Yeovil District Hospital NHS
NHS Foundation Trust

PATIENT ACCESS POLICY

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Approved by [Committee Name]	Somerset Clinical Commissioning Group		
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CONTENTS

1.0 INTRODUCTION

1.1 Policy Statement

The Trust is committed to delivering high quality and timely elective care to patients. This policy:

• sets out the rules and principles under which the trust manages elective access to outpatient appointments, diagnostics and elective inpatient or day case treatment

• gives staff clear direction on the application of the NHS Constitution in relation to elective waiting times

• demonstrates how elective access rules should be applied consistently, fairly and equitably.

The Trust's elective Access Policy was developed following consultation with staff, clinical commissioning groups (CCGs) and clinical leads. It will be reviewed and ratified at least annually or earlier if there are changes to national elective access rules or locally agreed principles.

The Access Policy should be read in full by all applicable staff once they have successfully completed the relevant elective care training. It should not be used in isolation as a training tool.

The Access Policy is underpinned by a comprehensive suite of detailed standard operating procedures (SOPs). All clinical and non-clinical staff must ensure they comply with both the principles within this policy and the specific instructions within SOPs.

The Trust is committed to promoting and providing services which meet the needs of individuals and does not discriminate against any employee, patient or visitor.

1.2 RTT National Operational Standard

The Trust is working to the national standard of 92% of patients on an incomplete Referral to Treatment (RTT) pathway should be waiting 18 weeks or less, as defined in the Department of Health's Recording and Reporting Referral to Treatment (RTT) waiting times for consultant-led elective care. (October 2015). This document covers the structural and procedural requirements in order to achieve this.
https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance

As part of the NHS Constitution (2012), patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.

1.3 Purpose and Key Principles

The purpose of this policy is to ensure all patients requiring access to outpatient appointments, diagnostics and elective inpatient or day-case treatment are managed equitably and consistently, in line with national waiting time standards and the NHS Constitution.

- This policy is designed to ensure the management of elective patient access to services is transparent, fair, equitable and managed according to clinical priorities.

- The Trust will endeavour to provide sufficient capacity so that patients can be treated within the national waiting times standards and NHS constitution of 18 weeks from referral.

- This policy will be applied consistently and without exception across the Trust. This will ensure that all decisions regarding a patient's waiting time will be made with the patient's

best clinical interests in mind ensuring patients are treated equitably and according to their clinical need.

- Patients will be treated in order of their clinical need. Patients of the same or comparable clinical priority will be treated on a “first come first served” principle, according to case mix irrespective of the referral source.

- The process of managing waiting lists will be transparent to the public and communications with patients will be timely, informative, clear and concise.

- All additions to or removals from waiting lists must be made in accordance with this policy and may be subject to validation.

- The Trust’s Patient Administration System namely TRAKCARE must be used to administer all waiting lists. All information relating to patient activity must be recorded accurately and in a timely manner reflecting the patient’s perceived pathway. In addition to TRAKCARE, according to the users role – care pathways must be accurately updated when validation occurs, ensuring that all patients are booked in chronological order, according to urgency.

1.4 Individual Patient Rights

The NHS Constitution clearly sets out a series of pledges and rights stating what patients, the public and staff can expect from the NHS. A patient has the right to the following:

- choice of hospital and consultant
- to begin their treatment for routine conditions following a referral into a consultant-led service, within a maximum waiting time of 18 weeks to treatment
- to be seen by a cancer specialist within a maximum of two weeks from a GP referral for urgent referrals where cancer is suspected.

If this is not possible, the NHS has to take all reasonable steps to offer a range of alternatives.
The right to be seen within the maximum waiting times does not apply:

- if the patient chooses to wait longer

- if delaying the start of the treatment is in the best clinical interests of the patient (note that in both of these scenarios the patient’s RTT clock continues to tick)

- if it is clinically appropriate for the patient’s condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage.

All patients are to be treated fairly and equitably regardless of race, sex, religion or sexual orientation.

1.5 Communication

All communications with patients and anyone else involved in the patient’s care pathway (eg general practitioner (GP) or a person acting on the patient’s behalf), whether verbal or written, must be informative, clear and concise. Copies of all correspondence with the patient must be kept in the patient’s clinical notes or stored electronically for auditing purposes.

GPs or the relevant referrer must be kept informed of the patient’s progress in writing. When clinical responsibility is being transferred back to the GP/referrer, eg when treatment is complete, this must be made clear in any communication

2.0 SCOPE OF DOCUMENT

This Access Policy applies to all Trust staff and will be made available on Y Cloud.

3.0 GOVERNANCE OF THE RTT PATHWAY

3.1 Roles and Responsibilities

3.1.1 The Trust Roles and Responsibilities

Although responsibility for achieving standards lies with the Business Units and ultimately the Trust Board, all staff with access to and a duty to maintain elective care information systems are accountable for their accurate upkeep.

- Deputy Director of Operations and Performance to oversee the weekly performance of access standards and provide strategic leadership.
- Business Managers are accountable for implementing, monitoring and ensuring compliance with the policy within their Business Units. They will be supported by the RTT Team and admin staff.
- The Information Team are responsible for the timely production of patient tracking lists (PTLs) which support the Business Units in managing waiting lists and RTT standards.
- Business Manager for the Contact Centre is responsible for ensuring the NHS e-referral service directory of services (DOS) is accurate and up to date.
- The RTT team supported by the information team are responsible for producing and maintaining regular reports to enable Business Units to accurately manage elective pathways, and ensure compliance with this policy.

3.1.2 The Referrer roles and Responsibilities

The Trust relies on all referring clinicians to the Trust to ensure that patients understand their responsibilities and potential pathway steps and timescales when being referred. This will help ensure that patients are referred under the appropriate clinical guidelines and are aware of the speed at which their pathway may be progressed and are in the best position to accept timely and appropriate appointments. Therefore, the Trust expects that, before a referral is made for treatment on an 18 week Referral to Treatment pathway, the patient is ready, willing and able to attend for an appointment and undergo any treatment that may be required. This will include being both clinically fit for assessment and possible treatment of their condition and available for treatment across that pathway. This is the responsibility of the referring clinician, e.g. the GP.

The provider and commissioners will work together to ensure that patients understand this before starting and that they are ready and able to attend the first outpatient appointment.

- Referrers must provide accurate, timely and complete information within their referral.
- Referrers must comply with national timeframes for referral attachments when referring via choose and book.
- Referrals to secondary care should only be made if all other alternatives have been explored (i.e. patient/clinical pathways have been followed) and the patient is ready, willing and available to be seen and commence treatment within the next 18 weeks.
- To minimise waiting times and to enhance patient access to services, Referrers are encouraged to make unnamed referrals (referred to as Dear Doctor referrals) unless there is a specialist requirement for a named consultant or there is a patient history which requires continuity of care.
- When referring children or adults who cannot understand or give consent for their own treatment, the referrer must provide details of who is legally able to act on behalf of the

patient.

- Referrers should identify any special communication requirements their patients may have and detail these on the letter. (e.g. literacy problems, need for BSL or other language interpreter).
- At the time of the referral the following information should be supplied
  i) Patient demographics & contact address.
  ii) NHS number (and hospital number identifier if known)
  iii) Home, work and mobile telephone numbers wherever possible
  iv) All relevant clinical information together with the referrer's assessment of the level of clinical urgency
  v) The patient's availability (as well as their willingness to be seen at short notice). For 'routine' referrals, if it is known that patients will be unavailable to be seen for a period of time, the referrer should delay the referral.
  vi) Any relevant information regarding the patient's capacity or relevant information related to safeguarding.

- Patients should be referred having already undergone all relevant tests, as outlined in the pathway of the relevant specialty.
- Referrers are required to ensure that all suspected cancer referrals are made through the agreed route
- Referrals should be made electronically through e-RS.
- After a referral has been made, the referrer must inform the hospital if the patient no longer wishes or requires to be seen.
- On making a referral, the referrer must inform the patient that:

  i)they need to honour agreed appointments or admission dates, and to expect to be discharged if they do not. Patients should be advised to contact the Trust as soon as possible if there is any likelihood that they will not attend their appointment in order to use this appointment for another patient.
  ii) patients will be fast tracked to the most appropriate specialist who may be another Consultant or an appropriate specialist.
  iii) an appointment may not be available at the patient's local site so an appointment at an alternative trust hospital site may be necessary
  iv) Patients should be ready, willing and able to receive treatment within the next 18 weeks from their referral
- The referrer must notify the trust of the patient's eligibility for NHS care.
- The referrer has a responsibility to follow agreed referral pathways of those directed by commissioning and contractual arrangements. Where referrals do not follow the agreed pathway then the referral should be returned as directed to the commissioning agency.

3.1.3 CCGs Roles and Responsibilities

- The CCGs are responsible for ensuring there are robust communication links for feeding back information to GPs. GPs should ensure quality referrals are submitted to the appropriate provider first time and these should be electronic.
- The CCG must ensure that there is no more than a 1 week (5 working days) delay (from date of GP referral) in referrals from a Referral Management Service.

3.1.4 Patients Roles and Responsibilities

The NHS Constitution recommends the following actions patients can take to help in the management of their condition:

• Patients can make a significant contribution to their own, and their families, good health and wellbeing, and should take personal responsibility for it.

• Patients should be registered with a GP practice as this is the main point of access to NHS care as commissioned by NHS bodies.

- Patients should provide accurate information about their health, condition and status.
- Patients should keep appointments, or cancel within a reasonable timeframe.

3.2 Monitoring and Reporting

RTT performance is monitored daily via Qlikview and weekly via the RTT Trending tool.

A weekly RTT meeting chaired by the Deputy Director of Operations and Performance provides a reporting framework to support escalation of issues and actions required to improve or sustain performance with all key stakeholders.

The Trust is required to complete monthly statutory returns on 18 week incomplete RTT pathways to the CCG and NHS Improvement and NHS England. These will be produced from the Trust data warehouse and validated by the Business Units with support from the validation team.

3.3 Data Quality for RTT

Data quality for RTT is the responsibility of everyone involved with RTT pathway management and it is essential that correct information is recorded accurately and without delay. All incomplete pathways greater than 18 weeks will be validated on an ongoing basis. A data quality audit will take place on a monthly basis this will be led by the Patient Pathway Performance Manager.

3.4 Waiting List Validation

Regular validation of all waiting lists, coordinated by Operational Support Managers/Operational Managers will ensure that lists are always as up-to-date as possible, and that the most efficient use is made of the Trust's Inpatient and Day Case resources.

4.0 MANAGEMENT OF THE ROUTINE ELECTIVE PATHWAY

4.1 Recording of the Patient Pathway

Throughout the patient's pathway all clinical outcomes must be recorded on the relevant Trust system in real time.

