University Hospitals Coventry and Warwickshire NHS Trust

PATIENT ACCESS POLICY	
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Date Approved by Trust Board *(if Applicable)*	N/A
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Title of Relevant Director:	Chief Operating Officer
Target audience:	Referrers, Patients, Commissioners and All Staff
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This Trust-wide CBR has been developed / reviewed in accordance with the Trust approved ***'Development & Management of Trust-wide Corporate Business Records Procedure (Clinical and Non-clinical strategies, policies and procedures)'***	Version **9.0**

Summary of Trust-wide CBR: *(Brief summary of the Trust-wide Corporate Business Record)*	Policy covering the way in which University Hospitals Coventry & Warwickshire NHS Trust will manage administration for patients who are waiting for or undergoing treatment on an admitted, non-admitted or diagnostic pathway
Purpose of Trust-wide CBR: *(Purpose of the Corporate Business Record)*	To provide staff with a clear understanding of their roles, responsibilities and procedures which support this policy
Trust-wide CBR to be read in conjunction with: *(State overarching/underpinning Trust approved CBRs)*	N/A
Relevance: *(State one of the following: Governance, Human Resource, Finance, Clinical, ICT, Health & Safety, Operational)*	Operational
Superseded Trust-wide CBRs (if applicable): *(Should this CBR completely override a previously approved Trust-wide CBR, please state full title and eLibrary reference number and the CBR will be removed from eLibrary)*	Patient Access Policy V2.0

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Department/Specialty:	Patient Access

CHANGE CONTROL

Revision Date	Section Title	Page Numbers	Summary of Changes

Version	Title of Trust Committee/Forum/Body/Group consulted during the development stages of this Trust-wide CBR	Date
0.4	LHC Consultation Group	12.12.08
0.5	Directors of Ops, General Managers and Admin Managers Review	07.01.09
0.5	LHC Consultation Group	07.01.09
0.5	Medical Director/Clinical Leads	08.01.09
2.0	Patient Access Team, Dendrite System Manager, Lead Nurse for Safeguarding Children	28.02.11

2.0	UHCW Chief Operating Officer, Directors of Ops, General Managers	20.04.11
2.0	Coventry PCT and Warwickshire PCT representatives	20.04.11
3.0	Chief Operating Officer	28.07.16
3.0	Patients Access Team, Clinical Leads, Group Managers and Associate Group Managers	11.08.16
3.0	UHCW Quality Governance Committee	23.08.16
3.0	CCG CDG	23.08.16

1.0 INTRODUCTION

This policy covers the way in which University Hospitals Coventry & Warwickshire NHS Trust manages the administration of patients who are waiting for or undergoing treatment on an admitted, non-admitted or diagnostic pathway. The focus of the policy is on fair, equal and timely access to treatment for patients based on clinical urgency, as well as compliance with national waiting times. It is supported by a reference guide for all staff administering patient pathways called the Patient Access Policy – Standard Operating Procedures.

2.0 POLICY STATEMENT

2.1 The Principles of the Policy are as follows:

- Every administrative process in the management of patients who are waiting for treatment must be clear and transparent to the patients and to partner organisations and must be open to inspection, monitoring and audit.
- The Trust will give priority to clinically urgent patients treating everyone else in order of waiting time and pathway complexity, allowing for the need to use resources effectively
- The Trust will work to meet and improve the maximum waiting times set by the Department of Health for all groups of patients.
- The Trust will at all times negotiate appointment and admission dates and times with patients.
- The Trust will work to ensure fair and equal access to services for all patients.
- The Trust will ensure that all policies, procedures and performance information will be made widely available, including to the general public (unless there is a specific reason for restricted availability).
- The Trust will ensure that an appropriate training programme is in place which supports all levels of staff on an ongoing basis with special regard given to newly recruited staff. All staff involved in the implementation of this policy, clinical and clerical will undertake training and regular updating. Policy adherence will be part of the administrative staff appraisal process.
- The Trust will ensure that Information Management of all waiting lists and activity is recorded on an appropriate electronic system.

