Patient Access Policy

Version control

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General Note

NHS Borders acknowledges and agrees with the importance of regular and timely review of policy/procedure statements and aims to review policies within the timescales set out.

New policies/procedures will be subject to a review date of no more than 1 year from the date of first issue.

Reviewed policies/procedures will have a review date set that is relevant to the content (advised by the author) but will be no longer than 3 years.

If a policy/procedure is past its review date then the content will remain extant until such time as the policy/procedure review is complete and the new version published.

1. FUNCTION

1.1. This policy sets out how the principles of the National Access Policy will be delivered in NHS Borders.

1.2. The National Access Policy has been developed to provide a common vision, direction and understanding of how NHS Boards should ensure equitable, safe, clinically effective, and efficient access to services for their patients. NHS Borders will strive to follow this concept.

1.3. This Patient Access Policy details how these National Principles apply to local services in NHS Borders including possible and reasonable service locations without being exhaustive or prescriptive.

1.4. This Patient Access Policy has been approved by NHS Borders Board in an open session and is available on NHS Borders internet/intranet site to ensure openness and transparency.

1.5. It is essential that NHS Borders uses resources in a cost-effective way. It is recognised that a culture of continual service redesign and improvement is necessary to achieve transformational change. The need to improve consistency of care and reduce variation across NHS Borders is part of an explicit ongoing commitment to evidence based clinical practice.

1.6. Improvements in waiting times will be delivered in NHS Borders through an effective partnership between Primary and Secondary Care, with appropriate protocols and documentation in place.

1.7. This Patient Access Policy aims to ensure consistency of approach in providing access to services and as such it supports The Patient Rights (Scotland) Act 2011. The Patient Rights (Scotland) Act 2011 establishes a legally binding 12 weeks (84 days) maximum waiting time for eligible patients

where an agreement to inpatient/daycase treatment has been agreed between the patient and NHS Borders.

1.8. The guidance contained in this policy and any associated flow charts and standard operating procedures should be applied fairly and accurately.

2. LOCATION

2.1. All Inpatient services in NHS Borders, with the exception of:

- Assisted Reproductions.
- Obstetrics services
- Organ, tissue or cell transplantation whether from living or deceased donor
- Designated national services for surgical intervention of spinal scoliosis.
- The treatment of aesthetic procedures, injuries, deformities, or disease of the spine by an injection or surgical intervention.

2.2. Outpatient appointments are conducted through face to face (within a clinical setting) by telephone or via the video consulting service Near Me, allowing patients to attend appointments from home or wherever is convenient.

3. RESPONSIBILITY

3.1 Patients

3.1.1. Patients must inform the hospital of any changes to their name, address, telephone number or General Practitioner (GP). All written communication to patients must include details on how/who to contact to make changes to the information NHS Borders hold on them.

3.1.2. Patients who have active Medical Power of Attorney should ensure that a copy of the signed declaration is provided to NHS Borders by sending this to the Medical Records Department, Borders General Hospital, Melrose, TD6 9BS. Failure to do so may result in delays in receiving appointment and will restrict our staff providing Power of Attorney's with information about the patients' care.

3.1.3. Patients should keep their appointment paying particular attention to the location, the day and the time, as some clinics may be scheduled for weekends or public holidays. The appointment may also be Face to Face, Virtual (Near Me) or Telephone as indicated in the appointment letter. If patients are unable to make the appointment, they should inform the hospital with as much notice as possible.

3.1.4. Patients must inform their GP if their medical condition improves or deteriorates in a way which may affect their attendance. This is likely to be either a telephone or personal contact with their GP.

3.1.5. Patients who no longer wish to have their outpatient appointment/admission, for whatever reason, must advise the hospital immediately by contacting the telephone number on their appointment letter.

3.1.6. Patients, who are on a Patient Initiated Review pathway should advise the department identified in their Patient Initiated Review pathway letter if they feel they need to make an appointment for the same condition. Patients will have been sent a letter describing the process for making a further appointment regarding the same condition. This does not require a further GP referral.

3.1.7. Patients who know that they will be unavailable for any periods of time (e.g., due to holiday or work commitments or if they are ill or self-isolating as a result of emergency measures e.g. due to a pandemic) and therefore will not be able to attend for an appointment/admission should inform the hospital at the earliest opportunity, to ensure the information NHS Borders holds is accurate and up-to-date.

