Index No: W10a

ELECTIVE CARE PATIENT ACCESS POLICY

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Approval and Authorisation

Completion of the following signature blocks signifies the review and approval of this process.

Name	**Job Title**	**Signature**	**Date**
	Chief Operating Officer		

Local Committee approval (where applicable)

Name of Committee	**Name of Chairperson**	**Date of Approval**

Change History

Version	Date	Author	Reason
2.3	August 2014	Matthew Thurland / Sarah Hudson	Update from v2.2
2.4	September 2014	Matthew Thurland	Incorporation of comments
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2.6	January 2015	Maxine White	Cardiology
	January 2015	Tracey Reid	Diagnostics
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3	February 2015	Matthew Thurland / Imran Devji	Final Review
4	February 2016	Chris Anyan	Changes to reflect RTT national guidance
5	May 2017	Amanda Thomson	Annual Review
6	June 2018	Susan Perks	Annual Review

Impact Assessment

Undertaken by	**Date**
TBC	

A translation service is available for this policy. The Interpretation/Translation Policy, Guidance for Staff (I55) is located on the library intranet under Trust wide policies.

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1. EXECUTIVE SUMMARY & POLICY STATEMENT

The purpose of this document is to both outline and define how the Trust and its staff manage access to its key services, ensuring fair treatment for all patients. The successful management of patient waiting lists is fundamental to achieving NHS England's objectives in reducing waiting times and improving patient choice.

The policy describes the processes to be followed to ensure transparent, fair and equitable management of waiting lists. It includes guidance and procedures to ensure:

- Waiting lists are managed effectively
- High quality service to patients
- Optimum use is made of resources at all locations within the Trust.

This document is intended to be used by all staff in KGH and for the local health economy that refers to KGH. It will ensure that patients are treated in order of clinical priority, and that patients of the same clinical priority will be seen in turn. It will also help provide equity of access within specialties throughout the Trust.

The policy is not intended to replace local and departmental operational policies and procedures including defined Patient Administration System processes set out in Medway user guides, but act as a framework to support them. It will be reviewed annually to ensure that it accurately reflects changing local, regional and national priorities.

1.1 ROLES AND RESPONSIBILITIES

The Chief Operating Officer is accountable for the delivery of operational standards relating to the provision of elective care, diagnostic and cancer services. Divisional Operational Managers, Chiefs of Divisions, Clinical Teams, Outpatient and Waiting List teams have overall responsibility for implementing and ensuring adherence to the policy within their areas.

When issues arise with any member of staff complying with the policy, the issue will be resolved between that individual's line manager, the relevant Divisional Director and the individual concerned. Any failure to reach agreement will be managed through KGH HR policies and processes.

Failure to adhere to this policy will be dealt with through the Trust's disciplinary process.

This policy reflects the core principles established within the NHS Constitution, which can be viewed here:

https://www.gov.uk/government/publications/the-nhs-constitution-for-england

Any future guidance about the patient access or patient choice from the Department of Health or commissioners will supersede any guidance in this document.

1.2 SCOPE

This policy applies to all clinical and administrative staff and services relating to patient access managed by KGH. All staff involved in the management of patients' access to the organisation are expected to follow this policy and associated Standard Operating Procedures (SOP). Any specific roles and responsibilities are identified in relevant sections of the Policy and Procedures. Each clinical service must follow this policy and related SOPs to deliver high quality, consistent care to patients across the organisation as a whole.

Key performance indicators (KPIs) have been identified to monitor compliance with the policy, and where performance is below the expected thresholds corrective action must be taken e.g. further training and support. In accordance with training needs analysis, staff involved in the implementation of this Policy and Procedures, both clinical and administrative, must undertake

training provided by the Trust both at induction and by way of regular annual updates. It is the responsibility of all members of staff to understand the principles and definitions which underpin delivery of all elective access performance measures; cancer, referral to treatment (18 weeks) and diagnostics.

2. INTRODUCTION

This Elective Care Patient Access Policy for Kettering Hospital NHS Foundation Trust has been developed and reviewed following investigation of best practice, together with consultation and good practice throughout the local health economy. This has included partnership working with the Clinical Commissioning Groups (CCGs).

The aim of this document is

- To establish a consistent approach to patient access across the Trust
- To ensure that national and local standards of care are met through clarity of definition and procedure
- To provide an operational guide for all areas to work consistently, in conjunction with local operational procedures which cover the detail of day-to-day administrative processes. This policy does not replace local operational procedures but seeks to support them.

Medical staff, managers and administrative staff have an important role in managing waiting times effectively. Treating patients and delivering high quality, efficient and responsive service, ensuring prompt communications with patients is a core responsibility of the Trust, all staff and the wider local health community.

Staff must ensure that national standards are met and that all notification rules are adhered to. These are detailed throughout the policy and summarised below for ease of reference.

There are a number of Standard Operating Procedures and guides available within the appendices and on the RTT pages of KGH intranet.

3. NATIONAL STANDARDS

3.1 The NHS Constitution for England

From April 2010 patients have had the right to:

- Start their consultant led treatment within a maximum of 18 weeks from referral for non-urgent conditions
- Be seen by a cancer specialist within a maximum of 2 weeks from a GP referral for urgent access where cancer is suspected.