- Monitoring of achievement of standards associated with procedures in this policy will be via the Trust's Admin Academy Dashboard.
- Although described as the 'Referring Clinician' throughout the document, this may be any health care professional with referring rights, eg GP, Nurse Specialist, Consultant or Allied Health Professional.
- For cancer pathways please refer to the Cancer Access Policy
- Prior to referral on to an 18 week pathway GP's must establish that patients are ready and available to receive treatment within this timeframe.
- We will ensure that children and vulnerable adults are not disadvantaged by application of the policy. Patients with a health condition that affects communication with them, such as dementia, learning disabilities or deafness will be clearly identified wherever possible and their pathways managed appropriately.

Patient safety is our first priority. The policy is not intended to override clinical judgement and all staff are expected to make decisions based on the best interests of patients.

3.0 DEFINITIONS

3.1 OUTPATIENTS

Patients referred by a General Practitioner, General Dental Practitioner or any other care professional permitted to refer for clinical advice or treatment.

DNA - Patients, who have been informed of either their admission date or appointment date and who, without notifying the hospital, do not attend.

External Referral - External referrals are used to record a new referral from outside the Trust. This will include all other NHS Trusts, Private Sector, Primary Care, Social and Educational Services.

GDP – General Dental Practitioner

GP – General Medical Practitioner

Internal Referral - Internal referrals are used for any referral between care professionals within the Trust. This is primarily used when patients require specialist treatment in another specialty or by another clinician within the same specialty for specialist opinion.

NHS E-Referrals - Is an electronic referral programme that GP's use to refer patients into the Trust.

Non-Admitted Pathway - A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment' mainly in an outpatient setting.

Outpatient procedure - Patients who require a procedure but do not require a hospital bed or recovery following the procedure.

Outpatient Waiting list - An Outpatient Waiting list is a record of patients waiting for a new outpatient appointment. This includes new GP referrals and other referrals into consultant led services. The organisation of the waiting list helps the regular review and assessment of patients waiting for a New outpatient appointment.

Pre-Booking Fully Booked - The patient is given the choice of when to attend. For full booking the patient is given the opportunity to agree a date at the time of, or within one working day of, the referral or decision to treat. The patient may choose to agree the date when initially offered, or defer their decision until later.

Pre-Booking Partial Booked - The patient is given the choice of when to attend. For partial booking the patient is advised of the total indicative waiting time during the consultation between themselves and the health care provider/practitioner. The patient is able to choose and confirm their appointment or admission approximately six weeks in advance of their appointment or admission date.

Referral - A referral is when a request is made for a patient to be seen in a consultant led service for advice, consultation, investigation or treatment.

Referring Clinician – This can be a health care professional with referring rights, eg GP, Nurse Specialist, Consultant or Allied Health Professional.

3.2 INPATIENTS

Patients who require admission to hospital for treatment

Admitted Pathway - A pathway that ends in a clock stop for admission for treatment (day case or inpatient).

Day Case - Patients, who require admission to hospital for treatment, who require the use of a bed but are not expected to stay in hospital overnight.

DNA - Patients, who have been informed of either their admission date or appointment date and who, without notifying the hospital, do not attend.

Elective Booked - Patients awaiting elective admission who have been given an admission date which was arranged at the clinic at the time of decision to admit. These patients form part of the active waiting list.

Elective Planned - Patients who are to be readmitted as part of a planned sequence of treatment or investigation. They may or may not have been given a TCI date.

Elective Waiting List - Patients awaiting elective admission for treatment and are currently available to be called for admission.

Original Date on List - The date of the original decision to admit a patient to a Healthcare Provider for a given condition which results in the patient being placed on an elective waiting list.

Patient Initiated Delays - Patients who, on receipt of offer(s) of admission, notify the hospital that they are unable to come in. Patients who on receipt of a written or verbal offer to attend outpatients notify the hospital that they are unable to accept the offer.

RTT - Referral to Treatment – the overall waiting time a patient has between these two points

Suspension – PAS function to enable periods of patient unavailability to be recorded to enable waiting list management.

4.0 ROLES, RESPONSIBILITIES, ESCALATION & ACCOUNTABILITY

4.1 Committees

- Senior Access Meeting is responsible for the implementation of the policy and for ensuring that processes are in place at specialty level to monitor and manage adherence to the Policy. The Group will review the Policy at regular intervals to ensure that it reflects local and national guidance.
- Data Quality is responsible for the monitoring of adherence to the Data Quality policy. The specialties are responsible for data quality in line with data quality policy and standards.