4.2 Internal Waiting Time Standards for Routine Elective Patients

To support the delivery of 18 weeks RTT the below details the key internal waiting time standards:

Activity	**Time Frame**	**Responsibility**
Registration of Patient	24hrs	Registration Clerk
Vetting of Referrals	72 hrs	Clinicians
First Outpatient Attendance for admitting specialities	6 weeks	Booking Officers
First Outpatient Attendance for non - admitting specialities	10 weeks	Booking Officers
Diagnostic Tests	6 weeks	Booking Officers
Reporting Results to patients	2 weeks	Clinicians
Elective Admission	Maximum of 12 weeks	Booking Officers

4.3 Clinical Exceptions

It is noted that not all patients can or should be treated within 18 weeks these reasons include:

- Patients for whom it is not clinically appropriate to be treated within 18 weeks (clinical reasons)
- Patients who choose to wait longer for one or more elements of their care (patient choice)
- Patients who do not attend appointments (co-operation)

These patients will be taken into account in a tolerance set as part of the delivery standard of 92%.

4.4 Transfer between Consultant Teams

The Trust follows Schedule 8 of the National Contract in managing their onward referrals in that: -
Where a patient has been referred to one service within the Trust by the GP, or has presented as an emergency, the contract allows the provider clinician to make an onward outpatient referral to any other service, without the need for referral back to the GP, where:

- either the onward referral is directly related to the condition for which the original referral was made or which caused the emergency presentation
- or the patient has an immediate need for investigation or treatment (suspected cancer, for instance).

By contrast, the Trust cannot refer onwards where a patient's condition is non-urgent and where the condition for which the referral would be made is not directly related to the condition which caused the original GP referral or emergency presentation. In this situation, the hospital consultant should refer back to the patient's GP. If the GP agrees, the onward referral can then be made (either by the provider clinician or by the GP but the GP may instead choose to manage the patient's condition him/herself or to refer into a different service.

Any transfer between consultants should be undertaken under the approval of the original consultant.

4.5 Inter-Provider Transfers (IPTs)

Patients may be transferred from the Trust to another provider, or may be transferred into the Trust from another provider. The responsibility for RTT reporting for the patient is transferred with the clinical responsibility and as such the originating provider should ensure that the patient's initial RTT clock start date forms part of the onward referral information.

Hospital-initiated transfers to alternative providers after referral to the Trust must always involve the consent of the patient; their GP and the Consultant must be informed of the transfer of any of their patients. A mandatory minimum data set i.e.: Inter Provider Transfer Form must be completed by the consultant/secretary and transferred to the receiving provider. This will include the patient's pathway identifier (PPID). By sharing information via the minimum data set for inter provider transfers all parties involved can be fully aware of the patient's pathway.

If the outgoing IPT is for a diagnostic test only the Trust retains responsibility for the RTT pathway.

4.6 Clinician Policies – Interventions Not Normally Funded

Prior Approval Procedures Guidance must be adhered to – any procedures that require prior approval that are undertaken without prior authorisation, will not be authorised for payment by the CCGs. A GP should seek approval prior to referral to secondary care and provide documentary evidence that authorisation has been obtained. Somerset CCG have committed that they will respond to an application within 5 working days of receipt. The Trust is required to check that the documentary evidence has been obtained and is attached to the referral. If prior approval has not been sought by the GP and if there is the relevant information available, the secondary care consultant can seek prior approval if they believe it is the right thing to do by completing an individual funding request form (the clock still continues). Alternatively, the consultant can refer back to the GP if it is in the best interest of the patient. This would stop the clock.

5.0 THE REFERRAL PROCESS

5.1 Choice at the Point of Referral

Every hospital appointment should be booked at the convenience of the patient, making it easier for the patients and their GPs to choose a hospital and consultant that best meets their needs. Patients will be able to:

- Choose the organisation that provides their NHS care when referred for their first outpatient appointment with a service that's led by a consultant.
- Book their appointment with their preferred provider through the E-Referral System (where available).
- Access information to support them in choosing a provider.
- Be involved in discussions and decisions about their healthcare.
- Accept or refuse treatment that is offered, and not to be given any physical examination or treatment unless valid consent has been given.

CCGs will be responsible for ensuring that choices are available and the necessary systems and process are in place to offer and support choice and to enable booked appointments to be made.

The Trust is responsible for ensuring that appointment bookings are honoured and the Directory of Services is accurately maintained.

5.1.1 Directory of Services

The Directory of Services is the shop window of the services offered at the Trust to its patients. As such it is an important document that needs to contain all the relevant information of the services provided and the average waiting times. It is the responsibility of the Business Managers to ensure this information accurately reflects the services provided.

5.2 Referrals into the Trust

It is the responsibility of the referrer to ensure that the referral letter contains accurate and up to date demographic information regarding the patient, including NHS number and both daytime and evening contact telephone numbers including a mobile number where available. The National Spine will be updated when required by the referrer.

The demographic details provided will be updated on the Trust Patient Administration System. When a patient is new to the organisation a Hospital Number will be created via Medical Records.

All referrals (with the exception of Cancer and GP Direct Access referrals) should come through the Contact Centre or via e-RS. If referrals are received elsewhere they should be immediately passed to the appropriate team within the centralised Contact Centre for logging.

All referrals are scanned and uploaded into TRAKCARE within 24 hrs of receipt for the consultant to vet within 72 hrs. If upon review, it is felt that the patient's appointment should be expedited, this will be carried out on a case by case basis.

5.3 RTT Clock Start

The RTT clock starts when any healthcare professional (or service permitted by an English NHS commissioner to make such referrals) refers to a consultant-led service.

A referral to most consultant-led services starts an RTT clock but the following services and types of patients are excluded from RTT:
• obstetrics and midwifery

• planned patients
• referrals to a non-consultant led service
• referrals for patients from non-English commissioners
• genitourinary medicine (GUM) services
• emergency pathway non-elective follow-up clinic activity.

The Trust will establish the wait start date for each patient, according to the following criteria:

- For appointments that are booked though the e-RS, the clock start date will be the date that the patient converts their UBRN via the Referral Management Centre (RMC).
- For referrals made by letter, the clock start date is the date that the referral letter is received by the Referral Management Centre (Somerset Patients).
- For referrals made by letter from outside of Somerset (or that never went through the RMC) the clock start date is the date that the Trust received the letter.
- If a patient is referred directly from one consultant to another for a separate condition to that for which they were originally referred (see 5.3.2), the patient will begin a separate RTT pathway, with the wait start date being the date that the referral was made (NOT the date it was received within a department).
- Fax referrals for routine appointments the clock start will be the date fax received.
- During follow-up care after first treatment, a decision is sometimes then made to provide the patient with further treatment. The decision for a new or substantially different treatment would start a new RTT pathway clock. An example of where this would occur would be for bilateral procedures such as cataract surgery.

5.3.1 Referrals from interface services (such as MSK interface –OASIS)

For referrals received from MSK interface services (within Somerset this is OASIS) the clock start date should be clearly identified on the referral. For patients that were referred from their GP to OASIS but did not have treatment, active monitoring etc. The clock start date would be the date OASIS received the referral **and NOT** the date of the referral from OASIS, nor the date the RMC received it, nor the date when received into the Trust. It is the Contact Centre's responsibility to ensure that the correct start date is inputted into TRAKCARE as the date automated from e-RS may require overriding.

5.3.2 Consultant to Consultant referrals

Patients referred from one consultant to another for the same condition will remain on their original RTT clock.
Normally patients will not be referred by consultant to consultant referrals for a separate condition to that for which they were originally referred unless it is deemed in best clinical interest for the patient. It is expected that new conditions should be referred back to the GP so that choice can be offered. If a consultant to consultant referral does happen for a new condition this will begin a separate RTT pathway. The wait start date will be the date the referral was made (NOT the date the referral was received by the department).

5.4 Referrals to non-consultant led services

The Trust will manage all referrals to non-consultant led services as though they were RTT applicable, which will allow the Trust to ensure good practice and equity to all patients.

As patients are referred into secondary care, referrers have a responsibility to ensure that they are supplying the Trust with precise details of the start of the patient's 18 week clock. The Trust will record this information and endeavour to treat the patient within 18 weeks of their clock start date.

5.5 E-Referral System (e-RS)

All appointments should be booked via the Electronic Referral System (e-RS).

Consultants will have the opportunity to review the appropriateness of referrals into their service and expedite any routine referrals they consider clinically urgent. Referrals will be vetted on TRAKCARE within 72hrs. It is at this review stage that referrals more appropriate for a consultant within the same specialty should be re-directed. Referrals that have not been reviewed in that timeframe will automatically be deemed as appropriate for the appointment booked.

GP's are required to electronically attach the referral to the e-RS within 24 hours for diagnostic or urgent referrals and 3 days for routine referrals of the request for the appointment being made. If the attachment is not attached after 5 days than the patient's appointment will be cancelled, the patient discharged and the request returned to the GP. The GP is responsible for contacting the patient and informing them of the cancellation.

Once the patient has chosen to be seen at Yeovil District Hospital, and the referral made on the e-RS, they are then required to either contact the hospital as per referral documents to agree on an appointment date and time or book their appointment electronically.
Note that;

- The patient's waiting time begins:
    - On the date that the patient UBRN is converted to an appointment
    - Or if there is not capacity available for the patient to book an appointment, the date the patient was referred to the provider within e-RS
- The appointment should be allocated on the basis of the specific service selected by the GP and the shortest waiting time within that service
- Any patient who attends an agreed outpatient appointment when the referral has not yet been approved or rejected must be seen
- If the patient chooses to attend Yeovil District Hospital and there is not sufficient available capacity to book their appointment, the following is applied:

Referrals deferred are immediately visible in the Appointment Slot Issue (ASI) work list; therefore, this date corresponds to the date that the referral enters the ASI process. The Contact Centre will manage the ASI list and book patients following triage by the consultant / clinical team.

5.6 Management of Paper Referral Letters

- All Paper Referral letters for Somerset CCG patients should go via the Referral Management Centre and the date stamp applied by them should be used as the clock start. This is the responsibility of the Registration Team. A minimum dataset (MDS) form must be used to transfer 18 week information about the patient to the Trust.

- Paper Referral letters for patients outside of Somerset CCG (ie Dorset) must be date stamped on the day that they are received by the Trust and this date is to be used as the clock start. This is the responsibility of the Registration Team.

- Under no circumstances should a referral leave the hospital unless its removal has been noted and recorded as such by the Contact Centre team.

- Copies should only be made if absolutely necessary and the copy clearly marked as such when it is necessary for referrals to be moved they should be delivered by person i.e. not via the internal post or left on staff desks

5.7 Processing of Referral Information

It is important that every referral letter is actioned as quickly as possible, and that all steps in the pathway of booking patient appointments are completed as efficiently as possible.