3.1.8. When emergency measures are in place e.g., during a pandemic, patients may be asked not to enter the hospital building more than 15 minutes prior to their appointment time (due to physical distancing measures). Where possible, patients should come on their own unless there is a need for a parent/carer to be present.

3.1.9. While the mode of communication with patients is normally by telephone, those sent letters asking them to make contact to arrange admission for treatment/procedure must do so within the timescales advised (7 days of receipt of letter). If the patient fails to call back within the 7 days of receipt of the letter, they will be removed from the waiting list and returned to the care of their referrer/GP. The exception to this will be if the receiving clinician decides it is not appropriate to remove the patient due to a clinical reason. This is likely to refer in particular to Urgent, Cancer or Paediatric referrals.

3.1.10. Text reminders, where appropriate, will be sent out to remind patients of their upcoming appointments unless the patient has opted out of the reminder service.

3.2 Referrers

3.2.1. Those involved in the management of waiting times have a responsibility to make it as efficient as possible:

- Prior to referral the clinician should explain the range of options to be considered and that the patient may not need access to specialist or consultant led services.
- Referrers must provide accurate, timely and complete information within their referral.
- Referrals should only be made if all other alternatives have been explored i.e. patient/clinical pathways have been followed.
- To minimise waiting times and to enhance patient access to services, referrers must make unnamed referrals (Dear Dr) unless there is a specialist requirement for a named consultant however it may not always be possible to support this request.
- Referrers should identify any special communication requirements or support needs their patients may have and detail these on the letter (e.g. literacy problems, need for BSL or other language interpreter).

3.2.2. At the time of the referral, in addition to the patient's name, CHI number, contact address, telephone number (home and mobile) and e-mail address the following information should be supplied:

- All relevant clinical information together with the referrer's assessment on the level of Clinical urgency
- Ensure the patient is available to commence treatment; if not, referral should be delayed until such time as the patient is available
- The patient's availability e.g. is the patient known to be unavailable for given period(s) of time. When the referrers are aware that patients will be unavailable to be seen for a period of time, the referrer should either delay sending the referral until they know the patient is available or note the patient's unavailability period on the referral
- The patient's willingness to be seen at short notice and preferred method of contact (e.g. daytime phone, mobile phone, letter, e-mail)
- Armed forces status, including any current treatment pathway(s) the service personnel may be on, as well as wait experienced
- Veteran status including whether on balance of probability their condition is related to their service, as per national guidance
- If requesting an onward referral to another Health Board area, the additional information field must be completed with evidence why the patient meets one of the exception criteria for treatment out with NHS Borders.

3.2.2. Patients should be made aware that their appointment could be at any appropriate healthcare facility within NHS Borders or other Health Board area where this has been agreed as part of NHS Borders's plan for achieving waiting times.

3.2.3. The referring clinician should advise patients of why they are being referred, the expected waiting time and outline to patients their responsibilities for keeping appointments and the consequences of not attending.

3.2.4. Where treatment cannot be provided locally and the patient needs to travel elsewhere, the patient should be made aware of that as early as possible.

3.2.5. Referrals should be made electronically where possible using locally agreed systems (into TRAKcare or EMIS patient administration systems via SCI Gateway) and as per locally agreed protocols.

3.2.6. Wherever possible patients should be referred for Diagnostic tests prior to the referral being made for the first outpatient appointment.

3.3 Health Records and related administrative staff /waiting list management

3.3.1. Relevant administrative staff will have the responsibility of ensuring that the patient administration waiting list module is immediately updated and that letters as appropriate are sent to both the General Practitioner and the patient.

3.3.2. Systems, processes, and resources should be in place to ensure that all staff are adequately trained to use TRAKcare or EMIS to administratively manage patient flows on behalf of consultant/clinicians.

3.3.3. Patients are booked in turn, according to clinical priority. Patients should be seen within maximum standard waiting times. However, this may not always be possible during times of emergency measures e.g. a pandemic or severe weather. Potential breaches must be reported to Service Managers in sufficient time to enable actions to be taken to avoid a breach in line with a formal NHS Borders escalation process.

3.3.4. Relevant administrative staff will ensure that details of patients on the waiting list who are admitted as emergency admissions are communicated to the waiting list management office for Acute services. For other services, please refer to your internal Standard Operating Procedures.

3.3.5. Systems and procedures should be in place to ensure that Service Managers and other relevant clinical/administrative teams involved in the patient's pathway are aware of any patient cancelled on the day of or after admission.