The current maximum waiting times for elective care are set out in the NHS constitution and the handbook to the NHS constitution. This can be found at:

https://www.gov.uk/government/publications/the-nhs-constitution-for-england

Handbook to the NHS Constitution 2015

https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england

In addition to the individual patient rights as set out in the NHS Constitution (and its supporting handbook) there is a set of waiting time performance measures for which the NHS is held accountable for delivering by NHS England.

http://www.nhs.uk/NHSEngland/appointment-booking/Pages/nhs-waiting-times.aspx

3.2 NHS OPERATING FRAMEWORK

From April 2011 all patients referred for an outpatient appointment have been able to choose a named consultant-led team. From April 2011, providers have been required to:

- Accept patients who are referred to a consultant-led team as long as the referral is clinically appropriate
- List their service on NHS e-referral in a way that allows users to book appointments with consultant led teams
- Publish information about services so that patients can use it to make choices about their healthcare and support people to use this information

3.3 PRIVATE PATIENTS AND MOVING BETWEEN NHS & PRIVATE CARE

It is imperative that NHS capacity is utilised for NHS patients. The trust must be transparent in relation to the use of NHS resources and access to NHS treatment.

As an overriding principle, NHS and Private Patient capacity should remain separate. All staff, both administrative and clinical must ensure that private patients being referred to the trust do not take priority over patients waiting on NHS lists.

For patients who are seen privately but then transfer to the NHS, if they are transferring on to a RTT pathway, the RTT clock should start at the point at which the clinical responsibility for the patient's care transfers to the NHS i.e. the date when the NHS trust accepts the referral.

The RTT clock stops for patients who choose to leave NHS-funded care to fund their own care in the private sector. The clock stops on the date that the patient informs the provider of this decision.

For patients who are treated in the private sector under NHS commissioning arrangements (i.e. they are NHS patients whose care has been funded by the NHS and commissioned by the NHS from the private sector), the clock continues to tick until one of the clock stop events outlined in the RTT rules suite takes place (for example, first definitive treatment commences or the patient is referred to primary care for non-consultant led treatment.)

4. NATIONAL PERFORMANCE MEASURES

4.1 REFERRAL TO TREATMENT (RTT)

In June 2015 NHS England announced changes to the performance management arrangements of RTT waiting times, with a focus on open (Incomplete) pathways. With the national target of:

- 92% of patients on open (Incomplete) pathways should be waiting less than 18 weeks from referral.

4.2 CANCER WAITING TIMES

The headline performance measures are against a minimum threshold of:

- 93% of patients to be seen within two weeks of an urgent GP referral for suspected cancer
- 93% of patients to be seen within two weeks of a GP referral with breast symptoms (where cancer is not suspected)
- 96% of patients to receive their first definitive treatment for cancer within 31 days of the decision to treat
- 94% of patients to receive subsequent treatment for cancer within 31 days of the decision to treat/earliest clinically appropriate date to start a second or subsequent treatment where that treatment is *surgery*
- 98% of patients to receive subsequent treatment for cancer within 31 days of the decision to treat/earliest clinically appropriate date to start a second or subsequent treatment where that treatment is an anti-cancer *drug regime*
- 85% of patients to receive their first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer
- 90% of patients to receive their first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service (breast, bowel and cervical)
- Patients will wait a maximum of 62 days from a consultant upgrade of urgency of a referral to first treatment.

4.3 DIAGNOSTIC WAITING TIMES

Speed of diagnosis is a significant factor in the quality and timeliness of care.

- 99% of patients will have a maximum wait of 6 weeks for a diagnostic test

5. KEY PRINCIPLES

This policy will be applied consistently and without exception across the Trust. This will ensure that all patients are treated equitably and according to their clinical need.

All staff employed by Kettering Hospital will adhere to the Waiting Times and Patient Access Policy.

All stakeholders; including CCGs, NHS Improvement, patient representatives, patients and others will have access to this policy.

Patients will be treated in strict order of clinical priority and chronological waiting time. Patients of the same clinical priority will be seen in turn according to the Trust targets and standards.

Patients will be invited to choose and appointment date/time within the defined booking period. Patients will agree at the time of attendance the date/time of their next appointment.

The following symbols will appear throughout this document to allow easy identification of clock events and data entry.

This symbol indicates a CLOCK START / STOP event

This symbol indicates a DATA ENTRY requirement

5.1 REFERRAL TO TREATMENT PRINCIPLES

As a general principle, the Trust expects that before a referral is made for treatment, the patient is clinically fit for assessment and treatment. The patient must be available for treatment within 18 weeks of referral.

The Trust will work with GPs, CCGs and other primary care services to ensure patients have a full understanding of this before starting and elective care pathway.

The 18 Week RTT Rules apply to all patients who are referred to a Consultant-led service for assessment with a view to potential treatment, regardless of the referral mechanism.

5.2 REASONABLE OFFERS

A reasonable offer is when a time and date is offered to the patient with 3 or more weeks (15 working days) from the time the offer was made.

5.3 RTT CLOCK STARTS

5.3.1 New patients

An RTT pathway is initiated when any health professional (or service permitted by an English NHS Commissioner to make such referrals) refers to a Consultant-led service. This is most commonly a General Practitioner, but can include General Dental Practitioners, Community Nurse-led Services, Opticians and Optometrists.

The RTT clock starts the date the Trust receives the referral. For referrals received through NHS e-Referral, the RTT clock starts on the date the patient converts their unique booking reference number (UBRN). For paper referrals the clock starts on the date of receipt into the trust.

5.3.2 Existing patients

For patients already on an 18 Week RTT Pathway whose clock has already stopped, a new clock will start under the following circumstances:

- Their initial treatment plan has been completed, and the patient now needs a new treatment that was not part of their initial plan.
- Following a period of Active Monitoring, a clinical decision has been made that the patient now requires treatment (this decision can also be made by the patient themselves e.g. a patient wishes to wait and see for 6 months before committing to invasive surgery and how now decided they wish to proceed.

