

PATIENT ACCESS, TRANSFER OF CARE AND DISCHARGE FROM CARE PROTOCOL

1. INTRODUCTION

Solihull CCG, as coordinating commissioner, together with other West Midland CCG general acute contract signatories, fund the activity that occurs in outpatient departments whether the appointment results from a referral by a primary care, secondary care or community clinician. West Midlands CCG contract signatories are updating this protocol to increase awareness, and help control demand, arising from the transfer of care (referral and discharge) of all patients from primary to secondary care and includes the transfer of care resulting from consultant to consultant referral.

Within the current health economy, this activity, and the costs arising from it, should be subject to continuous improvement through partnership working. It is important that constraint is exercised upon this activity in the context of a jointly managed risk share agreement.

The Patient Access Policy covers all services across the local health economy (LHE) incorporating the Heart of England NHS Foundation Trust, Birmingham Cross City CCG, Solihull CCG, South East Staffordshire and Seisdon Peninsula CCG, and Birmingham South and Central CCG and describes how the health economy will manage access to its services and ensure fair treatment for all patients.

The successful management of waiting times is covered in this policy using general workable principles for patient access. It is vital that these principles are applied by the Trusts to achieve the national objectives to ensure that at least 90% of patients are treated within 18 weeks, and improve patient choice and experience.

2. POLICY STATEMENT

2.1 The aims of the transfer of care protocol are:

- To ensure good planning at or before referral, admission or discharge.
- To promote safe and appropriate referral practice. Minimise inconvenience to the patient.
- To ensure no delay to onward referral for assessment/treatment where there is a clear diagnosis that treatment must be undertaken as it relates to the presenting condition as opposed to advice to the GP of other diagnosed conditions that might require future treatment.
- Provide care closer to home wherever possible by ensuring management of patients within primary care where appropriate.

- To minimise inappropriate referrals from whichever referral source.
- To ensure clear communication with patients and between primary and secondary providers and social care.
- Ensure the most cost effective use of resources for the healthcare economy as a whole.

This protocol should not act to override the patient’s right to exercise choice or 31/62 day or 18 week referral to treatment national waiting time standards in the timing. This choice should be exercised in the full knowledge of the available alternative options and both the Commissioners and the Providers accept their respective responsibilities in offering this choice.

2.2 The patient access policy aims to achieve the following:

- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.

- Waiting time expectations:

Outpatient Department	Elective Care
Rapid access within two weeks	Cancer targets 31/62 days
Urgent new appointment within two weeks	Urgent procedure within 6-8 weeks
Routine new appointment within 5-8 weeks	90% of routine procedure within 18 weeks in line with Planning for Patient – Everyone Counts

- Support the reduction in waiting times and the achievement of patient access targets across the Local Health Economy (LHE) thereby increasing the number of patients with a booked outpatient or in-patient / day case appointment, thereby reducing Did Not Attend (DNAs), cancellations and improving the patient experience.
- This policy will be applied consistently and fairly across the local health economy.
- The policy will support delivery of the Value Based Clinical Commissioning (Procedures of Low Clinical Value) Policy.
- The policy will provide a framework and guidance for staff to follow, complimenting the HEFT Patient Access training policy.
- To improve communication between General Practitioners and Secondary Care/Community clinicians supporting patient pathways and patient compliance.

3. SCOPE OF THE PROTOCOL

Through the implementation of this protocol and associated agreed Pathway Specific Protocols, where specified in Schedule 2 of the Acute and Community Services Agreement, the process of managing the risk associated with the transfer of care between primary and secondary/community care and within secondary/community care is defined through appropriate referral and discharge mechanisms. The implementation of this framework supports the delivery of CCGs’ commissioning intentions to reduce inappropriate referrals and to ensure clinically appropriate levels of follow up required in secondary care.

4. GENERAL PRINCIPLES FOR TRANSFER OF DISCHARGE

- The protocol relates to referrals and discharge for outpatient appointments only.
- The protocol should not delay urgent care or unduly inconvenience patients; in the event of any conflict with national access targets, the former will take precedent.
- Care should follow established pathways wherever possible.
- Patients who can be managed in primary care should be (for some conditions this may be supported by inter-practice transfer arrangements, an enhanced service or a specific care closer to home/community service).
- Prices should be determined by national/local tariff but can be amended if jointly agreed, that a local price better supports the health economy and integrated care priorities, and then amended as a contractual variation.
- Patients should be able to exercise choice as set out in the NHS Constitution
- Outpatient referrals by non consultants/non GPs, whether in secondary, community or primary care and other healthcare professionals such as nurse specialists, extended scope practitioners, optometrists and dentists are covered by this protocol.

5. GENERAL PRINCIPLES FOR ACCESS

- 18-week wait targets will not take precedence over clinical need. Implementation of this policy should ensure that patients are treated in accordance with their clinical need and that this should determine when patients receive their treatment.
- Patients will be assessed on their clinical need and urgent patients will be seen at the first available appointment, as outlined within the waiting time framework above.
- The maximum length of wait for a routine first appointment should not exceed **five to eight weeks** (according to Directorate Specific slot polling range) from the date the referral is received by Heart of England Foundation Trust (HoEFT), either through manual referral or Directly Bookable Services. All patients should have to opportunity to participate in the choice of their clinician, appointment time, date and location (where choice is available).
- **Cancer Referrals**
 - Urgent referrals for suspected cancer fall outside this Patient Access Policy and current cancer pathways should be adhered to (further information is available from the Pan-Birmingham Cancer Network Information for Professionals at <http://www.birminghamcancer.nhs.uk/staff>). NB: Rapid access referrals will only be accepted on the Pan Birmingham Cancer Network proforma - <http://www.birminghamcancer.nhs.uk/staff/rf>. In order to avoid any delay in delivering urgent patient care and assessment, if a practice does not use the appropriate form we will continue to book the outpatient appointment, however the Trust will feedback to the relevant Practice Manager that an incorrect form has been filled in. Following

this feedback we will not accept further incorrect referral proformas and future incorrect referrals will be returned to the General Practitioner.

- All rapid access patients will be seen in the outpatient clinic within two weeks of their referral date as set out by the Pan-Birmingham Cancer Network guidelines. If a patient fails to attend their outpatient appointment the outpatient team will update the General Practitioner by fax within 24 hours.

