Moorfields Eye Hospital NHS
NHS Foundation Trust

Patient Access, Booking and Choice Policy

for Moorfields City Road and all Moorfields satellites

Policy Summary
This policy is intended to provide guidance on the approved process for managing patients' access to outpatient and admitted care services at Moorfields Eye Hospital NHS Foundation Trust. This policy covers Moorfields City Road and all Moorfields satellites.

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Contents

Executive Summary

This policy provides general guidance on the approved processes for managing referrals to outpatient clinics, procedures and operations, to allow consistent and fair care for all patients and to minimise the risks to patients following altered and cancelled apointments or failure to attend.

This policy covers Moorfields City Road and all Moorfields satellites.

1 Introduction

1.1 Introduction

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 instruction on the operational management of waiting lists. It promotes consistency and fair treatment to all patients and aids provision of timely, accessible and high quality patient centred services.

The length of time a patient needs to wait for hospital treatment, both as a day case patient or an outpatient, is an important quality issue and is a visible and public indicator of the efficiency of the hospital services provided by the Trust. The trust will work with national and local commissioners to ensure that best practice waiting list management is applied and that all national access targets are met.

1.2 Key principles

The key principles underpinning this policy are:

- Clinical priority must be the main determinant of when patients are seen as outpatients or admitted for elective procedures. Patients of equal clinical priority should be treated on a first come first served basis.

- This policy will be applied consistently and without exception across the Trust. 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 within the current maximum national guaranteed waiting times.

- A patient should only be placed on a waiting list for a procedure if:
    - There is a sound clinical indication for the operation
    - The patient is clinically and socially ready to undergo surgery.

- The process of waiting list management should be transparent to the public.

- A referral letter is required for any patient to be offered an appointment or admission.

- Communication with patients will be timely, informative, clear and concise.

- All additions to or removals from waiting lists must be made in accordance with this policy.

- Reasonable offer of date rules apply to all patients.

- The principles of a booked appointments system will be applied across the Trust; that is, patients will have the opportunity to negotiate their appointment / admission date at each stage in their pathway.

- All information relating to patient activity must be recorded accurately and in a timely manner.

- All patient pathways are actively managed and monitored to prevent any patient being lost to follow up.

2 Scope

This policy document applies to all Trust staff employed at Moorfields Eye Hospital NHS Foundation Trust.

3 Purpose

This purpose of this policy is to provide guidance on the process for patient access to care following referral.

4 Policy

4.1 Key Access Performance Targets

The performance targets to be adhered to are:

	Subject	Target
1	Referral to treatment (RTT)	• A total patient pathway wait of 18 weeks from referral to treatment for 90% of admitted patients. • A total patient pathway wait of 18 weeks for 95% of non-admitted patients. ▪ A waiting time of less than 18 weeks for 90% of untreated patients on the Open RTT Waiting List
2	Cancellations on the day of surgery	• Total number of patients whose operation is cancelled on the day of the operation by the hospital for non clinical reasons must not exceed 0.8% of total elective admissions • All such patients will be offered another procedure date within 28 days of the cancelled procedure date
3	Convenience and choice – elective (inpatient and day case) and outpatient booking.	• 100% of patients attending as a day case or an elective inpatient must be booked with choice of date • 100% of referred patients attending as a new outpatient must be booked with choice of date and time
4	Diagnostic waiting times maximum stage wait	▪ A maximum wait of 6 weeks for all diagnostic waits

	Subject	Target
5	Reasonable notice period	• All patients must be given reasonable notice of appointments and admission dates. Reasonable notice is three weeks • This guidance is not applicable to urgent patients or hospital non-medical cancellations on the day of surgery to be re-booked within 28 days
6	Cancer Targets	▪ Two week maximum wait from receipt of an 'Urgent Suspected Cancer' GP referral to first outpatient appointment ▪ Maximum waiting time of 31 days from decision to treat to treatment for all cancers. Includes sequential treatments and recurrent cancers ▪ Maximum waiting time of 62 days from urgent GP referral to treatments for all cancers ▪ A consultant will be able to upgrade non-GP referrals to a 62 day pathway where appropriate
7	Diabetic Screening	▪ All patients must be seen as per National Screening Guidance i.e. - R3 (Urgent) within 2 weeks from the date of screening - R2 (Soon) within 6 weeks from the date of screening - R1 (Routine) within 13 weeks from the date of screening
8	Internal Targets	• <u>Access:</u> • Maximum 6 week wait from receipt of referral to first appointment • Maximum 10 week wait from decision to admit to admission date • Administration: • Staff to be appropriately trained and performance to be monitored – see Appendix 5 for detail

4.2 Outpatients

4.2.1 Referrals

The Trust follows the general principle of referral into specialty areas and clinic types rather than direct to named consultants. All GP referrals will be treated as open and pooled within the speciality. Exceptions to this are: referrals to specific sub-specialities; special interest; research; patients with previous treatment history under the care of a specific consultant; and requests for second opinions.

The demographic details provided by the referrer will be updated on PAS and then used when arranging appointments. It is the responsibility of the patient to inform the Trust of any change in their contact details.

If a referral has been made but the special interest of the consultant does not match the needs of the patient, the consultant will redirect the patient to an appropriate colleague (within their specialty only) who is able to provide such a service and the referral details amended on PAS. This does not constitute a consultant to consultant referral.

4.2.1.1 Referral letter documents

Referral letters should be treated as important documents. Losing or unnecessarily delaying a referral can potentially put a patient at risk. In this eventuality, the Trust and/or individual members of staff may be considered to have failed in their duty of care.

1. Referral letters must be date stamped on the day that they are received within the Trust and this date must be used when registering the patient on PAS. This is the responsibility of the Booking Centre. Any referral letters received in the Trust's satellite sites at Mile End, St Ann's, Barking, Loxford, and Potter's Bar must be date stamped on receipt and sent to the Outpatient Booking Centre within 24 hours
2. No referral letter should remain unactioned for more than 5 working days.
3. Robust filing procedures must be put in place to reduce the risk of misplacement and to ensure compliance with national guidance on data protection. Referral letters should only be kept in the Booking Centre, or in patients' notes held within the Medical Records Department.
4. Under no circumstances should a referral leave the Trust. Tracking of referrals from receipt to outpatient appointment is essential to ensure this.
5. Paper copies should only be made if absolutely necessary and the copy clearly marked as such. The exception to this is paper copies of Choose and Book referrals printed for review by consultants without access to Choose and Book.
6. When it is necessary for referrals to be moved, they should pass from hand to hand i.e. not via the internal post or left on staff desks.

4.2.1.2 Registration of new referrals when a referral already exists

If a patient is already under the care of Moorfields and another referral is received for a different condition this will be classed as a new referral.

If a referral is received for the same condition (e.g. request for another appointment or an appointment to be brought forward) and the patient has previously been discharged from the service the referral will be classed as new.

If the patient is still under the care of the service and has been seen recently or has an appointment in the future then the letter will not be registered as a referral and instead will be passed on to the service team for action.

4.2.1.3 Non-Choose and Book referral allocation

All referrals will be entered on to PAS within one working day of receipt in the Booking Centre. The clock start date for waiting time purposes is the date the referral is received in the trust.

