Access Policy

Version 4

Policy Profile	
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Document Management

Version	Date	Changes made by:	Summary of changes:
V1	01/03/2023	Melissa Ball	1st version review after changes to national policies
V2	01/07/2023	Melissa Ball	2nd version for review after 12 months,
V3	02/12/2024	Richard Armitage	Multiple changes following feedback from ICB
V4	15/01/2025	Andrew Sheen	Review and updates based on NHS Trust, ICB feedback and National guidelines review

Contents:

1.0 Introduction

The purpose of this policy is to outline the approved processes for the management of Cataract and YAG Laser Capsulotomy referrals into all Optegra sites within England as well as highlighting the responsibilities of all Optegra staff, both clinical and administrative.

This policy sets out the key principles including standardisation of administrative pathways in relation to patient access to provides a consistent, equitable and fair approach to the management of patient referrals and treatment that meets the NHS requirements.

Optegra aims to provide patients with a seamless service, assuring that all referrals are managed in the same way.

This policy is to ensure that Optegra have a robust process in place to ensure that patients, their relatives and carers are informed of their rights and what they can expect in terms of access to any Optegra site within England. The document will outline the processes, responsibilities and actions by which Optegra will manage patients through their pathways, specifically:

- The national 18-week Referral to Treatment (RTT) pathway
- National Cancer Waiting Times for all suspected and diagnosed cancers.
- The national 6-week guidance for diagnostic tests.

In accordance with the NHS Constitution everyone has the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible. This includes a right to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions; and

This policy sets out the way in which Optegra will accept patients who are waiting for treatment or on treatment pathways. It covers the management of patients at all sites where Optegra operates within England.

Optegra will adopt a fair, consistent and transparent approach to the management of patients. All communication with patients will be clear and informative and will be consistent.

Patients will be seen firstly according to clinical priority and then in chronological order based upon the 18-week RTT pathway.

All patients are contacted within 72 hours of Optegra receiving the referral to complete a pre-operative assessment. This, along with any referral information provided will support in our administrative team determining the clinical priority of a patient or any special requirements required.

This policy is intended to be used by all those individuals within Optegra, who are responsible for managing referrals, adding to, and maintaining waiting lists for organising patient access to treatment. The principals of the policy apply to both medical and administrative waiting list management.

2.0 Purpose

To advise and inform patients, relatives, carers and Optegra staff of the processes for managing access to services provided by Optegra UK Ltd.

3.0 Scope

The Access Policy is applicable to all Optegra Eye Hospitals and Optegra Eye Clinics in England.

4.0 Definitions

RTT – Referral to Treatment

PWL –Patient Waiting List

DNA – Patient did not attend

PPCCRs – Procurement, Patient Choice and Competition Regulations

Active Monitoring - An 18 - week clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures. A new 18 - week clock would start when a decision to treat is made following a period of active monitoring

NHS e-Referral service - A method of electronically booking a patient into the service of their choice.

First Definitive Treatment - An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes First Definitive

Treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.

Commissioners – NHS body accountable for assessing needs, planning and prioritising, purchasing and monitoring health services, to get the best health outcomes.

ICBs – Integrated Care Boards

NICE guidance – The National Institute for Health and Care Excellence. NICE guidelines are evidence-based recommendations for health and care in England.

Individual Funding Request - An individual funding request is a request for NHS funding for treatment that is not normally available and one which is only paid for under certain circumstances.

RADAR – Optegra system for managing quality, audits, patient safety, risk management and compliance processes.

YAG Laser Capsulotomy – is a procedure carried out to treat a common cataract post-operative complication which can occur after Cataract surgery.

5.0 Roles and Responsibilities

UK Leadership Team:

Responsible for the overall application and adherence to this policy and procedures within their areas of responsibility.

UK Head of Governance and Risk:

Responsible for supervising the management of the regulated activity provided by Optegra regulated by the Care Quality Commission (CQC), including where that involves compliance.

To ensure that this policy is up to date and that Optegra adheres to best practice in accordance with regulatory bodies e.g.: CQC; and to advise on best practice based on guidelines and recommendations from professional bodies such as NICE and the Royal Colleges e.g. RCOphth

Ensuring that robust and transparent processes are in place to identify, report, prioritise, investigate and learn from all events.

