Consultant-led Services Access Policy (General)

CONTENTS

1. INTRODUCTION

This policy sets out the standards which the organisation expects its all directly and indirectly employed staff to adhere to in relation to the care and control of patients accessing consultant led services. The policy takes account of current legislations, official guidance, recommendations and professional codes of practice. These, however, change with time and all staff have a responsibility to identify where new guidance may conflict with this policy.

This policy lays out the key principles for accepting, triaging and managing patients referred in line with updated guidance and contractual obligations. Individual services can then develop local procedures within this framework in consultation with the Director of Clinical Services and commissioners, private practice organisations or other bodies CHEC chose to work with. Any local procedure or changes must be approved by the Director of Clinical Services and Medical Director and commissioning body and must adhere to both regulations and professional body standards/requirements.

2. PURPOSE AND OBJECTIVE OF POLICY

The purpose of this policy is to provide generic patient access arrangements for all consultant led services.

This policy will be in conjunction with specific policies and procedures at procedure or speciality level and also CHEC's Patient Choice Policy.
The Referral to Treatment Standard (RTT) is;
- At least 92 per cent of patients on incomplete pathways should have been waiting no more than 18 weeks from referral for definitive treatment

This policy reflects the requirement to comply with:
- The NHS Constitution
- The referral to treatment standards (RTT)
- The National Cancer waiting time standards
- CHEC Performance Framework
- NHSI Governance Framework

This policy is reviewed every two years or updated as required in line with Department of Health guidelines or changes in CHEC systems review includes reference to all national guidance and equality impact assessments. CHEC work with local ICBs to ensure the achievement of all the patient's constitutional rights and to ensure that we deliver against all key standards set out in our contracting agreements. The policy is designed to ensure that access to hospital services is fair and equitable. This policy sets out the rules and definitions of the 18 week standard to ensure that each patient's 18 week clock starts and stops fairly and consistently. It does not provide detailed guidance on how the rules should apply to every situation, but provides CHEC with an over-arching framework to work within to make

clinically sound decisions locally about applying them, in consultation with relevant stakeholders.

CHEC is committed to providing high-quality healthcare services to patients referred for our care. We acknowledge and respect the principles outlined in the NHS Constitution and adhere to the guidelines set forth in the Referral to Treatment (RTT) process. This Access Policy Statement outlines our commitment to ensuring timely and equitable access to healthcare services for all patients, in accordance with the NHS Constitution and RTT standards.

Patients with the same clinical priority will be treated 'in turn' based on their clock start date, where this reduces overall waiting times, and does not disadvantage patients already dated. Patients and Commissioners will receive clear and honest communication about waiting lists and waiting times. The process of waiting list management will be open, visible and accessible to patients, staff and commissioners. The 'clock stop' time is built into defaults into our PAS system limiting the risk of paper and manual processes distorting waiting times unintentionally. With CHEC's electronic process every patient interaction is traceable, with date and time stamps.

Our commitment is to ensure:

- **Equal Access:** We ensure that all patients have equal access to our services regardless of their age, gender, race, religion, sexual orientation, disability, or socioeconomic status.
- **Timely Services:** We strive to provide timely and efficient services to our patients. We aim to minimize waiting times and ensure prompt access to consultations, diagnostics, and treatments.
- **Transparency:** We are transparent about our services, including treatment options, costs, and expected waiting times. Patients are provided with clear and accessible information about their treatment and care.
- **Respect and Dignity:** We treat all patients with respect, dignity, and compassion. We involve patients in decisions about their care and respect their choices and preferences.
- **Collaboration with the NHS:** We work collaboratively with the NHS and adhere to the RTT guidelines. Referrals and treatments are conducted in consultation with NHS professionals, ensuring seamless and coordinated care for our patients.
- **Quality of Care:** We are committed to maintaining high standards of care. Our healthcare professionals are qualified, experienced, and dedicated to providing safe and effective treatments to our patients.

