Standard Operating Procedure (SOP) Clinical Triage using the NHS e-Referral Service system and subsequent Administrative Management of Referrals	University Hospitals of Leicester NHS NHS Trust Trust Reference Number: B41/2021

Details of Changes made since last approved by PGC:

Section	Change
1.3	Addition of ability of referrals to be received by e-RS from Detained Establishments.
2.2.2	Updated link to Patient Access Policy for Elective Care UHL Policy 12.07.23
2.2.3	Addition of robotic process automation details
2.2.5	National change in timescale within patient letters generated from e-RS (NHS England)
2.2.7	Addition of need for Consultants to alert admin staff regarding 2WW upgrades
4.1.2	Update of e-RS Dashboard changing from fortnightly to monthly
4.2.1	Update of escalation process
4.2.2	Update of escalation process
4.2.3	Update of escalation process (previously Planned Care Board)

1. Introduction

1.1 The NHS e-Referral Service system (e-RS) is the standard system in use for secondary care providers to receive elective referrals into Consultant-led outpatient services. For some specialties referrals into non-Consultant-led services are also received via e-RS.

1.2 e-RS is a smartcard, role-based system where access is limited to ensure that end-users only have access to referrals that they have a legitimate right to see. Access is controlled by the central e-RS Team for UHL (Operations, Corporate), and by nominated individuals within the Alliance hospital sites.

1.3 Referral can only be received via e-RS from General Practitioners (GPs) and Medical Officers within Detained Environments (e.g. prisons, secure institutions) within England.

1.4 e-RS is a web-based application and is accessible from any UHL/Alliance PC or laptop at any hospital site or from home.

1.5 Growing numbers of secondary care clinicians within UHL/Alliance are being given access to review referrals directly on e-RS to enable swift clinical triage and enable safer transmission of information – both to primary care and secondary care admin staff - to enable the next steps to be taken.

1.6 This SOP applies to all staff involved in the triage and onward processing of referrals within the e-RS system, which includes: medical staff at all levels, allied healthcare professionals (e.g. physiotherapists, pharmacists), nurses, administrative and management staff. This list is not exhaustive and will include all staff with the designated roles on their smartcard and with allocated access rights to the e-RS system.

2. Guideline Standards and Procedures

2.1 Guidelines

2.1.1 Referrals awaiting triage are visible on the “Referrals for Review” worklist within e-RS. The process of how to review referrals and what steps need to be taken on e-RS are documented within the Clinician user guide. Where clinical triage is occurring outside of e-RS (e.g. the referral is printed and the specialty admin staff update e-RS with the clinical triage outcome), a separate user guide is available. User guides for both Clinicians and Admin teams will be sent to Specialties as part of their pre-go live work-up.

2.2 Standards

2.2.1 The Referral to Treatment (RTT) 18 week clock starts from the date that the GP sends the referral into triage.

2.2.2 The timeframe target for referrals to be clinically triaged is 2 working days Access Policy for Elective Patient Care UHL Policy B3/2004). The purpose of clinical triage is to ascertain the clinical priority and to direct the referral into the most clinically appropriate service (if not sent to the correct service at the point of referral).

2.2.3 The target for administrative steps to be completed is within 5 working days of the triage outcome being known (whether that is recorded on e-RS or clinician annotation on a printed referral). It is imperative that referrals are registered on HISS as soon as possible after triage. (The 5 day timeframe is the same as when processing e-RS referrals received as Appointment Slot Issues that are unable to be converted into a booking.)

2.2.4 Where it is known that onward booking via e-RS is not going to be possible, registration of triaged referrals can be done via the robotic process automation (RPA) to ensure that referrals are registered in a timely manner (within 5 days of triage being undertaken) and to ensure accurate data quality. **However, it must be noted that if the patient’s address is not known within the hospital PAS system, RPA will fail and so specialties are responsible for checking if registration has occurred and, if not, must manually create an outpatient registration specific to the referral (including the creation of an RTT pathway as appropriate).**

2.2.5 When patients are referred into Triage services, they can be issued with a letter from their GP practice, which is generated from e-RS. The letter includes key details to identify the patient and the specific referral reference number. The letter invites the patient to contact the UHL/Alliance department by telephone if they have not been made aware of the triage outcome within 8 days (for referrals graded as “urgent” by the GP) or within 40 days (for referrals graded as “routine” by the GP). The department telephone number (as contained within the service description on e-RS) automatically pulls into the patient letter.

