



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.

Version: 5.0

Status Final

Approval Date 13th September 2016

Date Ratified 27th September 2016

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.
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.
For use by:	All clinical, administrative and managerial staff that are responsible for managing referrals, appointments and elective admissions.
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 Hostel Standard Operating Procedure The RTT Protocol
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Version and Document Control

Version	Date Issued	Brief Summary of Change	Author
1.0	Sept 2008	New Policy	M. Allison
2.0	Jan 2013	Update	M. Reinink A. Flynn A. Davis
3.1	December 2014	Draft Updated Policy with specific RTT Guidance	M. Sherry K. Marshall
3.2	January 2015	Updated Access Policy with specific RTT guidance and booking processes	M. Sherry K. Marshall
3.3	October 2015	Update of National Guidance Update of Internal Referral Process Additional responsibilities for disseminating updated national guidance	R. Russell K. Marshall
4.0	March 2016	Update of guidance for the management of follow up/ surveillance patients. Update of RTT rules for the management of corneal transplants. Additional guidance for the management of RTT pathways for new patients that fail to attend. Additional guidance for the management of NHS England 2ww referrals (local agreement)	K. Marshall
5.0	April 2016	Removal of RTT guidance and re-focus on the aim to inform patients, relatives and staff of their rights and what to expect from the Trust <i>Note: the content of this version is approved, but the format may be subject to future revision</i>	K. Hunter

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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.

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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, including 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 sub specialty 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 CCG 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 ensure patients are treated in a timely and effective manner, specifically to:

- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.
- Reduce waiting times for treatment and ensure patients are treated in accordance with agreed 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.
- Increase the number of patients with a booked outpatient or in-patient / day case appointment, thereby 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 overseas 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 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 routes to be followed in the effective management of patient access to services. It describes the principles and processes for managing referrals for outpatient appointments, diagnostic investigations and elective surgery, and instructions for the operational management of waiting lists. 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 not on an RTT pathway can expect their ongoing care to be managed within the same principles.

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 should be treated in chronological order.

- This policy will be applied consistently and without exception across Moorfields NHS locations. 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.
- 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, preferably in writing to the patients address provided by the referrer, and 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.

The 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 outpatient consultation, diagnostics and in-patient treatment.

This is a maximum wait not a target and the majority of patients will need to be seen in a much shorter timeframe to ensure compliance with the overall target, and the Trust's intention is 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 ready to start their pathway from two weeks of the initial referral.

The Trust will work with the Lead CCG 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 should be allowed 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 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 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 calls to make an appointment and gives their unique 18-week booking reference number (UBRN). For NHS e-referral Service referrals, this is the date in which the referral is received on the NHS e-referral Service system.

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 then 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.

- 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 DNA's, 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. 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 reappointed the clock continues to tick. The clock stops for subsequent DNA if the patient is discharged back to their GP.

Clocks cannot be stopped because a patient has rearranged an appointment. However if the patient cancels and re-books their appointment more than twice they may be referred back to their GP 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 active monitoring. Treatment will often continue beyond the first definitive treatment and after the clock has stopped.

Administration teams (Including reception, booking and admission teams) managing patient pathways will ensure the referral is closed at the time the treatment and any associated follow up is complete or when a patient DNA's as per this policy.

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 is designated as having overall responsibility to develop, implement and regularly monitor the Trust's elective service access policy, 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 General Managers/Service Managers (GM's/SM's)

The Deputy Chief Operating Officer will monitor compliance with the Policy via the weekly Patient Tracking List (PTL) and Access Meeting. GM's and SM'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:

- Ensuring the service waiting list reports are updated and maintained on the main Trust Silverlink. The day-to-day management of the waiting list is undertaken by the services inpatient and outpatient teams.
- 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 site and speciality.
- 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.

3.05 Clinical Directors and Service Directors

Medical/Clinical Directors are responsible for ensuring 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 for any purpose unless there are exceptional circumstances.

3.06 Consultants/Clinical Teams

3.06(1) NHS e-referral Service

Each Consultant is responsible for:

- Reviewing all patient referrals directly within the NHS e-referral Service. 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 General 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.

3.06(2) Paper / Fax referrals:

Each Consultant is responsible for:

- Receiving the paper/fax referral from the Booking Office Team.
- Accept or reject referral on paper form.
- For accepted referrals, 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 and arrange for medical secretary to copy into Open Eyes.

3.06(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, the patient must be referred back to their GP or referring clinician with a recommendation to refer to the appropriate service. This will allow the GP or referring clinician to decide, in consultation with the patient, whether a new hospital referral is appropriate. Such patients should not be referred directly to services except in the following situations:

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 Silverlink to ensure the RTT clock start date for the new service is accurate.

3.07 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 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 carers with treatment options and decision making at the time of the appointment.
- 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.
- 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.

3.08 Appointments Teams

3.08(1) NHS e-Referral Service referrals:

- The Booking Office Team will contact the patient and make an outpatient appointment, ensuring wherever possible that patients are given reasonable notice and choice relating to appointment dates. Any issues relating to insufficient capacity will be escalated to the Booking Centre Manager and Service Managers for resolution.
- The central appointments team will ensure the referral documentation is passed to the scanning team for uploading onto Open Eyes in time for the clinic appointment.

3.08(2) NHS e-Referral Service direct bookings:

Note: these are direct bookings made on the NHS e-referral Service system; and will only involve the Booking Office Team if the patient has cancelled and re-booked more than twice.

3.08(3) Paper/Fax Referrals

- All paper/fax 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 Silverlink.
- The Booking Office Team will pass to the appropriate clinician to accept or reject the referral.
- For accepted referrals, the clinician will assign clinical priority
- For rejected referrals, the clinician will dictate a letter back to the GP confirming the decision which will also be recorded in Open Eyes
- For accepted referrals, once clinical priority is assigned, it will be passed to the Booking Office Team to arrange for the referral documentation to be scanned into Open Eyes and subsequently 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.