3.3.6. Systems and procedures should be in place, on a weekly and monthly basis, to review and validate waiting lists to ensure accuracy.

3.3.7. Inpatient Waiting List Audits should be carried out monthly to ensure equitable and sustainable delivery of waiting times standards. Quarterly audit reports are presented to the Access Board. (See Appendix 1 for Waiting Times Audit Standard Operating Procedure)

3.3.8. Relevant administrative staff will ensure standard communication is in place to notify the referring clinician when treatment is delayed as a result of the patient being medically unavailable. NHS Borders medical secretarial staff will ensure this letter is sent and auditable.

3.3.9. Onward referral should be completed to ensure that the receiving healthcare provider has the necessary information to manage the patient treatment pathway. Any transfer of data must comply with NHS standards in relation to data security and confidentiality.

3.4 Receiving Clinicians

3.4.1. Consultants/Clinicians are responsible for applying this policy and ensuring that it is applied consistently and with equity for their practice.

3.4.2. Patients referred with suspected cancer must be marked as 'URGENT-SUSPICION OF CANCER' with the exception of patients who are downgraded at vetting at which point the referrer must be informed of this decision. All urgent cancer patients are required to be seen as soon as possible within cancer waiting time standards.

3.4.3. Armed Forces personnel, veterans and their families who move between areas will retain their relative point on the pathway of care within the national waiting time standards, if advised by GP/referrer.

3.4.4. All veterans (including those who have served as reservists) should receive priority access for any conditions which are likely to be related to their armed forces service, even when they are not in receipt of a war pension, subject to the clinical needs of all patients. Their status must be advised by GP/referrer.

3.4.5. It is the receiving consultant/clinician's responsibility to communicate with the referrer, within 3 working days, to offer advice on whether a referral is suitable. This will avoid unnecessary outpatient appointments.

3.4.6. Any referrals received for a service that is not delivered in NHS Borders should be returned to the original referrer with advice. Where it is judged that the referral would be more appropriately managed by another service provided by NHS Borders, the vetting Clinician will ensure the referral is passed to that service and the referrer informed using the referral vetting function within the TRAKcare patient administration system. Electronic triage through TRAKcare should be completed within 3 working days of receipt and appropriate action taken. Those services using EMIS should refer to their local Standard Operating Procedures.

3.4.7. Receiving clinicians must ensure that waiting lists properly reflect their clinical priorities and are managed effectively and in line with Patient Rights (Scotland) Act 2011 – Treatment Time Guarantee. This includes ensuring that the patient has been assigned the correct appointment type for their condition.

3.4.8. Patients who require treatment for different conditions may be on two separate pathways. Consultants/clinicians should have instructions in place to identify what condition should take precedence.

3.4.9. Consultants/clinicians must ensure systems and procedures are in place to allow them to manage and record all clinical outcomes electronically on TRAKcare or EMIS at clinics for New and Return patients and advise of additions or alterations to the waiting list electronically. This must be done in real-time. Clinical outcomes used will be from the nationally defined set of codes.

3.4.10. Consultant/clinicians must ensure that all patients undergoing a surgical procedure, that is subject to the legally binding Treatment Time Guarantee, have provided clear verbal communication to the patient at the outpatient clinic and ensure that NHS Borders medical secretarial staff are provided details of patients to be added to the Inpatient/Daycase waiting list timely and accurately including any unavailability. NHS Borders medical secretarial staff will ensure a letter is sent and is auditable with TRAKcare to the patient advising them they have been listed for treatment/procedure and their legally binding guarantee date.

3.4.11. Consultant/clinicians must ensure that patients are only added to a waiting list if they are clinically ready and available to commence treatment.

3.4.12. Some patients will be managed through an Active Clinical Referral Triage (ACRT) pathway. This process is used when a referral is received for a common condition that causes concern but normally only requires advice or reassurance. For specific diagnoses, patients will be sent information explaining the condition and how to manage it, for example with exercises and self care. If after consideration the patient wishes to discuss further options, then the ACRT letter will detail how the patient can make an appointment to speak to the most appropriate person. On a few occasions, it might be that an appointment is not required. This may be due to further information being required from the referrer or where it is felt that the hospital service is not required. A letter explaining this will be sent to the patient and referrer.