4.2 Individual Officers

- The Chief Executive is ultimately accountable for the delivery of the national access targets.
- The Chief Operating Officer has delegated responsibility for ensuring that robust systems and processes are in place to support the achievement of the access targets and that there is accurate reporting both internally and

externally.

- The Director of ICT has responsibility for ensuring that there are effective systems in place to enable the Groups to collect data accurately
- Senior Director of Performance & Programme Management is responsible for the reporting of information and support the accurate monitoring and reporting of waiting list and performance against access targets
- Clinical Directors & Group Managers are responsible for ensuring that waiting lists are managed appropriately within their Group. It is the responsibility of Groups to ensure that their patients are managed in accordance with this policy and the procedural guidelines which underpin it. The clinical management of individual patients on the waiting lists is the responsibility of the Clinician in charge of the patients care.
- Administration Staff are responsible for the day to day management of patient pathways and adherence to the policy ensuring compliance with Trust processes, procedures and administration tools.
- UHCW expects patients to take responsibility for their health and wellbeing which includes being registered with a GP, keep appointments or cancel within reasonable time (The NHS Constitution – Patients & The Public – your responsibilities)

5.0 DETAILS OF POLICY

All patients have the legal right to start non-emergency NHS consultant-led treatment within a maximum of 18 weeks from point of referral, unless the patient chooses to wait longer or it is clinically appropriate to wait longer. Where it is not possible to treat within maximum wait times we will take all reasonable steps to offer a range of suitable alternative providers. The NHS Constitution[5&6] sets out patients legal rights to receive first definitive treatment within 18 weeks.

5.1 Patient Choice

Patients have the legal right to choose the provider (Trust) and consultant-led team for his or her first outpatient appointment. Patients may be offered the choice of an earlier appointment with another consultant-led team but, if a patient turns down this offer, their RTT pathway will continue and no adjustments can be applied.

UHCW offers services across 2 sites and patients will be offered treatment at either site in accordance with clinical appropriateness and resource availability.

5.2 Primary Care Commissioning Policies

The Trust will support all agreed Commissioner Treatment policies, both in terms of the application of any eligibility criteria and any commissioner requirements for Prior Approval contained within those policies (e.g. Low Priority Procedure Policies, Clinical Thresholds, Prior Approval processes and Individual Funding Request processes). Policy documents can be found at www.coventryand rugbyccg.nhs.uk

The Trust will make reasonable efforts to support initiatives introduced by Primary Care Commissioners to manage levels of activity and will provide feedback to commissioners with regard to any significant areas of inappropriate referral.

6.0 SPECIAL PATIENT GROUPS

6.1 Safeguarding Children, Young People and Vulnerable Adults

It is essential that we recognise our responsibility to ensure the safety and welfare of children and vulnerable patients and identify these at the point of referral.

Patients must be provided with communications in the appropriate format to access services.

When safeguarding issues are identified Trust procedures must be followed. Refer to the Trusts Safeguarding Vulnerable Adult Policy, Local Guidance Referral Pathway and Paediatric DNA policy.

6.2 Priority Treatment for War Veterans[1]

If a patient is a war veteran and the condition they are referred with is related to their military service, they will be entitled to priority treatment. The referrer must clearly indicate this at point of referral.

These patients will not take priority over other patients with a higher clinical priority.

6.3 Patients transferring to NHS from Private care

Patients can transfer their status from private to NHS within the guidelines identified in the Department of Health Guidance, A Code of Conduct for Private Practice[2]. Professional fees. Patients will not be charged once they have been transferred to NHS status. The Trust will ensure that a private patient transferring to become a

NHS patient will gain no advantage over other NHS patients. The RTT clock will start at the point at which the clinical responsibility for the patients care transfers to the NHS which is the date the NHS Trust accepts the referral for the patient.

If first definitive treatment has already started or been given, then a referral from private to NHS care would not start an RTT pathway unless the patients requires a substantially new course of treatment in which case the clock would start at the point clinical responsibility for the patient is accepted.

The RTT clock stops for patients who choose to leave NHS funded care to fund their own care in the private sector. The clock stops on the date that the patient informs the provider of their decision.

6.4 Overseas Patients Entitlement to NHS Treatment

The Trust has a legal obligation to identify patients who are not eligible for free NHS treatment. The National Health Service provide healthcare for people who live in the United Kingdom. People who do not normally live in this country are not automatically entitled to use the NHS free of charge – regardless of nationality or whether they hold a British Passport or have lived and paid National Insurance contributions and taxes in this country in the past.