- Referrals will be actioned the day they are received in the Trust
- Consultants will vet within 72 hrs. Consultants will be expected to review referrals electronically for their service on TRAKCARE.
- Where a referral results in a patient being placed directly onto an Elective Admissions List or scheduled for investigative treatment, the specialty booking officer will be responsible for adjusting the patient episode on TRAKCARE.
- The booking officer is responsible for ensuring any patient whose appointment (first or follow-up) is no longer required, for example if the patient transfers to a private provider, that the system is cancelled and pathway stopped in TRAKCARE.

5.8 Appropriateness of GP referrals

The Trust will continue to work with Clinical Commissioning Groups to ensure that all referrals are made appropriately and to establish pathway driven referrals where appropriate. If a consultant, on reviewing a referral letter, deems the referral to be inappropriate it must be rejected, with an explanation as to why it is inappropriate and advice on best management of the referral. The patient will be discharged back to the GP and the RTT clock stopped.

If a referral has been made and the special interest of the consultant does not match the needs of the patient the consultant will redirect the patient to an appropriate colleague (within their specialty only) who is able to provide such a service and the referral details amended on TRAKCARE.

5.9 New Clock Starts for the Same Condition

Following active monitoring
Some clinical pathways require patients to undergo regular monitoring or review diagnostics as part of an agreed programme of care. These events would not in themselves indicate a decision to treat or a new clock start. If a decision is made to treat after a period of active monitoring/watchful waiting, a new RTT clock would start on the date of decision to treat (DTT).

Following a decision to start a substantively new treatment plan
If a decision is made to start a substantively new or different treatment that does not already form part of that patient's agreed care plan this will start a new RTT pathway clock and the patient shall receive their first definitive treatment within a maximum of 18 weeks from that date.

For second side of a bilateral procedure
A new RTT clock should be started when a patient becomes fit and ready for the second side of a consultant-led bilateral procedure.

6. RTT CLOCK STOPS

6.1 Clock Stops for the start of first definitive treatment

The end of the RTT pathway and clock stop will be at the start of definitive treatment. Start of definitive treatment can be described as the start of the first treatment or intervention that is intended to manage a person's disease, condition or injury and avoid further intervention.

Clock stops will be highlighted through entering the outcome directly onto TRAKCARE by the decision-making Clinician.

Patients whose clocks have stopped for treatment may remain under the care of the Trust (i.e. follow-up care), in which case the rules of equitable access to services will continue to apply.

6.2 Clock stops for non-treatment

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

- it is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care
- a clinical decision is made not to treat
- a patient did not attend (DNA) which results in the patient being discharged
- a decision is made to start the patient on a period of active monitoring
- a patient declines treatment having been offered it.

Clock stops for non-treatment can only occur if a decision not to treat is made, treatment is refused or patient starts a period of active monitoring.

Where the patient refuses or it is in the clinical best interest not to treat the patient should be subsequently returned to the care of their GP or initial referrer.

6.3 Active Monitoring

Active monitoring is where a decision is made that the patient does not require any form of treatment currently, but should be monitored in secondary care. When a decision to begin a period of active monitoring is made and communicated with the patient, the RTT clock stops. Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made.

It is not appropriate to stop a clock for a period of active monitoring if some form of diagnostic or clinical intervention is required in a couple of days' time, but it is appropriate if a longer period of active monitoring is required before further action is needed. Stopping a patient's clock for a period of active monitoring requires careful consideration case by case and needs to be consistent with the patient's perception of their wait.

7.0 OUTPATIENTS – Non-Admitted RTT Pathways

7.1 General Principles for Outpatients

- All patients are to be seen in order of referral (and where appropriate, clinical priority)
- Referral dates and waiting times are to be correctly recorded and measured
- Patients are to be able to choose/negotiate their appointment time and date (recognising that clinics are held on specific dates during set time periods)
- No patient waiting for an outpatient appointment should be suspended for medical or social reasons instead if in the patient's best clinical interest, they will be discharged and referred back to the GP (RTT clock stop).

7.2 Hospital Reschedules – Outpatient Appointments

It is the Trust's policy to avoid hospital reschedules wherever possible. The Trust has an agreed leave policy which states a minimum of 6 weeks must be given by all medical staff to minimise the disruption to clinics and patient cancellation. Any clinic reschedules within 6 weeks require Business Manager authorisation.

Approval for any appointment reschedules must be obtained from the Business Manager, and a contingency plan outlined for accommodating the rescheduled patients if there are patients who may be clinically at risk, or have a protracted wait adversely affecting their RTT pathway.

Patients that have been previously rescheduled should not be rescheduled a second time.

Waiting times are not reset in the event of Trust reschedules for outpatient appointments.

When follow-up appointments are rescheduled a reasonable approach should be followed when re-booking appointments. This will ensure that patient care is not adversely affected, especially taking into account each patient's clinical needs. In addition, a significant number of these patients will be on the RTT pathway, and so careful attention will be required in order to ensure that patients remain within the expected waiting timeframe.

7.3 Patient Initiated delays – Outpatient Appointments

7.3.1 Declining Appointment Dates

Patients will be offered a choice of at least two appointment dates with three weeks' notice. Should they decline the dates offered, and it is in their clinical best interest the Clinician responsible for their care will discharge and refer back to the GP (RTT clock stop). There are no blanket rules.

7.3.2 Patients who 'Did Not Attend' (DNA) an Outpatient Appointment

Patients (except for paediatrics – see section 9.2) who Did Not Attend (DNA) their first appointment after initial referral will have their clock stopped and nullified and their referral will be returned to the GP (or other referrer). Another option for clinical consideration is to place the patient on a Patient Initiated Follow Up (PIFU) list for a defined period of time (usually 6 months). This will also stop the RTT clock (7.4). The Trust will need to be able to demonstrate that the appointment offer was agreed in principle and clearly communicated to the patient. A new clock will start, if required, upon receipt of a new referral. However, it may be considered clinically inappropriate to return the referral to the GP and in these cases the patient will be given a new appointment, but the patient will have a new clock start from the date of the missed appointment.

7.3.3 Patient Cancellation of Outpatient Appointment

Patients who cancel their appointment (at any point) will not have their clock stopped or nullified in line with Department of Health RTT guidelines.

Patients who cancel their first appointment and then subsequently cancel their rescheduled second consecutive appointment will be reviewed by the clinical team to determine if it is in their clinical best interest to be referred back to the GP or other referrer. If it is decided to offer another appointment the clock continues.

If a patient DNAs a follow up appointment, there must be clinical engagement regarding the appropriate action to take. Should the action be to discharge the patient, a letter must be generated and sent to both the patient and GP. This would stop the clock. No further appointment will be provided unless a new referral is received.

7.4 Patient Initiated Follow Ups

Where "open" or patient initiated follow-up appointments are given this will stop the clock. The patient has the option to contact for a further appointment for a clearly defined period of time, usually 6 months.

7.5 Outpatient Clinic Template Changes

All changes to clinic templates must be discussed and agreed by the clinician and the Business Manager for that service. When required this should also be agreed by the information team. This is particularly critical for proposed reductions in new outpatient slots. Reductions can only be approved when an agreed plan exists to ensure patient access times are not compromised in the future as a result of the proposed alterations.

Records must be kept of all amendments to clinic templates.

7.6 Clinic Episode Outcome

Every Outpatient Clinic attendance must have a definitive outcome recorded on TRAKCARE either during or immediately following the attendance. This includes urgent walk-in patients and patients attending follow-up appointments.

Whilst it is Outpatient's Reception staff responsibility to check that every clinic has 'completion' it is essentially the clinician or a member of their team that will indicate the outcome of each clinic attendance onto TRAKCARE. This will ensure that the Trust is able to record all the information required and to record outcomes for monitoring patient's progress on the RTT pathway.

This requirement applies equally to consultant-led and non-consultant-led clinics.

In addition, any GP letters produced after attendance at a clinic should be provided to the patient for information in line with Government guidelines.

The outcome options include:

Patients on an open pathway

- Clock stop for treatment
- Clock stop for non-treatment
- Clock continues if requiring diagnostics, therapies or being added to the admitted waiting list.

Patients already treated or with a decision not to treat

- New clock start if a decision is made regarding a new treatment plan.

• New clock start if the patient is fit and ready for the second side of a bilateral procedure.

• No RTT clock if the patient is to be reviewed following first definitive treatment.

• No RTT clock if the patient is to continue under active monitoring

• Accurate and timely recording of these RTT statuses at the end of the clinic are therefore critical to supporting the accurate reporting of RTT performance.

7.7 Booking Follow Up Appointments

7.7.1 Patients on an open pathway

Where possible, follow up appointments for such patients should be avoided, by discussing likely treatment plans at first outpatient appointment, and/or use of telephone/written communication where a face-to-face consultation is not clinically required. Where unavoidable, such appointments must be booked to a timeframe that permits treatment by week 18 (unless the patient choses a later date).
Follow-up appointments should be agreed with the patient prior to leaving the clinic. This provides the best opportunity for patient choice to be accommodated within the required timescale for achievement of the RTT standard. Where insufficient capacity is available, the clinic receptionist will escalate in line with local arrangements to obtain authorisation to overbook.

7.7.2 Patients not on an open pathway

Patients who have already been treated or who are under active monitoring and require a follow-up appointment should be managed via the partial booking of follow-ups (PBFU) process. Before they leave the clinic, the process will be clearly explained to the patient:
• They will be added to the PBFU waiting list.

• Nearer to the time that their follow up appointment is due; they will be sent an ‘invitation to book’ letter.

• An appointment will then be agreed with the Contact Centre.

• Should the patient fail to contact the Contact Centre; an attempt will be made to contact the patient at three different times of days.

• If unable to make contact, a clinical review will take place to decide on the best course of action.

7.7.3 Did not attends for Follow Ups

All did not attend (DNAs) follow-ups will be reviewed by the clinician at the end of clinic in order for a clinical decision to be made regarding next steps. Paediatric and vulnerable patient DNAs should be managed with reference to the trust’s safeguarding policy.

8.0 INPATIENTS – RTT ADMITTED PATHWAYS

8.1 Decision to Admit (DTA)

The decision to add a patient to a schedule for surgery (Inpatient or Day Case) must be made by the consultant team, or under an arrangement agreed with the consultant team.

Patients who are added must be clinically fit for the procedure else a period of active monitoring should be initiated which stops the RTT clock until the patient is deemed clinically fit to proceed. If it is deemed by the clinician that the patient will never meet the criteria for surgery they should be discharged back to care of GP and RTT clock stopped.

To aid good practice in the management of patient initiated delays, patient's choice must be documented in the 'comment' field on TRAKCARE. Although this will have no impact on the RTT clock (clock continues) it will ensure patients are treated in order of clinical priority.