Identifying where any barriers to reporting and learning from patient complaints exist and seeking assurances (including a documented action plan), that any barriers identified are being addressed.

Head of Sales & Operational Planning:

Responsible for the daily management of hospital diaries.

Responsible for providing daily and monthly reports to support the planning and diary management of Optegra hospitals, highlighting potential risks to wait times.

Clinical Staff:

Consistent application and adherence of this policy and its principles.

Consideration is to be given by clinical staff for cross-cover arrangements during periods of annual leave or other absences.

A minimum of 6 weeks' notice is necessary for consultant and medical staff planned leave to ensure

patient appointment dates are honoured and to reduce the need for changes and cancellations.

All leave requests must be authorised by the line manager.

NHS Team Leader:

Responsible for the application of this policy within Administrative teams.

Responsible for training their staff as it relates to patient access and administration.

Responsible for providing information and analysis support to monitor targets and adherence to this policy.

NHS Referral Management Centre:

Responsible for the day-to-day management and application of their responsibilities in line with this policy.

Healthcare Technician (HCT):

To ensure competencies are up to date

Work within competencies and escalate as per guidelines.

Work under the supervision of the registered Healthcare practitioner.

Individuals are personally responsible for ensuring that their conduct, attitude and behaviour are always professional.

Patients, Family members or Carers of Patients:

Patients should keep appointments, or if they must cancel, cancel within a reasonable time in order that the appointment can be re-used for another waiting patient. Receiving treatment within the maximum waiting times may be compromised unless patients try wherever possible to keep their original appointments.

5.0 Polices

Optegra understand the importance of Patient Access Management and this policy will make clear the processes taken to ensure this is adhered to.

The Patient's Rights (NHS Constitution)

Patients have a right to expect to be seen and treated within national operational standards for waiting times, in addition to this the department of health has set out other patient expectations, these include:

a) To be seen by a health professional whom they trust.
b) To get a clear explanation of their condition and what treatments are available.
c) To know what the risks, benefits and alternative treatments are. • To give written consent before any operation or procedure.

d) To see their patient records and be sure that the information recorded will remain confidential (data protection act 1998).
e) Young people aged 13 – 19 years also have standards that affect their care in an outpatient setting

Patient Choice & Referral acceptance:

Optegra will accept referrals from GPs or Optometry if they have been referred directly or via NHS eReferral Service as per Patient Choice Guidelines and on the basis the referral demonstrates;

- The patient has an elective referral for a first outpatient appointment (new episode of care)
- the patient is referred by a GP, Optometrist into secondary care
- The referral is clinically appropriate as determined by the referrer
- The service and team are led by a consultant
- The provider has a commissioning contract with any ICB or NHS England for the required service.

Cataract referrals should not be accepted unless a formally documented shared decision making process has been performed by their referring primary care optometrist with the patient (and their family members or carers, as appropriate) as part of a referral. This includes but is not limited to:

- How the cataract affects the person's vision and quality of life
- Whether one or both eyes are affected
- What cataract surgery involves, including possible risks and benefits
- How the person's quality of life may be affected if they choose not to have cataract surgery
- Whether the person wants to have cataract surgery.

In line with NICE guidance, we not restrict access to cataract surgery on the basis of visual acuity.

Referral Queries:

If there is any doubt as to whether a patient needs to be managed by Optegra or whether a patient should be offered another choice of hospital, consultant or treatment option, the NHS Referral Management Centre should contact the patient's GP to discuss the case.

Patients will only be added to a waiting list if there is an expectation of treating them and they are clinically fit or there is an expectation that they may become fit and ready to undertake the treatment within 18 weeks.

All referrals will be reviewed and prioritised within contract KPI timelines of receipt.

At least 3 weeks' notice must be given to the patient when agreeing an appointment date. The only exceptions to this are:

1. Where it is clinically urgent
2. For a diagnostic test/procedure, where a reasonable offer is 10 days or more.
3. Where patients make themselves available at short notice.