Patients who are referred to a specialty rather than a specific Consultant will be allocated to the Consultant with the shortest waiting time.

If a referral is made to a specific consultant the patient will be allocated to that consultant unless instructed otherwise by the Service Director or General Manager.

Any patient who attends an agreed outpatient appointment whose letter has not yet been received should be seen and their referral chased with the referring GP or clinician.

When arranging first appointments every effort must be made to contact all patients, regardless of speciality or referral source, by telephone to agree an appropriate appointment date and time. Patients will be offered a choice of at least two appointments on different days, with at least three weeks notice before the first of these appointments (DoH definition of "reasonable notice"). Patients may choose to take advantage of a short notice cancellation but, if this is refused, it will not be counted as a patient cancellation.

If the Booking Centre is unable to contact the patient by telephone then a partial booking system will be used. The patient will be sent a letter and asked to call in to make an appointment (see Appendix 4). Any unsuccessful attempts to contact a patient should be documented.

Special efforts must be made to arrange appointments for groups of patients who are particularly difficult to contact e.g. HMP patients. Such issues should be referred to the Outpatient Booking Centre Manager.

The Booking Centre will aim to appoint all referrals within 6 weeks (unless the patient chooses to wait longer). If a patient wishes to wait longer than 12 weeks for their appointment they will be asked to return to their GP to be re-referred when they are ready.

If an appointment is to be booked **urgently** every effort must be made to contact the patient by telephone. If it is not possible to contact the patient by telephone then an appointment may be allocated and sent out in a letter posted first class, including instructions to call the hospital if the appointment is not suitable. All urgent appointments must be booked within 2 weeks unless otherwise specified by the service.

4.2.1.4 Choose and Book referral allocation

All GP referrals should be made via Choose and Book (national requirement from January 2006). GPs or community referring clinicians are therefore encouraged to use Choose and Book to refer patients into the Trust.

For referrals made though the Choose and Book (CAB) system, the clock start date will be the date that the patient books the appointment. This can be either at the GP or referring clinician surgery or when they convert their Unique Booking Reference Number (UBRN) by either booking on-line or via the Choose and Book Telephone Appointments Line. If the Trust has to change the patient's appointment to another more appropriate service/clinic, the original Date Received remains as the clock start.

Choose and Book Referrals will be registered onto PAS automatically and appointment dates will already be given. Choose and Book referrals will be reviewed in the Booking Centre on receipt. Where it is clear that appointments have been made in the incorrect clinic, the Booking Centre will contact the patient and book in the appropriate clinic.

Any patient who attends an agreed outpatient appointment when the referral has not yet been received, approved or rejected must be seen.

4.2.1.4.1 ASI process

If there is no appointment availability visible on CAB, the Trust will receive the referral request via Appointment Slot Issue work list in CAB (ASI). The trust will follow the National

Procedure and contact the patient within 2 working days of receipt (either by telephone or if no reply, sending a letter asking the patient to call to agree an appointment date). In order not to disadvantage the patient, the Date Received (clock start) will be the date the request was received as an ASI.

4.2.1.4.2 Cancelling UBRNs

If an appointment cannot be made using CAB (sometimes following an ASI request or change of clinic) and is booked manually in PAS, it will be necessary for the trust to cancel the UBRN to prevent the patient receiving reminder letters from CAB.

When a patient cancels their appointment and does not make another one, the UBRN will continue to be valid for rebooking. The patient should receive 2 reminder letters from CAB. If a new appointment has not been made one month after the cancellation, the trust will cancel the UBRN and notify the GP and patient.

4.2.1.5 Reminder service

Where a mobile number is recorded on PAS the trust will send the patient a text message in advance of their outpatient appointment reminding them of the location and time of their appointment. The text will include a number to call if the patient wishes to cancel or change their appointment.

4.2.1.6 Consultant to consultant referrals

When a consultant identifies a possible condition in a patient other than that identified in the original GP referral or reason for admission, the patient will 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 and, if so, give the patient a choice of provider. Such patients should not be referred direct to another service 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. neovascular age related macular degeneration or significant corneal disease.
- Malignancy
- Ophthalmic conditions in children [under 16]
- Genetic eye conditions
- Neurological conditions
- Ocular co morbidities which need to be managed simultaneously by 2 or 3 services;. e.g. cataract surgery in patients with diabetic retinopathy.

A referral to the relevant service within the Trust, or to another Trust in some cases of a different specialty, is expected with a new clock start date;

Discussion with the patient should take place to agree the appropriateness of this action and the GP or referring clinician informed of the decision.

4.2.1.7 Private referral

Some patients do not immediately qualify for treatment under the NHS. These include overseas patients and private referrals. If a private referral is received or an overseas patient is referred for an outpatient appointment, the referral must be directed to the John Saunders suite for action. See the *Private and Overseas Patient Policy* for further information.

4.2.1.8 Scrutiny process

Clinical scrutiny should 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 included in the referral, the patient will be allocated to Primary Care.

It is the responsibility of each service to ensure that scrutiny is carried out at least once every working day. It is best practice for scrutiny to be carried out in the Booking Centre. Scrutiny will take place no longer than 5 working days after receipt by the Trust. If upon scrutiny, it is felt that the patient's appointment should be expedited, this will be carried out.

It is the responsibility of the Booking Centre to print off the GP referral letters from CAB within 2 working days and send for scrutiny. All referrals must be returned promptly to the Booking Centre for action on CAB. Where possible a referral will be redirected to the most appropriate clinic, rather than rejected and returned to the GP.

The Booking Centre will contact GP surgeries when the referral letter has not been attached within CAB by the due date. In the exceptional circumstances of the referral not being obtained for clinic, then the patient should 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 by Choose and Book, the Booking Centre will make every effort to contact the patient and change the appointment. Where the patient is not contactable by telephone, and there is sufficient notice, a letter will be sent informing the patient of the change.

Requests should only be made to change appointments where absolutely necessary. Requests to change an appointment within the same service will only be carried out in exceptional circumstances.

For an appointment to be changed, the request must be received at least one week prior to the appointment date.

Where a request has been made to change an appointment and this can not be carried out (e.g. unable to contact patient, too short notice) the patient will be seen and the consultant and the administrator for the clinic will be informed.

Unscrutinised referrals for CAB appointments will be accepted one week prior to the appointment date.

4.2.1.9 Escalation procedures

Where the Outpatient Booking Centre is consistently unable to book first appointments within the 6 week target wait this will be escalated for action to the relevant Assstant General Manager/Service Manager. If capacity cannot be created this must be escalated to the General Manager.

4.2.2 Patient cancellations

4.2.2.1 First appointments

Patients who cancel their first appointment should be given an alternative date at the time of the cancellation.

If a patient cancels two appointments and their referral is graded as routine, they will be removed from the waiting list and discharged back to the referrer. However, if the patient's referral is urgent, medical staff must review their case notes to ensure that there is no clinical risk involved in not seeing the patient before the patient is removed.
Exceptions to this rule are listed in Appendix 6.