All NHS Trusts have legal obligation to:

- Ensure that patients who are not ordinarily resident in the UK are identified
- Assess liability for charges in accordance with the Department of Health Overseas Visitors Regulations
- Charge those liable to pay in accordance with Department of Health Overseas Visitors Regulations

Patient eligibility will be checked at first attendance at the Trust.

(See Overseas Patients: Information About Hospital Treatment for Overseas Visitors Policy)

7.0 OUTPATIENTS (Non-Admitted Pathway)

7.1 Referrals

The referral vetting process will be a locally agreed process within the specialty depending on the clinical priority and/or inappropriate referrals. The Clinician or nominee will determine if the referral is appropriate.

Any inappropriate referrals including those that do not meet agreed criteria will be

rejected and returned to the referrer with a clear explanation or will be forwarded on to the appropriate specialty.

There are 5 recognised referral streams:

7.1.2 NHS E-Referrals

Wherever possible, patients should be referred via NHS E-Referrals.

Each specialty should maintain their Directory of Service within NHS E-Referral reviewing on an annual basis in conjunction with the leads of the service.

7.1.3 Non-NHS E-Referrals (External Paper referrals)
Paper referrals received into the Trust will be accepted and offered appointments equitably in line with referrals received by NHS E-Referrals

7.1.4 Cancer Referrals
For Cancer Referrals please refer to the Cancer Access Policy.

7.1.5 IPTs (Inter-Provider Transfers)
If a patient is transferred from a Consultant in one provider to a Consultant in another provider for the same condition this is known as an Inter Provider Transfer (IPT). This also includes patients referred from a Clinical Assessment Service (CAS). The referrals are managed in line with the Inter-Provider Transfer process which ensures the patients RTT pathway transfers with them together with all necessary information.

7.1.6 Internal Referrals
An Internal referral will be created for patients referred to another clinical team as part of an agreed pathway of care. The patient and GP will be informed of the referral mechanism and reason for referral and a discussion will take place with the patient regarding options in terms of choice of provider.

Internal referrals should not be created for routine patients requiring referral to another clinical team after being seen for an unrelated condition (e.g. patient referred with a joint complaint and following clinical assessment a dermatological condition is noted). The patient should be referred back to the GP/GDP to enable them to make

any decisions regarding further management including the possibility of onward referral.

7.2 Outpatient Appointments

7.2.1 Reasonable Notice

UHCW aims to provide all patients with reasonable notice of appointments of at least three weeks' notice where possible. However shorter notice with be given if appropriate due to clinical priority.

Appointments booked by patients via NHS E-referrals are considered reasonable notice due to this being patient choice.

Patients will be scheduled a follow-up in accordance with clinical instructions within a specific timeframe.

7.2.1.1 Unable to Make Contact

Where the patient does not respond to letters or phone calls, (ie. Contact attempted for at least a week with two phones calls in working hours plus one out of hours, or they do not respond to a contact letter within two weeks of the letter date), then it is assumed that the patient is not fulfilling their obligation to make themselves available for appointments and they may be discharged back to their GP if clinically appropriate.

7.3 Outpatient Appointment Cancellations/DNA

7.3.1 Patient Appointment Cancellations

Patients who cancel an agreed outpatient appointment will be offered a second appointment by contacting UHCW or booking online. If a patient cancels an appointment date for the second time a clinical review should be undertaken which could lead to discharge back to the GP but should be based on the individual patient's best clinical interest. All referrals back to a GP should be a clinical decision based on the patient's best clinical interest.

7.3.2 Hospital Appointment Cancellations

UHCW aims where possible to avoid hospital appointment cancellations. However if

unavoidable we will reschedule with choice where possible and provide an alternative appointment aiming to avoid any further delays in the patients pathway.

7.3.3 Outpatient DNAs (Did Not Attend) with the exception of:
Paediatrics patients 18 years and under (refer to Paediatric DNA policy)
Two Week Wait Referral patients (refer to Cancer Access Policy)

A DNA is where a patient fails to attend without prior notice.

7.3.3.1 New Patient DNA – If the patient fails to attend their first appointment following referral the pathway is nullified as effectively, the patient has chosen not to start their pathway. The patient will be referred back to their GP unless the Clinician feels it's appropriate to offer the patient a new appointment, then a new RTT pathway will start on the date that the patient agreed the new appointment date.