Refusal of Referrals:

NHS guidance states that providers should accept all clinically appropriate referrals made to them. Patients choosing a particular NHS provider must be treated by that provider as long as this is clinically appropriate and in accordance with the patient's wishes.

Referral to Treatment (RTT) principles:

Once a referral to treatment (RTT) waiting time clock has started it continues to tick until:

a) the patient starts first definitive treatment

or

b) clinical decision is made that stops the clock.

The provider will ensure that all clock stops without treatment are made in the best clinical interest of the patient and are not influenced by the impact on incomplete pathway waiting time performance.

Patients should be allowed to choose their time of treatment taking account of clinical advice where undue delay may present a risk to them.

Clock Starts

An RTT clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to:

a) a consultant led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner;

b) An interface or referral management or assessment service, which may result in an onward referral to a consultant led service before responsibility is transferred back to the referring health professional or general practitioner. •

An waiting time clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional.

Upon completion of an RTT period, a new RTT clock only starts:

a) When a patient becomes fit and ready for the second of a consultant-led bilateral procedure

b) Upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.

c) Upon a patient being re-referred in to a consultant-led; interface; or referral management or assessment service as a new referral;

d) When a decision to treat is made following a period of active monitoring.

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

Clock Stops for treatment

The 18 week clock stops when:

a) First definitive treatment starts. This could be:

i) Treatment provided by an interface service;

ii) Treatment provided by a consultant-led service;

iii) Therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions;

c) A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

Clock stops for non-treatment

A waiting time clock stops when it is communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay that:

a) It is clinically appropriate to return the patient to primary care for any non consultant-led treatment in primary care;

b) A clinical decision is made to start a period of active monitoring;

c) A patient declines treatment having been offered it;

d) A clinical decision is made not to treat;

e) A patient DNAs their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient

f) A patient DNAs any other appointment and is subsequently discharged back to the care of their GP, provided that:

i) the provider can demonstrate that the appointment was clearly communicated to the patient discharging the patient is not contrary to their best clinical interests;

iii) discharging the patient is carried out according to local, publicly available/published, policies on DNAs;

iv) These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g. children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders

After the 18 Week Clock Stops:

Upon completion of an 18 week RTT period, a new clock starts:

a) When a patient becomes fit and ready for the second of a consultant led bilateral procedure with a new pathway.
b) Upon decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan with a new pathway.
c) Upon a patient being re-referred into a consultant-led service as a new referral, with a new pathway.
d) When a decision to treat is made following a period of active monitoring, using the same pathway.
e) When a patient rebooks their appointment following a first appointment DNA that stopped and nullified their earlier clock

Priority treatment for Military Veterans:

All veterans are entitled to priority access to NHS care for any conditions which are likely to be related to their service, subject to the clinical needs of all patients. Veterans are encouraged to inform their General Practitioner about their veteran status in order to benefit from priority treatment.

f) Clinicians must ask patients about veteran status during initial assessments and ensure this is recorded in their notes.
g) Veterans should be prioritized in appointment scheduling without compromising other patients with greater clinical need.

Patients with Learning Disabilities:

Where a person is recognised as having a learning disability, the clinician should ensure that the notes are recorded appropriately to support the teams, the patient and their carers/family with access to the appointment and any reasonable adjustments that may be required during subsequent appointments / treatment episodes. Patients with a learning disability and their families / carers must be supported with reasonable adjustments to ensure equitable access to treatment.

6.0 Outpatients

Unnecessary and Incomplete Referrals

An unnecessary referral for a clinical reason would be defined as a referral into a provider for one of the following reasons:

a) A referral for a clinical reason that could have been treated in either primary care or within a community setting.
b) A referral that could have been dealt with by using e-Referrals advice and guidance.

c) A referral for a clinical reason that has not been commissioned i.e. a procedure of low clinical value, cosmetic procedure or service commissioned through an alternative provider
d) A referral sent to the wrong department or specialty

An incomplete referral is defined as a referral where a key piece of patient or clinical information is missing. This would include diagnostics, BMI, smoking status, NHS number, patient demographics or specific reason for referral.