3. PATIENT AND REFERRER RESPONSIBILITIES

CHEC relies on all referring clinicians to ensure patients understand their responsibilities and potential pathway steps and timescales when being referred. This will help ensure that patients are referred under the appropriate clinical guidelines and are aware of the speed at

which their pathway may be progressed and are in the best position to accept timely and appropriate appointments. CHEC expects that, before a referral is made for treatment on an 18 week Referral to Treatment pathway, the patient is ready, willing and able to attend for an appointment and undergo any treatment that may be required. This will include being both clinically fit for assessment and possible treatment of their condition and available for treatment across that pathway. This is the responsibility of the referring clinician, eg the GP. CHEC and commissioners will work together to ensure that patients understand this before starting and that they are ready and able to attend the first outpatient appointment.

- Referrers must provide accurate, timely and complete information within their referral.
- Referrers must comply with national timeframes for referral attachments when referring via e-Referral System.
- Referrals to a choice provider should only be made if all other alternatives have been explored (i.e. patient/clinical pathways have been followed) and the patient is ready, willing and available to be seen and commence treatment within the next 18weeks.
- To minimise waiting times and to enhance patient access to services, Referrers are encouraged to make unnamed referrals
- When referring children or adults who cannot understand or give consent for their own treatment, the referrer must provide details of who is legally able to act on behalf of the patient.
- Referrers should identify any special communication requirements their patients may have and detail these on the letter. (e.g. literacy problems, need for BSL or other language interpreter).
- At the time of the referral the following information should be supplied
    - o Patient demographics & contact address.
    - o NHS number (and hospital number identifier if known)
    - o Home, work and mobile telephone numbers wherever possible
    - o All relevant clinical information together with the referrer's assessment of the level of clinical urgency
    - o The patient's availability (as well as their willingness to be seen at short notice). For 'routine' referrals, if it is known that patients will be unavailable to be seen for a period of time, the referrer should delay the referral.
    - o Any relevant information regarding the patient's capacity or relevant information related to safeguarding

CHEC expect patients to:

- Provide accurate and complete information about their health, medical history, and current condition.
- Follow the prescribed treatment plans and attend appointments punctually.
- Treat our staff, fellow patients, and facilities with respect and consideration.
- Feedback on services to help us improve services. Patients are encouraged to provide feedback, suggestions, or raise concerns through our dedicated feedback system. Complaints are taken seriously and are addressed promptly and professionally.

4. DUTIES AND RESPONSIBILITIES

Chief Executive Officer	The Chief Executive Officer has overall responsibility for the strategic direction and operational management, including ensuring that CHEC process documents comply with all legal, statutory and good practice guidance requirements.
All Staff	All staff, including temporary and agency staff, are responsible for: Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken. Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities. Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly. Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager. Attending training / awareness sessions when provided

5. ACCEPTING REFERRALS

Each consultant led service may have a different route of entry into CHEC services. These may include direct from GPs, eRS, optometrists or dentists as per legislation. In locally agreed contracts Contracts teams will agree inclusion and exclusion criteria for services. A consultant led triage will be a necessary standard where only referrals that meet the specification are accepting. Where referrals are deemed urgent (e.g. cancer), these referrals should be routing through administrative teams to the correct service within 24 hours. Non urgent referrals that do not meet the service specification should be rejected and sent back to the referrer for choice of appropriate provider.

Where no local contract is agreed, national guidelines are applied. Triage is still important to ensure CHEC only manage the most appropriate patients. For example, if a locally commissioned service does not require diagnostics to be performed, diagnostics for 'choice' patients outside the host commissioner may not be available and as such the patients maybe offered 'choice' of a regional CHEC service or rejected back to the GP after patient discussion.

6. TRIAGE FUNCTION/REFERRAL MANAGEMENT

All referrals are received through a single point of access. Referrals can be received through e-referral, NHSmail or post. This adds the patient directly onto the electronic patient record system preventing patients being lost in the system. Triage is a consultant delivered function. Our services are published on the DoS to ensure visibility to GPs. E-referrals are booked directly into a triage service. Referrals received undergo a 2-stage triage function. An administrative triage occurs within 4 hours of receipt, where patients within the inclusion criteria are booked for clinical triage. Those outside criteria will be offered choice of 3 appropriate local secondary care providers. Stage 2 triage within 24 hours involves clinical triage by a consultant relevant to the service, where the decision to designate urgency of review, investigations required, the correct subspecialist doctor to review is made. This ensures the right patient is seen by the right person at the right time, preventing unnecessary follow-ups and improving efficiency and aiding capacity.