3.09 Appointments Team – general responsibilities:

- To book outpatient appointments, within 5 working days
- The Booking Office Team will ensure that all outpatient appointment offers are recorded on Silverlink
- To enter full free text reasons for cancellations onto Silverlink
- To ensure Silverlink is updated correctly and timely with any patient choice decisions.
- To ensure the appropriate Referral to Treatment (RTT) status is accurately recorded on Silverlink. 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.
- Responsible Officer for the management, communication and dissemination of the Trust Access Policy within their team.
-

3.10 Responsibilities of Medical Secretaries/Admissions/Validation 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 Silverlink waiting list entry screen.
- To ensure patients are given reasonable notice and choice relating to admission dates.
- Ensure that all admission offers are recorded on Silverlink.
- To enter full free text reasons for cancellations onto Silverlink.
- To ensure Silverlink is updated correctly and timely, including free text reasons with any patient choice decisions.
- To ensure that any 'consultant to consultant' referral requests are sent to the booking centre.
- To track patients 'awaiting results', ensuring once results are received, the clinician reviews and advises on next steps. To close referral where necessary and to ensure

there is a face-to-face follow up or telephone appointment if necessary. Also confirm action taken to GP.

- To regularly validate waiting lists to ensure lists are complete and correct at all times.
- To ensure the appropriate Referral to Treatment (RTT) status is accurately & timely recorded on Silverlink.

3.11 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 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.

3.12 Service Managers (SM's)

Service Managers 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 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 RTT Meeting.

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 Silverlink 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 and will 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 sub specialty clinics.

3.15 Patient Responsibilities

Patients have a responsibility to keep appointments to allow the Trust to meet its obligations in meeting the national referral to treatment standards. Where it is not possible for a patient to attend their appointment the patient must also give reasonable notice.

Patients are responsible for notifying their GP and the hospital of any change in their address, contact telephone number and their GP when attending appointments.

3.16 Performance and Information Teams (P&I)

Performance and Information are responsible for providing operational, accurate, user-friendly reporting systems to enable the operational teams to monitor performance against access and RTT standards.

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). All statutory RTT submissions are signed off before submission by Performance and Information and by the RTT General Manager.

The Head of Performance and information and RTT General Manager 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.

The above will ensure the unify2, NHS England and NHSIMAS websites are reviewed on a regular basis to review for updates.

<http://www.england.nhs.uk/>

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).

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 either by the referring GP, or one of their administrative staff booking an appointment using the NHS e-referral Service system, by the patient themselves making booking online using the NHS e-referral Service system, or by the patient contacting the NHS e-referral Service National Call Centre. The hospital will be notified of the appointment details as soon as the appointment is booked and will show on the relevant speciality work list. This will start the 18-week clock.

Where appropriate, GP's are being encouraged by CCG'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.

The Trust's aim is to receive all outpatient referrals via an electronic referral using the NHS e-referral Service system in line with national guidance and best practice. 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.

If a 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 to be 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. This must be actioned in writing for paper referrals. 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

On receipt of a paper referral, the Trust aims to contact a patient within 5 working days of the paper referral being accepted. If unable to contact the patient then further attempts will be made and a letter will be sent to the patient requesting that they contact the Hospital. Where a patient does not make contact with the Hospital, the patient will be returned to the care of their GP to consider whether they still wish to be referred.

All new paper based referrals (with the exception of 2 week wait cancer referrals) will be date stamped, scanned and registered/entered onto Silverlink on receipt of referral and within 24 hours 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.

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 GP to ensure that the referral letter contains accurate and up to date demographic information regarding the patient. 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 and the GP informed. The GP is responsible for informing the patient in this instance.

Referral letters must be passed to the Consultant within 24 hours of receipt to be triaged. It must be ensured that referral letters are delivered prior to and immediately after bank holidays.

Referrals should be prioritised within 72 hours of receipt by the Consultant to whom the patient has been referred and then sent directly to the Outpatient Appointment Team. Any generic 'Dear Doctor' referrals should be prioritised within the speciality to which the patient has been referred within the same timescale.

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 Silverlink being backdated to the original referral date received from the referring Trust.

Inbound and outbound requests for IPT information are the responsibility of the booking office on the City Road Site. The Booking Office 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 for a diagnostic investigation then the 18-week clock continues ticking and the ongoing management of the patients pathway remains with this Trust.

4.04 Internal Referrals

For all other internal referrals EXCEPT Oncology referrals:

- Fellows/trainees: must dictate and print the referral letter from OpenEyes, and hand the letter to the clinic receptionist who is responsible for ensuring the referral letter is sent to the booking office within 24 hours.
- Consultants: secretaries will type the referral letter and then email this to the relevant Booking Centre.
- **NB** All inter-site internal referrals (e.g. satellite to City Road) must be sent via email (not via internal post) to avoid delay.

Email: bookingcentre@moorfields.nhs.uk Fax: 020 7566 2351

It is the long-term aim of the Trust to work towards a fully electronic referral process.

Similarly, 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 only:

- All Oncology referrals MUST be sent via fax or email to the dedicated Oncology fax and email as below.
- All doctors should alert their clerks/secretaries to the presence of any oncology referrals in their paperwork to avoid delay and ensure these are sent to the correct fax and email.

Oncology fax: 020 75662073

Oncology email (internal referrals only): Ocularoncology.referrals@ Moorfields.nhs.uk

4.06 Diabetic Eye Screening Program (DESP) Referrals (previously known as DRSS)

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>

- R3 (Urgent) within 2 weeks from the date of screening.
- R2 (Soon) within 6 weeks from the date of screening.
- R1 (Routine) maximum 13 weeks from the date of screening.