If the patient cannot attend their initial offer, they will be rebooked into the next available rapid access slot. If the patient cannot attend a second appointment the outpatients department will inform the General Practitioner of the same through the use of a faxed proforma, requesting that a discussion takes place between the General Practitioner and the patient on the importance of such an appointment. If patient accepts the initial offer date but DNAs they will be referred back to their GP. Once the patient has agreed to attend their rapid access appointment the General Practitioner should sign the received proforma and fax this back to the rapid access team, where a further appointment will be offered. The Rapid Access clock will start again when the proforma has been re-received.

General Practitioners should not refer a patient to the Trust in the knowledge that they are unavailable to attend an urgent outpatient appointment within the 2 week national standard period. General Practitioners should make the referral when the patient is available to attend.

Current Rapid access/two-week wait services include:

- Breast Services 2WW
- Hot Joints (Rheumatology); Haematology
- Respiratory; TIA
- Urology 2WW
- Cardiology 2WW
- ENT 2WW
- Colorectal Surgery 2WW; Upper GI Surgery 2WW
- Dermatology 2WW
- Gynaecology 2WW

The preferred process for receiving manual 2ww referrals is:

- GP contacts the HEFT rapid access team by telephone
- Appointment is given to General Practitioner immediately, who in turn discusses with patient
- Appointment logged onto the HEFT appointments system
- Referral is subsequently faxed to Lyndon Place (using the Cancer Network standard form)
- Appointment confirmation letter is sent directly to the patient

If, in the event the Trust has a capacity issue within a Directorate, the GP will be asked to fax the referral through to the rapid access co-ordinator who will subsequently make contact with the said directorate to increase rapid access capacity. An appointment will be sent directly to the patient at this point. The Trust is currently reviewing the fax arrangements for rapid access services with a view to implementing an email function to increase safety and offer GP reassurance that the referral has been acknowledged and received.

In addition 2ww diagnostic services (directly bookable) are available for colonoscopy and flexible sigmoidoscopy, with a view to introducing OGD and haematuria clinic in 2014. Echocardiogram and ECG will be live shortly.

General Practitioners will enter into discussion with their patient on referral regarding timely access to secondary care – HoEFT will usually book appointments for patients within five weeks of referral. If the patient, chooses to book an appointment beyond five weeks but no later than six weeks (to support the 18 week pathway), the secondary care provider must accept the referral and book the patient into the first available appointment that is also convenient to the patient. The patient should not be returned to the general practitioner (GP) unless they are unable to attend their appointment within a six week period.

The Trust work within the agreed Cancer Standards target dates for patients who require treatment:

- Rapid access referral – patient's expected to be treated within 62 days (Target = 85%)
- Routine/urgent referral – patient's expected to be treated within 31 days from the decision to treat (Target = 96%)
- Subsequent treatment for cancer – patients expected to be treated within 31 days from the decision to treat (Target = 94% for surgery, 98% for chemotherapy)

The Trust closely monitor the cancer pathways of all patients with designated MDT co-ordinators linked to each of the relevant specialities. MDT Co-ordinators will facilitate early appointments, tests, treatment and/or surgery in order to support the patient journey and accessing treatment within the agreed timeframe. Waiting times are also audited annually, externally by KPMG and internally between cancer services and performance.

6. PATIENT CHOICE

To enhance patient choice it is strongly recommended that General Practitioners make full use of the Choose & Book system. HEFT provide a centrally managed email support service for general GP enquiries, including any queries relating to the Choose & Book system - bhs-tr.appointments-centre@nhs.net

Transparency – all communications with patients and primary care practitioners will be informative, relevant, complete, timely, clear and concise.

The majority of patients who are referred through the Choose & Book system will be able to book their appointment either on-line or through the Telephone Appointments Line. This will allow patients to choose their appointment date, time and location (and also named Consultant if the General Practitioner has chosen this route).

A small group of HEFT patients will be unable to book their appointment immediately due to lack of capacity at a given point in time. The contract target for Actual slot issues (ASIs) in 2013-2014 is 10%. HEFT performance has improved consistently over the past 3 years with regular review of slot poll ranges, providing improved access to outpatient appointment slots. The Trust will contact patients to confirm that they are on the "Appointment Slot Issue" (ASI) Report within 24 hours of initial contact informing the patient they are aware of their referral

and the need for an appointment and will endeavour to book their appointment within four working days.

For all General Practitioners using the Choose & Book system, in line with National Guidelines, all referrals should be attached to the Choose & Book system within 72 hours. The Trust has enhanced their Choose & Book service significantly over the last 2 years, developing Advice and Guidance services, direct appointments for both rapid and general services, directly bookable tests and more recently a Clinical Assessment Service. General Practitioners must attach the referral immediately on initiating the appointment through Choose & Book.

7. PATHWAYS DEVELOPMENT PROCESS

There are many examples of clinical practice where patients follow recognised and established pathways. However there are also many clinical situations where pathways are yet to be defined or agreed.

This process should include the improvement of the patient pathway as management of the patient journey is crucial to improving overall patient experience and outcome and making the best use of bed and clinic capacity and all other resources.

Pathways should be jointly developed between clinical commissioning leads and clinical service leads with the Provider and consensus achieved prior to adoption within any formal agreement.

8. PRIMARY CARE REFERRAL TO SECONDARY CARE THROUGH REFERRAL BY GP OR APPROPRIATE HEALTHCARE PROFESSIONAL

Any referral to secondary care must originate from either a GP or appropriate healthcare professional, such as Nurse Practitioners, Dentists, Optometrists and Extended Scope Practitioners. Prior to referral the following will occur:

- The GP or appropriate healthcare professional must have either examined the patient or undertaken a commissioned triage process (unless there is a commissioned patient self referral pathway).
- Any required tests must have been undertaken; any indirect impact of this protocol on direct access radiology, pathology and other contracted volumes will be monitored by HEFT and cluster contract management teams.
- Test results will be made available to the receiving consultant and included wherever possible in the original referral letter, except where this conflicts with urgent or cancer and cardiac two-week pathways (the statutory two weeks appointment should be available on the spot and also that the appointment is made with the appropriate specialist). Where diagnostic test results are not included in the referral HEFT's booking administration are unable to follow up with the respective clinician or practice.
- Prior to referral the GP or Healthcare Professional makes an initial diagnosis and follows the appropriate documented pathway where available, for example via Map of Medicine or NICE or a locally agreed pathway.