At the time of decision to admit (DTA) the consultant team must complete an 'Addition to the Waiting List' proforma (Waiting List Sheet) or enter directly on TRAKCARE. It is the clinician's responsibility to ensure that the proforma is filled out clearly, correctly and completely with details of any patient unavailability and decision to admit date. The Addition to the Waiting List proforma should be collected at the end of the clinic by the outpatient/nursing staff and sent to the appropriate booking team within 24 hours.

When logging a patient on the waiting list within TRAKCARE the elective booking clerk must ensure that:

- Patients are not already listed for the same condition
- The entry is recorded correctly as either Elective or Planned
- Patients are not scheduled for surgery and suspended at the same time as this may result in offering actual dates that are inappropriate
- Full treatment text to be added to the waiting list entry
- That the patient is not already scheduled for surgery for another procedure
- Patients will be scheduled in clinical and length of wait order

Any communication with the patient must be recorded on TRAKCARE in the comment field of the system.

8.2 Inpatient and Day Case Primary Target List

To assist administrative staff involved in the process of booking patients the Trust produces an 18-week PTL (Green List). It is essential to note that the order of patients for treatment may not be the order in which they were scheduled i.e. a patient only very recently scheduled may be approaching the maximum 18 weeks target as they may have taken a while to be diagnosed and a decision to admit agreed. A patient may have been scheduled for a longer period of time yet has a shorter overall length of pathway. It is essential that listing is in accordance with clinical priority or pathway length and not according to the time spent solely on the elective waiting list.

8.3 Admission Information about the patient

When a decision to admit is made by the clinician the following information should be obtained by the clinician and written clearly on the proforma.

- Whether the patient is socially ready for admission e.g.: holiday booked or other social commitments that would prevent them accepting a date.

- Any special circumstances requiring longer than usual notice for admission i.e. carer's responsibilities, transport arrangements, clinical arrangement i.e.: equipment and special person requirements (loan kit / assistance in theatre)
- Patient's telephone number (home and work; daytime and mobile telephone if applicable) or a number through which he or she can be contacted - Email address where available should be captured
- Approval for the procedure if it is an Intervention Not Normally Funded (section 4.6)

8.4 Pre-operative assessment before admission

Pre-operative assessment will be used in elective surgical cases to determine the patient's fitness for surgery at the proposed time. A patient may be assessed by questionnaire/telephone or they may attend either on the day of the decision to admit or at a later date prior to surgery. If the patient DNAs the appointment they will usually be given one more opportunity for a future appointment before being discharged back to the GP and the clock stopped (this differs to outpatient appointments where the usual is after the initial DNA the patient is discharged back to their GP see section 7.4). If the patient is found to be medically unfit follow the steps as explained in section 8.5).

8.5 Medically unfit patients

This excludes those patients for whom the risk of not having surgery outweighs the risk of proceeding when unfit. The decision to proceed with these types of patients lies entirely with the consultant anaesthetist/consultant surgeon who following a review will make a decision whether to proceed.

At the time of decision for surgery/treatment

Patients who are known to be unfit for surgery at the time of the decision to admit and are likely to be for more than 21 days should be discharged back to the GP if in the patient's best clinical interest. This would stop the clock. If a decision is made to continue to review the patient within secondary care until they are fit for surgery this would start a period of active monitoring. This also stops the clock.

Whilst waiting for surgery/treatment

Patients awaiting admission who become medically unfit for surgery should be considered to return back to the care of their GP if it is in the patient's best interest, this will stop the RTT clock. This will usually be for periods longer than 21 days. This is to ensure discharges only occur when clinically appropriate and not, for example, if a patient has a mild condition like the common cold or a cut.

A GP may reinstate a patient on the schedule (waiting list) within 3 months of the discharge by writing to the relevant consultant who will review the request either from the letter/ notes or by seeing the patient in an outpatient clinic. If longer than 3 months has elapsed, the patient must be referred to the appropriate consultant via outpatients. In both these cases a new RTT clock begins from the date the new referral is received.

8.6 Patient Choice to Delay their Admission and Thinking Time

Patients may choose to delay their admission. If a clinician decides this is clinically appropriate, then this delay should be allowed. However, if the clinician feels that is not in the patient's best interest to delay without clinical review then the patient will be referred back to the GP and the RTT clock is stopped. The elective booking officer must record any patient-initiated unavailability by adding a comment in TRAKCARE recording the date of unavailability. The measurement of the

RTT pathway will not be adjusted for suspended patients however these pauses will highlight patient choice when patients are choosing to wait longer for treatment.

8.6.1 Thinking Time

The maximum thinking time set is 2 weeks as to whether the patient chooses to proceed with treatment unless it is clinically stated it is not in the patient's best interest. The RTT clock will continue.

8.7 Patients who Did Not Attend (DNA) Admission Date

It is important that the patient has been given instructions of who to notify and how if they subsequently cannot come in for their operation/procedure and that the letter clearly states the consequences of not attending for their operation/procedure date (admission).

Patients who did not attend (excluding paediatrics see 9.2) for their admission will be discharged and referred back to the care of their GP and the RTT clock stopped unless the Clinician believes this is not in patient's best interest.

Exceptions to this rule are:

- Patients undergoing cancer treatment
- Urgent referrals based on clinical judgement
- Paediatrics
- Maternity

8.8 Trust Cancellations and 28 Day Returns

If the Trust cancels an operation/procedure on the day for non-clinical reasons, the patient must be offered a new date which is within 28 days of their original date and within the RTT pathway timescale. This date should be offered within 5 working days of the cancellation.

When a patient's surgery is cancelled at any point in time prior to surgery the booking officer will always attempt to contact the patient by telephone and offer a new date. YDH have set an internal standard that this will be within 35 days of their original date and this will be offered within 5 working days of the cancellation.

The final authorisation to cancel a patient's operation on the day of surgery for non clinical issues is the responsibility of the relevant Business Manager and where possible after a discussion with the patient's consultant. This should also be discussed with the Director for Elective Care or Deputy and out of hours the On Call Director.

All reasons for cancellation will be added to TRAKCARE by the elective booking officer.

8.9 Patients Listed for More Than One Procedure

Patients will only be put on the waiting list for one procedure at a time. The RTT clock will stop when the first definitive treatment begins (i.e. when the procedure is carried out). A second new clock starts once the patient is ready to proceed with the second procedure.

If the decision to treat involves two-part treatment – i.e. right and left knee replacements etc, then the patient will, before being discharged from part one of their treatment, be offered

- Either a date for the second part
- Or an early outpatient appointment for review of their condition.

If the decision to treat involves two procedures as part of a single pathway of treatment – i.e. – T&O insertion of metal work and planned removal the clock stops when the first treatment begins. The subsequent procedure is undertaken based on clinical need as part of the same pathway but the clock has already stopped.

8.10 Planned procedures

Patients on planned schedules are outside of the scope of the RTT pathway if treated within the required time period. Planned procedures are part of an agreed programme of care, which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Planned activity is also sometimes known, as “surveillance” i.e. repeat check cystoscopy or colonoscopy.

Patients must only be included on a planned schedule if there are clinical reasons why the patient cannot have the procedure or treatment until a specified time.

If the patient is unable to be accommodated within the time period when the planned procedure should have taken place, the patient will be transferred to an active pathway and a new RTT clock started, with diagnostic and RTT standards applicable.

8.11 Post-Operative Follow-up Care

It is considered most appropriate for follow-up care to be provided by the consultant who carried out the patient’s treatment, although this is not a strictly enforced rule, rather depending upon the circumstances of each individual patient.

9.0 PAEDIATRICS

9.1 Management of all Paediatric Appointments Regardless of Specialty

The safeguarding of children must be a priority consideration in the management on non-attendance of all paediatric appointments.

The clinician / professional responsible for delivering care at the appointment should complete the following process for non-attendance of all outpatients, emergency ward appointments and ward attendance appointments whether the patient has failed to attend or has cancelled the appointment and not rescheduled.

The risk of significant harm to the child or any safeguarding implications of non-attendance must be considered and documented.

Appropriate agencies and referring clinicians must be notified of the outcome of any decisions or concern with clear documentation in their medical records. For example, if the child is subject of a child protection plan the allocated Social Worker should be informed.

9.2 Management of Paediatric Non Attendance

The below outlines the procedure to follow when a patient fails to attend their planned out-patient appointment this is detailed in the policy for Managing Cases where Children Did Not Attend planned Hospital Appointments

Patients commonly miss appointments. Adolescent patients, those with chronic disorders and psycho-socially disadvantaged children and families are at particular risk of doing so. Paediatric non-attendance is a special circumstance, because the patient (a child) is usually brought to the appointment by an adult (usually a parent). Thus non-attendance may reflect deficiencies in the level of care provided to the child by the responsible adult, in addition to all the more mundane causes for non-attendance common to adult and paediatric patients alike (appointment sent to wrong address, transport difficulties, inconvenience, forgetting, problem now resolved etc). **In certain cases persistent non-attendance may be an indicator of child abuse and neglect.**

Procedure:

When a patient does not attend a booked outpatient appointment, the clinician due to see the child will determine the next course of action, and will notify the out-patient booking team accordingly. This applies to patients that do not attend / are not brought along for appointments without due notice, and also to patients who repeatedly have appointments cancelled and re-booked by their carers, but who miss serial medical reviews as a consequence of this.

What needs to be done when a child fails to attend their OPA depends upon the circumstances, notably whether it is the initial appointment or a follow-up that has been missed, whether there have been other non-attendances and whether child protection concerns exist about that child.

In every case, whether the child has missed a new appointment or a follow-up appointment, the clinician must review the child's medical notes, noting any ongoing medical and / or safeguarding / social concerns before a deciding upon the appropriate action to take.

First / New Appointments Missed:

A new appointment may be re-booked. Consider whether the address may be incorrect, and whether there is still a need for medical review. Write to the family and the referring GP, and, if the child is under 5 years old, the Health Visitor informing them of the non-attendance, and the planned new appointment.

When, after consultation, a new appointment is not considered necessary then this must be conveyed to the referring GP, the family and the Health Visitor (if under 5 years of age), notifying them of this decision.

If safeguarding concerns exist about the child, the appointment must be re-booked, and the Trust safeguarding team notified. Children's Social Care must also be informed of the child's non-attendance at the appointment.

Follow-up Appointments Missed:

If a child fails to attend a follow-up appointment, a further appointment should be sent to the family if there is ongoing medical need. If there is no ongoing medical need for clinic follow-up, and there are no safeguarding concerns about the child, they can be discharged from further clinic follow-up. This must be conveyed in writing to the GP, family and Health Visitor (if under 5 years).