When a patient cancels their appointment and does not wish to arrange an alternative, a discharge letter should be sent to the patient and their GP by the Booking Centre and the referral discharged on PAS.

4.2.2.2 Follow up

Patients who continually cancel and rebook their follow up appointments will be discharged and will require re-referral. Any patient who cancels and reschedules the same follow up appointment on 2 occassions will be removed from the waiting list and discharged back to the referrer. Likewise, any patient who cancels and reschedules consecutive follow up appointments on 2 occassions will be discharged back to the referrer. However, medical staff must review their case notes to ensure that there is no clinical risk involved in not seeing the patient before the patient is discharged. Exceptions to this rule are listed in Appendix 6.

4.2.3 Hospital cancellations

It is the Trust's policy to avoid outpatient cancellations wherever possible. The Trust has an agreed leave policy, which states that a minimum of 8 weeks notice must be given by all medical staff in order to minimise disruption to clinics and patient cancellations.

If a patient's appointment has to be rescheduled due to a hospital cancellation, every effort will be made to contact the patient by telephone to offer an apology and a new date. The new date must be within target timescales and reasonable offer rules still apply. If it is not possible to contact the patient by telephone then an appointment may be allocated and sent out in a letter, posted first class if cancelled within 10 working days, including instructions to call the hospital if the appointment is not suitable. If the referral is urgent, the case should be discussed with a consultant.Waiting times are not reset in the event of Trust cancellations for outpatient appointments.

Where patients have to be cancelled at less than 8 weeks notice, the case notes must be reviewed by medical staff.
Patients that have been previously cancelled should not be cancelled a second time.

4.2.4 Management of outpatient clinics

4.2.4.1 Clinic template set up

Clinic templates should match as closely as possible the numbers and types of patients who can be seen within each clinic given the number of rooms available and number of

clinical staff avaiable. Any changes to clinic templates must be discussed and agreed by the Consultant, Service Director and the Assistant General Manager/Service Manager for that service. Records must be kept of all amendments to clinic templates.

Reductions to service availability can only be approved when an agreed plan exists to ensure patient access times are not compromised in the future as a result of the proposed alterations.

Capacity issues must be escalated to the Assistant General Manager/Service Manager.

4.2.4.2 Setting up new clinics

Any requests to set up new clinics must be discussed and agreed by the Service Director and the Assistant General Manager/Service Manager for that service.

When new clinics are to be set up the Assistant General Manager/Service Manager should inform the PAS Manager. It is the responsibility of the Assistant General Manager/Service Manager to agree arrangements with support departments to ensure that adequate resources are provided to enable all aspects of the new clinic to run effectively.

Any new patient slots will be electronic booking compliant (EBS) unless specified by the Assistant General Manager/Service Manager.

4.2.4.3 Cancellation or reduction of clinic slots

The only acceptable reason for any clinic slot to be cancelled is the absence of clinical staff. This can result from planned annual/study leave, audit sessions or unplanned sickness absence. Clinic slots should not be cancelled outside of these reasons unless there are exceptional circumstances.

A minimum of eight weeks notice is required of planned annual leave or study leave where this will result in a clinic being cancelled or reduced.

Clinic slots that need to be cancelled with less than eight weeks notice, with the exception of illness or emergency, will require approval from the Assistant General Manager/Service Manager.

The Service Administrator is responsible for managing the clinic slots and reducing them for planned leave.

New slots should either be available for booking or cancelled. Where slots are cancelled the reason for this must be indicated on PAS. New elements should not be put ‘on hold’, however it may be appropriate to use the ‘on hold’ function for other elements.

4.2.4.4 Actions on the day of clinic

It is the responsibility of the clinic clerk sitting the clinic to ask each patient if their contact details or GP details have changed since their referral (for a new patient) or their last appointment (follow up). Any changes must be put onto PAS prior to the patient being seen to avoid letters containing sensitive personal information being sent to the wrong address.

4.2.5 Patients who do not attend (DNA) an outpatient appointment

Non-attendance of a patient (Did Not Attend, DNA) occurs when the patient fails to attend or respond to the appointment for consultation or treatment, or where they (or their carer) have not made contact with the trust to cancel or amend the appointment. It is required that a reasonable effort is made to maintain contact with all patients receiving care within the Trust in order to ensure their continued assessment, monitoring and support and to minimize risk of harm to the patient.

At the end of a clinic session, the notes of all patients who have failed to attend their booked appointment should be taken to the consultant or other nominated clinician. It is the responsibility of the clinician (consultant/other member of the service with appropriate experience and training) who has been allocated the referral to follow up non-attendance and to ensure that the appropriate action is taken.

After two DNAs, if the patient contact details have been checked and found to be correct, and the consultant responsible has reviewed the patient notes, the patient should be discharged, unless any exceptional circumstances apply (see Appendix 6). A letter confirming these arrangements must be sent to the GP or other referring clinician and a copy sent to the patient.

4.2.5.1 New referrals

Adults who DNA a first appointment will be discharged, and a letter sent to the GP and the patient informing them of the discharge. The patient will only be offered a further appointment at the request of the consultant. It is therefore recommended that the consultant or a member of the consultant's team will review the notes of each patient who DNAs, following the clinic.
Patients considered to be high risk will be offered another appointment (see Appendix 6). If the patient DNAs a second time, they should be discharged as above.
A patient who DNAs through no fault of their own or who had contacted the hospital to advise that they would not be attending will be offered another appointment.
If a new patient is to be given another appointment following a DNA, the appointment will be arranged by the booking centre.

If a second appointment is granted a new clock will start. If a second appointment is offered, the patient should be contacted by letter or phone, informing them that they have missed their appointment and that they have been offered a second appointment. At this point the patient's record on PAS must be checked to ensure that the contact details are up to date and correct and whether language or disability is an issue to be considered.
If the patient has a second DNA they should be notified in writing that they will not be offered a further appointment. Exceptions to this guidance, at the discretion of the Consultant, may include, for example, severe sight-threatening disease, tumours and children; for a comprehensive list of exceptions see Appendix 6.

These actions should be recorded in the medical records and onto the Trust's Clinical Information System. The referrer and GP must be copied into any of the above correspondence.
A patient who fails to attend through no fault of their own, or who had contacted the hospital to advise that they would not be attending, will be offered another appointment. If the patient contacts the Trust within 24 hours of the missed appointment with an acceptable reason for their failed attendance, and the consultant agrees to see the patient, the original referral will be reinstated, but the waiting time will be reset to start from the

date of the missed appointment. An acceptable reason predominantly refers to circumstances beyond the patient's control that had prevented the patient from attending and from informing the Trust in advance of their non-attendance. Forgetting an appointment is not an acceptable reason for non-attendance.

Where a new patient is to be reappointed following a DNA, the appointment will be arranged by the Booking Centre.

4.2.5.2 Follow-up appointments

Where patients who are already under the care of a Service fail to attend their appointment, in most cases a further appointment should be offered in writing, including a statement explaining that failure to attend for a second time will result in the patient being discharged back to the GP. However, if the responsible consultant feels that the nature of the problem of the patient is routine and probably self-limiting (e.g. chalazion), it would be acceptable to discharge the patient.