CLOCK START: First Activity in RTT Period (10)

DATA ENTRY: Use code 10
The date the decision is made and communicated to the patient and GP

5.4 RTT CLOCK STOPS FOR TREATMENT

An 18-week clock stops when:

- A patient receives definitive treatment in an outpatient setting; this could be medication, advice, fitting of a brace or appliance, or the initiation of a therapy treatment plan. This treatment is intended to manage their condition and avoid further intervention.
- The patient is admitted for treatment, or is given definitive treatment during a diagnostic procedure e.g. polyps are removed during a diagnostic colonoscopy.

When the treatment requires day case or inpatient admission, the clock stops on the day of admission. It does not stop where admission is for diagnostic tests only.

CLOCK STOP: First definitive treatment (30)

DATA ENTRY: Use code 30
The date of admission/treatment

5.5 RTT CLOCK STOPS FOR NON-TREATMENT

An RTT clock stops when a clinical decision has been made and communicated to the patient that:

- A clinical decision has been made not to treat the patient, or treatment is not necessary (this is expected to be followed by a discharge back to the care of their GP. If the consultant wishes to review the patient again in a set time period, please consider Active Monitoring instead).
- A patient declines treatment having been offered it (this is expected to be followed by a discharge back to the care of their GP. If the patient wishes to be reviewed again at the hospital within 12 months, please consider Active Monitoring).
- A patient dies before treatment commences
- A patient DNAs their first attendance on the pathway. (Please see DNA section for further guidance)

CLOCK STOP: DNA First Attendance (33) / Decision not to treat (34) / Patient declined treatment (35) / Patient died before treatment (36)

DATA ENTRY: Use code 33 / 34 / 35 / 36
The date the decision is made and communicated to the patient and GP

5.6 ACTIVE MONITORING / WATCHFUL WAIT

In many pathways there will be times when it is clinically appropriate to start a period of active monitoring without further clinical intervention or diagnostic procedure. The clock stops when this decision is made and communicated to the patient.

Some clinical pathways require patients to undergo regular monitoring/review. These events would not of themselves indicate a decision to treat or a new clock start.

It is not appropriate to stop a clock for a period of active monitoring if some form of diagnostic or clinical intervention is required. Placing a patient on Active Monitoring must be consistent with a patient's perception of their wait, the patient must always be made aware they are on Active Monitoring when the decision is made. If a patient has received any kind of treatment, we would use a code 30 (first definitive treatment) and code 90 (treatment given/started previously) for any follow-up activity. Active Monitoring is only to be used for patients who are not receiving any treatment.

All patients on Active Monitoring should be on a Planned Procedure waiting list, an Outpatient waiting list, or have an outpatient appointment, diagnostic test or TCI booked.

CLOCK STOP: Active Monitoring / watchful wait (31/32)

DATA ENTRY: Use code 32
The date the decision is made and communicated to the patient and GP

If a decision is made to treat after a period of active monitoring / watchful waiting, a new RTT clock starts on the date of the decision to treat (DTT).

CLOCK START: Active Monitoring end (11)

DATA ENTRY: Use code 11
The date the decision to treat is made

5.7 MANAGING PATIENT FITNESS

The overriding principle regarding patient fitness for treatment is that all patients must be FIT, READY and AVAILABLE.

Where patients are on an RTT pathway, and a previously undiagnosed or untreated condition occurs, this is to be escalated to the lead Consultant for that pathway. A decision must be made whether to continue that pathway, place the patient on Active Monitoring or discharge the patient back to their GP. An example of this might be a patient on an Ophthalmology pathway

waiting for routine cataract surgery who is subsequently diagnosed with a heart condition which needs to be optimised before the patient can be considered for cataract surgery. Where a decision is made to continue the pathway, the 18 week clock continues to tick.

In most cases, the patient will be discharged to their GP to be re-referred to the Trust once they are fit for treatment. Exceptionally, a Consultant may decide to monitor the patient's fitness within the Trust. In this case, the patient is to be placed on Active Monitoring. If the patient is on an Elective Waiting List for a procedure, they are to be removed.

CLOCK STOP: Decision not to treat, patient returned back to GP for monitoring/Clinician initiated Active Monitoring/Watchful Wait

DATA ENTRY: Use code 34/32
The date the decision is made and communicated to the patient and GP

5.7.1 Restarting the clock following removal due to fitness

Where a patient has been discharged back to their GP, once they are re-referred back to the Trust they can re-enter their clinical pathway at the same point that they left following ratification of the new referral by the relevant consultant. A new 18 week clock starts once this referral is received by the Trust. The patient is then to be treated within the guidelines set out in this policy. If the patient was on the Elective Procedure Waiting List when they were discharged, they can be re-added to the Waiting List without being seen again in Outpatients pending ratification of this referral by the appropriate consultant.

Where a patient has been removed from an Elective Procedure Waiting List and placed on Active Monitoring, once they are declared fit for treatment, they are to be added back on to the waiting list and a new 18 week clock started.

NB – where a patient is unfit in the short term e.g. due to a cold, and this has no effect on the original decision to treat, they are to remain on the waiting list and the 18 week clock will continue to tick. Whether fitness is considered short or long term must be decided on a case-by-case basis, but a good general guideline is three weeks.

CLOCK START: Patient fit to proceed with treatment plan

DATA ENTRY: Use code 11
The date the patient is added to the waiting list or the date of the outpatient review

5.8 PATIENT-INITIATED DELAYS

5.8.1 Unavailability for social reasons

Patients are entitled to delay their care if they wish. Patients must be allowed to plan their treatment around their personal circumstances. However, if a patient wishes to delay the next step of their pathway (be it an outpatient appointment, a TCI or a diagnostic procedure) for a substantial period of time they must be clinically reviewed to decide if the delay is appropriate.