If a child fails to attend 2 or more consecutive follow-up appointments, the child's GP (and HV if under 5 years old) must be contacted to check the child's contact details, to ensure the ongoing medical necessity of the clinic review, and to inform them of the non-attendance.
If, after consultation, the decision is made not to offer further appointments because there is no ongoing medical need, and no safeguarding concerns, this must be conveyed in writing to the family, GP and HV (if under 5 years).

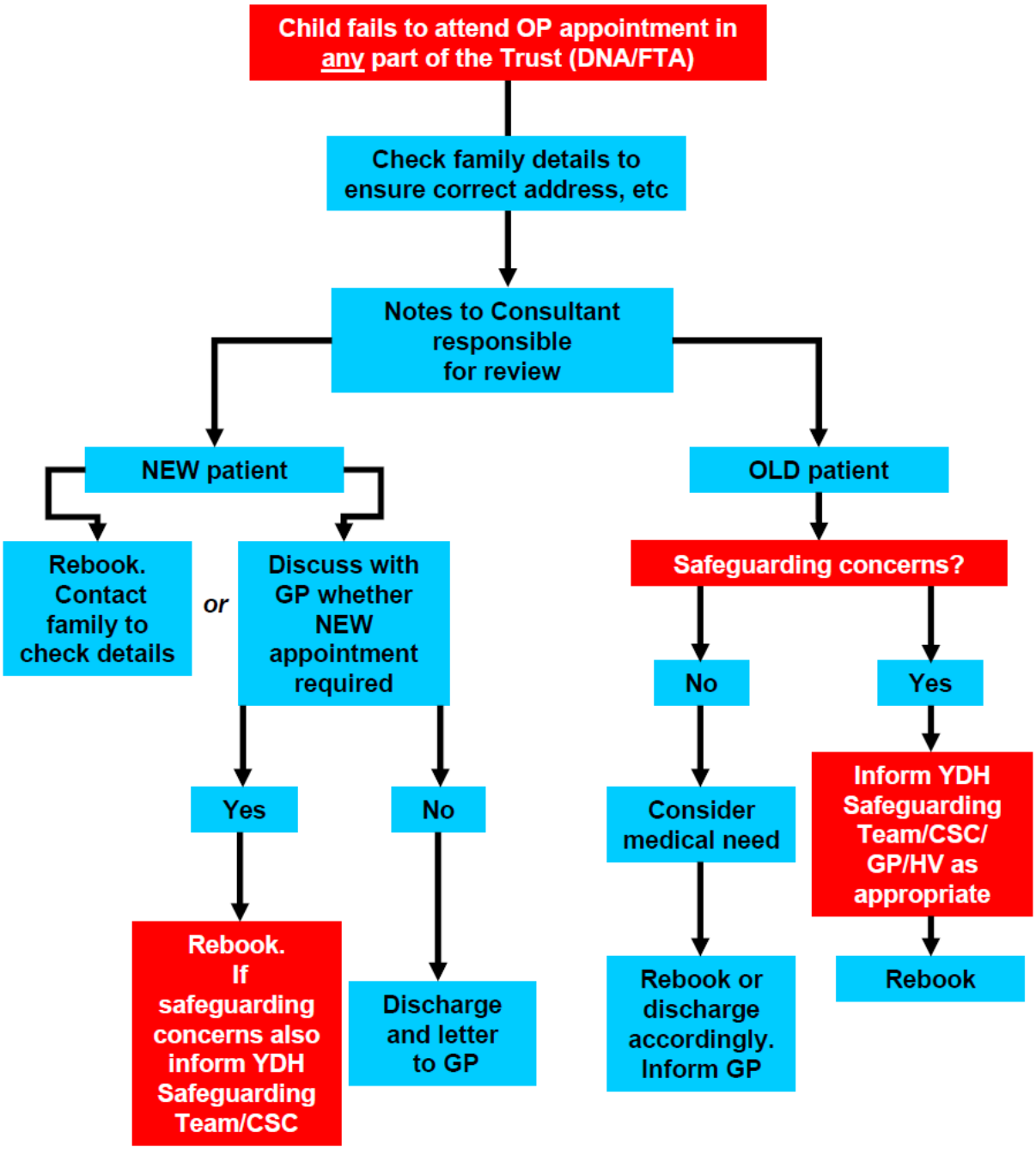
If there is ongoing medical or social need for clinic review, a further appointment can be sent.

If a child does not attend for 2 or more consecutive appointments, and is assessed to have ongoing medical or social need requiring clinic review, the responsible clinician must contact Children's Social Care to discover whether or not the child is subject to a Child Protection Plan (CPP). If the child is in receipt of a CPP, the clinician must contact the child's key-worker within Children's Social Care to inform them of the child's non-attendance.

Whenever there are concerns about abuse &/or neglect, and/or the ongoing medical necessity of a clinic review +/- treatment, direct contact must be made with family, GP, and HV (under 5's). The Trust Safeguarding Team must also be informed, and the case discussed with Children's Social Care (Social Services). In all such cases, the Trust Safeguarding Team must be informed of the child's non-attendance in clinic.

Patient Non-attendance

(for children <18 years)



Note: Second or subsequent FTA/DNA – ALWAYS inform GP and consider referral to YDH Safeguarding Team/CSC re safeguarding procedures

10.0 DIAGNOSTICS

A diagnostic is a test or procedure used to identify and monitor a person's disease or condition and which allows a medical diagnosis to be made. The national standard is that 99% of diagnostics will be managed within 6 weeks. Every month the Trust is required to submit a return (DM01) stating the number of patients waiting over 6 weeks at month end and performance against the standard. More information can be found on https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01-guidance-v-5.32.pdf and https://www.england.nhs.uk/statistics/wp-content/uploads/.../DM01-FAQs-v-3.0.doc

10.1 Diagnostic Clock Start

The diagnostics section of an RTT pathway is a major pathway milestone. A large proportion of patients referred for a diagnostic test will also be on an open RTT pathway. In these circumstances, the patient will have both types of clock running concurrently:

• their RTT clock which started at the point of receipt of the original referral

• their diagnostic clock which starts for internal referrals when the request for the diagnostic was made (not the date received). For external paper referrals ie direct access GP referrals the start time is from the date the referral was received. For choose and book the start time is the date the UBRN was converted.

10.2 Diagnostic Clock Stop

The diagnostic waiting time clock stops when the patient receives the diagnostic test/procedure.

10.3 Straight to test arrangements

For patients who are referred for a diagnostic test where one of the possible outcomes is review and if appropriate treatment within a consultant-led service (without first being reviewed by their GP) an RTT clock will start on receipt of the referral. These are called straight-to-test referrals.

10.4 Patient Choice/ Appointment Offer

The Trust will seek to fulfil "reasonableness" criteria when offering patients appointments for diagnostic tests/procedures. Patients are to be offered a minimum of two appointment dates and have at least 3 weeks' notice of the appointment. The clock then continues. If a patient refuses these offers then the clock restarts from the latest date offered. For further information on "reasonableness", please refer to Data Set Change Notice (DSCN) 37/2003 at the link below:

http://www.isb.nhs.uk/documents/dscn/dscn2003/372003.pdf

Appointments can be offered that do not fulfil the reasonableness criteria where it is in the best interest of the patient, for example to receive an appointment with less than 3 weeks notice. However, clock resets for cancellation or failure to attend appointments (see section 4.4) that do not fulfil reasonableness criteria should not be applied.

10.5 Patient cancels or DNAs their diagnostic appointment

Patient Cancellation
If a patient cancels an appointment for a diagnostic test/procedure that has been offered under "reasonable" criteria (10.5.3) then the diagnostic waiting time for that test/procedure is set to zero and the waiting time starts again from the date of the appointment that the patient cancelled. If a patient cancels more than three times, they will be removed from the waiting list, following a review

of their medical records by medical staff to ensure that there is no clinical risk involved in not seeing the patient. The patient and their GP should be informed of this in writing.

If a patient declines an offer of an appointment sent by post that does not fulfil "reasonableness" criteria, the clock is not reset and the patient should be offered an alternative appointment date.

DNAs
If a patient does not attend their diagnostic appointment, then the same DNA procedure should be followed as in 8.7. It is important that the patient has been given instructions of who to notify and how if they subsequently cannot come in for their diagnostic and that the letter clearly states the consequences of not attending.

Patients who did not attend (excluding paediatrics see 9.2) for their diagnostic will be discharged and removed of the diagnostic waiting list and referred back to the referrer.

Exceptions to this rule are:

- Patients undergoing cancer treatment
- Urgent referrals based on clinical judgement
- Paediatrics
- Maternity

If another appointment is given then then the diagnostic waiting time for that test/procedure is set to zero and the waiting time starts again from the date of the appointment that the patient missed.

10.6 Diagnostic scenarios and impact on clock stop

If a patient is admitted for a diagnostic procedure, but cannot tolerate it under local sedation, resulting in the procedure being stopped, they are then relisted to that the procedure done under general anaesthetic. Does the waiting time restart at the point they are relisted, or does it still continue from original date on list?
Clock re-starts are only allowed in very specific circumstances as detailed in the guidance. The scenario would not qualify for a re-start of the clock. The 1% tolerance built into the performance standard is there to cover cases such as this.

If a patient fails to complete the necessary preparation for a test, should this be reported as a clock restart?
6 week waits in these circumstances would be covered by the 1% tolerance and would not warrant a clock restart.

Is there a clock restart if a patient (Day Case or Elective Inpatient) is admitted, but is found to be medically unfit for the procedure at that date?
6 week waits in these circumstances would be covered by the 1% tolerance and would not warrant a clock restart.

Is there a clock restart if a test is delayed due to a problem with the equipment which is rectified but the patient refuses to wait>

The only clock adjustments available in diagnostics are for patients turning down reasonable appointments and DNAs. Therefore, there's no adjustment appropriate in either case, unless the patient was unreasonable and wouldn't wait 10 mins for the equipment to be fixed for example.

10.7 Imaging General Principles

- All patients are to be seen in order of clinical priority and length of wait within the stream of the specialty
- Referral dates and waiting times are to be correctly recorded and measured

- Patients are to be able to choose/negotiate their appointment time and date
- Patients are to be kept fully informed of their waiting list status and have a clear point of contact at the Trust
- No patient waiting for an imaging appointment should be suspended for social reasons

10.7.1 Imaging Referral Management

- Paper imaging requests will be date stamped upon arrival in the department
- Imaging referrals are managed via the department's Radiology Information System (RIS)
- Details of the request must be entered onto RIS within one working day.

Internal Referrals:

- All internal referrals will be made by the completion of a request card or electronic referral, which will then be immediately sent to the Imaging Department.
- Referrals without sufficient details will be highlighted to the referrer who must amend and re-send the referral.