Follow up DNAs will be dealt with by the clinic administrative teams.

After a second consecutive DNA, the consultant should assess the case and depending on the outcome of that assessment and the risk, the next course of action can be determined. In most cases this will be discharge from the service and / or a referral back for continuing care to the GP or, in unusual cases, the offer of another appointment.

At the time of discharge, a letter should be sent to the GP outlining the diagnosis, the current management and the possibility of referring the patient back should this be deemed necessary for further management.

For dependents, including children, additional consideration should be given as often the patient will not be responsible for the DNA, with further follow-up appointments at the discretion of the Consultant. In such cases, additional efforts should be made to contact the parent/carer, ideally by phone. All communication, including records of phone calls/voicemail messages, should be recorded in the patient's medical records and onto the Trust's Clinical Information System.

4.2.5.3 Exceptional circumstances and individual services

It is anticipated that each sub-specialty will have certain conditions where there is a risk to the patient if they are discharged without reasonable attempts to ensure that their ocular / general medical condition is stable. Such conditions include uveitic glaucoma, diabetic screening patients, patients suspected of having a malignant lesion and patients on immunomodulatory therapy. Other conditions may also be considered exempt from this DNA policy at the discretion of the Clinical or Service Director of each sub-specialty.
For a comprehensive list of these circumstances and services see Appendix 6.

4.2.6 Management of follow up appointments and discharging patients

Follow-up appointments should not be booked as a matter of routine. They should only be made when the consultant or a member of their team has indicated that there is a proven clinical need for the continued intervention of specialist 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 more

appropriate) or where the relevant Royal College or NICE guidance indicates, the patient should be discharged to the care of their GP or referring clinician. Open appointments will not be given out; patients should either be given an appointment or discharged back to the original referrer. As a general rule, patients who do not need an appointment in the next 12 months should be discharged to the original referrer; but in some specialties, longer intervals between appointments may be appropriate. This is at the discretion of the consultant responsible.
When discharging patients from clinic, it is the clerk's responsibility to record the correct reason for discharge on PAS and close the referral. This must be done at the end of every clinic and the clinic 'cashed up' within 1 working day of the clinic taking place.

4.2.7 Recording of clinic outcomes

As the patient moves along their pathway within the Trust, it is essential for accurate monitoring that every relevant piece of information about their care is promptly recorded, including the outcome of all outpatient appointments. This includes urgent walk-in patients and patients attending follow-up appointments. Patients who fail to attend (DNA) must also have outcomes recorded.

This process will be managed through the use of Clinic Outcome Forms (COF). Each outpatient attendance or decision to 'stop a clock' will result in the completion of a COF, details from which will be recorded on PAS. The clinical team managing the patient are responsible for ensuring that COFs are completed for every patient episode, although responsibility for managing this process lies with the Directorate Teams. It is the responsibility of the clinician to indicate specific timeframes for re-booking patients, eg '1 week', or '2 months', rather than using less specific terms such as 'soon' or 'routine'.

PAS should be updated appropriately ('cashed up') within 1 working day of the clinic taking place by the responsible clerk.

4.2.8 Open Patient Pathways

Any patient pathway that remains open and has no activity or outstanding appointments for over 8 weeks must be investigated by the relevant Assistant General Manager/Service Manager. This will result in either a further follow up appointment or the patient being discharged back to the care of their GP or referring clinician and the pathway being closed.

4.2.9 Discharging and cancelling referrals

Where a decision has been made to discharge a patient following a DNA, a failure to appoint due to no contact from the patient, or where a patient decides treatment is no longer required, it is the Booking Centre staff or Clinic Administrator's responsibility to cancel the appointment, close the referral and the RTT pathway, and to discharge the patient and notify the GP.

4.3 Non-admitted RTT waiting list management general principles

1. Patients will be added to the waiting list on receipt of referral.

2. The Performance & Information Team will produce weekly reports to ensure all referrals are appointed in a timely fashion and to ensure management of patient pathways to meet the 18 Week RTT Performance Target.
3. It is the responsibility of Booking Centre staff & Clinic Administrators to escalate capacity issues that could negatively impact trust performance to the AGM.
4. The Performance & Information Team will produce weekly reports on all attended appointments with no recorded RTT outcome; open RTT pathways with no follow up OPA or listing for the Clinic Administrator to investigate and correct. Accurate RTT reporting is the responsibility of the AGM/Service Manager.

4.4 Admitted Care

4.4.1 Adding patients to waiting lists for admission

As Moorfields Eye Hospital NHS Foundation Trust is a multi-sited Trust and it is necessary that all resources are fully utilised and the length of waits for services is equal for all patients who access them, patients must be advised that they could have admission dates offered to them at any appropriate MEH site and by any appropriate surgeon.

A patient should only be placed on a waiting list if:

- There is a sound clinical indication for surgery.
- The patient is clinically and socially ready to undergo surgery.

The decision to add a patient to a waiting list must be made by a consultant, or a member of the consultant's team.

Patients who are not fit, ready and able to come in on the date the decision to admit is made must not be added to the waiting list.

If a patient is either not fit or not ready for surgery they should be either:

- Returned to their GP's care to be re-referred when they are fit and ready.
- Referred for further advice or management in secondary care.
- Reviewed again in an outpatient clinic with a view to assessing the patient again and planning a future date for surgery.

4.4.2 Decision to admit (DTA) form

All patients who have a decision to admit must have a DTA form completed at the time of the decision to admit. This form can either be completed electronically or in hard copy. The form should be completed by the consultant or member of the consultant's team.

A decision to admit is defined as the time when there is an agreement between the patient and the consultant to proceed with surgery. The DTA form should only be completed when the decision to proceed with surgery is confirmed.

When completing the DTA form the following information must be confirmed with the patient:

- Confirmation of the patient's address (including postcode) and referring General Practitioner.
- Patient's telephone number (home, work and mobile) or a number through which he or she can be contacted during normal working hours.
- Availability to come in at short notice (less than 1 week notice) if an unexpected vacancy arises.
- Any special circumstances requiring longer notice than usual for admission (e.g. caring for elderly relative, transport arrangements etc).
- Any dates when the patient will not be available for admission e.g. booked holiday, etc.
- Any special requirements on the day of admission (e.g. hospital transport, interpreter)

In addition the following information regarding the admission must be supplied on the form by the Consultant or a designated member of his team:

- Diagnosis
- Intended procedure and eye
- Approximate time that the operation will take
- If a date has been agreed with the patient
- If two reasonable dates were offered and turned down by the patient (i.e. patient's choice to wait longer)
- Clinical urgency i.e. urgent or routine
- Type of anaesthetic required i.e. local or general
- If a Consultant must be present for the procedure
- Paediatric or adult list
- Any other relevant information

DTA forms in hard copy must be delivered to the Admissions Team within one working day of the decision to admit. The Admissions Team will ensure that all DTA forms are processed electronically within one working day of receipt.

Where possible and practicable patients should be referred directly from clinic where the DTA has been agreed to the Pre-Assessment Unit as a walk-in patient for pre-operative assessment.