3.4.13. Consultant/clinicians must ensure that new and return outpatients only receive a return appointment if there is a clinical need.

3.4.14. Consultant/clinicians who triage referrals may not see the patient at Outpatient clinic if there is a capacity issue but will be seen by one of the clinical team. A patient seen by a particular consultant/clinician in Outpatient clinic may have their treatment/procedure carried out by another member of the clinical team. Consultant/clinicians should be advised in this situation.

3.4.15. Patients who “Do Not Attend” without prior notification whether for Outpatient or Inpatient/Daycase treatment will normally be removed from the waiting list and returned to the referrer. The exception to this will be if the receiving clinician decides it is not appropriate to remove the patient due to a clinical

reason and this is recorded electronically on the TRAKcare or EMIS patient administration systems. This will particularly apply to Urgent, Cancer or Paediatric patients.

3.5 Service Managers on behalf of General Managers

3.5.1. Service Managers are responsible for implementing this policy in their area of responsibility. It is the responsibility of these management staff to ensure that this policy is embedded into routine practice. In addition they must ensure that nursing and administrative staff undertake appropriate action by completing all documentation and updating records as appropriate.

3.5.2. Service Managers must ensure they respond timely to any reported potential breaches and ensure that remedial action is taken to avoid a breach or ensure plans are put in place to manage each patient effectively. It is to be noted that during times of emergency measures e.g. a pandemic when footfall within the hospital is reduced to allow physical distancing, it may not be possible for all Routine patients to be seen within the waiting times standards. Priority will be given to Urgent and Urgent Suspicion of Cancer patients.

3.5.3. Service Managers must ensure they have an established escalation process in place to notify the Director of Acute Services/Clinical Directors, General Managers /Clinical Leads of likely breaches.

3.5.4. In order to ensure the effective management of referrals being vetted using the vetting referral function on TRAKcare Service Managers must ensure that there is active monitoring of referrals to ensure that they are clinically triaged within 3 working days. EMIS users should refer to their local Standard Operating Procedures.

3.5.5. Service Managers should ensure that capacity and demand is managed effectively.

3.5.6. The ability to effectively monitor and manage services requires good quality data. This helps to inform performance and identify areas for future improvement. Service Managers are responsible for using information to support improvements in service provision

3.5.7. The factors which influence waiting times, such as changes in referral patterns, should be regularly monitored and management action taken in sufficient time to ensure waiting time standards are maintained.

3.5.8. Service Managers will review new to return and DNA ratios and take necessary steps to address any issues as necessary.

3.5.9. Service Managers will regularly review and agree clinic templates to ensure they reflect changing demands.

3.5.10. Service Managers will ensure the effective monitoring of efficiency and productivity and support necessary change where required.

3.5.11. Benchmarking information should be used wherever possible in reviewing clinic templates and efficiency.

3.6 Director of Acute Services, Clinical Directors, General Managers and Clinical Leads

3.6.1. These individuals are responsible for the leadership and accountability of delivery and improvement of waiting times and achieving waiting times standards.

3.6.2. They should ensure that consultants/clinicians in their service understand the policy and apply it consistently and with equity for their practice.

3.6.3. They should ensure that communication is effective between primary and secondary care as well as with patients.

4. OPERATIONAL SYSTEM

4.1 Key Principles

There are several key principles that underpin the achievement of the aims of the Patient Access Policy and delivery of waiting time standards outlined below:

- The patients' interests are paramount.
- Patients are offered care according to clinical priority and within agreed national/legally binding waiting time standards (for inpatient/daycase activity).
- Sufficient capacity must be available and optimally utilised to deliver waiting times.
- Referrals are managed wherever possible through the referral vetting function on TRAKcare or EMIS which allows real time electronic triage.
- NHS Borders aim to provide common pathways for electronic triage and include the option of providing advice to the referrer or an appropriate appointment.
- Variations in referral patterns are identified and reduced.
- Waiting lists are managed effectively using a combination TRAKcare and EMIS.
- Patients must be referred to a clinical team and will be seen by an appropriate member of that team rather than a named consultant. Within NHS Borders there may be occasions that request for a named consultant,

on receipt of referral may be accommodated, in certain circumstances, but this cannot be guaranteed.

