity to agree a date at the time of, or within one working day of, the referral or decision to treat. The patient may choose to agree the date when initially offered, or defer their decision until later.
Pre-Booking Partial Booked	The patient is given the choice of when to attend. For partial booking the patient is advised of the total indicative waiting time during the consultation between themselves and the health care provider/practitioner. The patient is able to choose and confirm their appointment or admission approximately six weeks in advance of their appointment or admission date.
Outpatient procedure	Patients who require a procedure but do not require a hospital bed or recovery following the procedure.
DNA	Patients, who have been informed of either their admission date or appointment date and who, without notifying the hospital, do not attend.
Original Date on List	The date of the original decision to admit a patient to a Healthcare Provider for a given condition which results in the patient being placed on an elective waiting list.
Inpatient	Patients who require admission to hospital for treatment and are expected to remain in hospital for at least one night.
Elective Waiting List	Patients awaiting elective admission for treatment and are currently available to be called for admission.
Elective Booked	Patients awaiting elective admission who have been given an admission date which may have been arranged at the clinic at the time of decision to admit or thereafter. These patients form part of the active waiting list.
Elective Planned	Patients who are to be admitted as part of a clinically planned sequence of treatment or investigation. They may or may not have been given a TCI date.
Day Case	Patients, who require admission to hospital for treatment, will need the use of a bed but are not expected to stay in hospital overnight.
Patient Initiated Delays	Patients awaiting admission who are put on hold due to patient choice of unavailability or surgeon unavailability as they are not available to be called for admission.
RTT	Referral to Treatment – the overall waiting time a patient has for stages of treatment.
Non-admitted Pathway	A pathway that results in a clock stop for treatment that does not require and admission or where no treatment is required.
Admitted pathway	A pathway that ends in a clock stop with admission for treatment either as an inpatient or day case.
Direct Booking	Where a patient is able to be referred and book an appointment through the Choose and Book System

Indirect Booking	Where a patient is able to be referred via Choose and Book but needs to contact the hospital separately to book their appointment
CCG	Clinical Commissioning Group – An NHS organisation accountable for purchasing services from Secondary Care
Tertiary Referral	A referral sent from one Hospital consultant to another
Pooled Waiting List	Where there is a single waiting list for a specialty rather than for a named clinician
Primary Target List	A waiting list which details which order the patients should be booked, taking into account various aspects of patient's stages of treatment
APN	Administrative Process Note – document detailing PHNT standard process for managing patients to be used in conjunction with this policy