- All care appropriate to a primary care setting will continue to be considered including:
 - Direct Access Pathology and Radiology Tests
 - Treatment options in the community or primary care
 - Information obtained using GP advice and guidance
 - Patient medication
- The referring GP or healthcare professional must provide sufficient information to enable the provider to determine the most appropriate clinic/consultant. Details should include:
 - Patient demographics, including NHS number
 - Results of tests undertaken and medication
 - Other relevant clinical/patient history details such as allergies and co-morbidities
 - Make clear what the referrer is asking the provider to do
- Referral must be in line with any agreed pathways, documented within the contract for the provision of acute services
- In complex cases where the most appropriate consultant to assess the patient is not clear or where the need for referral requires clarification then the GP or healthcare professional should have the opportunity to seek expert advice from secondary care before formal referral; tariffs for access to expert advice will be agreed annual as part of the LDP process. To support access to Consultant advice the following services deliver an advice & guidance service via the Choose & Book system

Directorates		
Dermatology	Breast Surgery	Rheumatology
Cardiology	Colorectal Surgery	Trauma & Orthopaedics
Paediatrics	General Surgery	Chemical Pathology
Gastroenterology	Paediatric Surgery	Pain Management
Urology	Upper GI Surgery	Gynaecology
Diabetes	Elderly Care	
Endocrinology	Thoracic Medicine	
Renal Maxfax	Thoracic Surgery	
Haematology	Vascular Surgery	
	Infectious Diseases	
	Clinical Immunology & Allergy	

- The referrer must inform the patient that referral is appropriate and offer choice of provider.

- GPs are strongly recommend to utilise the Choose and Book system in making the referral and where seeking expert advice as indicated above.
- To ensure maximum use of Choose and Book by primary HEFT are required to ensure that the Directory of Services for acute and community services is kept up to date and regularly reviewed to support referrers making the most appropriate choice (vague service narrative such as “Not Otherwise Specified” should be avoid).
- Consultant replies to GPs should provide the advising consultant name and be clear as to whether a GP referral is clinically warranted.

Clinical Assessment Service

In May 2013 the Trust commenced a 3 month pilot Clinical Assessment Service delivered via the National Choose & Book system. The following five directorates will develop and deliver this service:

- Dermatology
- Diabetes
- Endocrinology
- Cardiology
- Haematology

The Clinical Assessment Service will provide a triage service for Outpatient referrals allowing Consultants to deliver one of four options post review:

- Outpatient Appointment – patients who do require an outpatient appointment will be booked directly into the correct appointment slot, the first time, following Consultant initiation.
- Advice & Guidance – the Secondary Care Consultant will provide advice to the General Practitioner supporting the management of the patient in Primary Care. This method of service delivery also enhances Primary Care knowledge and education.
- Direct to Test – The Consultant will identify that the patient requires a test. This is arranged by the Consultant with a follow up appointment arranged if required (if not the Consultant will write to the General Practitioner with the results). This method of service delivery reduces the patients overall pathway and secondary care attendance.
- Referral reject – This option will only be used if the General Practitioner fails to attend to their referral letter immediately or if the content of that referral letter is inadequate putting a safe triage service at risk.

The Clinical Assessment Service has been developed with specific objectives:

- To ensure the patient receives their care in the right place, first time; their care may be delivered by a Secondary Care Consultant or their own General Practitioner following initial
- To improve the education and knowledge of General Practitioners
- To reduce the patients overall pathway, and outpatient attendance
- To support a reduction in outpatient attendances

- To increase the usage of the national Choose & Book system to 50%

The Clinical Assessment Service pilot will be reviewed during Autumn 2013 after the initial pilot period. Feedback will be sought from Primary and Secondary Care clinicians as well as administrative staff. A review meeting will then be scheduled to assess the results of the pilot and identify if the objectives have been achieved.

9. REFERRALS WITHIN SECONDARY CARE INCLUDING CONSULTANT / OTHER CLINICIAN-TO-CONSULTANT REFERRAL MAY OCCUR

In general consultant-to-consultant referral may take place when:

- Clinical judgment determines that symptoms and signs suggest that a delay might be life threatening or is likely to impact on the long term prognosis. If the presenting condition or subsequent diagnosis does not warrant an urgent progression to treatment or onward referral to a specialist for an urgent clinically related issue then the patient must be discharged back to their GP (practice) for the GP/patient to decide when to refer in and which provider/consultant.

Appendix 1 provides some real clinical case examples and possible application of the policy to provide a guide.

- A Consultant determines that the patient requires an appointment with a more appropriate Consultant within the same specialty or condition pathway or is a condition related to the presenting condition that requires urgent treatment/assessment. This should be appropriately redirected within the specialty/condition pathway (additional guidance can be found in the 2013/14 Payment by Results technical guidance).
- It is necessary, as part of the investigation of the presenting problem, to perform specialist investigations. A referral to a Consultant with the necessary skill should be made.

In the following specific pathways of care Consultant-to-Consultant referral may occur:

- Any referral that is on a two-week or emergency pathway. Examples include:
 - Oncology referrals arising from MDTs
 - TIA/Stroke prevention services
- Transfer of a patient/condition from paediatric to adult service to preserve continuity where required.
- Referrals to Cardiology to confirm a patient's suitability for surgery.
- Any referral to tertiary services (i.e. services that routinely receive referrals from secondary care or are the only provide within the region). Examples include:
 - TB, Occupational lung, Cystic Fibrosis, Sleep Apnoea
 - Thoracic surgery
- Referral to established multi-specialty combined clinics. Examples include:
 - Medical and Surgical weight management services
 - Rheumatology and Orthopaedic lower limb, upper limb and hand
 - Infectious diseases/Orthopaedic bone infection Diabetes and Obstetric antenatal and postnatal Diabetes and Ophthalmology retinopathy

- Gastroenterology and General Surgery inflammatory bowel
- Referrals relating to chronic multi-system disease where specialist management or intervention is required with close collaboration (i.e. sharing of complex clinical information). Examples include:
 - Rheumatoid or connective tissue disease with lung, renal or skin involvement
 - Renal disease requiring vascular access
 - Elderly care and neuropsychiatric for Parkinson's, Alzheimer's or depression
- Referrals that facilitate discharge from or prevent an acute admission. Examples include:
 - Biliary colic referred for outpatient ultrasound
 - Acute medicine/rapid access or emergency outpatient clinic (any specialty)
 - New emergency Acute Medical and Respiratory Day Clinics (proposed across the three HEFT sites in 2012/13) which are designed to avoid the need for an emergency hospital admission.
- The HEFT 'Trust Key Indicators' monitored through the acute contract includes a KPI for Consultant to Consultant referrals (for all West Midlands CCG signatories to the 2013/14 contract).