7.3.3.2 Follow-up DNA – Patients who DNA a follow up appointment whilst still on an RTT pathway will be discharged from the Clinicians care and returned to the GP unless following clinical review of the notes a further appointment is required on clinical grounds.

Patient should only be discharged back to their GP if the appointment was clearly communicated to the patient and/or discharging the patient is not contrary to their best clinical interests.

Any further appointments made following a DNA must be verbally agreed with the patient to avoid a further failure to attend. The patient's pathway will continue with no adjustments.

7.4 Diagnostics (Non-admitted & Admitted Pathway)
Diagnostic services form part of the RTT pathway. All referrals received within the diagnostic departments need to be seen within the current diagnostic waiting time.

Where a patient is referred for a diagnostic to take place in an outpatient or inpatient setting as part of an RTT pathway, the outpatient/inpatient section of the policy must be adhered to in terms of patient booking, cancellation and DNA's .

Diagnostic reporting turnaround times should not be exceeded.

7.5 Treatment that did not form part of original treatment plan
Where further (substantively new or different) treatment may be required that did not form part of the patient's original treatment plan, a new RTT pathway should start. This will include situations where less intensive treatment has failed and more aggressive treatment is necessary for the same condition (if additional treatment did not form part of the patient's agreed care plan).

A new pathway will start at the point the subsequent decision to treat is made and communicated to the patient. However if a patient is referred for diagnostics or specialist opinion with a view to treatment it may be more appropriate to start the RTT pathway at this point (onward referral date).

8.0 INPATIENTS AND DAYCASES (Admitted Pathway)

8.1 Listing of Patients

Patient's who are clinically fit and able to proceed with their admission, will be added to the admitted waiting list. (see Royal College Guidelines).

All patients who require surgery must have an E-Waiting List Card created by the Clinician listing them for surgery.

Patients requiring Low Priority Approval must be listed on the Inpatient Waiting List subject to the approval decision the patients RTT pathway continues.

All patients for elective treatment must be placed on the appropriate waiting list on PAS and Theatre system within 24 hours of their E-Waiting List being marked 'Ready for Listing' or 'Remove by Pre-Operative Assessment'.

8.1.1 Elective Planned

Patients requiring a treatment or set of treatments at intervals or require treatment at a specific point eg. age related should be listed on the planned list. Any patient's who do not receive treatment within the planned timescale will become an active RTT

pathway.

8.1.2 When Patients Should NOT Be Listed for Surgery

Patients who need investigations to confirm that surgery is required should not be added to the waiting list until the investigation results are known and the decision to treat is taken.

Patients should not be listed when there is no serious intention to admit the patient or agreement by the patient to have the operation.

Patients should not be listed for a procedure that has not been commissioned by Primary Care eg. reversal or sterilisation – these referrals should be sent back to the GP)

8.1.3 Patient “Thinking Time”

When a patient has been informed about their proposed treatment, particularly if this treatment is invasive, it is not unusual for them to seek “thinking time”. If thinking time (up to 5 working days) is short it would be unreasonable to stop the patients RTT pathway.

If the ‘thinking time’ required delays delivery of the patient’s care, active monitoring may be more appropriate and this will stop the RTT pathway. A new RTT period will start on the date the patient communicates to the consultant that they now wish to proceed with their treatment plan.

When a patient indicates they no longer wish to proceed the patient RTT pathway will stop. The PAS system must be updated with a clear auditable record of the discussions held.

8.1.4 Bilateral/ multi staged surgery

A bilateral procedure is a procedure that is performed on both sides of the body at matching anatomical sites. Examples include hip, knee replacement or cataract surgery. Bilateral procedures have a separate RTT period for each procedure. The RTT clock for the first consultant-led bilateral procedure will stop once the first procedure is completed. A new RTT period will begin once the patient is fit and ready

for the second consultant-led bilateral procedure.

8.2 Pre-Operative Assessment

The Pre-Operative Assessment service will aim to see all adult patients (16 years and over) requiring a general anaesthetic, on the day of the decision to list for surgery. If this is not possible the patient will be contacted and an appropriate appointment arranged. For patients to proceed with surgery they must have been passed fit in pre-operative assessment within the last 6 months and have had MRSA screening.