Consultants must give responsible booking staff guidelines around clinically acceptable delays. Any patient wishing to delay any longer than this guideline must be escalated to the consultant. It is not appropriate to apply blanket rules that do not take account of the circumstances of individual patients.

If the clinician responsible for the patient's care is satisfied that the patient is not putting themselves at risk of harm by delaying their procedure, the trust should allow the delay.

If the clinician is not satisfied that the proposed delay is appropriate, the clinical risk should clearly be communicated to the patient. The responsible clinician must act in the best clinical interest of the patient. If the clinician feels that it is in the best clinical interest of the patient to discharge the patient back to the care of their GP and inform them that treatment is not progressing then this must be made clear to the patient.

Patients must never be allowed open-ended delays. An available date must always be sought from the patient.

5.8.2 Patient-initiated delays

Where the patient is responsible for initiating the next step in the pathway, an appropriate time limit must be clearly communicated to the patient. Once this time limit has expired without the patient taking appropriate action, the patient must be contacted and given one final deadline for completing the required action. It must be clearly communicated to the patient that once this deadline has passed, they will be returned to the care of their GP.

Examples of patient-dependent delays include, but are not limited to:

- Providing photographs
- Rebooking appointments, diagnostics or TCIs where they are unable to provide availability at the time of booking e.g. a patient wishes to check their diary and arrange childcare before committing to a TCI date.
- Provide a medical sample for analysis

5.8.3 Patient thinking time

Patients may wish to spend time thinking about the recommended treatment options before confirming they are willing and able to proceed. It would not be appropriate to stop the 18 week RTT clock where this amounts to under two weeks. However, it may be appropriate to stop the 18 week RTT clock (patient initiated active monitoring) where the patient requests a delay of two or more weeks before coming to a decision. This concurs with the guidance on patient thinking time which is provided by NHS England in 'Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care'.

Patient 'thinking time'
Stopping a patient's clock for a period of active monitoring requires careful consideration on a case by case basis and its use needs to be consistent with the patient's perception of their wait.
Where a patient is given 'thinking time' by the consultant, the effect on the RTT clock will depend on the individual scenario. If the agreed 'thinking time' is short, then the RTT clock should continue to tick. An example is where invasive surgery is offered as the proposed first definitive treatment but the patient would like a few days to consider this before confirming they wish to go ahead with the surgery.
If a longer period of 'thinking time' is agreed, then active monitoring is more appropriate. An example is where the clinician offers a surgical intervention but the patient is not keen on invasive surgery at this stage, as they view their symptoms as manageable. A review appointment is agreed for three months' time and the patient is placed on active monitoring. The RTT clock would stop at the point that the decision is made to commence active monitoring.
A new RTT clock would start when a decision to treat is made following a period of active monitoring.

CLOCK STOP: Patient active monitoring (31)

DATA ENTRY: Use code 31
Date patient requested thinking time

If the patient decides to go ahead with the recommended treatment he/she can be added to the waiting list and a new clock started when the patient confirms they are willing to proceed. The consultant in charge of the patient's care may decide to add the patient straight on to the waiting list, or may offer the patient an outpatient appointment.

CLOCK START: Active monitoring end

DATA ENTRY: Use code 11
Date patient confirms they are willing to proceed or the date the new referral is received

5.9 UPGRADING AND DOWN GRADING REFERRALS

Referrals can be upgraded if a clinician suspects there is a possibility of cancer, or if they feel on review of the referral that the case is urgent rather than routine. The GP or referrer should be informed that their patient has been upgraded. The following clinical priorities apply:

- Suspected cancer 2WW patients
- Clinically urgent patients
- Routine patients

Referrals cannot be downgraded without agreement between the consultant and the referring clinician. Only the referring clinician can agree to downgrade a referral. Such decisions should be recorded in the patient notes and the patient should be informed.

5.10 PATIENT INFORMATION

Patients should be given information about their appointment and what they can expect to happen at their appointment, including who they might see, any information they are likely to be asked, what medication they are taking, and whether they should bring someone with them. This should include information on how to change or cancel an appointment, what happens if they do not attend and how this will affect their overall pathway and waiting time.

Patients will be given copies of letters and reports with a covering explanation.

5.11 PATIENT TRANSFERS

5.11.1 Interprovider Transfers (IPT)

Transfers to and from other providers (be they NHS Trusts, private organisations offering NHS services, or Referral Management Services) must be managed with the consent of the patient and consultant. A Minimum Data Set (MDS) form must be included with all transfers.

A patient's 18 week pathway starts when they are referred to secondary care. If the patient is transferred between secondary care organisations, this is a continuation of the same pathway. If the patient's 18 week clock is ticking at the point of transfer, it continues to tick

with the receiving organization. Only one organisation is considered clinically responsible for that patient's treatment, and thus only one organisation reports the clock status.

In some circumstances, the patient may be referred on to an external organisation for diagnostics or second opinion, in which case the clock stays with the referring organisation and completion of a MDS is not required.

5.11.1.1 Incoming IPTs

Where patients who are referred to the Trust having already started an 18 week RTT pathway at another provider organisation, the Minimum Dataset must be included with the referral, and this information must be put onto Medway PAS at the time of inputting the referral.

If this information is not included with the referral, A&C staff are to contact the referring organisation to request the MDS information.

5.11.1.2 Outgoing IPTs

When referring patients to other organisations for further treatment, an IPT form must be completed by the referring team and sent along with the referral. The IPT form does not need to be completed when a patient chooses to go private for their treatment.

Kettering General Hospitals' Inter Provider Transfer Process is included within the appendices.

5.11.2 Transfer of Consultant

On occasion, patients may be offered the opportunity to reduce their waiting time by having their procedure performed by another Consultant within the same Specialty. Where a patient declines a reasonable offer it would not be acceptable to stop the clock and their RTT clock will continue to tick.