Optegra will accept all clinically appropriate referrals but referrals that are felt to be incomplete make it difficult for the clinical teams to assess appropriateness and thus may be returned to the referring GP/GDP with an explanation and reason why the referral has been returned.

NHS E-Referral Service:

NHS e-Referral Service is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. The guidance states that the responsibility for the effective implementation of NHS e-Referral Service should be shared between organisations. For example:

Providers are responsible for ensuring that services are made available on NHS e-Referral Service and that patients can book into appointments using the system

Referrers are responsible for using NHS e-Referral Service effectively to find suitable services for their patients

Commissioners are responsible for ensuring that services available on the system accurately represent the clinical needs of their patient population and that those referrers and providers use the system effectively for the benefit of all patients.

Consultant to Consultant & Consultant to GP Referrals:

Direct referrals will be appropriate for:

1. Suspected cancer.
2. Urgent problems for which delay would be detrimental to the patient's health. The expectation here would be that the patient needs to be seen within 2 weeks.
3. Referral as part of the same clinical problem.
4. Part of the recognised pathway of care for the condition
5. Transfer of responsibility of care for an on-going condition, when it would be more convenient for the patient to be seen in a different location.

Referral back to GP will be appropriate for:

1. Conditions that are unrelated to the presenting problems and do not require urgent referral.
2. Incidental findings.
3. Conditions that can be dealt with by the GP.
4. Those patients who Did Not Attend (DNA) their appointment (subject to the KPIs/local agreements).

5. Those patients who cancel their appointments on multiple occasions (subject to KPIs/local agreements)

Referrals from referral management centre:

For RTT pathways that start within an interface service(all arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care), the correct clock start date will be the date that the interface service received the original referral and not the date that the onward referral from the interface service was received by us.

For NHS e-Referral Service patients who are referred to secondary care via an interface service, there may be two UBRNs associated with the same pathway. When a second UBRN is created along the same RTT period this will be linked with the first UBRN and the date of conversion of the first UBRN will be the date of the RTT clock start. The RTT clock keeps ticking whilst the patient converts the second UBRN.

Pre-Operative Assessment (POA)

Upon receipt of referral, the Optegra Referral Management Centre will review the details of each patient and book them in for a virtual pre-operative assessment. This will be within 72 hours of receiving a referral.

All patients will be contacted for a virtual pre-operative assessment by the automated AI assistant “Iris”. If the patient has failed to engage with Iris or complete their POA after 5 days, attempt to reach the patient will be made by a member of the Clinical Assessment Team.

Pre-operative assessment provides an opportunity to optimise treatment of any existing disease and make a detailed plan for care during and after surgery.

Where patients are identified as having complex needs for example a complex medical history, do not speak English as a first language or requiring best interests discussion then patients are booked into face to face hospital pre-assessment clinics.

Where we have been unable to contact a patient for a virtual POA for any other reason a letter will be sent advising them to attend a face to face appointment at the hospital.

A traffic light guidance has been written with a multidisciplinary team to ensure that the practicalities of conducting pre-assessments in Optegra has been captured and provides safe assessment criteria.

The criteria are as follows:

RED Not suitable for surgery at present in Optegra
AMBER Review - additional information or review by registered nurse or Surgeon required.
GREEN Suitable for surgery

All patients must have a full pre-assessment carried out as per our NHS Cataract Pathway.

If we are unable to contact a patient on 3 occasions, we will write to the patient three times . If no response is received we will make contact with the referrer to advise. We will then request that the referrer makes contract with the patient to arrange contact. If after three months we do not receive a response, the patient will be discharged back to their referrer and the clock stopped

Patients are to be seen within their maximum waiting times allowable.

If the patient was discharged more than 6 months ago, referrers will have to re-refer if an appointment is required for the same condition and a new clock will start.

Referrals are not expected to be routinely rejected. Optegra can reject a referral that hasn't been accepted in NHS e-Referral Service, other rejections are maintained on the EPR post registration. The rejection process sends the patient back onto a work list at their GP surgery and the appointment is automatically cancelled on the EPR and NHS e-Referral Service. Optegra will take responsibility the patient of their cancelled appointment.