8.2.1 Patients requiring multiple tests prior to being declared fit

There will be some patients who may require multiple tests eg. ECG, prior to being classed as fit. These patients will be moved onto the Pre-Operative Assessment deferred list whilst awaiting results for a maximum of 28 days. When the results become available and the patient is deemed fit for surgery, the Pre-Operative Assessment nurse will update the E-Waiting list card with the appropriate status.

8.2.2 Patients informing us of unavailability at the time of Pre-Operative Assessment

A Pre-Operative Assessment is valid for 6 months therefore if a patient is unavailable for a period of less than 3 months the assessment should continue and be completed. All periods of unavailability should be recorded within the E-Waiting List.

8.2.3 Patient DNA in Pre-Operative Assessment

If the patient DNA's the agreed appointment date they should be contacted by Pre-Operative Assessment and given another appointment. If the patient should DNA again the E-Waiting List Card should be updated as 'removed' and submitted to the scheduler for clinical review and decision regarding discharge.

8.2.4 Unfit Patients identified in Pre-Operative Assessment

Patients deemed unfit in Pre-Operative Assessment will be monitored for 28 days within the service and their status maintained. In some cases this will mean that the patient may not proceed with surgery.

8.3 Medically Unfit Patients

8.3.1 Long Term Medically Unfit

Long term medically unfit patients, are those patients who are medically unfit for a period which exceeds 28 days. When a patient contacts us to notify us of a condition which will make them medically unfit to proceed with their surgery we need to ascertain the likely nature and duration of time that they will be unable to proceed for. A clinical review will need to be obtained to understand if the patient should be actively monitored by the Clinician or returned to the patients GP for ongoing care. The patient's pathway will stop during this period of time.

Another example of this is when a patient is seen in an outpatient appointment and it's established that they need to lose weight or stop smoking prior to proceeding with surgery. In this scenario the patient should not be listed and their clock stopped placing them in active monitoring until they are fit to proceed.

If a decision is made to refer the patient back to the GP and the GP subsequently deems the patient to be fit they must make contact with the Clinician for a decision to be made as to whether the patient can be referred directly back to Pre-Operative Assessment or requires a clinical review in Outpatients.

8.3.2 Short Term Medically Unfit

Short Term Medically Unfit patients, are those patients who are deemed fit within 28 days and have a short self limiting illness eg. cold, urine infection. The RTT pathway of patients deemed short term medically unfit should continue.

8.4 Reasonable Notice

UHCW aims to provide all patients with reasonable notice of TCI dates of at least three weeks where possible.

Patients must be dated in order of clinical priority then in accordance with RTT wait time or other relevant standard ie; diagnostic.

8.4.1 Patient Initiated Delays

Patients who wish to delay their wait for a period of time may be subject to a clinical review of their pathway to ensure effective care management. This could result in a

clinical decision to continue consultant care or refer back to the original referrer eg; GP.

Patients who cancel any hospital admissions/appointments on multiple occasions are also subject to the above clinical review to ensure effective care management of their condition.

No blanket rules should be applied to the maximum length of a patient-initiated delay that does not take into account individual patient circumstances.

8.4.2 Patient TCI Date Cancellations

Patients who cancel an agreed TCI date will be offered a second TCI admission date. If a patient cancels a TCI date for the second time a clinical review should be undertaken which could lead to discharge back to the GP but should be based on the individual patient's best clinical interest. Referrals back to a GP should be a clinical decision based on the patient's best clinical interest.

8.4.3 Inpatient / Day case – DNAs (Did Not Attends) (See Appendix A12)

8.4.3.1 DNA – Routine Admission

The patient will be discharged back to their GP unless following clinical review of the notes the Clinician requests a further date on clinical grounds.

8.4.3.2 DNA – Urgent Admission (including cancer)

The patient will be contacted by telephone or letter to arrange a further date and will only be discharged back to their GP if all efforts have been exhausted to contact the patient.

For a patient to be discharged they must have been given reasonable notice of their TCI admission date and this won't represent a clinical risk. The patient's notes must be reviewed by the clinical team.

8.3.4 Hospital initiated cancellations of admissions

The Trust makes every effort not to cancel agreed admissions dates for non-clinical reasons. If a patient's operation (including day cases) has been cancelled at the 'last minute', defined as: on the day of admission, after the patient has arrived in hospital

or on the day of operation for non clinical reasons. This must be recorded as a hospital cancellation and the patient's length of wait will not be affected.