Booking of referrals follows CHEC generic Consultant led services pathway:

- The administration services for a particular service are delivered by the relevant booking teams and managed by The Referral Booking Management, Centre manager and assistant manager.
- Bookings Team receive the referral via NHS e-Referral or NHS email or CHEC portal dependent on speciality.
- Referrals are reviewed for suitability and processed within 48 hours (2 working days). The referral is then entered onto the EPR where an automatic triage task list is generated for all new referrals.
- The triage task list is reviewed three times per week by a gastroenterologist, ophthalmologist, dermatologist or ENT consultant dependent on the referral speciality. Patients active on the task list are triaged accordingly.
- Where the consultant specialist feels direct listing for procedures is required, patients will be directly listed for the procedure under consultant care, e.g. Cataract surgery or direct listing endoscopy.
- Following triage, the relevant speciality booking team telephone the patient and offer an appointment appropriate and in line with the contractual requirements, whether direct listing or initial consultant consultation prior to management
- Following consultation, decision is made to discharge, treat and discharge, follow up with monitoring, requirement for diagnostics, place on waiting list or refer to secondary care.
- Once the patient has been seen a copy of their outcome letter is sent electronically to the patient's GP via Docman within 24 hours with subsequent outcomes communicated until after discharge.

Referrers will be informed when patients are added to the waiting list for treatment as part of the clinic letter, when patients are treated as part of the discharge summary and when they are removed from the list. In addition they will be told why the patient has been added to the list and whether they have been added to the planned or active list.

Our administration system automatically sends appointment details, together with maps and leaflets. Appointment reminders to patients via SMS, email and courtesy calling reduces DNAs. Where patients fail to attend, they are contacted the next working day. A further 2 appointments are offered and then discharged to the GP with a letter if no response. DNA rates are monitored and audited.

7. MANAGING PATIENTS

CHEC offer a full end to end consultant led service for all patients, where referrals are triaged, appropriate referrals accepted, consultant led consultations undertaken. Diagnostics, treatments and future management is managed within CHEC services where possible. On occasions, patients referred for a particular condition are found to have a different more serious condition. CHEC will have worked through the urgent pathway for each contract prior go live with the acute trusts for emergencies or cancers.

The process of referral for such conditions must follow our emergency policy. CHEC will monitor all referrals sent to secondary care to ensure Critical Handoff points are managed and the required patient records are transferred together with diagnostics.

For all patients being transferred on to another provider, a minimum data set is required as per National Guidance.

- To ensure that only patients with a condition requiring treatment not available in primary care are referred on to secondary care.

- To ensure that onward referrals to secondary care do not disadvantage patients.

- To ensure that onward referrals to secondary care do not add delay to a comparable pathway with GP direct referral to secondary care by ensuring all onward referrals are made within agreed pathways ensuring patients receive first definitive treatment within 18 weeks

Handoff is also required on transfer to secondary care, diabetic screening services or other stakeholders involved in delivering care. Information transfer is key, where records, diagnostics and results of procedures (including histology) are transferred electronically to the onward provider. GPs and patients are copied into correspondence to ensure patients' investigations are not lost, particularly in urgent cases.

8. OPEN APPOINTMENTS AND CANCELLATIONS

When a full discharge is not possible or in the patients best interest, and a fixed appointment may not be required an open appointment is made available under patient initiated follow up (PIFU). Patients can access CHEC for 6 months after their last attendance. The clock stops at this point. Patients are provided with a PIFU letter with a specific reference to book.

If patients cancel appointments, another appointment is arranged. A cancellation does not stop the 18 week clock. If 2 consecutive cancellations occur, the clinician may decide that it is safe to cancel the patient on clinical grounds and write to the referrer and patient as such. The RTT clock stops. It is the clinicians role to safeguard patients discharge.

If CHEC cancels appointments, the clock continues. A further appointment is offered within 28 days if the condition requires treatment. If the condition has resolved and further treatment not required, the decision not to treat is referred back to the referrer and the clock stops as a result.

Patients are not able to be reinstated onto an RTT pathway once removed. A ref-referral is required, generating a new clock start.