All inappropriate referrals will be referred back to the referrer for them to review the choice of provider prior to the referral being redirected.

Information reports should be used to actively plan capacity to ensure achievement of waiting time targets and thus incur no breaches.

Referrals and booking rules should be actively monitored in order to respond flexibly to demand and to deliver flexible capacity.

Did Not Attend (DNA):

Optegra aims to reduce the incidence of patients failing to attend appointments and acknowledges that it is best achieved by agreeing the date with the patient in advance. We also operate an automatic appointment reminder service via text message to help reduce DNAs.

If a patient fails to attend their appointment (new, follow up) and it was clearly communicated with reasonable notice as per national guidance and this can be demonstrated, the patient may be referred back to the care of their GP, however, this is a clinical decision and will trigger a review to determine if appropriate to either reappoint or discharge. Both patient and GP will be notified in writing ensuring the referring GP is aware and can action further management of the patient if necessary.

For new appointments, the RTT clock will be nullified on the day the patient DNA's a new appointment and will restart on the day the patient is rebooked.

For all DNA's post a patients first appointment, the RTT will not automatically stop unless a clinical decision is made to do so.

DNA Subsequent Appointments (OPD, Diagnostics, TCI)

Patient DNAs at any other point on the RTT pathway will not stop the RTT clock, unless the patient is being discharged back to the care of their GP or optom. This is a clinical decision and will trigger a review to determine if appropriate to either reappoint or discharge. Both patient and GP will be notified in writing ensuring the referring GP is aware and can action further management of the patient if necessary

The action of discharging the patient will stop the clock, provided that:

a) The provider can demonstrate that the appointment was clearly communicated to the patient;

b) Discharging the patient is not contrary to their best clinical interests, which may only be determined by a clinician as there may be circumstances where the clinician feels it is detrimental to the patient's health if the appointment is not rebooked, in which case the patient must first be contacted to ascertain the reasons for DNA and ensure compliance to attend the rescheduled appointment.

c) Discharging the patient is carried out according to local, publicly available, policies on DNAs;

d) These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients and are agreed with clinicians, commissioners, patients and other relevant stakeholders.

If the above criteria are fulfilled, then the RTT clock stops on the date that the patient is discharged back to the care of their GP / optometrist

Outpatient Appointment - Hospital Cancellations:

A minimum of 6 weeks' notice is required from all clinicians, in all but exceptional circumstances, to cancel or reduce any outpatient sessions for reasons of annual, or study leave or on-call commitments.

The RMC will not action any short notice cancellations without this authorisation from the Regional Head of Operations or Regional Head of Clinical Services.

If a patient's appointment has to be rescheduled due to a hospital cancellation, the patient will be contacted to arrange an alternative appointment date and time.

Appointments must be made as close to the original appointment as possible. This is particularly important when patients need to re-attend for test results, or to review medication as the 18 week clock continues to tick during this time if the patient has not yet had their first definitive treatment

Changing/Cancelling Appointments at Patient Request:

Patients may have an additional option to cancel and change their outpatient appointment on line, via NHS e-Referral Service appointments must be cancelled and changed using the NHS e-Referral Service telephone appointments line or website.

If patient requests a rearrangement or cancellation within 24 hours of the appointment time it must be recorded as a patient cancellation and the 18-Week RTT clock will continue ticking and the reason for cancelation must be recorded.

Post operative follow up

Follow-up appointments are still considered clinically necessary after even routine cataract surgery at it ensures that the visual acuity of the patient is satisfactory and that as appropriate they may either have a new glasses prescription or be referred for a second eye procedure

There are a number of pathways available for follow-up appointments:

a) Telephone follow up by AI
   - Suitable only for patients who's treatment plan is indicating a second eye procedure will be necessary and where the surgery was uncomplicated

b) Community follow up
   - Conducted by an accredited optometrist ideally back at the patients referring practice and where the surgery was uncomplicated

c) Hospital follow-up
   - Appropriate for patients who may have had complicated surgery and/or are unwilling or unable to visit their community optometrist

Patients will be advised on the ward of the appropriate follow-up process and a suitable letter to the patient and GP will be provided. Instruction will be passed to the RMC to ensure the patient is placed on the appropriate waiting list.