External Referrals:

- Direct Access Referrals are received from GP surgeries within the local healthcare community. If there is an expectation that the patient may require treatment for the condition for which they are being investigated, this would start an 18-week pathway clock (see the above section on the 18 week pathway).

10.7.2 Imaging Booking Appointments

All patients will be offered appointments within the current guidelines for patient choice and within indicated maximum waiting times, unless the patient specifically chooses to wait outside the standard.

- Patients are sent a letter with a specified appointment date and time and asked to contact the imaging department by phone to change the appointment if it is not convenient.
- In circumstances where patients are given less than 7 days' notice, they will be telephoned to be offered the appointment and will not be penalised if they are unable to accept it.

10.7.3 Patients who 'Did Not Attend' (DNA) an imaging appointment

Patients who are Urgent (category A) that do not attend for their diagnostic investigations without notification will be phoned to offer another date. The clock will be set to zero from the date the appointment was missed. Routine patients (category B and C) that Do Not Attend should follow the procedure as in 10.5.4 ie Patients who did not attend (excluding paediatrics see 9.2) for their diagnostic will be discharged and removed of the diagnostic waiting list and referred back to the referrer with some exceptions.

10.7.4 Patient Cancellations - Imaging appointments

Patients who cancel their appointment should be given an alternative date at the time of the cancellation. If a patient cancels more than three times, they will be removed from the waiting list, following a review of their medical records by medical staff to ensure that there is no clinical risk involved in not seeing the patient. The patient and their GP should be informed of this in writing by the Imaging Department. For any patient cancellations, the waiting time will be set to zero with the new start date set to the date of the cancelled appointment.

When a patient cancels their appointment and does not wish to arrange an alternative, a discharge letter should be sent to the patient from the consultant responsible for the patient's care and the patient episode discharged on TRAKCARE.

Cancelled appointment slots should be offered to another patient and not left vacant wherever possible.

10.7.5 Imaging Extended Patient Deferrals

If a patient makes themselves unavailable for an appointment for more than four weeks, the referral will be rejected and the GP will be advised to re-refer the patient when they are willing to attend for an appointment. The patient will be removed from the waiting list.

10.7.6 Imaging Reporting

Imaging reports should be available to the referrer within 48 hours of the investigation having taken place.

10.7.7 Management of the 18 Week Pathway within Imaging

Clinical Exceptions

Aside from routine examinations, there are a number of more complex procedures which are not always available within 2 weeks of request. While the Trust will always aim to improve access to its service and reduce waiting times wherever possible, it is circumstances such as these that require an operational tolerance to be set when recording patient overall waiting time for treatment.

Waiting Time Adjustments

Waiting time adjustments are not currently intended to be taken into account when calculating a patient's entire wait for the purposes of 18 weeks. Therefore it is important to reschedule patients' appointments as quickly as possible in the case of cancellation or DNA.

11.0 CANCER

11.1 Cancer Waiting Principles

As defined in the NHS Constitution, patients have the right to expect to be seen and treated within national operational standards ensuring timely diagnosis and treatment, equity of care and patient choice.

Patients will, wherever possible, be offered dates for appointment or treatment in chronological order, based on the number of days remaining on their cancer pathway, unless there are clinical exceptions.

Wherever possible, patients will be given reasonable notice and choice of appointments and TCI dates as defined within the policy.

Accurate data on the trust's performance against the national cancer waiting times is recorded in the cancer management system and reported to the National Cancer Waiting Times Database within nationally predetermined timescales *www.digital.nhs.uk/cancer-waiting-times*

Where patients are at risk of breaching any of the cancer standards it is expected that all staff will follow the published cancer escalation policy.

11.2 Roles and Responsibilities

The roles and responsibilities are the same as in section 3.1 with additional responsibilities to the Cancer Access Manager and Cancer Clinical and Nursing Leads for ensuring that access targets are achieved and that high standards of cancer clinical care are delivered across the organisation in a timely manner.

11.3 Cancer Standards

Table 1: Key cancer waiting time standards

Service standard	Operational standard
Maximum 2WW from urgent GP referral for suspected cancer to first appointments	93%
Maximum 2WW from referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment	93%
Maximum 31 days from decision to treat to first definitive treatment	96%
Maximum 31 days from decision to treat/earliest clinically appropriate date (ECAD) to start of subsequent treatment(s) where the subsequent treatment is surgery	94%
Maximum 31 days from decision to treat/ECAD to start of subsequent treatment(s) where the subsequent treatment is drug treatment	98%
Maximum 31 days from decision to treat/ECAD to start of subsequent treatment(s) where the subsequent treatment is radiotherapy	94%
Maximum 62 days from urgent GP referral for suspected cancer to first treatment	85%
Maximum 62 days from urgent referral from an NHS cancer screening programme for suspected cancer to first treatment	90%
Maximum 62 days from consultant upgrade of urgency of a referral to first treatment	No operational standard as yet
Maximum 31 days from urgent GP referral to first treatment for acute leukaemia, testicular cancer and children's cancers	No separate standard, monitored as part of 62 days from urgent GP referral.

11.4 Cancer Clock Start

2WW
A two week wait clock starts at the receipt of referral**.**

62 day
A 62-day cancer clock can start following the below actions:
• urgent two-week wait referral for suspected cancer
• urgent two-week wait referral for breast symptoms (where cancer is not suspected)
• a consultant upgrade
• referral from NHS cancer screening programme
• non NHS referral (and subsequent consultant upgrade).

31 day
A 31-day cancer clock will start following:
• a DTT for first definitive treatment
• a DTT for subsequent treatment
• an ECAD following a first definitive treatment for cancer.

If a patient's treatment plan changes, the DTT can be changed, ie if a patient had originally agreed to have surgery but then changed their mind and opted for radiotherapy instead.

11.5 Cancer Clock Stop

A 62-day cancer clock will stop following:
• delivery of first definitive treatment
• placing a patient with a confirmed cancer diagnosis onto active monitoring

Removals from the 62-day pathway (not reported):
• making a decision not to treat
• a patient declining all diagnostic tests
• confirmation of a non-malignant diagnosis.

A 31-day cancer clock will stop following:
• delivery of first definitive treatment
• placing a patient with a confirmed cancer diagnosis onto active monitoring
• confirmation of a non-malignant diagnosis.

For a more detailed breakdown of the cancer rules please read the latest *Cancer waiting times guidance* or the cancer operational policy.

In some cases where a cancer clock stops the 18-week RTT clock will continue, ie confirmation of a non-malignant diagnosis.

11.6 GP/GDP suspected cancer two-week wait referrals

All suspected cancer referrals should be referred by the GP/GDP on the relevant cancer pro forma provided and submitted via e-referral. GP/GDPs should ensure that patients are willing and able before referring so that they can be seen within 2 weeks. There is also a responsibility on the GP/GDP to ensure that the patient is well informed that they are being referred on a cancer pathway and its importance.

Day 0 is the date the referral was received.

The first appointment can be either an outpatient appointment with a consultant or investigation relevant to the referral, ie 'straight to test'.

All 2WW referrals will be checked for completeness by the 2WW Contact Centre team 24 working hours of receipt of referral.

For 2WW referrals received by the Trust without key information the 2WW team will contact the relevant GP surgery by phone within 48 hours of receipt of referral to obtain the missing information. The referral process should begin, ie outpatient appointment booked for patient while information is being obtained, to ensure there is no delay to the patient's pathway.
Any 2 WW referral received by the Trust for service the Trust is not commissioned to deliver will be sent back to the GP.

11.7 Downgrading referrals from two-week wait

The Trust cannot downgrade 2WW referrals. If the consultant believes the referral does not meet the criteria for a 2WW referral they must contact the GP to discuss. If it is decided and agreed the referral does not meet the 2WW criteria, the GP can retract it and refer on a non 2WW referral pro forma. (It is, however, only the GP who can make this decision.)

11.8 Two referrals on the same day
If two referrals are received on the same day, both referrals must be seen within 14 days and, if two primary cancers are diagnosed, treatment for both cancers must start within 62 days of receipt of referral if clinically appropriate.

11.9 Screening pathways

The clock start is the receipt of the referral (day 0) which for the individual screening programmes is as follows:
• breast: receipt of referral for further assessment (ie not back to routine recall)

• bowel: receipt of referral for an appointment to discuss suitability for colonoscopy with a specialist screening practitioner (SSP)

• cervical: receipt of referral for an appointment at colposcopy clinic.

11.10 Consultant Upgrades

Details on the process and clock starts for consultant upgrades should be described in the access policy. The example below will be applicable for most trusts, but it is important to check that is it consistent with your local processes.

Hospital specialists have the right to ensure that patients who are not referred urgently as suspected cancer referrals or through the screening programmes, but who have symptoms or signs indicating a high suspicion of cancer, are managed on the 62-day pathway. This can be achieved by upgrading the patients onto a 62-day upgrade pathway.

The 62-day pathway starts (day 0) from the date the patient is upgraded.

Upgrade must occur before the DTT date. Patients not upgraded at this point will be measured against the 31-day DTT to first definitive treatment.

An upgrade is intended for suspected new primaries only, not those who may be suspected of a recurrence.

11.10.1 Who can upgrade patients onto a 62-day pathway?

The specialist team receiving the referral or reviewing the patient or diagnostic result can delegate the responsibility to upgrade the patient. This could be:
• specialist nurse/practitioner, either by triaging the referral form/letter or at nurse led initial clinic.

• specialist registrar either by triaging the referral form/letter or at initial clinic.

• radiologist/histologist/other trust clinicians on reviewing patients and/or diagnostics.

11.10.2 Responsibilities for Upgrading

The consultant or delegated member of the team upgrading the patient is responsible for informing the MDT co-ordinator (by completing the upgrade pro forma) that an upgrade has occurred, in order for the patient to be tracked on the correct pathway.
If a patient has been upgraded to a 62-day pathway this must be communicated with the patient so they understand why they are being upgraded, and the GP should be notified by the upgrading clinician.

11.11 Subsequent treatments

If a patient requires any further treatment following their first definitive treatment for cancer (including after a period of active monitoring) they will be monitored against a 31-day subsequent treatment clock. The clock will start following the patient agreeing a treatment plan with their clinician. This will be the decision to treat (DTT) date.

In some circumstances it may be appropriate for the clinician to set an ECAD (earliest clinically available date) which is when a patient needs to recover following their first definitive treatment. An ECAD can be adjusted but only if the date has not passed. The 31 day clock start date should be the same as the ECAD date for these patients

11.12 Reasonableness

For patients on a cancer pathway, an offer will be deemed to be reasonable if 48 hours' notice of an appointment/diagnostic test/admission is given.

11.13 Waiting-time adjustments

It is possible to make adjustments (pauses) to patient clocks in two instances. Both of these instances are included below. The Trust should make sure that these adjustments are understood by their operational teams and are defined in their processes and documentation.