10. INTER-SPECIALTY REFERRAL OUTSIDE ESTABLISHED PATHWAYS

All other situations should not normally initiate a consultant-to-consultant referral.

Acute providers need to ensure that Consultants, in particular, do not refer patients to other Consultants for the following defined range of conditions:

- Management of diabetes (service specific protocol)
- Management of hypertension
- Management of non-malignant skin conditions, in particular viral warts, seborrhoeic warts, molluscum contagiosum, acne, eczema, urticaria, psoriasis and moles. Exclusion to this would be those with severe disease requiring complex treatment or recognised investigations can only be undertaken in secondary care.

Note: where there is a suspicion of malignancy which can only be ruled out through direct observation, biopsy or other test, an attendance may be appropriate. This may be the case where, say a chest physician or diabetologist for instance, believes they do not have the knowledge/proficiency to rule out a malignancy.

- Management of asthma or chronic obstructive pulmonary disease (unless there are extenuating circumstances involving particularly challenging patients).

Note: Some of the conditions prohibited from onward referral may not be appropriate for paediatric patients, for example: psoriasis, severe previously unrecognized asthma.

In particular the following should be noted:

- Where an investigation of the presenting problem turns up some incidental abnormal finding (e.g. an elevated blood sugar in a patient who is well and who has no symptoms of diabetes) the abnormal result must be communicated to the patient and GP, the patient must be advised to consult their GP for further advice (with an indication as the appropriate timescale) and the further management of the patient must be left with the

GP. The clinical care of the patient should be returned back to the general practitioner. Where appropriate a suggested on-going management plan should be given including recommendations (rather than mandatory instruction) for onward referral to community or specialist care where this should be considered.

11. PATIENT INITIATED REFERRAL

Patient initiated new referrals are appropriate in certain circumstances where this is indicated in the pathway of care, examples include GUM clinics or physiotherapy (where commissioners have approved).

In some circumstances telephone screening or triage may be appropriate to establish if management in secondary care is appropriate. This may require development of call management protocols.

12. JUSTIFICATION FOR FURTHER FOLLOW-UP

Should a further out-patient review be considered necessary, the reasons must be clearly documented. All In-patient and Out-patient letters must clearly state at the end the reason for the follow-up.

Where no follow up is clinically required patients should be told why no follow up will occur and that the reason is that this is clinically appropriate practice for the particular condition. It is also not acceptable for patients to be told that it is due to a lack of Commissioner resources.

Particularly in the care of the elderly multiple follow ups should be reviewed and put under the management of one care specialist wherever possible.

In some circumstances it may be appropriate to discuss outcomes and care management with the patient or their relative/carer but a face to face consultation may not be warranted. In these instances a telephone follow up may be appropriate e.g. as practices in gastroenterology or diabetes.

13. FOLLOW-UP FOLLOWING INVESTIGATION

Patients should not be brought back to clinic to receive negative test results, unless condition specific advice and guidance is required to be delivered face to face once those results are available.

Where Specialist tests have been sent away to third party laboratories which can take four to six weeks or longer to return, in such cases results should be communicated within two weeks of the trust receiving the result.

In this latter instance, if the Consultant is aware that such results generally take longer, he/she should inform the patient at the time of Consultation giving an indication of the likely timescale for reporting. Communications to the GP, where appropriate, should include a suggested on-going management plan with reasons when re-referral should occur.

14. DISCHARGING PATIENTS BACK TO PRIMARY CARE

The general principle of the policy is to achieve overall improvements in patient care while minimising disruption to primary care.

Where patients have been referred back to the General Practitioner as medically unfit for elective surgery General Practitioners can update the waiting list department via fax on the following numbers:

- Good Hope Hospital 0121 424-9559
- Birmingham Heartlands Hospital 0121 424-3498
- Solihull Hospital 0121 424-5044

Further HEFT referral contact information is provided in the table below and is updated periodically in Primary Care bulletins and newsletters.

Management:

The Centre Manager for the department is Karen Roberts.
The Appointments Manager is Tracie Morgan.

Function:

Patients are referred by their General Practitioner or other medical staff within or outside of the Trust.

The Departments operate from 8.30am to 5.00pm Monday to Friday. There is no service at weekends or on Bank Holidays. There is an Appointment Reminder Service during the evenings when patients are contacted to confirm attendance at their appointments.

The bookings undertaken can be for appointments at Good Hope, Heartlands, Solihull. Birmingham Chest Clinic book their own appointments but some allergy patients are booked by the Centre. The clinics provide speciality advice regarding investigation, diagnosis and treatment by Consultants and other staff allied to medicine.

The department is divided into four teams:

Appointments and Rapid Access: The staff are responsible for checking patients on the computer system, booking new appointments that are requested via the Choose & Book system or manual appointments received directly from the General Practitioner, internal or external consultants and follow up appointments associated with attendance or admission. Each member of staff spends time on the telephones and also has administrative time. This team also handle the post and faxes that come into the department.

Call Centre: There is a dedicated call centre dealing with patient appointment enquiries, rescheduling and cancellation of appointments.

Clinic Management and DBS team: Lyndon Place also houses the validation/rescheduling and Trust's Choose & Book team. This team is responsible for clinic builds, changes and validation to ensure that patients do not breach waiting times and work associated with Choose & Book. The team leaders are Anna Pittock, Tracy Horsfall and Susan Priestner. Sam Varghese is the Direct Booking contact.

Both Karen Roberts and Tracie Morgan can deal with queries regarding Choose & Book.