7.0 Day case procedures

Determining Patient Priority

All patients who are added to the surgery to book list will be treated in the chronological order in which they were added unless they have been given a clinical priority of urgent. Military veterans will be treated in line with national guidance. Clinical prioritisation will help Optegra to understand the level of risk on the waiting list, plan capacity to meet the demand and the priority order in which to treat patients. This process will form part of the Supply & Operation Planning (S&OP) process.

Changes to booking rules must be authorised by the Head of NHS and Head of UK Operations. The exceptions are:

1. Ad hoc requests with no reduction to patient booking numbers.
2. Changes to medical staff rotas.
3. Additions of target urgent slots for patients about to breach.

Systems should be in place to ensure patients do not breach the 18-week RTT targets. Head of Sales & Operational Planning will monitor pathways and escalate patients to the appropriate manager where a breach is expected.

Staff are to comply with electronic patient records (EPR) data quality standards.

The 'Date Request Received' in the EPR constitutes a clock start for those patients on an active 18- Week RTT pathway. This is the date an attempt was made to convert a Unique Booking Reference Number into a booking for NHS e-Referral Service patients and the date the referral letter was received into Optegra for paper referrals.

TCI Reasonable Offer Criteria:

For patients with a decision to admit for treatment, a reasonable offer of a To-Come-In (TCI) date is considered to be:

a) A written offer to a patient is deemed to be reasonable when the patient is offered a minimum of 2 dates on different days with at least 3 weeks' notice before the first of these admission dates
b) A patient may accept an offer of a shorter notice admission date. If a patient accepts this offer, the reasonable 3 weeks' notice is waived.

If a patient declines an offer of an earlier admission date at less than 2 weeks' notice, they may do so without any adverse effect on their waiting time.

Where the patient does not respond to letters or has not responded to an invite letter within 2 weeks of the letter date then the patient is not fulfilling their obligation to make themselves available for admission. In such cases their case will trigger a clinical review with their Consultant who will need to have clinical oversight and make decisions in agreement with the patient. The GP will also be informed so they can ascertain any reasons as to why the patient has not responded and to resolve any safe-guarding concerns.

Bilateral Procedures

Where a patient requires a bilateral procedure a new clock starts when the patient is fit and ready for the second treatment. These patients will be managed on the active waiting list.

Patient 'Thinking Time'

Where a patient is given 'thinking time' by the consultant, the effect on the RTT clock will depend on the individual scenario. If the agreed 'thinking time' is short e.g. 2 weeks, then the RTT clock should continue to tick.

If a longer period of 'thinking time' is agreed, then active monitoring is more appropriate. e.g. clinician offers a surgical intervention but the patient is not keen on invasive surgery at this stage, as they view their symptoms as manageable. A review appointment is agreed for a timeline that is clinically appropriate for the patient and the patient is placed on active monitoring (patient initiated). The RTT clock would stop at the point that the decision is made to commence active monitoring

Active Monitoring

Definition: Active Monitoring involves a deliberate decision to observe a patient's condition without initiating treatment at that time. This decision is made jointly by the clinician and the patient, considering the patient's best interests.

RTT Clock Status: When a patient is placed under Active Monitoring, the Referral to Treatment (RTT) clock is stopped. This means the waiting time measurement pauses during the monitoring period. If a decision to treat is made later, a new RTT clock starts from the date of that decision.

Application: Active Monitoring is applicable in scenarios such as:

- When it's clinically appropriate to observe the progression of a condition before deciding on intervention.
- When a patient chooses to defer treatment after being fully informed of the potential implications

Documentation: It's essential to clearly document the decision for Active Monitoring in the patient's medical records, including the rationale and any discussions held with the patient.

Follow-Up and Reassessment:
Schedule regular follow-ups to monitor the patient's condition and ensure no deterioration has occurred.

Post review, if a decision to treat is made following a period of active monitoring then a new 18-week clock would start.

Patient Choice and Unavailability

Delays as a result of patient choice are accounted for in the tolerance of 8% set for achievement in the incomplete pathways waiting time operational standard. Patients therefore have an element of choice when booking their appointment or TCI date etc. Management of patients should take into consideration any health inequalities impact. Patients who wish to defer treatment must be recorded on the ERM system.