DESP 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.

4.06(1) Desp DNA's

DESP DNA patients must follow the DESP guidelines see RTT Protocol.

4.07 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 DESP 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, either in the Trust or at another private provider and wishes to transfer to the NHS, the patient must first obtain a referral letter from their GP or referring consultant.

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.

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. Referral scrutiny must be carried out in the Booking Centre. Where a service has not scrutinised their referrals within 24 hours of receipt this will be escalated to the relevant SM/DGM. Where scrutiny has not taken place within 48 hours of receipt this must be escalated to the GM and Service Lead for resolution.

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. It is the responsibility of the Booking Centre to print GP referral letters and other correspondence from the e-referral system within one working day for clinical scrutiny.

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.

The Booking Centre is responsible for monitoring the missing referral letter work list. GP practices must be contacted 14 days prior to the appointment date where the referral letter has not been attached within the e-referral system. In exceptional circumstances of the referral not being obtained for clinic, the patient must be seen at their appointment, although this may result in a further attendance in another service.

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 this exceeds 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.

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 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 Patients who do not Attend their Appointment

Patients should be made aware of Trust DNA policy at the time of referral, to reduce DNA problems and unavailability for telephone contact and appointments. For first appointment DNA the clock will be nullified if reappointed. For any subsequent DNA where the clinician has indicated that the patient should be reappointed, the clock continues to tick. The clock stops for subsequent DNAs only if the patient is discharged back to their GP.

5.07 Appointment Notification and Reminders

The booking office will aim to make contact with all patients by telephone to arrange appointment dates and times convenient to the patient and within reasonable offer rules. Two attempts to contact the patient by telephone on different days must be made before the partial booking letter is sent asking the patient to make contact with the booking office.

All sites and services must have a procedure in place to implement a telephone 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.

5.08 Clock Pause

The Trust will not pause patients waiting for outpatient appointments (new or follow- up) or outpatient diagnostic tests for either clinical or social reasons.

5.09 Outpatient and Diagnostic Cancellations

5.09(1) Patient Cancellations

For routine referrals the patient can only cancel and rearrange an outpatient or diagnostic appointment twice, 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.

5.09(2) Hospital cancellations

A minimum of 6 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 6 weeks) clinic cancellations must be authorised in writing by the appropriate Clinical Director and General Manager and signed off by the COO. The Central Outpatients Team 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.

5.10 Reception Management

5.10(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 Silverlink system. Where details are inconsistent, they must be updated in both the health records and on Silverlink. Demographic details include:

- Patients Name.
- Date of Birth.
- Address.
- Telephone Number including mobile numbers.
- 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 Outpatient Team Leader in the first instance. If the issue cannot be addressed this needs to be escalated to the General Manager of the division for resolution within 2 working days.

5.11 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 appointment more than twice (new, diagnostic or follow up) and it was clearly communicated (see 5.3.1 above) the patient will be discharged and referred back to the care of the GP.

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, or 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 on the 18-week pathway the RTT clock is nullified, (activity not reported). If the Trust re-appoints the patient then the date that the new appointment is agreed with the patient this will start a new RTT clock.

For all subsequent DNA's on 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 haven't 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.

5.11(1) NHS e-referral non attendance

NHS e-referral Service patients who do not attend will automatically appear into the "Appointment for Booking Work Book". This is held and reviewed against the Outcome Form where the Clinician would indicate if a further appointment should be made or the patient referred back to their G.P.

There are two options:- 1) to make a further appointment 2) to cancel the UBRN, close the Silverlink referral and refer back to the G.P. This will then appear in the GP's Work list and they will decide on further action. Option 1 – The clock will be reset from the 1st appointment DNA date if appropriate and Option 2 will stop the 18-week clock.

5.12 TCI form

Once the decision to add a patient to the in-patient or day case waiting list has been made, the "To Come In" (TCI) pink form is completed, dated and signed. This form must be completed at the time of the decision to admit, which in most cases will be during the outpatient appointment. The clock start date (original referral date) must be added to the form. Patients can also be added to the DTA list on Open Eyes which will be checked daily by Admissions.

5.13 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 Silverlink. This will stop the 18-week clock.

Not all patients requiring a follow-up appointment should leave without an appointment date and time. The patient should not change follow up appointments or the hospital more than once and the reason for the change and the clinician authorising the change must be recorded in PAS.

5.14 Subsequent appointments

The Trust aims to ensure that, where possible, patients requiring further appointment(s) in their 18-week pathway, either outpatient, diagnostic or inpatient/day case treatment, should leave the hospital with an appropriate date within the 18-week timeline.

5.15 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.

5.16 Clinic outcome Form

A clinic outcome form must be completed correctly indicating the clinic visit outcome and also updating the 18-week pathway at every outpatient visit. Completed outcome form must be filed in notes. Outpatient team leaders must ensure that outcome forms are filed in the patient notes within a maximum of 72 hours. If outcome forms have not be filed within 72 hours of attendance this must be escalated to the Outpatient Manager and relevant specialty Service Manager.

5.17 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 is instructed how to use the contact lens.

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 8-12 weeks will 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. If the patient accepts an offer at shorter notice this also represents a reasonable offer in respect to subsequent cancellations of DNA's.

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.

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 8-12 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.

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. 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 within 6 weeks of the to be seen by date they should be transferred to an active list and an RTT clock should start and usual RTT monitoring be followed from that 6 week date.

6.04 Clock pause

6.04(1) Patients who want Thinking Time for more than 3 Weeks

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 patients 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 in- patient waiting list and if necessary be required to attend a further pre-operative assessment. This will start a new 18-week clock.