Contact information:

Please call the following numbers for information regarding referrals:

<p>Appointments Team Leader: Kath Hemming Tel – 0121 424-8967</p>
<p>Acute Medicine and Elderly, Neurology, Cardiology, Renal, Diabetes (Good Hope), Dermatology, Plastics, Clinical Haematology (Good Hope), T&O, Vascular, Respiratory, Breast, Urology, Oncology (Good Hope), General Surgery, DEXA scans, Gastroenterology, Rheumatology, Ophthalmology, ENT, Paediatrics (Good Hope), Allergy, Anaesthetics (Pain Management), Gynaecology</p>
<p>Call Centre Team Leader: Virginia Hall Tel – 0121 424-1234</p>
<p>Rapid Access Team Leader: Karen Baillie Tel – 0121 424-5000</p>

Karen Roberts, Centre Manager 0121 424-8937
Tracie Morgan, Appointments Manager 0121 424-8975

Appointments Fax	0121 424-8954
	0121 424-8952
Rapid Access Fax	0121 424-5001

Where to direct referral to:

Lyndon Place address:

Please remember that all letters should come through this address only and not to individual Consultants.

**Appointment Centre,
 Fourth Floor,
 Lyndon Place,
 2096 Coventry Road,
 Sheldon,
 Birmingham B26 3YU**

The following departments manager their own referrals and should be addressed directly to them at the appropriate site:

Speciality	Address
Infectious Diseases Obstetrics Diabetes Centre Paediatrics Medical Day Hospital Thoracic Surgery Oncology Haematology Radiology	Heartlands Hospital Bordesley Green East Birmingham B9 5SS
Dental Paediatrics Medical Day Hospital Oncology	Solihull Hospital Solihull B91 2JL

Radiology	
Obstetrics Dental Radiology	Good Hope Hospital Rectory Road Sutton Coldfield West Midlands B75 7RR

15. DISCHARGE

Managing effective discharge processes involves working in partnership with all those concerned including the patient, family, carers, provider, community and primary care based health care professionals, MDTs, social care and individuals and teams within the wider health economy.

The ultimate responsibility for the overall management of a patient including follow-up and discharge arrangements rests with the patient's consultant. However, should the GP wish to meet the on-going care needs of the patient they should be able to request that the patient be discharged to their care.

Note: An example of this is where HEFT/Solihull PCT in 2010/11 agreed a set of consultant, GP and patient pro-forma letters that could be used for this purpose including informing the patient of a return to primary care management.

On that basis such a request should not be unreasonably refused. Where the consultant believes the patients care needs to continue to be provided by the Consultant and his team, the Trust should communicate this to the GP.

The CCG and clinical commissioners will actively engage with providers to jointly develop discharge protocols for conditions in specialties where consultants want to transfer care not historically managed in the primary care environment and where this is achievable and clinically appropriate. This should be undertaken collaboratively to avoid perverse incentives e.g. high levels of new referrals back into secondary care, wherever possible.

The 2013/14 NHS Standard contract has the following sections which are also relevant to this protocol:

- Specific Condition 11 – Transfer of and discharge from care obligations

Furthermore, if on receipt of a new referral the triaging Clinician feels attendance in a Secondary Care environment is not warranted the Clinician will return the referral to the General Practitioner with advice and guidance, with the option that if the General Practitioner remains concerned the Trust will honour the referral request.

16. COMMUNICATION

All correspondence to GPs must be sent in line with the standards set out within the contract as detailed in Section C Part 7.1: Transfer of and Discharge from Care Protocols – Discharge Obligations. Providers and Commissioner will work together to continually improve the standard and timeliness of discharge information.

- The provider will complete a patient Discharge Letter containing, as a minimum, the

following additional information:

- Patient name
- Patient date of birth
- Patient address and post code
- Patient NHS No.
- Reason for admission
- Diagnosis
- Summary of treatments / procedures
- Summary medication including drugs taken and where appropriate the reason drugs were stopped / any reactions to them.
- Details of positive HCAI tests and treatment given
- If results of re-screening sent to CDC
- Relevant screening negatives
- Details of advice given to patient (and carer) on discharge
- Details of any follow up arrangements and status (ie appointment booked, patient will receive appointment within 6 weeks)
- Actions required by GP

In April 2013 the Trust began an E-letters project supporting electronic transmission of outpatient and consultant communication to local GP's. To participate the GPs should have access to the EDT Hub which supports smooth transference of text from the HEFT clinical letters system and System One/EMIS. Initially only patients attending the Heartlands & Solihull Hospital will benefit from this service due to software compliance. It is expected that all Directorates delivering outpatient services within these hospitals will deliver live transmission by December 2013. Good Hope Hospital services will be developed in 2014.

17. CODING CONVENTIONS FOR REFERRALS WITHIN ESTABLISHED PATHWAYS

The coding protocol with respect to charging 'New' or 'Follow up' appointments within established pathways will be in line with published DH PbR guidance and Connecting for Health definitional rules.

18. AUDIT

The Co-ordinating Commissioner and the provider through the Clinical Quality Contract Review Meeting (CQCRM) monitor the quality and safety of Trust clinical services. Appendix 2 details the current_main contract related groups that exist within the 2013/14 HEFT contract management framework.

Specific areas of audit focus will be subject to annual LDP negotiation and national commissioning and contracting guidance. Audit areas are likely to vary year by year.

19. ASSOCIATED PATHWAY SPECIFIC PROTOCOLS

Specific new pathways once jointly agreed they should be approved by the HEFT JCCG (Joint Clinical Commissioning Group) any Pathway Specific Protocols will be incorporated via a contract variation to Schedule 2.

20. WAITING LIST MANAGEMENT

If a patient is cancelled on the day of surgery, they shall receive notification of their new TCI date within five working days of their cancellation. All patients will receive their operative procedure within 28 days per national guidelines.

If a patient cancels their outpatient appointment, diagnostic procedure or elective procedure on the day of the appointment, this should be considered a clock stop, unless due to exceptional circumstances. If a patient fails to attend their pre-operative assessment or operative procedure on the day this should be considered a clock stop.

A patient should not be on two waiting lists at the same time (unless for diagnostic purposes, two local anaesthetic lists or one local anaesthetic/one general anaesthetic). It is important that the patient chooses which operation they feel is their priority.