11.13.1 Pauses

There are only two adjustments allowed on a cancer pathway, one in the 2WW pathway and the other in the 62-/31-day pathway:
• 2WW: If a patient DNAs their initial (first) outpatient appointment or attendance at diagnostic appointment, eg endoscopy, the clock start date can be reset to the date the patient rebooks their appointment (the date the patient agrees the new appointment not the new appointment date).

• 62-/31-day pathways: If a patient declines admission for an inpatient or day case procedure, providing the offer of admission was 'reasonable' the clock can be paused from the date offered to the date the patient is available.

If the patient during a consultation, or at any other point, while being offered an appointment date states that they are unavailable for a set period of time (eg due to holiday or work commitments), a

pause can be applied from the date that would have been offered to the patient to the date that they are available. This will apply to admitted treatments only (reference: *Cancer Waiting Times Guidance* version 9).

If a treatment is to be delivered in an outpatient setting such as an outpatient procedure or radiotherapy, a pause **cannot** be applied. No adjustments are permissible for medical illness.
Any pause must be supported by clear documentation in the cancer management system and PAS or other relevant clinical system. The trust will ensure that TCIs offered to the patient will be recorded.

11.14 Patient cancellations

If the patient gives any prior notice that they cannot attend their appointment (even if this is on the day of clinic), this should be recorded as a cancellation and not DNA. The trust will make every effort to reschedule patient appointments at the convenience of the patient. If a patient cancels an appointment the following guidance must be followed.

11.14.1 First appointment cancellations

2WW referral patients who cancel their first appointment should be offered another appointment within the two weeks of the referral being received.

11.14.2 Subsequent cancellations

Patients who cancel an appointment/investigation date will be offered an alternative date within seven days of the cancelled appointment (no waiting time adjustment will apply). 57 **|** Elective care model access policy

11.14.3 Multiple Cancellations

All patients who are referred on a 62-day GP pathway, screening pathway or breast symptomatic referral who cancel two consecutive appointments (ie outpatient, diagnostic investigation) will be contacted by an appropriate member of staff to identify any factors that may be stopping the patient attending. Another appointment will be offered if the patient agrees.

Patients can be discharged after multiple (two or more) appointment cancellations if this has been agreed with the patient. However, where a patient has cancelled multiple appointments on a 62-day GP pathway, screening pathway or breast symptomatic referral (ie outpatient, diagnostic investigation), an appropriate member of staff will contact the patient to identify any factors that may be stopping the patient attending and another appointment will be offered if the patient agrees.

11.15 Cancer Patient DNAs

Patients will be recorded as a DNA if they do not turn up to a clinic or diagnostic appointment, turn up late or turn up in a condition where the trust cannot carry out whatever was planned for them: for example, if they have not taken a preparation they needed to take before the appointment. (This also includes patients who have not complied with appropriate instructions prior to an investigation.)

11.15.1 First appointment DNA

All patients referred as suspected cancer including 2WW, screening, upgrade and breast symptomatic who DNA their first outpatient appointment should be offered an alternative date within 14 days of the DNA.

A waiting-time adjustment applies from receipt of referral to the date the patient makes contact to rearrange the appointment and all details must be recorded on the cancer management system.
If a patient DNAs their first appointment for a second time they will be escalated to the consultant in clinic for a decision on the next step which may include discharge back to the GP.

11.15.2 Subsequent appointment DNAs

If a patient DNAs any subsequent appointment they should be escalated to the consultant in clinic for a decision on the next step which may include discharge back to the GP. 58 **|** Elective care model access policy

11.16 Patients who are uncontactable
If the patient is uncontactable at any time on their 62-/31- day pathway, a record of the time and date of the call to them in the 'additional information' section on PAS should be made at the time of the call.

Two further attempts will be made to contact the patient by phone.

Each of these calls must be recorded in real time on PAS. These attempted contacts must be made over a maximum two-day period.
If contact cannot be made by such routes, the GP surgery must be contacted to ask for alternative contact routes.

If the patient remains uncontactable:
• For first appointments: An appointment will be sent to the patient offering an appointment within the 2WW standard, stating the trust has attempted to offer a choice of appointment, and that the patient should contact the 2WW office to rearrange the appointment if it is inconvenient

• Appointments (other than first) on 62-/31- day clinical pathway: Attempts to contact patient will be made as outlined above. If contact cannot be made, the consultant should decide:
– to send a 'no choice' appointment by letter

– to discharge the patient back to the GP.

11.17 Patients who are unavailable

If a patient indicates they will be unavailable for 28 days or more on their pathway after their first appointment, the patient's healthcare records will be reviewed by the managing clinician to ascertain if the delay is safe for the patient. If the clinician has any concern over the delay they will contact the patient to discuss if they can make themselves available. Patients will not be discharged if they make themselves unavailable.

11.18 Cancer Diagnostics

The Trust will maintain a 2WW for all diagnostic 'straight to tests' for patients on a cancer pathway and a 10-day turnaround for all subsequent diagnostic tests on a patient's 62-/31- day pathway.

11.18.1 Refusal of a diagnostic test
If a patient refuses a diagnostic test, the refusal will be escalated to the managing clinician to discuss with the patient. If the patient refuses all diagnostic tests they will be removed from the cancer pathway and discharged back to their GP.

11.19 Managing the transfer of cancer private patients
If a patient decides to have any appointment in a private setting they will remove themselves from the cancer pathway.
If a patient transfers from a private provider onto an NHS waiting list they will need to be upgraded if they have not made a DTT and the consultant wants them to be managed against the 62-day

target. If a DTT has been made in a private setting the 31-day clock will start on the day the referral was received by the trust.

11.20 Tertiary referrals

Inter provider transfer (IPT) forms will be used for all outbound referrals for patients on a cancer pathway. Where possible, information will be transferred between trusts electronically. Transfers will be completed via a named NHS contact. A minimum dataset and all relevant diagnostic test results and images will be provided when the patient is referred.

11.21 Entering patients on the tracking pathway

Suspected cancers: 2WW GP/GDP referrals
On receipt of a 2WW referral from a GP/general dental practitioner, the 2WW office will record the referral ((including known adjustments, referring symptoms and first appointment) onto the cancer management system within 24 working hours of receiving the referral.

The 2WW co-ordinators are responsible for confirming a patient's attendance at the first appointment and recording the outcome, checking all dates are correct and that DNAs/breach reasons are entered correctly.

Suspected cancers: screening patients
The MDT co-ordinating team will be responsible for entering patients referred via the screening programme onto the cancer management system database within 24 hours of receiving notification of the referral.

Suspected cancers: consultant upgrades
For upgrade before initial appointments the 2WW office will be responsible for entering patient details onto the cancer management system database and allocating the patient an appointment within the 2WW guidelines.
For upgrades at any other point of the pathway the MDT co-ordinator will be responsible for updating the cancer management system and will begin tracking of the pathway.

Suspected/confirmed cancers (31 day patients)
Patients not referred via a 2WW/screening/consultant upgrade referral should not be entered onto the cancer management system until they have a confirmed cancer diagnosis. The only exception is patients with suspected cancer who are being discussed at an MDT meeting.
Once a patient has been diagnosed with either a new cancer or recurrence, a record should be entered in the cancer management system, selecting the appropriate cancer status (by the MDT co-ordinator) within 24 hours of being notified.

Confirmed cancers
The MDT co-ordinator is responsible for ensuring a patient with a newly diagnosed cancer has a record entered on the cancer management system, and keeping that record updated.

11.22 Monitoring and audit

Monitoring and audit are an important part of cancer management and trusts will want to detail how this process is undertaken. The text below provides an example of how a trust may outline its approach.

It is the responsibility of the cancer information team to run a weekly programme of audits for data completeness and data anomalies.

Any data anomalies are highlighted to the relevant tumour site MDT co-ordinator for investigations and correction. Response to the cancer information team must occur within 24 working hours of

the anomaly being raised in order not to delay the audit programme and to ensure accurate performance available at all times.
In addition, a regular data quality programme will be established to review the following:

- comparative audit of data on the cancer management system and PAS
- comparative audit of diagnosis code on PAS, cancer management system and healthcare records
- comparative audit of cases removed from the 62-day pathway and re-entered as 31-day patients within four weeks of removal.

This will involve reviewing a random selection of healthcare records from each tumour site and will be led by the cancer information team.
The cancer information team will also capture numbers of patients ‘upgraded’ each month and will carry out a quarterly audit to ensure that patients are being ‘upgraded’ at the earliest opportunity.

12. OTHER PATHWAYS

12.1 Private Patients

Patients can choose to move between NHS and private status at any point during their treatment without prejudice. Where it has been agreed, for example, that a surgical procedure is necessary the patient can be added directly to the elective waiting list if clinically appropriate. The RTT clock starts at the point the GP or original referrer's letter arrives in the hospital stating NHS care is to be started.

The RTT pathways of patients who notify the trust of their decision to seek private care will be closed with a clock stop applied on the date of this being disclosed by the patient.

Top Up Patients - NHS patients who wish to top up their treatment with a drug that is not available on the NHS are able to do so, however this should be discussed with the consultant to verify which treatments are available and the costs involved.

12.2 Rapid Access Chest Pain Clinics

To meet the required NHS Standard National Service framework for coronary heart disease, patients who present to their GP with newly diagnosed chest pain must be seen in secondary care by a specialist within 14 days of the receipt of an E-Referral proforma (with all the appropriate information completed):

- Rapid Access Chest Pain clinic referrals are made either by a proforma which is faxed or mailed to the cardiology department or via the E-Referral system. Suitable appointments are then made and the patient informed.
- Standard rules apply regarding patient cancellations and failure to attend (see "Waiting Times adjustments" for further details)
- See the Department of Cardiology Rapid Access Chest Pain Clinic Operational Policy for further details

12.3 Colposcopy Clinics

To meet the required British Cervical Screening Programme standards, issued by the Department of Health, targets exist to ensure patients are seen promptly depending on the clinical need outlined on referral (see http://www.cancerscreening.nhs.uk/cervical/publications/nhscsp20.pdf for programme management).

- The patient pathway begins with their GP taking a smear test and sending it away for testing. If the results are positive then the testing organisation will send them to the Colposcopy Department at (as well as informing the GP)
- Colposcopy appointments are currently booked by the Women's Health Department, following referral
- Refer to local Colposcopy protocol on Ycloud regarding patient cancellations and failure to attend.
  http://ycloud/teams/ObstetricsandGynaecology/Trustwide%20documents/Forms/Colposcopy.aspx

13.0 SUPPORTING SERVICES

13.1 Medical Records

The Medical Records Department has a pivotal role in ensuring that health professionals have the relevant information to provide appropriate treatment to patients at the point of contact, thus minimising clinical risk.