Short-term transitory illness - If the reason is transitory (such as a cold) 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, such as a chest infection, time 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 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 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 either 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 patients 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 referred 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 booked Admissions Coordinator to remove the patient from the waiting list, close the RTT pathway and discharge the referral on PAS. The Admissions Coordinator will inform the patients' consultant of this action.

Where Urgent, cancer, paediatric or vulnerable adults decline the offer of a further pre-assessment appointment the consultant in charge of the patients 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 Silverlink 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. Best interests meetings – a DTA 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 supports an IFR.

This is in line with the IES CCG 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 e.g. a planned treatment event such as a six monthly examination under anaesthetic, should be offered a date within the time frame requested by their clinician.

It is the responsibility of the Admissions Coordinator to escalate potential breaches to the appropriate AGM/DGM/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 offer patients at least two choices of dates for surgery within 5 working days of the decision to admit. 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 8-12 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'.

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 Silverlink 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 Pathway. 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 6 weeks' notice (agreed Trust policy). Approved cancelled theatre sessions should be taken up by other Consultants/Speciality Doctors wherever possible to ensure maximum theatre utilisation.

All short notice cancellations must be authorised in writing by the Chief Operating Officer, following review by the appropriate Directorate Clinical Director and General 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 AGM/DGM/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 sub specialty 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 professional's 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 closed and the referral discharged on Silverlink.

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, or 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 Silverlink 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.
- The Trust's clinical pathways should be developed to allow patients who have been discharged back to their GP and re-referred to be treated in chronological order dependent upon their clinical condition. This is to ensure the most appropriate use of resources. A new 18-week clock would start, as this would be a new referral.

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.
- 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.
- When a patient rebooks their appointment following a first appointment DNA that stopped and nullified their earlier clock.

Section 7. Cancer Pathways

7.01 Two Week Wait (2WW) Patients

Patients must only wait a maximum of two weeks from urgent GP or tertiary referral to their first offered appointment within appropriate specialties. Optometrists can also refer patients on a 2-week wait cancer pathway. Once a two-week wait referral has been received, the Trust must offer an appropriate appointment within 14 days of receipt. This target is for all types of suspected cancer - compliance target 93%.

If a patient is unwilling, or unable to accept an appointment offered within 14 calendar days, then for audit/monitoring purposes, the reason given will be noted. GP's have been asked by the CCG to ensure that their patients are aware that they will be offered an appointment within 14 days and that they should be available to accept the appointment. (i.e. not on holiday within or close to the 14-day period) GP's have also been asked to ensure that their patients are aware of the reasons for the referral and that appointments may sometimes be offered at short notice.

Two-week wait referrals that are considered to be an inappropriate use of the rule may be downgraded, but only following a conversation between the GP/Optometrist and the appropriate clinician where the downgrade is mutually agreed.

The 2WW referral system can be used for a suspected recurrence. However if the recurrence was confirmed the patient would not continue on the 62 day period. They would however be covered by the 31 day subsequent treatment standards.

7.02 14 Day target – 2WW referrals

Patients referred on a 2WW must only wait a maximum time of 62 days from urgent GP two week wait referral to first definitive treatment date. This target is for all cancer types – compliance target 85%.

2WW patients diagnosed with cancer must begin treatment within 62 days of the receipt of referral by the Trust. Patients who are not subsequently diagnosed with cancer will then follow the normal 18 weeks pathway and cease to be monitored as a cancer wait.

Patients referred for suspicion of one cancer but diagnosed with another remain on the 62-day target pathway.

Where the Trust refers a cancer patient to a tertiary centre, the treatment is shared between the two providers (i.e. each Trust will carry 0.5 of any treatment, or breach against their monthly/quarterly compliance reports).

7.03 31-Day Target

Patients must only wait a maximum of 31 days from the decision to treat to their first definitive treatment. This target is for all patients who come into the Trust and are diagnosed with cancer, regardless of the referral route (e.g. A&E, routine and follow-up appointments). The 31-day target for first definitive treatment starts when a treatment plan is agreed with the patient – compliance

The 31-day target also applies to recurrent/relapsing cancers and subsequent treatment regimens. The 31-day clock for adjuvant treatments starts from the date that the Consultant decides that the patient is clinically fit to commence the next stage of their treatment.

7.04 Consultant 62 Day Upgrades

Consultants can allocate cancer patients not referred on a 2WW to the 62-day treatment target. The 62-day clock starts from the date the decision to upgrade is made. Consultant upgrades apply to suspected new primary cancers and not recurrences.

Consultant upgrades should be brought to the first available MDT meeting so that the 62-day pathway can be documented and implemented appropriately. There is currently no national performance standard set for Consultant Upgrades but this is being monitored against the national performance.

7.05 Interaction between 18 weeks, 31 and 62 day targets

Two-week wait patients, referrals from screening programmes and Consultant upgrades are subject to both the 31 and 62-day targets for their first treatment. The patient must be treated by whichever target falls first.

In all cases of treatment the 18-week target takes overall priority. Therefore in the case of Consultant upgrades, if the 18-week target is earlier than either the 31 or the 62-day target that is the date by which the patient should be treated.