Patients may be offered either hospital site for their surgery, providing adequate transport arrangements are in place – if they refuse a reasonable offer the Trust will pause their 18 week clock until the Trust can offer the patient a date on the site of their choice

21. PATIENTS REQUIRING PRIOR APPROVAL IN LINE WITH CLUSTER POLICY FOR VALUE BASED COMMISSIONING

In the 2013/14 Acute Contract CCG contract signatories have detailed and clarified the funding arrangement for treatments or procedures which have clear clinical guidance or evidence and associated commissioning policies. These treatments and procedures are listed as an appendix to Schedules 1/2/6 of the HEFT Acute contract and can be downloaded from the NHS Solihull CCG website at:

http://www.solihullccg.nhs.uk/publications/doc_download/161-appendix-3

If a patient requires a procedure excluded by the CCG, the patient's clock will keep ticking while authorisation is sought from the Birmingham, Black Country and Solihull CSU IFR team, providing the IFR request is requested by the secondary care clinician. Patients in these circumstances are complex and should not be removed from the 18-week pathway or returned to the GP. As per PLCV guidelines General Practitioners or Consultants may be requested to seek individual funding for patients where exceptionality can be demonstrated. There may be some instances when the GP can demonstrate that the patient's condition may impact their daily life and as such are exceptional. In this situation the secondary care consultant may feel that the General Practitioner is the most appropriate clinician to explain the impact on the patient's daily life. As such the patient will be returned to the GP's care until such time that funding has been agreed. If the GP is successful in obtaining funding they should inform the HEFT Consultant, as well as providing the authorisation code. The patient will then be re-added to the waiting list with a new clock start.

Birmingham, Black Country and Solihull CSU IFR Team has agreed to review pre-authorisation requests within five working days and provide a response. Failure to receive a response within five working days will result in the patient being offered a TCI date and CCG requirement to fund. All patients will be put on a waiting list whilst the pre-authorisation process takes place to maintain patient safety.

Patients cannot be reinstated on to an on-going 18 week pathway once removed due to decline in funding. If the patient's condition changes, the GP will need to re-refer; this will commence a new pathway and 18-week clock start. Likewise, if an additional request for funding is made and is successful the patient will be re-added to the waiting list and a new pathway and 18 week clock will start.

22. DO NOT ATTENDS (DNAs)

The following principles will apply:

One first outpatient DNA and then the patient will be referred back to the GP, unless this is against the clinical interests of the patient. In the case of patients who say they did not receive the first appointment there is an audit facility on the Trust's hospital computers that confirms whether an appointment letter has been printed (a recent Trust audit of the top five reasons for non-attendance did not include non-receipt of appointment letter). If a patient is offered a further new appointment the 18 week clock is reset in line with DoH guidelines

If a patient is reinstated (via a clinical decision) following a "DNA" and fails to attend a second first appointment arranged/agreed with the patient then the patient will be discharged back to the General Practitioners care, in line with the current Trust DNA policy. Similarly a patient who fails to attend two consecutive follow up appointments will be discharged if it is clinically safe to do so.

Paediatric DNAs will be treated in line with the HEFT Trust paediatric DNA policy supported by the Safeguarding of Children policy. (Please see flow chart on the next page)

For all Children's DNAs an address check against records should be made to ensure the appointment has been sent to the correct address

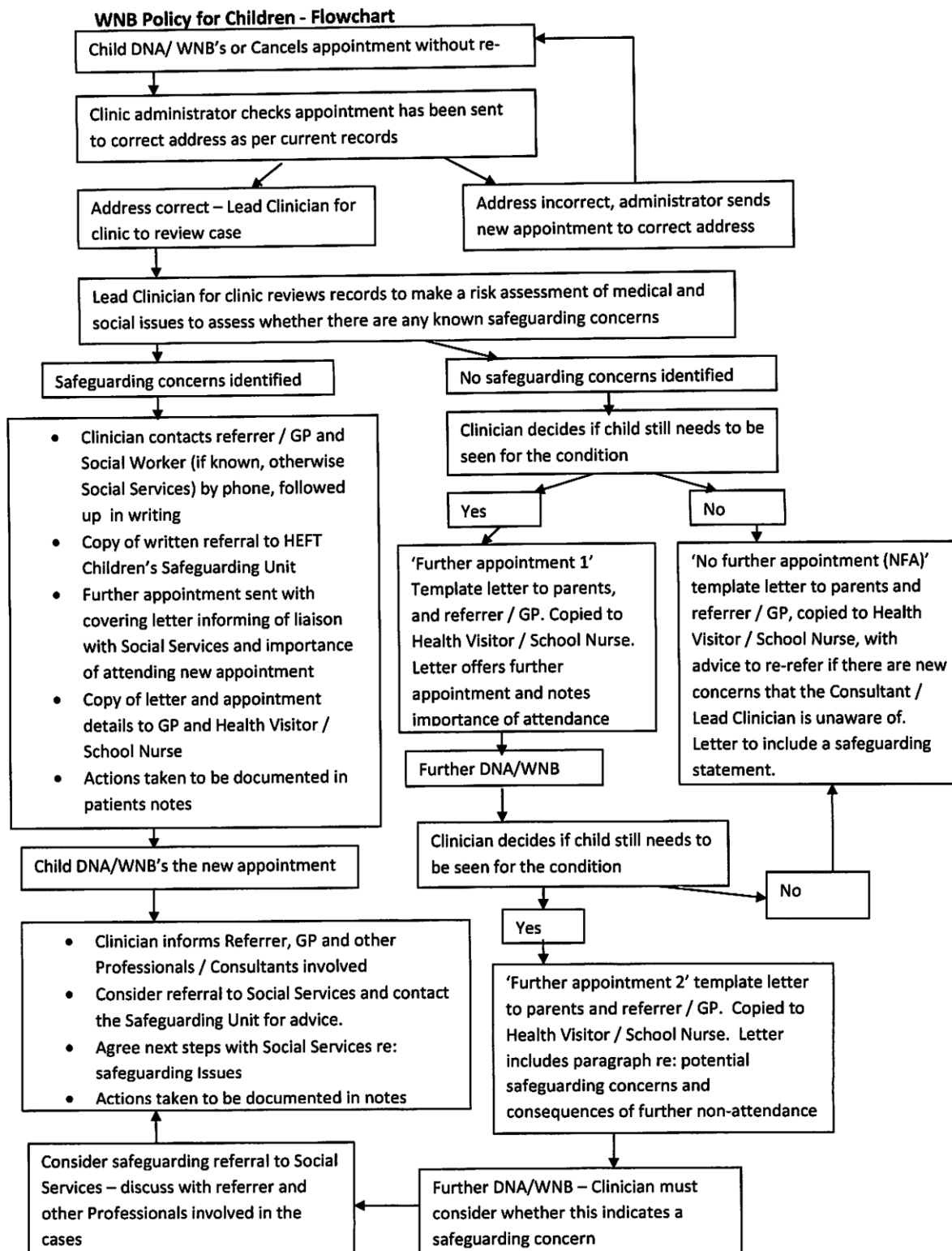
All Children's DNAs should be reviewed by the Consultant at the end of clinic. The clinician will decide whether further clinical follow-up is necessary and give due consideration to any safeguarding or child protection concerns. Central to the clinician's decision making is the use of what is the reasonably available information about a case. For new referrals this will usually only be the referral letter, for follow-ups the hospital records will help. Where doubt exists, consider discussion with the referrer who may have more knowledge of the child and family.