Patients who choose to Delay Treatments

1. The patient chooses to delay their treatment due to personal circumstances
    a. When a patient chooses to delay, for example when they respond to a letter or call, this should be captured on the ERM System. The delay reason is a patient request, and should be clinically reviewed to ensure it is safe for the patient to delay their treatment.
    b. If a patient who first chose to delay treatment is now ready to proceed with their treatment, the ERM system will need to be updated with a note.

2. Medically unfit:
    a. If a patient is not fit for surgery Optegra will ascertain the likely nature and duration of the illness. If the reason is that they have a condition that itself requires active treatment then a clinical decision will be made and they

will either be discharged back to the care of their GP where it may be more appropriate for their condition to be managed ((e.g. chronic hypertension or AF) clock stops and pathway ends) or they will be actively monitored for their original condition (clock stops).

b. If the reason is transitory and likely to resolve reasonably quickly (e.g, such as a cold or viral illness), then patients should contact the waiting list office and agree a new TCI date within a reasonable timeframe of the original date. This will allow patients with minor acute illness time to recover. The 18 week clock will continue to tick during this time. If the patient is not fit after that period a clinical decision will be made which may result in them being discharged and returned to their GP where it maybe more clinically appropriate for the management of their on-going chronic clinical condition. This will stop the 18 week clock and pathway.

Surgey - Hospital Cancellations:

A minimum of 4 weeks' notice is required from all clinicians, in all but exceptional circumstances, to cancel or reduce any outpatient sessions for reasons of annual, or study leave or on-call commitments.

The RMC will not action any short notice cancellations without this authorisation from the Regional Head of Operations or Regional Head of Clinical Services.

If a patient's appointment has to be rescheduled due to a hospital cancellation, the patient will be contacted to arrange an alternative appointment date and time.

Appointments must be made as close to the original appointment as possible. This is particularly important when patients need to re-attend for test results, or to review medication as the 18 week clock continues to tick during this time if the patient has not yet had their first definitive treatment

Patients who Cancel TCI dates:

Patients who cancel their own elective admission date for reasons other than sickness or extreme personal circumstances (e.g. death of a close relative, car accident or seriously ill dependent) at less than 48-hrs notice, after receiving reasonable notice of or agreeing the date will have a further offer of treatment, however subsequent cancellations will result in their case triggering a clinical review with their Consultant. On determining the best interest of the patient, may be removed from the waiting list with discharge back to the care of their GP / optom for any further action in primary care or re-referral when ready, willing and able to proceed. The 18 week clock will stop and the pathway ends

Patients who contact the Trust to cancel an agreed date for surgery due to sickness or extreme personal circumstances or are deferred on the day of surgery due to a short duration illness which is likely to resolve within a reasonable timeframe such as a viral illness will be cancelled and a new date agreed with the patient. The 18 week clock will keep ticking throughout this period.

Any medical condition that is not thought to be easily manageable or self-limiting within a reasonable timeframe will result in the patient's case being discussed with their Consultant and the patient will be referred back to the care of their GP. This will stop the 18 week clock and end the pathway. Clinicians will manage such cases and with agreement of the patient's best interest

Patient Did Not Attend TCI Date:

Patients must be informed clearly in all correspondence that in the event that they DNA an day-case procedure they will have their case clinically reviewed by their consultant who will determine if the patient should be reappointed or discharged. The Trust must demonstrate the dates were clearly communicated to the patient with reasonable notice as outlined in this policy. Discharge will stop the 18 week clock and end the pathway. Reappointed patients will continue with the existing referral dates and clocks. Patients who post clinical review are placed on a monitoring programme will be removed from the waiting list and their clock will stop for monitoring until future decisions are made

7.0 Training & Awareness

- This policy will be brought to the attention of all new members of staff at local induction. This includes volunteers and agency/temporary employees
- Any breaches to the principles highlighted in this policy should be reported to your line manager.
- Failure to comply with this Policy may result in individuals being managed under Human Resource policies and guidance.
- If there is anything in this Policy that you do not understand, please discuss it with your line Manager.
- This policy is listed on the Optegra website – www.optegra.com

8.0 Monitoring

Patient Waiting Lists (PWL)

A PWL is a list of patients who need to be treated by given dates in order to start treatment within maximum waiting times set out in the NHS Constitution. A PWL is an established, forward-looking, management tool that is utilised by Optegra to help achieve and sustain short Referral to Treatment and diagnostic waits. The PWL provides a prospective viewpoint, and so can act as a planning tool for managing patient waiting lists in a way that a retrospective data collection cannot.