7.05(1) Adjustments to the targets

All three cancer targets (two-week wait, 31-day and 62-day targets) can be extended for patients under limited circumstances. An explanation for any adjustment must be clearly evident either in the patient's notes or on Silverlink. These adjustments bring the cancer pathway in line with the 18 Week pathway:

- If a patient does not attend (DNA) their first appointment/diagnostic clinic that would have been recorded as DATE FIRST SEEN under the two week wait system. the clock can be re-set from the receipt of the referral (recorded as the CANCER REFERRAL TO TREATMENT PERIOD START DATE) to the date upon which the patient makes contact to rebook their appointment (not the date of the new appointment). This period is called the WAITING TIME ADJUSTMENT (FIRST SEEN) and is effectively deleted from the waiting time.
- The new appointment date must be within 14 days of the date that the patient is contacted/makes contact to rebook
- For cancer patients under the 31 or 62 day standard the adjustment would be the time between the date of the declined appointment (the offered To Come In date) to the point when the patients could make themselves available for an alternative appointment.
- For cases where the patient is unavailable for a period of time, such as a holiday, then this adjustment can be continued until the patients makes themselves available again. Any delay after that for medical suspensions or capacity issues would not be included in the adjustment.

7.06 Which patients are included within the cancer waiting service standards?

Cancer waiting times service standards are applicable to patients cared for under the NHS in England with ICD codes C00-C97 (excluding basal cell carcinoma) or D05 (breast carcinoma in situ). This includes those patients:

- being treated within a clinical trial;
- whose cancer care is undertaken by a private provider on behalf of the NHS i.e. directly commissioned by a CCG;
- whose care is sub-contracted to another provider – including a private provider - (and hence paid for) by an English NHS Trust i.e. commissioned by a CCG but subcontracted out by commissioned Trust;
- diagnosed with a second new cancer;
- without microscopic verification of the tumour (i.e. histology or cytology) if the patient has been told they have cancer and/or have received treatment for cancer;
- the two-week wait standard can only apply to patients referred with a suspected cancer from a Clinical Assessment Service (CAS) if the 'triage' GP or other health professional within the CAS is acting on behalf of the patient's GP and locally agreed guidelines are in place that authorise them to act in this manner.

The original 31-day standard and the expanded 31-day standard for subsequent treatments apply to:

- NHS patients with a newly diagnosed invasive cancer (localised or metastatic);
- NHS patients with a recurrence of a previously diagnosed cancer (previously excluded from the treatment standard);
- NHS patients (with a new diagnosis of cancer or a recurrence) regardless of the route of referral - this will include patients who may be diagnosed with cancer during routine investigations or while being treated for another condition (i.e. an 'incidental' finding);

The 62-day standard applies to patients who are referred;

- through the two week wait referral route by their GP/GDP with suspected cancer;
- upgraded by a Consultant (or authorised member of the Consultant team as defined by local policy) because cancer is suspected/diagnosed.

7.07 Which patients are excluded from monitoring under these standards?

Any patient:

- a) With a non-invasive cancer i.e:
 - i. carcinoma in situ (with the exception of breast which is included);
 - ii. basal cell carcinoma (BCC).
- b) Who dies prior to treatment commencing.
- c) Receiving diagnostic services and treatment privately, however:
 - i. where a patient chooses to be seen initially by a specialist privately but is then referred for treatment under the NHS, the patient should be included under the existing and/or expanded 31 day standard;
 - ii. where a patient is first seen under the two-week standard, and then chooses to have diagnostic tests privately before returning to the NHS for cancer treatment, only the two-week standard and 31-day standard apply. The patient is excluded from the 62-day standard as the diagnostic phase of the period has been carried out by the private sector.
- d) Patients who decline to undergo diagnostic tests are excluded from the 62-day timeline. However, if they are subsequently diagnosed with cancer they will follow the 31-day timeline for treatment.
- e) Patients who decline treatment are excluded from both the 31 and 62-day targets.

7.08 Cancer patients who do not attend

All dates for cancer patients, whether for outpatients, diagnostic tests or treatment, should be dates that are subject to choice and agreed with the patient. Trust policy is for patients who DNA two consecutive 2WW appointments to be referred back to the GP, except where a clinician decides the patient should be rebooked for clinical reasons. Patients with a suspected cancer who DNA and appointment will be contacted by the relevant clinician's secretary, or a member of the Outpatient team to ascertain the reason for the DNA.

If it is the patient's wish not to attend for the agreed care, then a letter will be sent to the GP or referring clinician informing them of the patient's decision. If a cancer patient DNA's two consecutive appointments, the patient will be referred back to the GP, unless the Consultant feels that this is clinically inappropriate.

Patients should not be referred back to their GP after multiple (two or more) appointment cancellations unless this has been agreed with the patient – by cancelling an appointment a patient has shown a willingness to engage with the NHS.

7.09 First definitive treatment

Cancer patients are generally treated with one or more of several broad categories below. The admitted date is used to calculate compliance with the 31& 62-day targets for surgical treatments.

Surgery – the following count as first definitive treatments:

- Excision biopsies if it is complete or if the intention is to remove the tumour.
- Enucleation.
- Exenteration.

Anti-cancer drug therapy:

- Chemotherapy.
- Hormone therapy.
- Brachytherapy

Other treatments may be considered as first definitive treatment, provided the intention is therapeutic or no other active intervention is intended (e.g. Blood Transfusion, antibiotics).

A partial excision sent for a biopsy is not first definitive treatment, it is diagnostic test and does not stop the cancer or 18 week pathway.

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 Silverlink 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 Central Outpatients Team will undertake initial training as part of their local induction arrangements. This will include training undertaken on NHS e-referral Service and Silverlink 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 Committee 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 RTT 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 PTL/RTT meeting, chaired by the Chief Operating Officer or a nominated deputy.

9.02 Stakeholder Engagement and Communication

The policy is circulated to all AGMs, Service Managers, GMs, Clinical Directors, Service Directors, Chief Operating Officer, Medical Director, Clinical Director for Quality and Safety, Lead CCG 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 Clinical Governance 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, DGM's and GM'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.