- Patients should not be added to a waiting list if they are not available for treatment due to medical reasons
- Offers of appointment should be made as soon as possible after receipt of referral/being placed on waiting list and not more than 6 weeks in advance to avoid the possibility of cancellation due to annual leave and emergency rota allocation.
- When making a reasonable offer it is good practice for appointment offers to be made as soon as possible after the patient agrees treatment, and ideally at least fourteen days before the proposed treatment date. (The minimum period of notice for a 'reasonable offer' of appointment is seven days.) The patient should receive the letter a minimum of seven days prior to the appointment date.
- A reasonable offer of appointment is the offer of up to two different dates of appointment for each stage of the patient's treatment pathway, with a minimum of seven days notice from the date of offer of appointment to the date of the appointment.
- If a patient refuses two reasonable offers, the hospital should refer the patient back to the referring clinician, normally their GP, unless the consultant has identified the patient as Urgent, Cancer or a Paediatric patient.
- Where an offer is made which is less than 7 days notice (short notice offer) then it cannot be counted as a reasonable offer and there will be no detriment to the patient and no changes to their waiting times clock if they decline such an offer. Accepted short notice appointments will then be classed as a reasonable offer. Urgent appointments are exempt from this and all offers are deemed reasonable.
- Patient Advised unavailability should only be applied by a specific request from the patient or their carer.
- NHS Borders will work to reduce non-attendance.
- NHS Borders will ensure the provision of short-stay surgery is maximised.
- Admissions to hospital are actively managed through pre-assessment services.
- Unnecessary follow up appointments are reduced.
- Information is used to facilitate improvements in service provision.
- There is partnership working with stakeholders in Primary, Secondary and Health and Social Care.
- NHS Borders aims to achieve inclusive and equal access for all service users which is in line with national guidelines and NHS Borders have incorporated regulations from the Treatment Time Guarantee under the Patient Rights (Scotland) Act 2011.

4.2 Location of services/treatment provided by NHS Borders

4.2.1. NHS Borders will always endeavour to treat patients locally, wherever possible and appropriate, based on clinical need and operational

effectiveness. An offer of service/treatment by NHS Borders in any of its location list (this is not exhaustive) will constitute a reasonable offer.

4.2.2. This includes any site within NHS Borders regardless of where the patient resides. This means any NHS Borders hospital, health centre or other premises deemed appropriate to provide clinical care.

4.2.3. This also includes any site out with NHS Borders where treatment is routinely provided or provided in order to meet capacity constraints and waiting times guarantees.
For NHS Borders this includes (this list is not exhaustive) :

- NHS Lothian
- NHS Glasgow
- Golden Jubilee University National Hospital

4.2.4. In certain circumstances limited use of alternative providers or Centres of Excellence is made by NHS Borders. This includes use of the Independent Sector providers and may be required in response to capacity constraint and achieving waiting times guarantees and would constitute a reasonable offer. This includes (but is not exhaustive depending on service required) – Spire Healthcare Murrayfield and Shawfair Park Hospitals, Edinburgh BMI Healthcare, Ross Hall, Glasgow and Kings Park Hospital, Stirling, The Edinburgh Clinic and Washington Spire.

4.2.5. Every effort will be made to advise the patient of this as early as possible, preferably when the decision to refer to secondary care is made, or at the first outpatient appointment. If an offer is to be made for treatment out of NHS Borders's area, or at a location not listed in the NHS Borders's Patient Access Policy, then clear and accurate communication is essential. NHS Borders has set out a good practice approach and "script" for staff's use in these circumstances.

4.2.6. If a patient refuses two reasonable offers, then they will normally be referred back to their referring clinician of GP unless the receiving clinician decides this is not appropriate for a clinical reason. This is likely to refer in particular to Urgent, Urgent Suspicion of Cancer or Paediatric referrals. Unavailability is not to be used in these circumstances. If this is not appropriate, the patient's waiting time clock will be reset to back to zero and the patient will go to the bottom of the waiting list.

4.3 Travel & Accommodation Costs

4.3.1. At the request of the patient, on an individual basis, where a patient is treated outside of NHS Borders Board area consideration will be given to covering the cost of any transport and accommodation arrangements necessarily and reasonably incurred by the patient and their carer (if appropriate).

4.3.2. Reference should be made to NHS Borders Patient Travel Expenses Protocol 2016 v1.11 for the most up to date position on patients' entitlement to travel expenses.

4.4 Did Not Attend (DNA)

4.4.1. All relevant staff will ensure patients receive adequate notice of their intended appointment in line with NHS Scotland Waiting Times Guidance, i.e. the patient should be offered a date at least 7 days in advance.