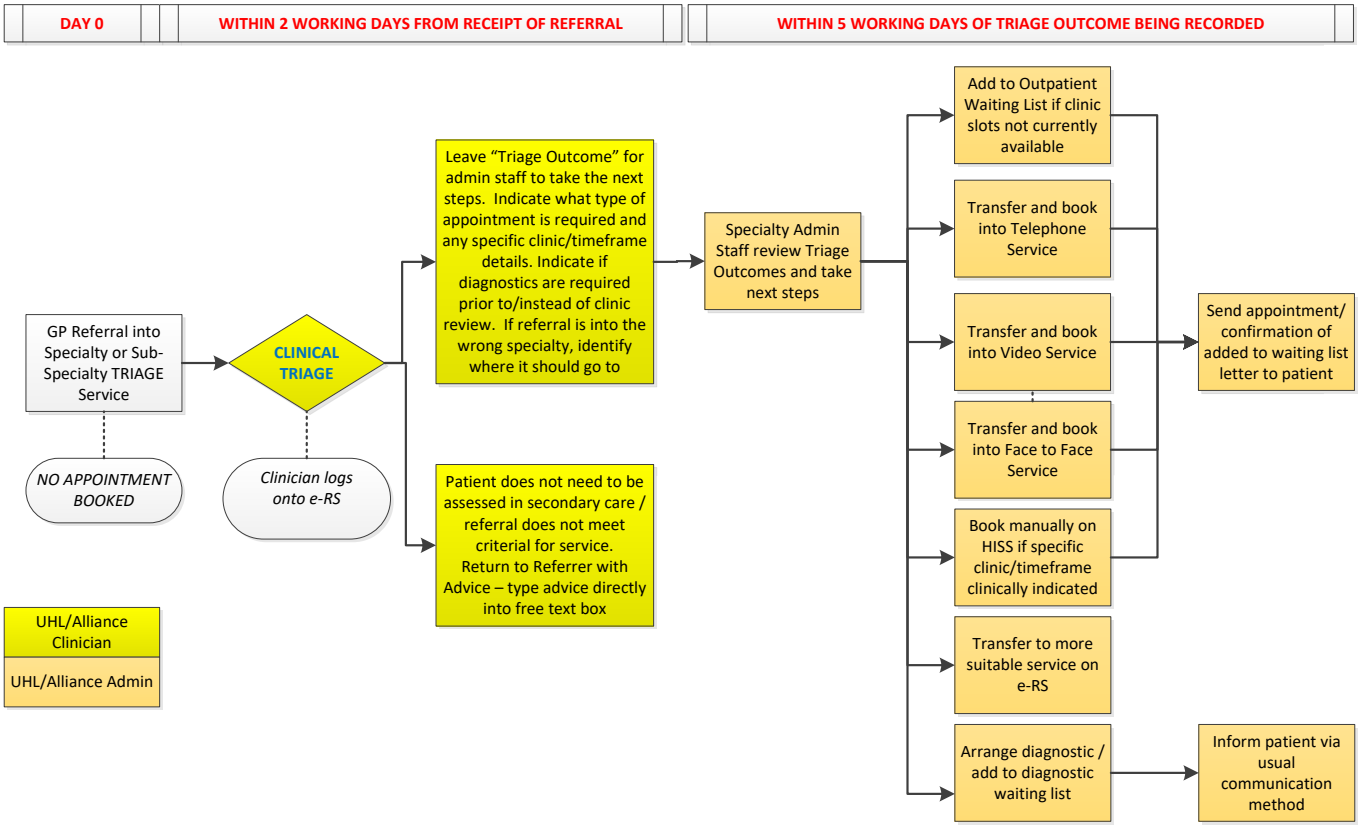
2.2.6 To minimise the number of patient phone calls, alleviate anxiety of patients awaiting triage outcome and to support achieving RTT standards, it is imperative that referrals are triaged and processed as near as possible to the timescales outlined within the Standard Process (2.3).