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 patient's 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 CCG that require specific

	referral criteria to be adhered to and specific agreement go procedure from the CCG
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.
Outpatients	Patients referred by a General Practitioner (medical or dental) or another Consultant / health professional for clinical advice or treatment
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.
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

<http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting--guidance-FAQs-v6-PDF-164K.pdf>

Policy for patients who require appointments for assessment, review and/or treatment - use of planned (pending or review) lists. Gateway reference: 16994

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

Going Further on Cancer Waits (GFOCW):

<http://systems.digital.nhs.uk/ssd/cancerwaiting/cwtguide9.pdf>

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>

Appendix 1 Exceptional Circumstances Preventing Patient Discharge from Service

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 of 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 and immediate post-operative patients requiring suture removal), further follow up appointments may be offered, or a telephone enquiry made, at the discretion of the senior clinician.

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 and an attempt should be made by the clinic clerk to contact the patient's parents to see if the condition has resolved prior to booking 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.

Cancellation of Appointments / Could Not Attend (CNA)

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 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.

Did Not Attend / Was Not Brought (DNA / WNB)

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.

The NHS Spine must be checked to confirm current address.

Check if child is being seen at an outreach or local clinic. Contact the families/carers of children and young people who fail to attend outpatient appointments or repeatedly cancel by phone, to discover the reason they failed to arrive.

If MEH is unable to contact the family then the GP and Health Visitor (in a child under 5 years) must be informed.

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.

SEE: RTT Protocol Non-Attendance at Appointments (DNA) Procedure Flowchart.

If a child DNAs an appointment, the clinic clerk or nursing staff must make attempts to contact the family by telephone. An individualised letter to the GP and carers must be made as to the risks of failing to attend, the further management plan, highlighting any safeguarding concerns; and where concerns exist on the medial implications of failing to attend.

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 (see RTT protocol) 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.

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.

Glaucoma

Exceptions to the DNA policy apply to patients with uveitic glaucoma at the discretion of the scrutinising clinician for each glaucoma clinic.

Medical Retina and Uveitis

There is a separate policy in place that applies to patient discharges from the uveitis clinics which should be followed for the uveitis patients' only (see Supporting Documents).

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 Silverlink 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.

Vitreoretinal

No exceptions reported for this service.

Appendix 2 Hostel Standard Operating Procedure

Version History

Version	Date Issued	Brief Summary of Change	Author
1.0	December 2011		Sinead Murphy, Sarah Wheatley, Xiang Yin, Joyce Morrin, Alex Edwards
2.0	January 2014	Hostel is permanently relocated to Mackellar Ward	Joyce Morrin, Xiang Yin, Alex Edwards
3.0	November 2015	Out of hours procedure for admitting lodgers	Xiang Yin, Joyce Morrin, Alex Edwards and Paul Adair

For more information on the status of this document, please contact:	Xiang Yin Moorfields Eye Hospital Foundation Trust, 162 City Road, London EC1V 2 PD
Author	X Yin, A Edwards, J Morrin and Paul Adair
Department	Surgical Services Directorate
Accountable director	Chief Operating Officer
Date of issue	December 2011
Reference number	
Last update	November 2015
Next update	November 2016
Approved by	Emergency Preparedness Resilience and Response Steering Group December 2011
Audience	All Trust Staff

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1. Introduction
2. Aim
3. Criteria for Using the Hostel Beds
4. Booking of Hostel Beds on Mackellar ward
5. Catering Facilities
6. Roles and Responsibility of Staff
7. Security of the Hostel Facility
8. Appendices

Appendix i – Working Instruction for the warden

Appendix ii – Welcome Letter for Lodgers

1.0 Introduction

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 1st 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.

For the purpose of this document, all clients staying in the hostel are called lodgers. They are not patients who need nursing care, but they are patients before admission or those who have been discharged from the hospital.

There are separate male and female bays on Mackellar, which can accommodate 6 hostel beds plus 2 beds for carers of the lodgers. These hostel beds are very much utilised on a daily basis though may not be to the full occupancy every day. There is however low usage during the weekends due to reduced surgical activity.

The hostel booking is electronic via the Room Bookings folder within Outlook. Relevant senior nursing staff including all the site cover nurses have access rights to bookings based on the booking criteria below. The list of authorised staff is maintained by the matron for Surgical Services Directorate.

2.0 Aim

- To ensure the continuity of the provision of hostel beds for patients who meet the criteria for hostel beds
- To minimise any disruptions and the impact that it may have on patient care.

3.0 Criteria for Using the Hostel Beds

Due to the limited number of hostel beds available, pre-assessment staff and all other authorised nursing staff will prioritise the requests for bookings based on the general criteria set out below. If patients who meet the criteria cannot be accommodated within the hostel facility, staff should try to arrange alternatives or offer suggestions as listed below

- Reschedule the date of surgery
- Offer the list of hotels near the hospital that the lodgers have to pay for
- As a last resort, liaise with Cumberledge Ward on the availability of beds but lodgers should be warned that there is no guarantee of beds

General criteria for patients who want to stay in hostel accommodation

Patients who have had a general anaesthetic or deep sedation who are fit for discharge but have no home support or no escort to accompany them home;

Patients who have had surgery and require review the following day and are unable to go home and return for the early review because they live too far away or are too frail;

Post-operative patients who do not require nursing care but live alone and are too frail to travel on the day of surgery;

Pre-operative patients who need to stay in the hostel the night before their surgery because they are required to book in for surgery at 7.30am, but live too far away to travel to the hospital on the same day;

Carers who will be required to look after the patients staying in the hostel.

Lodgers who are obviously intoxicated with alcohol or drugs should not be admitted into the hostel. Patients who are attending for outpatient appointments only will not be offered hostel accommodation.