4.4.3 Booking an admission date

The admission date must be agreed with the patient as soon as possible after the DTA. This may be:

- In clinic
- At the same visit by the patient attending the Pre-Assessment Unit
- After the clinic by the Admissions Team on receipt of a DTA form. Bookings will be arranged within 5 workings days of receipt of the DTA form.

4.4.4 Reasonable offer

For an offer of admission to be deemed reasonable the patient must be verbally offered at least two dates on different days, with at least three weeks notice before the first of these appointments (Department of Health definition of a reasonable offer).

Any patient may choose to wait longer than the two dates offered by the hospital; the 18 week RTT clock will be paused from the date of the first offer until the patient makes themselves available.

4.4.5 Booking process

The Admissions Team is responsible for ensuring that the patient has a pre-assessment and a post-op appointment (where appropriate) and has an admission letter. Ideally all this will be arranged on the day when the DTA is made.

The admission coordinator will initially make a reasonable attempt to contact the patient by telephone to agree the admission date. If the patient is uncontactable by telephone the admission coordinator will follow a partial booking process (see Appendix 4).

If the patient still does not make contact with the hospital after further attempts are made to contact the patient the patient's consultant will be informed and asked to make a decision whether to discharge the patient.

When booking the date for surgery the Admission Coordinator will also book the patient to attend pre-assessment and will also book the post-op appointment (if appropriate). The Admission Coordinator will send the patient a TCI letter including all the relevant details. The Admission Coordinator will also arrange for transport and for an interpreter if required.

4.4.6 Urgent patients

All urgent patients should have their date for surgery agreed on the day of clinic where possible.

Where this is not possible every attempt will be made to contact the patient by telephone to arrange a date.

If it is not possible to contact the patient by telephone then an admission date may be allocated and sent out in a letter including instructions to call the hospital if the date is not suitable.

4.4.7 Offer of date within breach date

All patients must be offered a reasonable date within their 18 week pathway breach date. Where this is not possible due to a lack of capacity it is the Admissions Team responsibility to escalate to the AGM.
A patient may choose to wait longer for their operation. In these circumstances the earliest reasonable date that was offered will be recorded and the 18 week RTT clock will be paused from the date of the first offer until the patient makes themselves available.

4.4.8 Patients directly listed for surgery following a referral

Certain patients may be directly listed for surgery without attending an outpatient appointment at Moorfields. A referral letter is required. The patient may have been seen by a Moorfields consultant at another organisation.

Once these patients have been given a DTA they will be managed as admitted and subject to the same procedures and targets outlined for admitted care in this document.
The DTA will be the date that the referral is received in the trust.

The referrals for this group of patients will be registered on PAS in the usual way. Once the DTA is entered on OpenEyes the patient will be given a dummy new appointment on PAS on the same date that the DTA is entered. The appointment will be given the outcome A1 (listed for surgery). These appointments will be non-chargeable.

If a patient has a post-op following surgery as a directly listed patient this will be made as a follow up.

4.4.9 Patient reminders

The Admissions Team will be responsible for contacting prior to their surgery date to check that they are still intending to attend for their procedure.

If a patient has attended for pre-assessment 2 weeks prior to the surgery date then they will be contacted 2-3 days before the surgery date.

If the patient has not attended for pre-assessment 2 weeks prior to the surgery date then they will be contacted 10 days prior to the surgery.

If a patient informs the Admissions Team that they will not be attending for surgery this will be dealt with as a patient cancellation (see below). Every attempt will be made to ensure that the slot is filled by another patient.

If a patient has questions of a clinical nature they will be referred to the appropriate nurse or doctor.

4.4.10 Planned patients

Planned waiting list patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or surgical investigation. These patients are not waiting for a first treatment date, they have commenced their treatment and there is a plan for the subsequent stages of that treatment.

Human tissue graft patients are also recorded as planned in order to remove them from the waiting list monitoring process.

Some examples of planned procedures may include:

- Age/growth related surgery
- Graft patients

- Examination under anaesthetic
- Any subsequent staged procedures

Patients waiting for surgery on their second eye are **not** to be recorded as planned. These patients start a new 18 week pathway when the decision is made to proceed with the second eye. Where the decision is made to treat both eyes at the time of listing, the second 18 week pathway will begin 2 weeks after the first operation as a default.

4.4.11 Managing the waiting list

The AGM/Service Manager for the relevant service
will ensure that the admitted RTT waiting list for that service is reviewed on a weekly basis.

The AGM/Service Manager will be responsible for ensuring that all patients on the admitted RTT waiting list are on a correct 18 week pathway. This will be done as patients are added to the waiting list.

Any patients on the waiting list without dates will be escalated to the Admissions Team for a date to be given. There will be further escalation if a patient has been waiting over 4 weeks without a date.

Any patients booked after their 18 week breach date will be forwarded to the relevant service by the Admissions Team to investigate the possibility of offering a date within breach.

Where it is not possible to book patients within their breach date this will be immediately escalated to the relevant AGM/Service Manager.

4.4.12 Pre-assessment

All patients attending the Trust for surgery must have an appropriate level of pre-assessment. This will either be carried out on the day when the DTA is made or will be scheduled by for a minimum of 2 weeks prior to surgery.

If a patient DNAs their pre-assessment appointment their surgery date will be cancelled. The Admission Coordinator will attempt to contact the patient to ascertain the reason for non-attendance and to rebook pre-assessment and surgery within the target date.

If the patient subsequently DNAs pre-assessment again the patient will be discharged unless there is a clinical decision made to offer another date.

The Admission Coordinator will inform the patient’s consultant of the DNA.

If at pre-assessment the decision is made to defer surgery due to the patient not being fit then the surgery date will be cancelled. Where a decision is made to defer or cancel surgery the pre-assessment department will inform the consultant and the relevant admission coordinator. The admission coordinator will be responsible for rebooking the patient where appropriate.

If a patient is cancelled due to not being fit for surgery it is expected that either a plan will be put in place for the patient to be fit for surgery within 6 weeks or that the patient will be referred back to their GP.

The admission coordinator will work with the consultant to ensure that any freed up theatre slots are filled prior to the date.

4.4.13 Cancellations

4.4.13.1 Cancellation of admission dates in advance of surgery

4.4.13.1.1 Cancellation by the hospital

If patients are cancelled by the hospital in advance of surgery the Admission Coordinator will telephone the patient and agree a new date at that time. The new date must be within the relevant target dates.

4.4.13.1.2 Cancellation by the patient

Any patient contacting the trust to cancel their surgery date will be directed to the Admissions Team.

If a patient needs to re-arrange their admission date or Pre-assessment date they will be given the opportunity to agree a new date at the time of the cancellation. If the new date is after the original date this will either pause 18 weeks RTT clock from the earliest reasonable offer date until the patients makes themselves available.

If the patient no longer wishes to have surgery the date will be cancelled and the Admission Coordinator will inform the patient's consultant for a decision to be made on further management e.g. review in Outpatients or discharge.

If a patient persistently rearranges their admission date (3 times or more) or is unsure whether they wish to proceed with surgery the Admission Coordinator will inform the patient's consultant for a decision to be made whether to discharge or review in outpatients.