4.4.2. Assuming a reasonable offer of appointment and/or admission has been accepted, if a patient fails to attend their initial appointment, the episode is closed and the referral is returned to the relevant GP or referral source. Care must be taken to ensure the DNA is factually correct (e.g. patient demographic details are correct and this is reliant on accurate referrer information) and that it is not clinically inappropriate to remove the patient from the waiting list in line with NHS Scotland Waiting Times Guidance.

4.4.3. NHS Borders administrative staff will ensure a letter is sent and auditable to the patient advising them of the action taken, to both the GP and the patient/guardian, advising that no further appointment will be sent.

4.4.4. If the patient is identified by a clinician to receive a further appointment, the patient will be asked to contact the booking team within 7 days to receive a further appointment after which the patient will be removed from the waiting list with the exception of Urgent, Cancer and Paediatric patients. These exceptions will be highlighted to the clinician prior to removal.

4.5 Could Not Attend (CNA)

4.5.1. For those patients cancelling an accepted reasonable offer of appointment, a further date will be offered. The patient should be advised at this stage that any further cancellation would lead to a referral back to the General Practitioner and automatic removal from our waiting list. If a patient requires to cancel for a second time, they will normally be removed from the waiting list and referred back to the referrer unless it is clinically inappropriate to do so. For patients who have been deemed by a health professional to be an urgent referral then agreement with the responsible health professional will be sought prior to removal from the waiting list to ascertain if this is clinically appropriate.

4.5.2. A Could Not Attend will apply to a patient contacting the hospital to say they are not willing to attend at an agreed date/time because they deem they are unwell and a member of the clinical team has advised that the minor illness will not prevent the agreed appointment or treatment from proceeding on the

agreed date. This is not considered as medical unavailability as it is not advised to the hospital or agreed by a clinician.

4.5.3. Any medical paediatric appointment being cancelled completely (i.e. no alternative arranged) by a parent or guardian should be brought to the consultant's attention.

4.5.4. In the event of severe weather where a patient chooses not to attend for an appointment this will be dealt with as a Could Not Attend.

4.5.5. NHS Borders administrative staff will ensure a letter is sent, which is auditable, to the patient advising them of the action taken, to both the GP and the patient/guardian, advising the appropriate course of action.

4.6 Bilateral Sequential Procedures

4.6.1. For patients waiting for sequential bilateral treatment the waiting time for the second treatment is measured as a separate, second pathway. It may be that the agreement for the need for both treatments is made at the same time. However, normally the agreement to commence the second treatment is only made on or after the post-operative review for the first treatment. The waiting time for the second treatment should not start until the clinician and patient agree to the agreed treatment. The sequential treatment must not be managed on a Planned Repeat waiting list.

4.7 Patient Communication

4.7.1. There is a need to ensure that patients are appropriately informed at all stages of the patient journey. Communicating effectively with patients will help to inform them of when, where and how they are to receive care and their responsibilities in helping to ensure that this happens.

4.7.2. NHS Borders will ensure that patients are provided with clear, accurate and timely information about how processes will operate for arranging for them to be seen or to be admitted to hospital.

4.8 Patient Advised Unavailability

4.8.1. This will only apply, for example, if a patient is going away on holiday, personal/work/carer/academic commitment or jury duty and the waiting times clock will then pause for that time duration. The start/end dates will be advised by the patient.

4.8.2. A patient may also request that they do not wish treatment/procedure prior to their holidays for a variety of reasons including flying. If this is advised by the patients then the full time period may be applied as one period of unavailability. This full time period should not exceed 12 weeks, anything more will be deemed indefinite unavailability.

4.8.3. NHS Borders administrative staff, on behalf of their consultant/clinician, must send a letter to the patient that is auditable advising that the period of unavailability has been added to their waiting time for inpatients/daycases.

4.9 Patient Advised Unavailability (Wishes Named Consultant)

4.9.1. NHS Borders will in normal circumstances, on receipt of referral to a named consultant, only allocate this to a named consultant if this will ensure continuity of care, patient safety or for other clinical or exceptional reasons.

4.9.2. This will also apply if a patient specifically contacts the hospital requesting a named consultant/clinician but should not be prompted by NHS Borders staff. Patients should be made fully aware that they are unable to choose their care provider however they can decline a single consultant/clinician. If they decline a second, they will then be informed that they will be removed from the waiting list and returned to their GP/referrer.