6. OUTPATIENT WAITING LISTS

6.1 REFERRALS

Referrals received by the Trust must be sent via the NHS eReferrals system, with few exceptions (please see appendix for referrals excluded from this mandate).

Where referrals are sent via routes other than eReferrals, they are to be returned to the referrer with a request to use the eReferrals system.

Both fall into two categories:

- Open referrals to pooled waiting lists in a given specialty
- Consultant specific referrals

Where clinically appropriate, referrals should be made to a service (an open/generic referral) rather than a named clinician. This is in the best interests of patients as it promotes equity of waiting times and allows greater flexibility in terms of booking appointments.

As a general principle, generic referrals will be sent to the consultant with the shortest waiting time in that specialty. However, it is the patient's right to request a named consultant.

6.1.1 Minimum Data Set

Referral letters are required to include an agreed minimum data set:

- Name, address, post code, date of birth, NHS number, local patient identifier
- Contact number and/or email address
- GP name, medical practice code, organisation name and code, professional name
- The service to which the patient is being referred
- For IPTs, RTT status, clock start date (if applicable), decision to refer date, referral reason

Where referrals are received without the minimum information, A&C staff should request further information from the referrer.

6.2 MANAGEMENT OF REFERRALS

All outpatient waiting lists must be managed using the PAS / NHS e-Referral systems.

6.2.1 Paper Referrals

Where authorised, all paper referrals must be date stamped upon receipt at point of entry to the Trust.

Details of the referral will be entered onto PAS at this point reflecting recorded date by the Trust. For patients referred by paper referrals this is the point that the Referral to Treatment (RTT) clock starts on waiting time standards and 18-week pathway.

CLOCK START: Date referral received by the Trust

DATA ENTRY: Referral details entered onto PAS

Referrals will be sent to Clinical teams for prioritisation. Prioritisation should be recorded as "Cancer" (where a 2WW pro forma has not been used) 'Urgent' or 'Routine'.

CLOCK STOP: Decision not to treat.

DATA ENTRY: Use code 34
Date decision made by consultant to discharge back to GP.

6.2.2 NHS e-Referrals

All NHS e-referrals must be reviewed and accepted / rejected by Clinical Teams within 24 hours for an urgent referral and 48 hours for a routine referral.

Where there is a delay in reviewing these referrals this will be escalated to the relevant clinical team and actions agreed to address this.

Where possible the Trust will endeavour to provide an NHS e-Referral appointment at the hospital site of the patient's choice. If this is not possible the patient will be offered an appointment at one of the other sites within the Trust.

If a patient's appointment has been incorrectly booked on the NHS e-Referral system into the wrong service by the referrer, the NHS e-Referral team will re-direct the patient to the correct service and a confirmation letter of the appointment change will be sent.

If an NHS e-Referral referral is received for a service not provided by the Trust, it will be rejected back to the referring GP advising that the patient needs to be referred elsewhere.

If there are no slots available for the selected service the patient will appear on the Appointment Slot Issue (ASI) work list. Patients on this list must be contacted within 14 days and offered an appointment as soon as one becomes available. If they cannot accept the appointment offered they will stay on the list until another is available. If they cannot accept the second appointment there should be a clinical review and a clinical decision made on an individual patient level about whether to offer the patient another appointment or whether discharging them is in their best clinical interest.

If the patient advises that the appointment is no longer required, they will be removed from the waiting list and discharged back to the GP. The 18 week clock will be stopped.

CLOCK STOP: Decision not to treat

DATA ENTRY: Use code 34
Date decision made by consultant to discharge back to GP.

6.3 CANCER 2-WEEK WAIT REFERRALS (INC BREAST SYMPTOMATIC)

GPs and GDPs must use the Trust's 2 week wait (2WW) pro forma and will ensure that patients are given the information sheet attached to all 2WW referral pro forma that explains the urgency of the referral.

Referrals must be faxed by the GP/GDP to the Trust (within 24 hours of the patient being seen). GPs who send referrals under this protocol will receive a faxed back confirmation of receipt of the referral.

NHS e-Referral 2 week wait referrals will be booked into an appointment slot within 14 days by the GP or patient. In the rare event that no slots are available on The NHS e-Referral system, the GP should use the “defer to provider function” on the system to notify the Trust. The Outpatients Team will liaise with the relevant Associate Divisional Manager to ensure that all patients are offered a date within 14 days.

GPs and GDPs should ensure their patients are able to attend an appointment within the following 2 weeks. If a patient is unavailable, GPs and GDPs should consider whether it is appropriate to defer the referral until such time that their patient can attend an out-patient appointment within 2 weeks of being referred.

If difficulty in meeting the booking guidelines is encountered, this must be escalated through the relevant Associate Divisional Manager and Divisional Director for action and resolution. The Cancer Services Manager must also be kept informed.

Two week wait referrals can only be downgraded by the GP - if a consultant thinks the 2 week wait referral is inappropriate, it should be discussed with the GP and the GP asked to withdraw the two week wait referral status.

6.3.1. Two week wait first appointment DNA

If a patient DNAs a 2WW first appointment, another appointment should be booked automatically. The patient should not be discharged or referred back to their GP. However, it is good practice to contact the GP to make them aware that the patient DNAd and ask them to find out why.

DATA ENTRY: Log the DNA on PAS and re-book another appointment recorded on PAS

Patients should be referred back to their GP after 2 consecutive DNAs.

If a patient DNAs their first outpatient appointment for the second time, the patient should be automatically discharged to their GP, removed from the outpatient waiting list and an automated PAS letter will be sent to the GP and the patient notifying them of this removal. The patient will be discharged from PAS, and cancelled on NHS e-Referral if appropriate.