One diagnostic DNA and the patient will be referred back to the GP, unless this is against the clinical interests of the patient.

Patients who DNA a pre-operative assessment will be referred back to the care of their GP, unless this is against the clinical interests of the patient. GPs will be able to fast track the patient back into a pre-operative clinic. As stated above, if the patient fails to attend a pre-operative assessment on the day, and the clinician requests a further appointment this will restart the 18 week clock. The decision to restart the 18 week clock for this group of patients has been reached locally by the commissioning CCG and Trust to reduce the potential bureaucracy linked to the patient being discharged back to GP's care following non-compliance, requiring immediate re-referral for a said procedure. Undertaking this local

agreement will reduce the process for the patient to gain re-entry into the Trust following failure to attend.

Patients who fail to attend a pre-operative appointment will be automatically taken off the waiting list, following a check of the audit trail for printing appointment letters that exists on the Trusts outpatient management system, unless clinically unsafe to do so. Access, booking & choice make every effort to verbally agree a pre-operative appointment with the patient in advance. Patients who fail to attend their operative procedure on the day will be discharged back to their General Practitioner if clinically safe to do so. If the Clinician requests a further operative date this will restart the 18 week clock. Again, the decision to restart the 18 week clock for this group of patients has been reached locally by the commissioning CCG and Trust to reduce the potential bureaucracy linked to the patient being discharged back to GP's care following non-compliance, requiring immediate re-referral for a said procedure. Undertaking this local agreement will reduce the process for the patient to gain re-entry into the Trust following failure to attend.



23. CANNOT ATTENDS (CNAs)

The following principles will apply:

Patients will have the option to alter one appointment during their outpatient or diagnostic pathway. If patients attempt to alter a further appointment during the 18 week pathway they will be discharged back to their GP's care. This section of the policy will be enforced in all specialities currently live with Partial Booking, given the Trust can assure that patients will not have their appointment moved more than once. All other specialities will be subject to the previous Patient Access Policy in that patients can reschedule their appointment twice, given the Trust cannot guarantee they will not undertake the same. Once all specialities are live with Partial Booking a full enforcement of this policy will be undertaken.

Patients who require a follow up appointment are given at least four weeks' notice of their appointment date and time. Patients who require a new appointment are given at least two to four weeks' notice of their appointment.

Patients who attempt to reschedule more than one appointment as outlined above will be discharged back to their GP's care. Exceptions to this rule are:

- Paediatrics
- Where patients are not given two weeks' notice
- When a patient is too ill to attend the clinic
- If the patient has a family bereavement
- If the patient is an inpatient

Patients who are unavailable for extended periods of time (i.e. six weeks or more for both new and follow up appointments) will be discharged back to their General Practitioners care.

Patients will have the opportunity to reschedule one operative procedure. If they attempt to reschedule for a second time they will be referred back to their GP.

Patients will be offered up to two pre-operative assessments. If these are not accepted, the patient will be referred back to the care of their GP if clinically safe to do so.

For patients who are unavailable for admission for an elective procedure for social reasons (social clock pauses), the secondary care provider will not pause (suspend) the patient pathway for more than 45 days. If the patient exceeds 45 days, the patient will be transferred back to the care of their GP.

Patients medically unfit need to be ready for surgery within 21 days (18 week clock still ticking). Patients should not be added to the waiting list if there are medical reasons that their planned procedure should not take place. If the patient is not fit for surgery within 21 days, the patient will be in-activated and returned to the care of either GP with reasons for the discharge and a plan to fast-track the patient into pre-operative assessment when fit to re-activate the episode of care (agreed in collaboration between the Consultant and the GP), or their operative Consultant who will inform the waiting list department when the patient is fit to proceed.

If a patient contacts the waiting list team stating they are unwell for surgery, this will be deemed as a social suspension, as there is no clinical evidence to support a cancellation from a Clinician.

If a patient is deemed unfit at pre-operative assessment, the pre-operative nurse will contact the General Practitioner and Consultant for review, assessment and action. The 21 day rule will continue during this period of time. The pre-operative nurse will clearly identify the requirements of the General Practitioner. In addition a contact name and telephone number will be made available to discuss the patients' condition if it is deemed necessary.

For clinic and theatre rescheduling, the following principles will apply:

- No clinic or theatre (where patients are in-situ) should be cancelled or rescheduled within six weeks of the clinic or theatre date, except in exceptional circumstances (for example for compassionate or sick leave).
- Patients must not be re-scheduled more than once – systems should be in place to ensure that patients are seen within the agreed access times.
- The Trust are in the process of implementing partial booking, with an aim to significantly reduce the hospital led reschedule of outpatient appointments, unless due to exceptional circumstances as outlined.

Policy Review Date: July 2014

The policy will be reviewed annually to ensure that it accurately reflects changing cluster, clinical commissioning group and national priorities and plans. Any revising to the policy will be signed off by the HEFT Joint Clinical Commissioning Group (JCCG).

APPENDIX 1

Clinical Case Examples and Possible Application of the Policy

Stroke/Cardiac-Like Chest Pain

A patient phoning their GP with cardiac like chest pain or a stroke should/could be referred on to hospital without necessarily being seen by the GP, this would usually be via a 999 ambulance. A hospital should not refuse to see a patient sent in by a GP who has concerns over symptoms that are of an emergency nature because he/she has not seen the patient or undertaken a commissioned triage process.