4.9.3. A reasonable offer of treatment relates to any competent clinician who is part of the consultant-led service which NHS Borders provides in that speciality or subspecialty and within the terms of good clinical governance.

4.9.4. NHS Borders cannot guarantee that the consultant/clinician assessing a patient at outpatient will undertake the inpatient/daycase treatment

4.9.5. If there is a genuine reason for a named consultant, then this will result in Patient Advised Unavailability (Wishes Named Consultant) being applied. It is anticipated that a very small number of patients will fit into this category.

4.9.6. NHS Borders administrative staff will ensure a letter is sent, and auditable, to the patient advising of addition of unavailability.

4.10 Patient Advised Unavailability (Wishes to be treated in NHS Borders)

4.10.1. NHS Borders will endeavour to provide Services/ treatments and would act reasonably with patients being treated out with NHS Board area.

4.10.2. Patients who prefer to wait locally for treatment even though that may make the waiting time longer than the treatment time guarantee would be

unusual. In order to accommodate such a request for a specific location of treatment, although this cannot be guaranteed, would result in Patient Request Unavailability (Requested Local Health Board) being applied. This must be at the patient's request and not prompted by NHS Borders staff. Patients should be made fully aware of the consequences of their decision. For inpatient/daycases NHS Borders medical secretarial staff on behalf of their consultant/clinician must write to the patient.

4.10.3. It is anticipated that a very small number of patients will fit into this category.

4.10.4. NHS Borders administrative staff will ensure a letter is sent, and auditable, to the patient advising of addition of unavailability.

4.11 Medical Unavailability

4.11.1. This will only apply when a patient is unavailable for the agreed treatment for a known period because a registered medical practitioner has advised or confirmed following a patient contact that the patient has another medical condition which prevents the agreed treatment from proceeding for that period of time.

4.11.2. Medical Unavailability may occur, for example, during pre-assessment. This will be the start date to medical unavailability and the end date would made by the clinician as to the likely resolution timescale. Medical unavailability may normally only be applied by a clinician or a health professional or nurse working under protocol as part of a consultant led service.

4.11.3. When the patient informs they have a minor illness such as a cold, which may prevent them from attending the appointment on the agreed date, clinical advice must be sought (where possible) as to the clinically appropriate course of action.

4.11.4. If the clinician has advised that the patient's minor illness will prevent the agreed appointment or treatment from proceeding on the agreed date, a known period of medical unavailability should be applied. This would normally be for a short period only, for example up to two weeks. Additional information should be provided in TRAKcare or EMIS.

canned text field as to which clinician made the decision and the medical condition.

4.11.5. If the clinician has advised that the patient's minor illness will not prevent the agreed appointment or treatment from proceeding on the agreed date, the appointment should go ahead as planned. No unavailability should be applied. Additional information should be provided in TRAKcare canned text field or EMIS as to which clinician made the decision and the medical condition.

4.11.6. If the clinician has advised that the minor illness will not prevent the agreed appointment or treatment from proceeding on the agreed date but the patient cannot attend (CNA) the agreed appointment, the patient's waiting time clock is reset to zero, where it is reasonable and clinically appropriate to do so.

4.11.7. Medical unavailability should not normally be applied at the request of a patient/carer. However, if the patient advises that they are ill or self-isolating as a result of emergency measures e.g. during a pandemic, then a period of medical unavailability can be applied. Additional information should be provided in TRAKcare or EMIS text fields.

4.11.8. NHS Borders administrative staff will ensure a letter is sent, which is auditable, to the patient advising of addition of unavailability.

4.12 Indefinite Unavailability

4.12.1. NHS Borders will not add a patient to a waiting list if they are indefinitely unavailable and will review the patient by another means until deemed fit. If the patient is already on a waiting list and they then become indefinitely unavailable then their waiting time guarantee will cease and consideration given to removing them from the waiting list and reviewing them in another way.

4.12.2. The patient must be written to by the consultant/clinician advising them of this. The reason must be recorded and the patient clinically reviewed within 12 weeks.

If they are still not available they may remain on list with a further 12 week clinical review. If they remain unavailable at that point then they must be referred back to their GP/referrer.