4.0 Booking of Hostel Beds on Mackellar Ward

Hostel accommodation must be booked through the Pre-Assessment Nursing Staff Monday to Friday, between 8:30 hrs and 19:00hrs. Outside the normal working hours, authorised senior nursing staff will need to book into the electronic diary according to the booking criteria set out above. Over-booking can only be authorised by the matron for surgical services directorate or in the absence of the matron, the site cover nurse at that time. Hard-copy of the hostel bookings is printed out daily by the warden or ward staff.

For each booking entered into the electronic booking diary, it should contain the following details:

- Lodger's full name and hospital number;
- Detailed reason for booking that matches with the booking criteria;
- Name of staff who made the booking and the date of booking.

5.0 Catering Facilities

Hot drinks are available in the hostel accommodation on Mackellar ward.

In the evenings the post-operative patients and their carers will be provided with sandwiches by the day care ward staff before being discharged to the hostel.

Food and drink is also available on the ground floor coffee shop between 7:00 hrs and 19:00 hrs Monday to Friday, on Saturday between 09:00 hrs and 16:00 hrs, and on Sunday between 11:00 hrs and 16:00 hrs.

Breakfast can be purchased in the staff restaurant from 07:15 hrs Monday to Friday - the hostel warden will accompany the lodgers to the restaurant and assist them as required.

6.0 Roles and Responsibilities of Staff

The hostel warden is available from 20:30 hrs to accompany the lodgers to the hostel waiting area on Mackellar ward, and the beds will be available at 21:00 when the day surgery facility closes. During the weekend, the warden is available from 19:30 hrs until 08:00 hrs the next morning. The warden will ensure that they have everything that they need. (See Appendix 1 for Working Instructions).

The opening time for hostel is between 21:00 hrs and 07:00 hrs. This is due to the ward closing times at 21:00 hrs and the ward will be opened for the admission of day surgery patients at 07:30 hrs the next morning.

The nursing staff on Mackellar ward will ensure that all the allocated beds are ready before the hostel lodgers' arrival at 21:00 hrs. This will involve the allocated beds being vacated and made ready for the arrival of hostel lodgers. If the bed areas are not clean, the ISS supervisor will be contacted so that remedial actions can be taken.

In the morning, the warden will ensure that the beds are made and the cleaner has the relevant ward area cleaned, so that the whole ward is ready for the admission of day surgery patients who will arrive at 07:30 hrs every morning. If the cleaner doesn't turn up on time at 07.00 hrs, the night ISS supervisor needs to be informed by the warden so that cleaning of the relevant areas on Mackellar can be ensured.

Post-op patients on Sedgwick ward who need hostel beds will go to Mackellar ward when Sedgwick ward is closed in the evenings.

7.0 Security of the Hostel Facility

All lodgers should be booked into the electronic hostel diary by the authorised nurses. Last minute booking or request for pre-surgery lodgers after normal working hours needs to be communicated to the site cover nurse by the staff who is making the request, and the warden is informed at the same time if booking is authorised by the site cover nurse.

The hostel facility should be locked at night to ensure everyone's safety. The warden should call 2222 in case of medical emergency, fire or security, and ask for the relevant assistance when the occasion rises. Security can also be called directly on 4333.

If a lodger turns up without booking to the hostel, the front main reception staff and the warden are not to admit the lodger until the site cover nurse sees the lodger and gives permission for the lodger to stay. The site cover nurse needs to carry out a reasonable search in the available hospital patient information system to verify whether the lodger has a legitimate reason to stay in the hostel facility. The following can be checked in order to confirm the lodger's need to stay in the hostel facility:

- Booking in PAS if any that confirms the lodger's arrangement for any surgery or procedure the next day; or
- Booking in OpenEyes that confirms planned surgery or procedure the next day; or
- If no bookings are found in either system for the next day, and there is no other written evidence that supports the lodger's claim, the manager-on-call should be contacted and details discussed before the decision is made.

Appendix i

Working instructions for the warden

Lodgers who are due to stay in the Hostel are recorded/booked in the electronic diary within Outlook. A list of lodgers staying overnight is printed daily by the warden or ward staff.

The pre-surgery lodgers are to arrive between 20:30 and 21:00.

The emergency number is 2222 for all emergencies including medical emergency, fire and security; it can be called from anywhere in the hospital from an internal phone or the warden's dect phone. The trust's security officer can also be called directly on 4333.

Role of the Hostel Warden

1. The warden reporting for duty should first collect the dect phone 4347 from the Main Reception as well as the ID badge. Carry the bleep and wear the ID badge at all times whilst on duty.
2. Collect the list of names of the lodgers from the front reception desk. If a new Agency person is working, the Recruitment Agency will be given instructions to give the agency warden a copy of this Hostel Working protocol to follow. The relevant estate manager for the warden will orientate an agency staff on fire procedures during week-days, and the nursing staff on Mackellar will need to do the same for an agency staff during weekends. The orientation should include fire procedures, fire exits and external assembly points specific to the evacuation of Mackellar ward.
3. The warden when reporting for duty needs to receive a hand-over/report from the nurse in charge on Mackellar Ward, including last minute bookings.
4. Collect any pre-surgery lodgers waiting in the main reception and take them to Mackellar Ward waiting area to join post-surgery lodgers who may be waiting there.
5. Familiarise the lodgers with the layout of the hostel bed areas on Mackellar, toilets and shower facilities. Check that the allocated beds are ready. Give lodgers a copy of the Welcome Letter (Appendix 3)
6. Familiarise the lodgers with the fire exits and the fire assembly point.
7. Assist all lodgers when necessary offering extra blankets or refreshments.
8. For security purposes, advise the lodgers to tell the warden of their whereabouts and if they decide to leave the hostel early or at any time. If the warden feels a lodger has gone missing, they must contact the site cover nurse immediately and inform Security at the same time.
9. The hostel facility should be locked at night to ensure everyone's safety. The warden should call 2222 in case of medical emergency, fire or security, and ask for the relevant assistance when the occasion rises.
10. If a lodger turns up without booking to the hostel, the warden is not to admit the lodger until the site cover nurse sees the lodger and give permission for the lodger to stay.