2.2.7 Where it is deemed necessary, triaging staff have the ability to upgrade referrals to the priority of “2WW” (suspected cancer). These are known as “Consultant Upgrades”. To ensure timely action by the admin team, triaging clinicians must alert their admin team to any such upgrades, by providing them with the patient details (name, NHS number and unique booking

reference number available in e-RS) to enable the admin team to locate the referral and take the next steps. This needs to be done at the point of triage, ideally by telephone or e-mail.

2.3 Standard Process

2.3.1 The high-level key steps and timescales are as follows:



3. Education and Training

3.1 When specialties move to e-Triage on e-RS, demonstrations and training will be given by the UHL e-RS Team via MS Teams meetings. The team can be contacted by e-mail: helen.cave@uhl-tr.nhs.uk or azrin.jagot@uhl-tr.nhs.uk

3.2 To supplement on-line training, documents will be issued to the specialty, and are available for Clinical and Administrative staff for the following scenarios:

- Triage where clinician logs onto e-RS
- Triage where Admin staff print referral and then update e-RS
- Triage where appointment booking/next steps are taken within e-RS
- Triage where appointment booking/next steps is made outside of e-RS

3.3 In addition training videos are available for both Clinical and Admin staff that can be saved on departmental shared drives. The training videos are available from helen.cave@uhl-tr.nhs.uk or azrin.jagot@uhl-tr.nhs.uk (who would need to be given access to the departmental shared drives to be able to transfer the videos onto a dedicated folder for e-RS materials).

4. Monitoring / Governance

4.1 Monitoring

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Triage turnaround time (2 working days).	Review of "Referrals for Review" worklist on e-RS	Responsibility for compliance of standard sits with the Specialty Head of Service*(HoS), supported by the General Manager (GM)	Initially weekly until the HoS and GM are satisfied that target is maintained. Monthly thereafter.	Any concerns or requests for support/retraining must be addressed to the Deputy Head of Performance for Outpatients/e-RS.
Admin turnaround time (5 days after triage by clinician)	Review of "Appointments for Booking" worklist on e-RS	Responsibility for compliance of standard sits with the Specialty General Manager*, supported by Service/Admin Manager	Initially weekly until the GM and SM/Admin Manager are satisfied that target is maintained. Monthly thereafter.	Any concerns or requests for support/retraining must be addressed to the Deputy Head of Performance for Outpatients/e-RS.

*Although responsibility for monitoring sits with the HoS/GM, performing review of the worklists can be delegated to relevant staff within their Specialty/CMG, who can be given suitable levels of access to e-RS. (Contact azrin.jagot@uhl-tr.nhs.uk or helen.cave@uhl-tr.nhs.uk for access.)

4.1.1 On a monthly basis the Deputy Head of Performance for Outpatients/e-Referrals will review worklists for Triage services to gain oversight of worklist management and turnaround times. Findings will be included in the monthly e-RS Dashboard, which is circulated to CMG management and administrative teams, along with relevant corporate areas (RTT / Performance). Details will include:

- Numbers and oldest RTT start dates of referrals awaiting triage within each Specialty
- Numbers and oldest RTT start dates of referrals awaiting admin processing within each Specialty

4.2 Governance

4.2.1 Any areas of concern identified by the Deputy Head of Performance for Outpatients/e-Referrals will be brought to the attention of the Head of Performance and Improvement.

4.2.2 Concerns will be addressed to the Specialty management teams at the Weekly Access Meeting (WAM) as referrals awaiting action on e-RS are not on HISS and therefore not able to be captured as a demand on capacity within the existing WAM reports.

4.2.3 Where a plan to swiftly resolve triage delays (referrals older than 2 week) cannot be found within the Specialty, backlogs will be escalated to the Operational Management Group. (If a single-

handed clinician is on leave and referrals are awaiting their return, then it is expected that the backlog will be dealt with within the first week of their return.)

5. Supporting References

Access Policy for Elective Patient Care UHL Policy B3/2004)

6. Key Words

Triage	New referral
e-RS	ERS
Choose and Book	Referral triage
Outpatient referral	GP referral

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Approved by Policy and Guideline Committee 17.11.23
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