4.13 Cancelled By Service/Hospital

4.13.1. Patients must not be disadvantaged as a result of changes such as cancellations resulting from operational circumstances. Should this occur, the patient's waiting time clock should continue ticking and the patient should be made a further reasonable offer as soon as possible and within the waiting time standards and Treatment Time Guarantee. During times of emergency measures e.g. a pandemic it may not be possible for all Routine patients to be seen within the waiting times standards. Priority will be given to Urgent and Urgent Suspicion of Cancer patients.

4.13.2. In the event of the Ambulance Service being unable to transport a patient for an appointment due to severe weather or other exceptional circumstance, this will be dealt with as a Cancelled by Service with no detriment to the patient who must be rebooked as soon as possible.

4.13.3. If having been admitted, a planned treatment is unexpectedly cancelled; the patient cannot be recorded as having started treatment. The patient must still undergo treatment within the waiting time standards and Treatment Time Guarantee.

4.13.4. In relation to Treatment Time Guarantee patients (inpatients/daycases), if a visiting consultant service cannot be provided in NHS Borders due to severe weather that prevents the visiting consultant from travelling to NHS Borders then the patient must be reviewed to see if the patient would be eligible to be offered an appointment out with NHS Borders within the Treatment Time Guarantee (i.e. meaning in practice that the patient would have to travel for such an appointment). This will be based on clinical priority and must be an efficient and effective use of NHS resources.

4.13.5. However, if the patient decides, rather than to attend an appointment for the agreed treatment out with NHS Borders to wait until the next scheduled visiting practitioner service, then the period from the date NHS Borders is made aware of the patient's decision to wait to the date of the next scheduled visiting practitioner service will not count towards the calculation of the Treatment Time Guarantee. Unavailability should be added – Patient Advised-Requested Local Health Board.

4.13.6. NHS Borders administrative staff will ensure a letter is sent, and auditable, to the patient advising of the addition of unavailability.

4.14 Suspension Due to Exceptional Circumstances

4.14.1. In the event of exceptional circumstances NHS Borders and/or Scottish Government request the use of this unavailability code for a specific time period. It is not intended for general use and will be monitored.

4.15 Onward Referrals

4.15.1. The transfer of any part of a patient's health care, following clinical vetting, to other Health Board areas or to the private sector must always be with patient agreement using the reasonable offer package. The transferring consultant should be notified of this decision. Patients vetted as not clinically suitable for onward referral should be treated within NHS Borders.

4.15.2. Appropriate documentation and information should be provided to the receiving Health Board (or Private Sector provider where appropriate). Scanned or paper copies should be provided where possible. There should be an agreed minimum data set between Health Boards.

4.15.3. If the patient does not wish to be transferred, then provided NHS Borders have clinically triaged the patient as suitable for transfer and used the

reasonable offer package the patient must be removed from the waiting list and returned to their referrer as refusing a reasonable offer.

5. RISK MANAGEMENT

5.1. The relevant Service Risk Register will incorporate any risks identified through the implementation of this policy, with any exception reports being made as necessary by the appropriate Executive Lead.

5.2. The key risk for NHS Borders is a failure to adopt and implement the policy, and achievement of the legally binding Treatment Time Guarantee, which might have an adverse impact on patient care and their care experience.

6. RELATED DOCUMENTS

6.1. Appendix 1 – Standard Operating Procedure – Waiting Times Audit – June 2021

Appendix 1 - Standard Operating P

6.2. Appendix 2 – Patient Travel Expenses Protocol 2016 v1.11

Appendix 2 - Patient Travel Expenses Proto

7. REFERENCES

7.1. NHS Scotland National Access Policy – July 2012

7.2. NHS Scotland Waiting Times Guidance – July 2012 (CEL 33, August 2012)

7.3. Patient Rights (Treatment Time Guarantee) (Scotland) Act Regulations & Direction 2012

7.4. Patient Rights (Scotland) Act 2011- Treatment Time Guarantee Guidance (CEL 32 August 2012)

7.5. Access to NHS Care for Armed Forces Personnel CEL 8 (2008) and CEL 3 (2009), CEL 39 (2010)

7.6. HDL 2006 16 – Priority Treatment for War Veterans

7.7. Effective Patient Booking for NHS Scotland

7.8. Adult Exceptional Aesthetic Protocol CEL 27 (2011)

7.9. The Patient Rights (Treatment Time Guarantee) (Scotland) Amendment Regulations 2014

7.10. The Patient Rights (Treatment Time Guarantee) (Scotland) Directions 2017