If a patient is removed from the waiting list for any reason a letter will be sent to the patient and the GP stating this and the reason for removal.

The Admission Coordinator, in liaison with the consultant, will make every effort to ensure that cancelled operation slots are subsequently filled.

4.4.13.2 Cancellations on the day of surgery

There are many reasons why a patient may have their operation cancelled on the day of surgery but these can be broadly grouped into cancellations by the hospital (medical and non-medical) and cancellations by the patient.

When any patient is cancelled on the day of surgery the Theatres department will inform the relevant Admission Coordinator with as much information as possible regarding the reason for the cancellation and the options for rebooking.

The Admissions Team will be responsible for ensuring that patients who have their surgery cancelled are followed up and offered another date.

4.4.13.2.1 Cancellations by the hospital (non-medical)

If a procedure is cancelled by the hospital on the day of surgery for non-medical reasons the patient will go back on to the waiting list and must be offered another date for surgery which must be within 28 days of the original planned date for surgery. Where possible this should be agreed with the patient on the day of their cancellation. Where this is not possible the Admission Coordinator will contact the patient as soon as possible to arrange a new date.

The AGM/Service Manager in the relevant directorate will be responsible for monitoring all non-medical cancellations by the hospital and ensuring that they have dates within the 28 day guarantee.

Where it is not possible to offer a date within 28 days this will be immediately escalated to the General Manager for the relevant Service and the Directorate Nurse Manager who will take further steps to ensure that the patient can be offered a date within 28 days.

If a date cannot be offered at Moorfields within 28 days the trust has an obligation to offer to pay for treatment to be carried out elsewhere.

Every effort will be made to ensure that patients cancelled once, are not cancelled a subsequent time for non-clinical reasons.

The total number of non-clinical, hospital cancellations on the day of surgery must not exceed 0.8% of total admissions.

4.4.13.2.2 Cancellations by the hospital (medical)

Where it is necessary to cancel surgery on the day due to medical reasons a decision should be made regarding the plan for this patient and this should be communicated by the ward to the Admissions Team.

All patients cancelled due to medical reasons must be reviewed by the pre-assessment team.

If the patient is to be rebooked the patient will go back on to the waiting list and the Admission Coordinator will be responsible for rebooking.

If the patient is to be discharged they will be removed from the waiting list and referred back to their GP.

If the patient is to be reviewed in outpatients the Admission Coordinator will book the appointment, update the RTT pathway and remove the patient from the waiting list.

4.4.13.2.3 Cancellations by patient

If a patient cancels their surgery on the day of admission for any reason the consultant will be informed so that a decision can be made whether to offer another date.

The admission coordinator will be informed by theatres of the cancellation and the decision.

If a decision is made to remove the patient from the waiting list, a letter must be sent to the patient and the GP explaining the decision. The RTT pathway and referral closed, the patient discharged and the GP notified.

If the decision is made to offer another date the patient will be returned to the waiting list and another date will be offered. The RTT pathway will be updated by the Admissions Team accordingly.

If the patient subsequently cancels again they should be considered for removal from the waiting list and either discharge or review in outpatients.

4.4.13.2.4 Patients who do not attend (DNA) their surgery date

If on the day of surgery it appears that a patient is not attending the admitting ward will attempt to contact the patient to ascertain whether or not they are coming and the reason for non-attendance.

If a patient does DNA the consultant will be informed and asked to decide whether to offer another date or discharge. The ward will inform the admission coordinator of the DNA and the decision whether to offer another date.

If a patient DNAs their surgery having previously verbally agreed the date the default position is that they will be removed from the waiting list and discharged back to their GP.

Patients who contact the hospital following their DNA appealing to be offered another appointment should be treated sympathetically and reinstated to the waiting list and offered another admission date.

If a decision is made to remove the patient from the waiting list, a letter must be sent to the patient and the GP explaining the decision. The referral and RTT pathway must be closed and the patient discharged from PAS.

4.5 Patients on a cancer pathway

There is number of specific access performance targets related to cancer patients that the Trust will meet:

- Two week maximum wait from ‘Urgent 2WW Suspected Cancer’ GP referral to first outpatient appointment.
- Maximum waiting time of 31 days from diagnosis to treatment for all cancers (excluding BCCs).
- Maximum waiting time of 62 days from urgent GP referral to treatments for all cancers (excluding BCCs).
- Patient’s GP to be informed within 24 hours of a diagnosis of cancer being made.

- Treatments for all cancers including sequential and recurrent cancers (excluding BCCs) will be subject to the 31 day target.
- A consultant will be able to upgrade non-GP referrals to a 62 day pathway where appropriate.

These specific targets require that patients on cancer pathways are managed and monitored in a slightly different way to other patients.

It is Trust policy that urgent suspected cancer patients will be managed in the same way regardless of source of referral.

4.5.1 Urgent suspected cancer referrals

In line with national guidance, all patients referred by their GP with an urgent suspected cancer must be seen within 14 days of the date the referral has been received by the Trust.

Trust policy is that urgent suspected cancer referrals from other sources will also be seen within 14 days.

GP's can refer suspected cancer patients electronically via CAB, by fax either using specific generic referral forms or by bespoke letter.

Where letters are used they must be clearly headed as **"Urgent suspected cancer"** or **"Two week wait referral".**

Urgent cancer referrals should be faxed to the dedicated centralised fax line, located in the Booking Centre, where the referral will be processed. The fax number is 020 7566 2073. Alternatively the form can be uploaded electronically to the Choose & Book 2WW Lid, Orbit & Conjunctiva Triage Service.

Urgent cancer referrals received by any other department must be forwarded immediately to the Outpatient Booking Centre.

All urgent suspected cancer GP referrals received in the Trust will be logged onto the Trust's cancer waiting times database and reported on the weekly cancer PTL.
All urgent cancer GP referrals will be on a 62 day pathway and where treatment is required patients will be offered treatment within 62 days of referral.

4.5.2 31 day target

Any patient in the Trust who is diagnosed with cancer (excluding BCCs) will be treated within 31 days of the 'decision to treat' (DTT) date. Patients who have had a DTT will be entered on to the Trust's cancer waiting times database and monitored through the weekly cancer PTL.

If following a DTT the patient is referred to another organisation, the MDT Coordinator will ensure that a cancer interprovider transfer form is completed and sent to the receiving Trust.

Where the patient is referred before the DTT is made, the patient will not be entered on the waiting times database.