If the responsible clinician wishes the patient to be offered another appointment in exceptional circumstances i.e. concerns regarding their clinical care or if the discharge would not be in the clinical interests of an at risk patient (Safeguarding Adults at Risk Policy S10) or Policy for Safeguarding Children); then this should be escalated to the Associate Divisional Manager.

CLOCK STOP: The pathway is discharged on the date the patient DNAs their second appointment

DATA ENTRY: Discharge patient on PAS and send appropriate correspondence

6.3.2 Two week wait first appointment cancellations

Patients should not be referred back to their GP after a single appointment cancellation.

DATA ENTRY: Log the cancellation on PAS and re-book another appointment recorded on PAS

Patients on a 2WW pathway should not be referred back to their GP after multiple (two or more) appointment cancellations unless this has been agreed with the patient – by cancelling an appointment a patient has shown a willingness to engage with the NHS.

The quality of suspected cancer referrals will be the subject of regular audit, (with appropriate feedback to individual GPs and the CCG).

If there is evidence of training needs in general practice in relation to Cancer referrals, or that this route is being misused to secure fast-track appointments, appropriate action will be agreed with the CCG.

6.4 REFERRALS FOR LOW PRIORITY TREATMENTS

Patients referred for treatment outside of existing contracting agreements will follow the agreed protocol as laid out in the Host Commissioner's Low Priority Treatment Policy before booking.

A list of procedures requiring prior approval by Corby CCG can be found here:

http://www.corbyccg.nhs.uk/prior-approval-policies/

A list of procedures requiring prior approval by Nene CCG can be found here:

http://www.neneccg.nhs.uk/prior-approval-policies/

Prior approval would be required in the following three instances

- During a consultation the GP suggests a service of procedure which requires prior approval (RED or AMBER, criteria not met) They inform the patient and seek approval
- During a consultation the GP decides that additional information or an opinion is required regarding the need for a service or procedure and refers their patient to a specialist. The specialist after assessment of the patient feels that this treatment would be beneficial and advises the GP accordingly. The GP then applies for approval.
- A consultant who wishes to undertake a procedure covered by a lower priority treatment policy can seek approval in the same way and using the same criteria as their GP colleague. This process applies regardless of the hospital at which the patient may be treated and only applies to NHS Commissioned Secondary Care.

In the instance of point three where there is a clinical decision made within the Trust that the patient requires an LPP, the patient should be added to the waiting list as usual and the Trust should apply to the CCG for approval. The CCG should respond within 4 working days.

If the CCG approves the procedure, the patient stays on the list until they are treated, upon which their 18 Week clock will stop.

If the CCG rejects the procedure, the patient should be discharged and their clock will stop.

6.5 OVERSEAS VISITORS

Separate guidance should be referred to when managing the treatment of overseas visitors, as access to the Health Service may be limited. Department of Heath guidance on overseas

visitors may be found at: https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations

6.6 MILITARY VETERANS

All veterans and war pensioners should receive priority access to NHS care for any conditions which are related to their service subject to the clinical needs of all patients, in line with December 2007 guidance from the Department of Health.

Military veterans should not need first to have applied and become eligible for a war pension before receiving priority treatment.

GPs should notify the Trust of the patient's condition and its relation to military service when they refer the patient so that the Trust can ensure that 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 clinical priority.

6.7 CONSULTANT TO CONSULTANT REFERRALS

Consultant-to-Consultant referrals will be kept to a minimum wherever possible and must relate to the original referred condition.

Consultant-to-Consultant referrals must follow the strict "Referral Protocol" process as agreed with the CCG. At present referrals may be accepted under the following circumstances:

- Consultant to consultant outpatient referral or Accident & Emergency to consultant outpatient referral is considered of benefit to the patient when a different specialist consultant opinion is needed to advance the management of the presenting or associated condition
- When the referral is for investigation, management or treatment of cancer, or a suspected cancer
- Symptoms or signs suggest a life threatening or urgent condition
- Surgical assessment of an established medical condition with a view to surgical treatment
- Medical assessment of an established surgical condition with a view to medical management
- Anaesthetic risk assessment
- A&E referrals to fracture clinic
- Referrals that are part of the continuation of investigation/treatment of the condition for which the patient was referred. These will continue their existing pathway.
- Suspected cancer referral. This will be vetted and dated by the receiving consultant and upgraded if deemed necessary. Once upgraded the patient will be treated within 62 days of the date the referral was received by consultant.
- Management of pain where surgical intervention is not appropriate

All other referrals must be returned to the referring consultant for referral back to the patient's GP.

Investigation for or treatment of any condition other than the condition for which the patient was originally referred requires the patient to be referred back to their GP for onward referral to a different specialist.

6.8 INAPPROPRIATE REFERRALS

If a referral has been made to a Consultant whose service/specialist interest does not match the needs of the patient, the Consultant should advise the GP promptly so that appropriate treatment can be sought.

If the opinion of a different specialty is required this should be made in agreement with the patient's registered GP and an onward referral made. This does not constitute a new referral. The original referral must be changed to reflect the change of consultant.

If the referral is for a service not provided by the Trust the referral letter will be returned to the referring GP with a note advising that the patient needs to be referred elsewhere. Such patients will not be registered by the Trust.

6.9 REFERRALS FROM MEDICAL ASSESSMENT AREAS AND WARDS

Patients who require an outpatient appointment for follow-up care or monitoring with the Consultant Team that was responsible for their care during their inpatient stay will be booked as "follow-up appointments". These patients do not need to be placed on an 18 week RTT pathway. Appointments should be agreed with the patient and booked by the ward before the patient is discharged.