Patients cancelled at the last minute by the Trust, should be offered a new date and treated within 28 calendar days of the last minute cancellation. (2014/15 NHS Standard Contract, NHS England)[10]

8.5 Clinical Validation

The scheduler/waiting list manager will bring to the clinician's attention to all patients waiting over 32 weeks to validate the clinical need for surgery with a view to possible outpatient appointment or GP review if clinically indicated. If surgery is to proceed, the pre-operative assessment must remain valid; if not a further appointment is to be arranged. Clinical validation review updates must be auditable within the inpatient waiting list general comments in the PAS system.

9.0 POLICY REVIEW, AWARENESS AND TRAINING

9.1 Patient Access Policy Review

The Patient Access Policy will be reviewed on a bi-annual basis to take account of any changes in national guidance / new directives.

9.2 Training

Specialties must arrange staff contextual RTT training with the Patient Access Team for new starters and regular refresher training for existing members of staff.

10.0 DISSEMINATION AND IMPLEMENTATION

10.1 An initial introduction to the Patient Access Policy will form part of the Admin Academy Induction. The individual line manager of the new staff member is responsible for ensuring the staff member understands and adheres to this policy

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11.0 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

11.1 Monitoring Table

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual department responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed
Achievement of standards associated with procedures	Trust's Admin Academy Dashboard	Performance & Programme Management Office	On-going	Patient Access Team / Divisions and Specialties	All Groups / Specialties
RTT / Activity Monitoring	PPMO reports & central returns	Performance & Programme Management Office	On-going	Department of Health	All Groups / Specialties

12.0 STAFF COMPLIANCE STATEMENT

All staff must comply with this Trust-wide Corporate Business Record and failure to do so may be considered a disciplinary matter leading to action being taken under the Trusts Disciplinary Procedure. Actions which constitute breach of confidence, fraud, misuse of NHS resources or illegal activity will be treated as serious misconduct and may result in dismissal from employment and may in addition lead to other legal action against the individual/s concerned.

A copy of the Trust's Disciplinary & Appeals Procedure is available from eLibrary.

13.0 EQUALITY & DIVERSITY STATEMENT

Throughout its activities, the Trust will seek to treat all people equally and fairly. This includes those seeking and using the services, employees and potential employees. No-one will receive less favourable treatment on the grounds of sex/gender (including Trans People), disability, marital status, race/colour/ethnicity/nationality, sexual orientation, age, social status, their trade union activities, religion/beliefs or caring responsibilities nor will they be disadvantaged by conditions or requirements which cannot be shown to be justifiable. All staff, whether part time, full-time, temporary, job share or voluntary; service users and partners will be treated fairly and with dignity and respect.

14.0 REFERENCES AND BIBLIOGRAPHY

1. Access to Health Services for Military Veterans, Guidance, Department of Health, Gateway Reference 9222 (2007)

2. A Code of Conduct for Private Practice, Guidance, Department of Health (2004)

3. Everyone Counts Planning for patients 2013/14
http://www.england.nhs.uk/everyonecounts/

4. Equality and excellence: Liberating the NHS, White Paper, Department of Health, Gateway Reference 14385 (2010)

5. NHS Constitution 2013 Gateway Reference 2900013 March 2013
http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

6. The Handbook to the NHS Constitution for England, Department of Health, Gateway Reference 2900877 March 2013
http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

7. DSCN 30/2007 18 Week Minimum Data Set (2007)

8. Going Further on Cancer Waits
http://www.ncin.org.uk/collecting_and_using_data/data_collection/gfocw

9. DoH MRSA Screening Operational Guidance 3 (2010)

10. 2014/15 NHS Standard Contract, NHS England

15.0 UHCW ASSOCIATED RECORDS

12. UHCW Leave Arrangements Policy HR-POL-012-06

13. UHCW Data Quality Policy (2015) GOV-POL-03-15

14. UHCW Disciplinary Procedure (2010) HR-PROC-004-07

15. UHCW Development & Management of Trust-wide Corporate Business Records (CBRs) Procedure 2011 GOV-PROC-005-08

16. UHCW Process & Guidance for Overseas Visitors (2013) FIN-POL-001-13

17. UHCW Safeguarding Vulnerable Adults Policy & Local Guidance Referral Pathway Procedure (2015) OPER-POL-004-10