5 Explanation of Terms Used

5.1 Glossary

Choose and Book A method of electronically booking the patient an outpatient appointment at the hospital of their choice.
Decision to Admit date (DTA) The date on which a consultant decides a patient needs to be admitted for an procedure. This date should be recorded in the case notes and used to calculate the total waiting time.
Decision to Treat (DTT) The date on which a decision is made to treat a cancer patient.
Did Not Attend (DNA) Patients who have been informed of their date of admission or pre-assessment (day case admissions) or appointment date (outpatients) and who without notifying the hospital did not attend for admission/ pre-assessment or outpatient appointment.
First Definitive Treatment An intervention intended to manage a patient's disease, condition or injury and avoid further invention. What constitutes First Definitive Treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.
Reasonable Offer For an offer of admission to be deemed reasonable the patient must be verbally offered at least two dates on different days, with at least three weeks notice before the first of these appointments (Department of Health definition of a reasonable offer). Any patient may choose to wait longer than the two dates offered by the hospital; the 18 week RTT clock will be paused from the date of the first offer until the patient makes themselves available.
Referral to Treatment (RTT) The period from the date the patient's referral is received by the Trust, until the start of definitive treatment. The 18 week pathway includes the whole patient pathway from referral to the start of treatment.
TCI (To Come In) date The offer of admission, or TCI date, is a formal offer in writing of a date of admission. A telephone offer of admission should not normally be recorded as a formal offer. Usually telephoned offers are confirmed by a formal written offer.

6 Duties

6.1 Chief Executive Officer

The Chief Executive Officer has overall responsibility to ensure that the Trust has appropriate strategies, policies and procedures in place to ensure the trust continues to work to best practice and complies with all relevant legislation and national guidance.

6.2 Chief Operating Officer

It is the ultimate responsibility of the Chief Operating Officer to ensure that this policy is adhered to and followed within all areas of the organisation.

6.3 Clinical and Service Directors, General Managers (GMs), Assistant General Managers (AGMs)/Service Managers

It is the responsibility of the individual service and directorate managers, reporting to the Service Directors, the Clinical Directors and ultimately the Chief Operating Officer, to ensure that the appropriate levels of training, awareness and governance are in place to ensure that the policy is followed.

The Assistant General Managers/Service Managers are responsible for finding or creating additional capacity as required, to ensure that patients are given suitable outpatient appointments, diagnostic tests or results, or admission dates to prevent breaches of the national targets. Any capacity issues affecting the Trust's ability to meet national targets must be escalated to the General Manager.

The General Managers are ultimately responsible for the delivery of the clinical services and should be aware of all their patients that will breach national targets.

6.4 Administrative and secretarial staff, clinical staff

All staff who are directly or indirectly involved with patients receiving appointments for, managing waiting lists for, or seeing patients in, outpatient clinics, diagnostic tests or surgical procedures are responsible for ensuring that they have received the appropriate training and are familiar with the contents of the access policy. They are responsible for informing their manager of any concerns regarding patient acces and ensuring that incidents associated with access are promptly reported in line with the Trust incident reporting policy as appropriate.

7 Training

7.1 PAS training including refresher training programme for existing staff
Essential Communications training.

8 Stakeholder Engagement and Communication

8.1 The policy is sent to all AGMs, Service Managers, GMs, Clinical Directors, Chief Operating Officer, Medical Director and Clinical Director for Quality and Safety.

9 Approval and Ratification

9.1 The policy is sent to the Clinical Governance Committee for approval and the Trust Management Board for ratification.

10 Dissemination and Implementation

10.1 Once ratified, the policy will be uploaded onto the Trust intranet to ensure all staff are able to access the policy at all times.

10.2 All staff will be notified of the new policy via the Trust weekly communications letter. General managers/ Deputy General managers/ AGMs/Service Managers are responsible for disseminating the policy to their administrative teams and effecting its

implementation within these teams. Clinical Directors and Medical Director are responsible for disseminating the new policy to the medical teams.

11 Review and Revision Arrangements

11.1 The policy will be reviewed every 2 years

11.2 The policy may be reviewed earlier than this if new guidance is issued or additions must be inserted following Trust findings.

12 Document Control and Archiving

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

12.2 Previously approved versions of this document will be removed from the intranet by the Risk & Safety team and archived on the corporate governance shared drive. Any requests for retrieval of archived documents must be directed to the Risk and Safety team.

13 Monitoring compliance with this Policy

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

Measurable Policy Objective	Monitoring/ Audit method	Frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to which groups/ committees, inc responsibility for reviewing action plans
No patients will be lost to follow up	Weekly report on 'Lost to Follow Up' patients	Weekly	AGMs/Service Managers with service administrators	Performance meeting (weekly)
% of patients treated within 18 weeks of referral	18 week breach report	Weekly	AGM/Service Managers, Booking Centre Manager	Performance meeting (weekly)

14 Supporting References / Evidence Base

Department of Health Policy document *"Tackling hospital waiting: the 18 Week patient pathway, an implementation framework "* (Gateway reference 6468)
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4134669.pdf

Department of Health – *The 18 week Rules Suite*
http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ReferraltoTreatmentstatistics/DH_089757
Department of Health – *The NHS Constitution for England 2012*
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132958.pdf

15 Supporting Documents

Supporting Documents/References	**Owner**
Uveitis discharge protocol (June 2012)	Carlos Pavesio, Medical Retina (MR) + Uveitis (UV) Service Director

Appendix 1 - 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.

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Gender reassignment	No	
	• Culture	No	
	• Pregnancy and maternity	No	
	• Marriage and civil partnership	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability (e.g. physical, sensory or learning)	No	
	• Mental health	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4.	Is the impact of the policy/guidance likely to be negative?	No	
5.	If so can the impact be avoided?	No	
6.	What alternatives are there to achieving the policy/guidance without the impact?	None	
7.	Can the impact be reduced by taking different action?	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 2 -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, Booking and Choice Policy

Policy (document) Author: M. Reinink, A. Flynn, A. Davis

Policy (document) Owner: Ruth Russell

		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)?	See comments	Clinical Governance Committee Management Executive Declan Flanagan Melanie Hingorani Alex Baldwin Amelia Price Alison Davis
	Has the policy template been followed (i.e. is the format correct)?	Yes	
4.	**Evidence Base**		

		Yes/No/ Unsure/NA	Comments
	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	
	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	
8.	**Review Date**		
	Is the review date identified and is this acceptable?	Yes	
9.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Yes	
10.	**Equality Impact Assessment (EIA)**		
	Has a suitable EIA been completed?	Yes	

Committee Approval (Clinical Governance Committee)

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	Clinical Governance Committee Meeting 22nd

		Yes/No/ Unsure/NA	Comments
			January 2013 Ammendments agreed 09th.February 2013
Ratification by Management Executive (if appropriate)			
If the Management Executive is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner			
Date: 19 February 2013			

Appendix 3 - Policy Applicability to Trust sites

This document applies to premises occupied by Trust staff/activities, as outlined below:

Site	Applicable (yes/no)
Arthur Steele Unit	No
Bedford	Yes
City Road	Yes
Community clinics	Yes
Ealing	Yes
Ebenezer Street	No
Homerton	Yes
John Saunders Suite/Cayton Street	No
Loxford	Yes
Mayday	Yes
Mile End	Yes
Moorfields Pharmaceuticals	No
Northwick Park	Yes
Potters Bar	Yes
Provost Street	No
RDCEC	Yes
St Ann's	Yes
St George's	Yes
Barking	Yes
Upper Wimpole Street	No
Watford	Yes