11. Seek advice from the site cover nurse on **bleep 4303** regarding any lodger who may complain of discomfort or feel unwell.
12. Inform the lodgers of the morning routine, i.e. the warden will wake them up at 06.00hrs; lodgers will have to vacate the bedded areas by 06:30 hrs for all the beds to be made and cleaning to take place. Breakfast will be at 07.15hrs in the staff restaurant and the lodgers will have to pay for their breakfast.
13. Ensure that the lodgers are comfortable and all queries and concerns have been addressed.
14. Observe them regularly throughout the night and assist as required.
15. Wake the lodgers up at 06:00hrs and facilitate the use of the shower rooms as required. Confirm with the lodgers who would like to have breakfast at the staff restaurant and ensure that they are aware that they will have to pay for their breakfast.
16. Ensure that lodgers vacate their beds and sit in the chair area to allow the beds to be stripped and made up with clean linen. If the cleaner hasn't turned up on the ward by 07:00 hrs the ISS supervisor needs to be informed on extension 4318 to ensure the ward will still be cleaned and ready for the day surgery patients coming in at 07:30 hrs.
17. The hostel warden will ensure that there are adequate supplies (tea, coffee, milk, etc.) by liaising with the Catering Manager and the estate manager for the hostel.
18. At 07:15 hrs, take the lodgers up to the 3rd floor restaurant and assist them with getting their breakfast as required. The warden will provide breakfast at weekends & bank holidays when the restaurant is closed.
19. Once breakfast has been completed take the lodgers to their respective wards as required.
20. Relay any concerns to the nurse in charge on the ward before leaving.
21. Return the dect phone to the switchboard on the ground floor and ensure that it is connected to the charger. Return the ID badge to the main reception.
22. The warden is responsible for completing their own time sheets if needed, and obtaining authorised signatures from the nurse in charge on Mackellar ward. This must then be handed over to the main reception so that it can be authorised by the relevant estate manager in the booking system where appropriate.

Appendix ii

Moorfields Hostel situated on Mackellar Ward

Welcome to the Moorfields hostel, a facility provided in the main hospital building on City Road by Moorfields Eye Hospital NHS Foundation Trust. Your suitability for the hostel is based on your ability to care for yourself. Should this ability change between your pre-operative assessment and your planned stay in the hostel, please contact the pre-assessment clinic on 0207 566 2393.

Hostel Facilities

- On-site warden, for assistance and advice
- Separate male and female bays but no single rooms
- Television in the main waiting area
- Tea and coffee will be provided
- Hospital restaurant opens from 7.15am to 2.30pm weekdays for all meals. **All food and drinks need to be paid for.** The warden will escort you to breakfast at 7.15am.
- Many local restaurants, cafes and shops are within walking distance

Please note that staying at the hostel does not mean that you have been admitted to the hospital and that there is no nursing or medical staff cover, except in emergencies. We are also unable to accommodate visitors. Smoking is not permitted anywhere on hospital premises, including the hostel.

When you arrive:

As a pre-surgery lodger you are advised to report to the reception desk in the hospital's main entrance on City Road between 8pm and 8.30pm. The hostel warden will collect you after 8:30pm, and take you to the waiting area on Mackellar Ward where the hostel beds will be available at 9pm.

As a post-surgery lodger you will be taken to the hostel facility on Mackellar ward around 7.30pm. You will be seated in the waiting area for a short while, until 9pm when the hostel service will open and the warden will assist you.

At 9pm, the warden will show you to your hostel beds and advise you on fire and other safety arrangements during your stay.

If you require emergency assistance during the wardens' break, usually taken at 1.30am weekdays and 2.30am weekends you can call them on 4347 from any phone on Mackellar Ward where it is used as the hostel.

At 6am the next morning, the warden will wake you up and by 6:30am you will need to be seated in the waiting area on Mackellar Ward so that the bed areas and toilets can be cleaned. At 7:15am, you will be escorted to the restaurant for breakfast which you will have to pay for. After breakfast, the warden will escort you to the relevant day ward if you are due for surgery in the morning.

Useful contacts:

Moorfields Eye Hospital NHS Foundation Trust

City Road, London EC1V 2PD

Ph: 0207 253 3411

www.moorfields.nhs.uk

Pre-Operative Assessment Clinic

Ph: 0207 566 2393

Monday to Friday 8.30am to 5pm

Moorfields Direct Telephone Helpline

Ph: 0207 566 2345

Monday to Friday 9am to 4.30pm

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.
	<ul style="list-style-type: none"> Race 	
	<ul style="list-style-type: none"> Gender (or sex) 	
	<ul style="list-style-type: none"> Gender Reassignment 	
	<ul style="list-style-type: none"> Pregnancy and maternity 	
	<ul style="list-style-type: none"> Marriage and civil partnership 	
	<ul style="list-style-type: none"> Religion or belief 	
	<ul style="list-style-type: none"> Sexual orientation including lesbian, gay and bisexual people 	
	<ul style="list-style-type: none"> Age 	
	<ul style="list-style-type: none"> 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 corporate governance, 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 corporate governance (ext. 2306)

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.

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 RTT General Manager

Policy (document) Owner: RTT General Manager

		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 Deloitte on an annual basis
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	

<u>Committee Approval (Clinical Governance Committee)</u>			
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	Declan Flanagan	Date	23 rd September 2016
<u>Ratification by Management Executive (if appropriate pick one or the other)</u>			
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: 27 th September 2016			