Essentially, a PWL contains the data required to manage patients' pathways, by showing clearly which patients are approaching the maximum waiting time so referral management centre staff can offer dates according to clinical priority and within maximum waiting times.

The NHS Standard Contract requires providers to submit information on referrals and waiting times. Where this is requested, a PWL data set they are to be provided.

Monitoring of this policy

This document has been created following the Optegra Policy Guidelines.

This policy will form part of the Optegra annual audit plan to ensure compliance and effectiveness. Compliance will be monitored by the Corporate / Regional Clinical Governance Committee.

Any changes in this Policy will be communicated to staff via RADAR and verbally at staff meetings and recorded minutes.

Clinical incidents will be reviewed on RADAR and discussed at the Clinical Governance and Risk Committee and will feed into Corporate Governance reports

9.0 References

https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks/referral-to-treatment-consultant-led-waiting-times-rules-suite-october-2022
https://ebi.aomrc.org.uk/
https://www.england.nhs.uk/personalisedcare/choice/
https://digital.nhs.uk/services/e-referral-service/providers
https://www.cqc.org.uk/provider/1-101725155
https://www.nice.org.uk/guidance/ng77

10.0 Associated Documents

- Clinical Consent Policy
- Medicines Management and Administration Policy
- MCA Policy incorporating DOLs
- Assessing Competency in Clinical Practice Policy
- Healthcare Records Management Policy
- Safeguarding Adults Policy
- Theatre Operating Policy
- Incident Policy
- Standard NHS Cataract Pathway Instructions and Procedures
- Local Standard Operating Procedures
- Pre-Assessment Policy
- Pre-Admission Questionnaire (PAMQ)

11.0 Equality Impact Assessment

Name of document to be assessed:	Optegra Access Policy	
New or existing document:	**Existing**	
Document aim:	The aim of this policy is to outline the approved processes for the management of Cataract and YAG referrals into all Optegra sites within England as well as highlighting the responsibilities of all Optegra staff, both clinical and administrative.	

Document Objectives:	To advise and inform patients, relatives, carers and Optegra staff of the processes for managing access to services provided by Optegra UK Ltd.
Document – intended outcomes:	That all patient being referred into Optegra are managed appropriately and in line with the details set out in this policy.
How we measure the outcome:	Monthly NHS Pathway Performance meeting UK Leadership Meetings Daily reports to Hospital and Administrative staff Patient Satisfaction
Who is intended to benefit from the policy:	All patients and Optegra employees involved in the process.

Is consultation required with the workforce, equality groups, local interest groups:	Yes	**No X**
If yes have these groups been consulted?	Yes	No
Please list any groups that have been consulted with?		

Are there concerns that the policy could have differential impact on:

Equality Strands:	Yes	No	Rationale for assessment / existing evidence
Age		**X**	
Sex		**X**	
Race/ Ethnic communities / groups		**X**	
Disability		**X**	
Religions / other beliefs Marriage and Civil partnership		**X**	
Pregnancy and maternity		**X**	
Sexual orientation, bisexual, Gay, heterosexual, lesbian		**X**	

You will need to continue to a full equality impact assessment if the following have been highlighted:

- You have ticked 'Yes' in any column above **and**
- No consultation or evidence of there being consultation – this <u>excludes</u> any *policies* which have been identified as not requiring consultation **or**
- Major service redesign or development

Is a full equality analysis recommended	Yes	**No X**
If a full impact assessment is not recommended, why?	There is no evidence of negative impact on equality.	
Name of individual completing assessment:	Melissa Ball	
Date:	1/7/2023	