Patients who require an outpatient appointment with a different specialty, a new Consultant Team or requiring further elective treatment following an inpatient admission will be booked as "New appointments". These patients fall under the 18 week RTT requirements, and a RTT clock will start at this point.

CLOCK START: Fist Activity RTT Period

DATA ENTRY: Use code 10
Date referral received by new consultant team

Waiting times standards will apply to these patients. Appointments should be agreed with the patient and booked by the ward before the patient is discharged.

Patients who require an outpatient appointment with a different specialty or new Consultant Team following an inpatient admission who are already under the care of that Consultant Team for out-patient treatment will be booked as "follow-up appointments". The appointment should be booked under the existing outpatient registration for that Consultant Team.

The guidance on consultant to consultant referrals must be applied when booking appointments for this group of patients.

6.10 PATIENT CONTACT

6.10.1 Booking Outpatient Appointments

All patients will be offered appointments within the current guidelines for patient choice and in line with the national guidance for waiting times.

Appointments must be made in chronological order and on a first come first served basis to ensure equity of access. This process should take no more than five working days

A reasonable offer is "an offer of a time and date 3 or more weeks from the time that the offer is made". Outpatient scheduling staff will ensure that all appointments offered are recorded on PAS.

Wherever possible; patients are to be contacted by telephone to agree their first outpatient appointment. Patients who decline one reasonable offer must be offered at least one further reasonable offer. Patients should be warned that after declining the first reasonable offer only one other date will be offered.

A written appointment to a patient must be deemed reasonable.

It is accepted that while all offers have to be reasonable, it is possible some patients may be willing to attend at short notice. If a patient accepts a short notice offer, this will be considered a reasonable offer if the patient subsequently cancels the appointment. However if a patient declines such an offer the patient's 18 week RTT waiting time must continue.

Patients who are not referred via NHS e-Referral will receive an invitation or acknowledgement letter confirming their first outpatient appointment.

Patients will be booked for their first outpatient appointment in line with specialty pathway milestones (where available).

NHS e-Referral patients will receive a confirmation letter once the referral has been reviewed and accepted by the Clinical Team.

DATA ENTRY: Log the offers made to the patient

If a patient declines two reasonable offers there should be a clinical review and a clinical decision made on an individual patient level about whether to offer the patient another appointment or whether discharging them is in their best clinical interest.

If the patient advises that the appointment is no longer required, they will be removed from the waiting list and discharged back to the GP. The 18 week clock will be stopped.

CLOCK STOP: Decision not to treat.

DATA ENTRY: Use code 34
Date decision made by consultant to discharge back to GP.

6.11 DID NOT ATTEND (DNA)

6.11.1 New Appointment DNA

For patients who DNA their first attendance at the hospital, their contact details will be confirmed with their GP, or via the National Spine (Summary Care Record application, SCRa). If the details are correct, the patient will be removed from the outpatient waiting list and an automated PAS letter will be sent to the patient notifying them of this removal. The patient will be discharged from PAS, and cancelled on NHS e-Referral if appropriate. The 18 week RTT clock is nullified. The clock is nullified no matter what the attendance type is i.e. if their first activity on the pathway is a diagnostic admission, this DNA would still count as a clock stop.

If the details are not correct, the patient is to rebooked and contacted using the correct details.

Patients who are clinically urgent including two week waits, under the age of 18 or have a Patient Safety alert recorded in PAS are to be escalated to the responsible clinician for awareness, and a new appointment booked. For children and adults identified as being at risk, the relevant safeguarding procedures should be followed. All second DNAs should be escalated to the appropriate consultant. In exceptional circumstances, they may wish to send the patient another appointment.

Where patients are discharged, an automated PAS letter should be sent to the patient and their GP informing them of the discharge.

Refer to section 6.3.1 for Cancer referral DNAs.

CLOCK STOP: DNA 1st appointment only

DATA ENTRY: Use code 33
Date of the DNA'd appointment

6.11.2 Follow-up Appointment DNA

All patients who DNA are follow-up appointment are to be escalated to the appropriate clinician for review. The Access Policy guidance is the same as for DNA of new appointments, with the exception being that a follow-up DNA does not stop the 18 week RTT clock unless the patient is discharged back to the care of their GP.

CLOCK STOP: Decision not to treat

DATA ENTRY: Use code 34
Date of discharge confirmed by clinician

6.12 PATIENT CANCELLATIONS

Patients who cancel their appointment should be given an alternative date at the time of the cancellation. They are to be informed that if they cancel their next consecutive appointment, they will be discharged back to their GP providing it is clinically safe to do so.

Patients who cancel their appointment via the eReferrals or text messaging systems are to be given 7 days to rebook their appointment. If they have not done so after 7 days, they are to be contacted to arrange an appointment.

Patients who cancel two consecutive appointments will be removed from the outpatient waiting list and an automated PAS letter will be sent to the patient notifying them of this removal. The patient will be discharged on PAS, and cancelled on NHS eReferral if appropriate. The RTT clock is stopped by the act of discharging the patient, not by the patient cancellation i.e. in exceptional circumstances a patient may be sent for again, their clock will continue to tick.

Patients who are clinically urgent including two week waits, under the age of 18 or have a Patient Safety alert recorded in PAS are to be escalated to the responsible clinician for and a clinical decision whether to rebook or discharge. For children and adults identified as being at risk, the relevant safeguarding procedures should be followed.

Where patients are discharged, the responsible clinician should write to the GP advising that the patient has been discharged following two consecutive patient cancellations.

CLOCK STOP: Decision not to treat

DATA ENTRY: Use code 34
Date decision made by consultant to discharge back to GP.