9. PATIENTS WITH ADDITIONAL REQUIREMENTS

During the booking and pe-assessment process, all patients are assessed for additional requirements they may have. CHEC will make arrangements for each patient with additional requirements to be accommodated. For instance: -

- Patients with physical, mental disabilities and additional learning needs. Examples include:
    - o Accommodating additional carer/support.
    - o Alterations to environment (i.e., quiet etc)
    - o Order of the list.
- Patients who are none-English speaking. Examples include: -
    - o Information sheets in different languages.
    - o Text message automatically defaulting to the language setting on the patient's phone.
    - o Electronic translation service.
    - o Use of CHEC's interpreter service (CHEC does not encourage the use of relatives/carers).
- Patients who have hearing and/or sight impairment. Examples include: -
    - o Use of CHEC's British Sign Language service.
    - o Accommodating things such as guide dogs.
- Patients who have mobility/access requirements. Examples include: -
    - o Additional support for movement and handling.
    - o Accommodation at a different site.
- Patients who have transport difficulties. Examples include: -
    - o Use of CHEC's transport facilities.

• Patients who are transgender.
    o Examples are outlined in CHEC's Transgender Policy.

10. CLINIC AND CAPACITY PLANNING

The capacity levels required for services are relating to the IAP or monitoring of weekly demand levels. We maintain a minimum of 30% capacity above indicative numbers. This allows us to absorb demand but also have the flexibility to cancel clinics if not needed if at overcapacity.
This is where as an organisation CHEC manage the capacity needs and have the flexibility to move doctors from region to region to cater for needs.

CHEC expects 100% attendance of staff and is committed to providing a healthy working environment to support this. We recognise that inevitably staff will experience periods of illness and those staff are entitled to sympathetic and supportive behaviour, acting in a fair, reasonable and consistent manner by the employer.

All planned clinician and administrative staff absences are covered from our group of clinicians and administrative staff. This has worked well in other contracts we deliver. We will require a minimum of six weeks' notice to book annual or study leave, otherwise leave is declined. As our policy outlines, we will limit leave to one clinician without appropriate cover being available to ensure business continuity.

For unplanned leave, all members of staff must notify their immediate manager of their absence. Unplanned absences will be covered from the same group of optometrists and administrative staff whenever possible. On very rare occasions, clinics may need to be cancelled, but this will only occur if a consultant cannot be found to cover. Administrative staff and HCAs have been trained regarding the patient pathway and will be able to assist and fill in at short notice if unplanned leave is taken for either of these tasks.

CHEC has an appointed contract manager for each area who monitors all aspects of contracts, including a demand management system. CHECs demand management policy is based on good planning and regular audits. For each contract we hold, we log weekly referrals and generate a cyclical plan of patient numbers. This is integrated with those requiring follow-ups which are tracked on a weekly basis on our electronic patient records where, at a glance, we see how many patients require review within a set period. Referrals received are logged and plotted weekly to ascertain peaks and troughs in demand.
CHECs demand management policy is based on good planning and regular audits. CHEC operates a demand management system where referrals received are logged and plotted weekly to ascertain peaks and troughs in demand. We achieve this by optimising clinic utilisation through:

- One stop services
- Courtesy calling/text reminder for patient's appointments, achieving a < 3% DNA rate
- Reliable and competent decision-making clinical staff.
- Providing patients information before appointments, and a copy of letters after the appointment.

The above ensures we utilise every clinic slot and are therefore have transparent overview of new and follow up referrals and the capacity to review these.

We monitor the contract and adapt to increases and decreases in workload whether planned or unplanned. Weekly audits of patient referrals and waiting times dictate forward workforce planning. A planned increase in workload is booked as extra clinical sessions. Unplanned increases will be accommodated by clinicians working longer sessions. The local contracts manager routinely monitors demand on a site by site basis including capacity and demand, to minimise risk of breaching waiting times.

Clinics are planned a minimum of 6 weeks in advance to allow cover to be planned in if required. CHEC operates all services to allow 30% overcapacity to allow patients to be moved around short term if required.

11. ROLES AND RESPONSIBILITIES

The Chief Executive Officer (CEO) has overall responsibility for the strategic and operational management of the organisation, including ensuring all policies are adhered to.

The Medical Director and Director of Clinical Services, on behalf of the CEO, will ensure that clinicians and their practice comply with this policy.