Clinic preparation is undertaken for all outpatient clinics, records that are pulled and prepared for clinic by the central medical records team will be "bundled" and available within the respective clinic area not less than 72hrs before a clinic. The exception to this would be when an additional ad-hoc clinic has been organised. Where the clinic preparation is undertaken within the specialty – the same standard applies. All staff pulling a clinic for outpatients, irrespective of the job role of the staff member are responsible for tracking the notes on TRAKCARE to their new location, and from that location when they leave.

Please refer to Health Records Policy in relation to records standards for non-elective and elective admissions.

14.0 MANAGEMENT INFORMATION

14.1 Elective Access Information for Trust Management

Summary information relating to the numbers of patients waiting and performance against the access targets will be published weekly and discussed at weekly RTT meetings.

An agreed set of performance measures will be reported on a monthly basis to the Management Executive. The Trust Board will receive a board performance scorecard alongside any additional analysis as required on a monthly basis.

14.2 Access Information to Department of Health/Regulators

Statistical information on performance against national key waiting time targets and PTL performance will be submitted to the Department of Health to meet the statutory requirements as set by the Information Standards Board.

14.3 Further guidance underpinning the Access Policy

Where this policy is unable to provide solutions to patient access issues, the first point of contact should be the central RTT validation team or the Deputy Director of Operations and Performance.

15.0 ACCESS PERFORMANCE INDICATORS

15.1 Current Waiting List National Targets

Elective Waiting Times:

- Patients have the right to access services within maximum waiting times of 18 weeks (126 days) from referral to first definitive treatment in accordance with Department of Health referral to treatment guidelines. The target is 92% of all incomplete RTT pathways will be within 18 weeks.

Cancer Targets:

- Maximum two-week wait from GP referral decision date (for a suspected cancer and breast symptoms) to date first seen (14 day target)
- Maximum two-month wait from GP referral decision date (for suspected cancer) to first definitive treatment for all cancers (62 day target)
- Maximum one-month wait from diagnosis (decision to treat date) to first definitive treatment for all cancers (31 day target)

Rapid Access Chest Pain

- Maximum two-week wait (14 days) from GP referral date (for new chest pain) to date first seen

Colposcopy Clinics:

- At least 90% of women with an abnormal smear test result should be seen in a colposcopy clinic within eight weeks of referral
- At least 90% of women with a test result of moderate or severe dyskaryosis should be seen in a colposcopy clinic within four weeks of referral

Diagnostics (Milestone):

- All diagnostics must be performed within six weeks of referral.

Cancelled Operations:

- All patients who have operations cancelled on the day of surgery for non-clinical reasons must be offered another binding date within 28 days.

16.0 MILITARY PERSONNEL AND VETERANS

In line with the Armed Forces Covenant, published in 2015, all veterans and war pensioners should receive priority access to NHS care for any conditions related to their service, subject to the clinical needs of all patients. Military veterans should not need first to have applied and become eligible for a war pension before receiving priority treatment.

GPs will notify the trust of the patient's condition and its relation to military service when they refer the patient, so the trust can ensure it meets the current guidance for priority service over other patients with the same level of clinical need. In line with clinical policy, patients with more urgent clinical needs will continue to receive priority.

17.0 PRISONERS

All elective standards and rules are applicable to prisoners. Delays to treatment incurred as a result of difficulties in prison staff being able to escort patients to appointments or for treatment do not affect the recorded waiting time for the patient.

The Trust will work with staff in the prison services to minimise delays through clear and regular communication channels and by offering a choice of appointment or admission date in line with reasonableness criteria.

18.0 PATIENT ELIGIBILITY

All Trusts have an obligation to identify patients who are not eligible for free NHS treatment and specifically to assess liability for charges in accordance with Department of Health guidance /rules.

The Trust will check every patient's eligibility for treatment. Therefore, at the first point of entry, patients will be asked questions that will help the trust assess 'ordinarily resident status'. Some visitors from abroad, who are not ordinarily resident, may receive free healthcare, including those who:

• have paid the immigration health surcharge

• have come to work or study in the UK

• have been granted or made an application for asylum.

Citizens of the European Union (EU) who hold a European Health Insurance Card (EHIC) are also entitled to free healthcare, although the trust may recover the cost of treatment from the country of origin.

All staff have a responsibility to identify patients who are overseas visitors and to refer them to the overseas visitor's office for clarification of status regarding entitlement to NHS treatment before their first appointment is booked or date to come in (TCI) agreed.

Kingston Wing oversee the management of patient eligibility.

19.0 OTHER ASSOCIATED DOCUMENTS

Associated documents to the Access Policy:

- DoH Referral to treatment consultant-led waiting times- Rules Suite
- DoH Referral to treatment measurement guidelines
- DoH Referral to treatment FAQ
- NHSI Elective Care Model Access Policy
- DoH Policy for patients who require appointments for assessment, review and/or treatment - use of planned (pending or review) lists
- DoH Referral to treatment consultant-led waiting times
- Guidelines for NHS Cervical Screening Programme
- Private Patient Policy

20.0 DEFINITIONS

ASA:	American Society of Anaesthesiologists (ASA) Physical Status Classification System grouping patients by physical status (code 1-6) http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/ar/asa_physical_status_classification_system_code_de.asp?shownav=1
Active Waiting List:	Patients awaiting elective admission and are currently available i.e. fit, able and ready, to be called for admission.
Admission Procedure:	The act of admitting a patient for a day case or inpatient
Admitted pathway	A pathway that ends in a clock stop for admission (day case or inpatient):
Fully Booked Patients:	Patients who have the opportunity to agree a date at the time of, or within one working day of, the referral or decision to treat.
E-Referral	An electronic booking software application designed to enable patients needing an outpatient appointment to choose which hospital they are referred to by their General Practitioner (GP), and to book a convenient date and time for their appointment.
Choice	Patients listed for elective surgery may be offered the choice of a different provider/consultant/dates
CCGs:	Clinical Commissioning Groups are groups of GP Practices that are responsible for buying health and care services for patients, taking over the role from Primary Care Trusts. They will implement the new commissioning roles as set out in the White Paper Equity and excellence: Liberating the NHS.
Consultant-Led Clinic:	An administrative arrangement enabling patients to see a consultant, the consultant's staff and associated health professionals. The holding of a clinic provides the opportunity for consultation, investigation and treatment. Patients normally attend by prior appointment. Although a consultant is in overall charge, the consultant may not be present on all occasions that the clinic is held. However, a member of the consultant's firm or locum for such a member must always be present. An individual consultant may run more than one clinic in the same or different locations. This also includes clinics run by GPs acting as consultants
Date on Waiting List:	The date on which the clinical Decision to Admit was made. Also known as 'Decision to Admit Date'
Day Case:	A patient who is admitted to hospital for treatment but is not intended to stay in hospital overnight
Decision to Admit:	A clinical decision indicating the intention to admit a patient, either as an urgent admission or at some time in the future as a routine admission. Each entry on the elective waiting list represents a single decision to admit.

Deferrals:	Patients who choose to change the date of a previously agreed appointment or admission date.
Did Not Attend (DNA):	Patients who have been informed of their admission date (inpatients/day cases) or appointment date (outpatients) and who, without notifying the hospital in advance, did not attend that admission/outpatient appointment.
DoS:	Directory of Services, which outlines all the services available within the Trust and is available to all GP's to assist them when referring through Choose and Book.
DSCN:	Data set change notices issued by the DoH to ensure compliance with national policy.
e-RS:	Electronic Referral System
First Attendance:	The first time a patient is seen in an outpatient setting following referral (from any source, including A&E) is referred to as a first attendance. This is also sometimes referred to as a 'new' appointment.
Follow-Up Attendance:	Following a first attendance, any subsequent attendance in an outpatient setting which is part of the same encounter (episode of care) is referred to as a follow-up attendance.
GDP:	General Dental Practitioner
Generic Referral:	A procedure whereby a GP makes a referral that is not addressed to a specific consultant, but which is allocated to the most appropriate clinician, taking account of sub-specialisation issues and waiting times.
GP:	General Practitioner. GPs account for a significant proportion of the patients referred to the Trust for assessment and treatment.
Inpatient:	Patient who is admitted to the hospital for treatment and is expected to remain in hospital for at least one night.
Non-admitted pathway:	A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment'.
Outpatient:	Patient referred to the Trust for clinical advice or treatment. An outpatient attendance usually takes place in a clinic setting, but occasionally will take place on a ward.
TRAKCARE:	This is the Trust's current patient administration system (TRAKCARE)
Planned Admissions:	Patients who are to be admitted as part of a planned sequence of treatment or investigation. They may or may not have been given a firm date. They are not counted as part of the active waiting list.
PTL:	Patient Target List - a tactical tool used to deliver both the maximum wait for inpatients and outpatients.

Pre-operative assessment: A system that assesses patients' health before they are admitted to hospital to ensure that they are fit to undergo the procedure

Referral to Treatment (RTT): Is the period from referral into a consultant led service to the start of first definitive treatment.

Referral Request Received: The waiting time for a first outpatient appointment is calculated from the date the referral request is received in the Trust, which must be date-stamped immediately upon receipt.

T.C.I: Planned Admission Date ('To Come In')

21.0 STATEMENT OF EVIDENCE/REFERENCES

Department of Health, 2013. NHS Constitution [WWW Document]. Department of Health. URL https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/448466/NHS_Constitution_WEB.pdf

Department of Health, 2015. Referral to Treatment Consultant-led Waiting Times Rules Suite [WWW document].URL https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

NHS Cancer Screening Programmes, 2010. Colposcopy and Programme Management-Guidelines for the NHS Cervical Screening Programme, 2nd ed. NHS Cancer Screening Programmes.URL. http://www.cancerscreening.nhs.uk/cervical/publications/nhscsp20.pdf

Information Standards Board, 2012. All Standards [WWW Document]. ISB.URL.http://www.isb.nhs.uk/library/all

Department of Health, 2015. Consultant-led Referral to Treatment Waiting Times [WWW Document]. DoH. URL. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464956/RTT_Rules_Suite_October_2015.pdf

1. ANNEX A – EQUALITY IMPACT ASSESSMENT TOOL

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes / No / N/A	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	
	Disability	No	
2.	Is there any evidence that some groups are affected differently?	Yes	Military Personnel & Veterans
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	Yes	Armed Forces Covenant
4.	Is the impact of the policy/guidance likely to be negative?	No	
5.	If so can the impact be avoided?	N/A	
6.	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Trust's lead for Equality & Diversity, together with any suggestions as to the action required to avoid / reduce this impact.

For advice in respect of answering the above questions, please contact the Trust's lead for Equality & Diversity.

Signed –David Waring **Date –** 31st August 2018