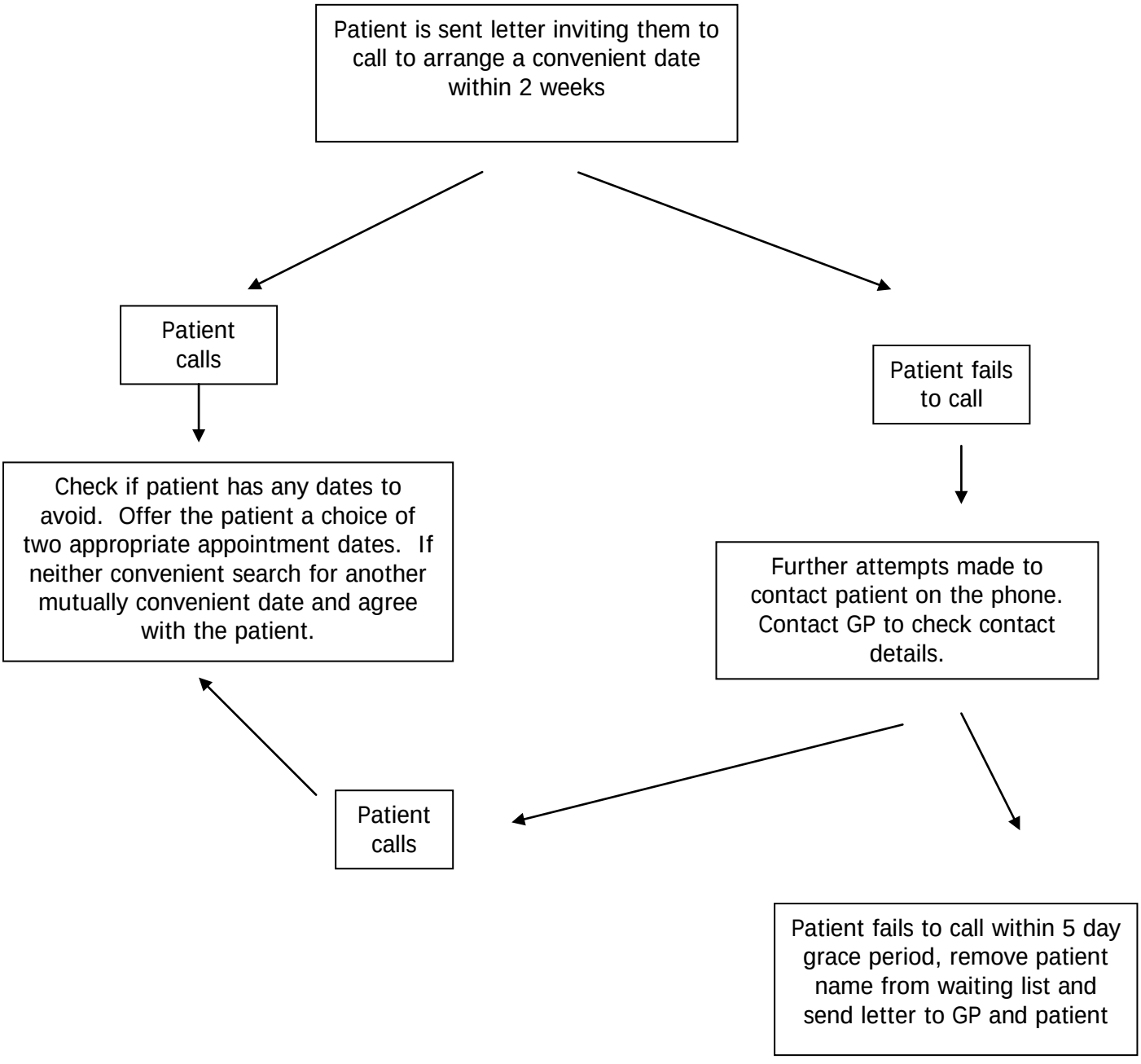
Where the list indicates that the policy does not apply, this implies that the Trust will adhere to the policy of the host. Where a query exists then this must be referred, in the first instance, to either the:

- SDU general/Directorate/nurse manager
- Policy owner
- Accountable director
- Service director

Moorfields Dubai will adhere to their own local policies and procedures and Trustwide documents will not apply unless explicitly stated otherwise.

Appendix 4 – Partial Booking process

When it is not possible to contact a patient by telephone to book an outpatient appointment or admission date it will be necessary to follow a partial booking process. It is the responsibility of the relevant Booking Centre manager to ensure that all patients following a partial booking process are regularly reviewed.



Appendix 5 - Internal targets – administrative staff training and performance

The following internal targets will apply

- All new administrative staff should be trained to PAS level 2 at induction. All temporary administrative staff should be trained to level 2 PAS training within 2 weeks of joining the Trust and should be closely supervised until this training has taken place.
- All administrative staff should attend any PAS training updates and this will be documented in the appraisal process as part of the mandatory training requirements.This will be a requirement for passing through the KSF gates. The Trust will ensure time and resources are available for updates to take place
- Senior service administrators and AGM should review the patients with no known outcomes each week and action should be taken to confirm follow up arrangements are in place within 2 weeks.
- Lost to follow up figures will be presented as part of clinical directorate monthly scorecard. If a patient is identified as being on the 'lost to follow' up list for more than 4 weeks this should be considered as a potential clinical incident. The AGM/Service Manager must discuss with the consultant and clinic administrator whether or not this is a valid clinical reason for the patients unknown outcome and an urgent action plan should be drawn up by the AGM/Service Manager. This may include reporting a clinical incident.

Appendix 6 - Exceptional circumstances preventing patient discharge from services

Paediatric Service

Children are dependent on parents or carers to attend appointments and special consideration should be given to their case before discharge. For paediatric DNAs 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 patients' parents to see if the condition has resolved prior to booking another appointment. If a child DNAs two consecutive appointments, consideration should be made to writing an individualised letter to the GP and carers as to the risks of failing to attend, the further management plan, and to highlight any safeguarding concerns; and where concerns exist on the medial implications of failing to attend, to also make attempts to contact the family by telephone by the clinic clerk.

For all child DNA's regardless of service, consideration should be given to the possible need to follow child protection pathways and if in doubt, the named nurse for paediatric safeguarding should be contacted.

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

Glaucoma

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

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.

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 under Supporting Documents). The exceptions that apply for the Medical Retinal service with regards to this 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 of the diabetic screening patients are correct in the notes and the PAS system. Diabetic screening patients who fail to attend for their appointments are currently sent back to their local diabetic screening service which will potentially delay the treatment of their ocular condition. Therefore, at the discretion of the scrutinising clinician, diabetic screening patients may be offered further follow up appointments.

Vitreoretinal

No exceptions reported for this service.

Adnexal

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 reattendances 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 followup appointment, will be discharged. However for high risk patients (e.g. thyroid eye disease patients, tumour patients, 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.

Neuro-ophthalmology

Exceptions are at the discretion of the scrutinising clinician.

Urgent suspected cancer patients

If an ‘Urgent Suspected Cancer’ patient cancels or DNAs he/she should be offered another appointment within 14 days. Every effort should be made to contact the patient to rearrange another appointment as soon as possible.

In instances where the patient cannot to contacted, the referring GP should be contacted to check the patient contact details.