The Board is responsible for ratifying this policy and ensuring it represents best practice and is based on current evidenced based information.

Service managers

- The requirements of this policy are brought to the attention of all employees for whom they are responsible, i.e. new recruits and existing staff members.
- Employees are supported in the identification of training and development needs and have access to training if required.
- Staff involved in any aspect of service delivery understand their responsibilities and are competent to undertake those responsibilities.
- Facilities and equipment being utilised are provided and maintained to the required standards.

- Systems for routine audit, review of adverse events and patient complaints relating to the implementation of this policy are in place.

The responsibility for monitoring this policy and advising on best and current evidenced-base practice is primarily vested in the Director of Clinical Services.
All staff must be aware of their roles and responsibilities under the current legislation and adhere to the safe practices outlined in this policy. Persons not complying with this policy will be subject to disciplinary procedures. Staff must also make themselves familiar with local standard operating procedures for specific areas of work. Staff have a responsibility to ensure that their practice is current and up-to-date and that they are competent to fulfil their role in all aspects relating to patient choice and managing the consultant pathway. Any breach of this policy is to be reported immediately to their manager. Staff also have a responsibility to ensure working practices of colleagues or co-workers, students and trainees under their supervision are complaint with this policy.
It must be recognised that compliance with this policy does not override any individual responsibility of healthcare workers to ensure that:

- Their practice complies with current legislation.
- They follow guidance issued by the Department of Health, professional bodies (e.g. Nursing and Midwifery Council, General Pharmaceutical Council) or other government departments such as the Home Office.
- They manage the risks to patients, relatives, carers and staff arising from the use of medicines that maybe dispensed as part of the patient treatment.

12. DEFINITIONS

Clock start is the date on which the provider receives the patient's referral. If from the e-Referral system, the clock starts with the UBRN. If not from eRS, clock start is when the referral is received for a Consultant led service. New clocks will start when new conditions are identified and require consultant led care or re-referral occurs, or when a patient DNAs there first appointment
Clock stop occurs in the following situations:

- First definitive treatment starts, e.g. via a consultant led service or interface service. A first definitive treatment is when an intended intervention is made to manage a condition and avoid further intervention.
- Therapy by an interface service if consultant led
- For non-treatments:
    - Clinically appropriate to return the patient to the GP
    - Active monitoring
    - Decision not to treat
    - DNA first appointment
    - DNA subsequent appointments and discharged

Document owner and approval

The DIRECTOR OF CLINICAL SERVICES is the owner of this document and is responsible for ensuring that this policy is reviewed by the due date.
A current version of this document is available to members of staff on the CHEC intranet.

Change history record

Issue	Description of Change	Approval	Date of Issue
1	New policy	DcS (S Boyes)	7/2019
2	Review	DcS (S Boyes)	9/2021
3	Review (v2)	DcS (A Fitzsimons)	7/2022
4	Review(v3)	DCS	10/2023

EQUALITY IMPACT ASSESSMENT FORM
PART A - INITIAL SCREENING FORM

Section One	
Name of proposal, policy, service review or report *(referred throughout as proposal)*	Accessing Consultant led services
Directorate / Service carrying out the assessment	
Name and role of person undertaking this EIA	
Give an overview of the aims, objectives and purpose of the proposal:	

Section Two		
Equality Groups:	**Could the proposal have a positive impact**	**Could the proposal have a negative impact**
People of different ages	yes	

People of different religions / beliefs.	yes	
People with disabilities (physical, mental or learning)	yes	
Women	yes	
Men	yes	
Transgendered people	yes	
People from different ethnic groups	yes	
Lesbian, Gay or Bisexual	yes	
Refugees and asylum seekers	yes	
Human Rights breaches	yes	

Section Three			
Is this proposal a major change in terms of scale or significance for CHEC? Is there a clear indication that, although the proposal is minor it is likely to have a major affect for people due to their protected characteristic?			
Yes		**No**	
High risk:		Low risk:	Yes

Section Four
It this proposal is low risk please give evidence or justification for how you reached this decision:
This Policy is to ensure compliance with clinical risk and therefore supports all people.

Sign off that this proposal is low risk and does not require a full Equality Impact Assessment:
EAI Reviewer Signed:

Date: **Alison Fitzsimons 21/10/23**