1. Solihull AMU?

Main Diagnosis: Collapse, seizure.

Symptoms/Findings: Two-minute loss of consciousness, dizziness before collapse (while sitting). Similar episode six months ago; significant weight loss; occasional headache and dizziness. Brother died of immune complex vasculitis. No other significant history.

Action:

- Attend Cardiology OP for 24 hour tape and echocardiogram
Comment – appropriate direct onward referral
- GP to trace autoimmune screen 'taken today and refer appropriately'.
Comment – should the GP be asked to do this given that an appropriate hospital C2C referral has been initiated?

2. Elective Admission

Main Diagnosis: Inflammatory changes of L psoas muscle

Other Diagnoses: Ulcerative colitis; sub-total colectomy and ileostomy 54 years ago; Type II diabetes; HTN and AF, Knee OA

Symptoms/Findings: Admitted with painful L groin lump – ill-defined mass; also noted venous changes of lower limb (from U/S no evidence of DVT; from CT no signs of vascular compromise). Patient improved with oral abx (continue for 5/7).

Action:

- GP to refer to T&O OP for review of L hip – although no collections seen on CT consultant wants an Orthopaedic review.
Comment – as the T&O opinion is related to the presenting condition question whether this should have gone back to GP for referral. Patient was admitted for six days - was it not possible to get an orthopaedic consult during that time?
- GP to refer for OP vascular review due to chronic venous changes in L leg.
Comment – appropriate to leave vascular referral down to GP

3. BHH Sigmoidoscopy Report

Indications: Overt rectal bleeding. Tenesmus

Findings: Large 3rd degree haemorrhoid x 2. Bleeding on contact. Mucosa normal to transverse.

Action:

- GP to refer to surgeons for haemorrhoidectomy.
Comment – if the finding is clear that surgery is required the patient should have been book directly rather than a request back to the GP to refer.

4. Cardiology OP

Diagnosis: AF post hip operation

Other Diagnoses/Findings: History of paroxysmal AF, OA and Hyperlipidaemia. Previously on Flecainide which controlled paroxysms quite well. Right THR 4 weeks ago but in persistent AF. So Flecainide switched to Bisoprolol. Now well since Dx.

Current medication – Bisoprolol, Warfarin, Pravastatin, Oestriol and Paracetamol
BP 129/85; irregular rhythm 150 bpm. 12 lead ECG suggested AF. Risk of AF returning within 12 months – patient not keen on cardioversion.

Action:

- Poorly controlled ventricular rate so GP recommended to add Digoxin - loading dose, then daily and increase Bisoprolol daily dosage.
Comment –
- Consultant to arrange a 24 hour tape for one months time; no further appointments to be arranged.
Comment – appropriate or it could have been part of a one stop community cardiology and diagnostic service.

5. AMU Discharge and Diagnostic Follow-up

Post Dx 24 hour tape and echocardiogram undertaken.

Findings: Mild LV diastolic dysfunction; left atrium mildly dilated; all other findings normal.

Action:

- GP to refer to cardiologist 'in view of the pauses'
Comment – if the hospital consultant with the information garnered from the diagnostics believes a cardiology consultant is required then he/she should have directly referred assuming the registrar's consultant has signed off that recommendation.

6. Emergency Admission (0 LOS)

Main Diagnosis: Fast AF (via ambulance).

Other Diagnoses: Previous paroxysmal AF in 2010 – successfully chemically cardioverted.

Findings: Treated with LMWH 13mg stat and DC cardioverted shock. Increased Flecainide to 100mg and arranged an echocardiogram.

Action:

- GP to refer to cardiology follow echocardiogram.
Comment – given that post echo the consultant still thought that that a cardiology appointment was necessary (early December) AMU should have directly referred rather than deflecting the referral to the GP – unnecessary delay.

7. BHH Pre-operative Assessment

Pre-op Checks: ECG, bloods and physical exam.

Findings: ECG reviewed by consultant anaesthetist – advised ECG abnormal.

Action:

- Surgery to proceed as gentleman asymptomatic
- GP to refer to cardiology
Comment – if the finding is clear then the patient should have been booked directly rather than a request back to the GP to refer.

8. (BCH) Paediatric Urology – Video urodynamics

Diagnosis: Urethral membrane resected 11 months of age (currently age 4+; megacystis; mitrofanoff; no further UTIs; hydroureteronephrosis decreasing; query polyuria.

Findings: Mild detrusor contradictions. Significant improvement on previous fill. No reflux, no leakage.

Action:

- Review in six months time arranged.
- Child has problem with cow's milk and has a soya diet for this. Lots of liquid stool possibly due to soya milk. GP requested to request to gastroenterology.
Comment – As the request is related to an existing condition and the Paediatric Urologist is requiring a consult from gastroenterology. Probably should be a C2C not GP referral.

9. Emergency Admission (5 days LOS)

Main Diagnosis: Relapse of sepsis following treatment of E coli sepsis

Other Diagnoses: Type II diabetes, HTN, recurrent UTIs, rectal Ca-anterior resection.

Findings: History of pyrexia and rigors. CT abdo/pelvis- gallstone in gallbladder, no other significant pathology. Dx onIV ertapenem with oral antibiotics.

Action:

- GP to refer to surgeons for query cholecystectomy re gallstones in gallbladder.
Comment – given the CT result, appears that a direct hospital referral was more appropriate than delay of referring back to the GP.

10. BHH Urology

Diagnosis: Dull niggling left side pain following 3x U/s, 1 CT and 1 urogram indicating no kidney abnormalities.

Findings: Given no structural abnormalities no further urological intervention required – remaining pain.

Action:

- GP recommended to refer patient to pain management. No C2C referral made citing CCG policy for non-urgent/non-malignant cases.
Comment – This would appear to be a correct application of the existing policy leaving the GP to decide the most appropriate course of action re patient's remaining pain.

Solihull has developed a wider database of recent cases across all Solihull practices and providers.

APPENDIX 2

Heart of England Foundation Trust Contract Management Structure for 2013/2014

HEFT Contract Meetings Map for 2013/14