6.13 HOSPITAL CANCELLATION

Patients who are cancelled by the hospital must be offered an alternative appointment date as soon as possible and the date must be within their 18 week RTT pathway. If an alternative appointment is not available, this should be escalated immediately to the Associate Divisional Manager for a resolution. Where the hospital does not have capacity to negotiate an appointment with a patient following a hospital cancellation, the patient is able to cancel that appointment without detriment.

If a patient has an appointment cancelled with less than 14 days' notice, the patient must be contacted by telephone and an alternative timely appointment will be offered at the time of cancellation.

Acceptable reasons for clinic cancellations are; absence of medical staff as a result of planned annual leave or study leave, audit activities, unavailability of equipment or equipment in need of repair, on call commitments or unplanned sickness absence.

A minimum of 6 weeks' notice is required from all clinicians and clinic nurse specialists (in all but exceptional circumstances) to cancel or reduce any outpatient or diagnostic sessions for reasons of annual leave or study leave. All cancellations must be authorised by the Divisional Director or the Chief of Division.

For adults at risk it is important that the arrangements for follow up appointments are agreed with their carer. These patients are identified on the PAS system. Some of these patients may find it difficult to deal with the Trust's administrative processes and if it is necessary to rearrange their appointment then it is essential that they and/or their carer's are contacted personally and not communicated with solely by letter.

6.13.1 Cancellations with six weeks' or more notice

- Only leave approved by the relevant Clinical Director and Associate Divisional Manager will be actioned.
- Session cancellation notifications will only be accepted if submitted on the appropriate form, unless there are exceptional circumstances.
- Session cancellation notification must be passed to the relevant administrative manager for action.
- Session cancellation requests will be actioned at the earliest opportunity and within a maximum of five working days.
- Where patients have to be cancelled, the relevant clinician should review clinical priorities and waiting times and identify the rebooking requirement.
- Patients who have previously been cancelled should not be cancelled a second time.

6.13.2 Cancellations with less than six weeks' notice

Clinics should not be cancelled with less than six weeks' notice unless there are exceptional circumstances.

No clinic should be cancelled without the authorisation of the Divisional Director or Chief of Division.

When clinics have to be unavoidably cancelled at short notice, liaison with nursing staff, the Outpatient Manager and relevant Associate Divisional Manager is essential. Identifying appropriate capacity for these patients to be rebooked remains the responsibility of the consultants and the Division, not the outpatient department. The identified short notice cancellation clinic code on PAS must be utilised in such circumstances.

6.14 Clinic attendances

All outpatient appointments must be given an outcome and an RTT status within 24 hours of the appointment taking place.

All appropriate actions should be taking within 48 hours of the appointment e.g. adding to Inpatient/Day Case Waiting List, sent for diagnostics.

No appointments are to be given an outcome of "open appointment" or equivalent, but are to be fully discharged back to the care of their GP where there is no intention to see the patient again.

Patients who are placed on Active Monitoring must be scheduled a review appointment. Three weeks before the review appointment is due to take place, the patient is to be contacted to confirm they still need the appointment.

Patients who are to be discharged pending satisfactory test results are NOT to be discharged from clinic. Once the tests results have been reviewed and a clinical decision made, the patient is to be either discharged, rebooked or added to a waiting list. **NB – where the test results indicate a clock stop, the clock stop date is the date that the decision was made and communicated to the patient, not the date of the previous clinic appointment**.

7. INPATIENT WAITING LIST

7.1 PRINCIPLES OF WAITING LIST MANAGEMENT

The decision to add a patient to a Waiting List must be made by a Consultant, or under an arrangement agreed with the Consultant.

Patients should not be added to the waiting list unless they are clinically ready for admission on the day the decision to admit is made. It is the responsibility of the clinician making the decision to admit to ensure that the patient is available and prepared to be admitted at any point within the remaining 18 week timeframe to ensure the RTT target is honoured. The overriding principle is that the patient must be FIT, READY and AVAILABLE if a bed became available tomorrow.

Please see section 5.7 for guidance around managing patients' fitness for treatment.

All waiting lists must be recorded on PAS. Under no circumstances should manual waiting lists be held outside of PAS, whether paper based or on a spreadsheet.

All patients must be added to the waiting list on PAS within two working days of decision to admit.

PAS alerts the user if the patient already has an open waiting list entry. If this is the case, both responsible consultants are to be notified and a plan agreed to ensure that there is no risk to the patient.

The use of effective early pre-operative clinics (POA) forms the basis of efficient waiting list management. The attendance at a POA clinic following the decision to treat determines the suitability and fitness to treat at an early stage. In cases where fitness is an issue continuing care via POA may be appropriate.

7.2 THE ACTIVE WAITING LIST (PTL)

The active waiting list should consist of patients awaiting inpatient or day case admission, who are currently fit and able to proceed with treatment. This includes local anaesthetic procedures and first endoscopic procedures.

All patients irrespective of procedure, form part of the elective waiting list and must be treated in line with Department of Health guidance.

- Clinical priority should be defined as urgent or routine only (includes 2 week wait)
- Patients of the same clinical priority must be booked in order of their overall RTT wait.
- To aid both the clinical and administrative management of the waiting list, elective waiting lists and planned lists will be listed separately but must be managed in line with this policy guidance and the intended management.

7.2.1 Patients requiring Commissioner funding approval

On receipt of the addition to waiting list proforma where funding has not already been applied for by the GP, a request will be sent to the CCG for approval. This is a four working day process and causes no delay in the patient pathway (the RTT clock will continue to tick while the funding decision is being made). Please see section 6.4 for further guidance.

7.2.2 Adding Patients to Active Inpatient / Day case Waiting Lists

The definition of an inpatient is any patient admitted electively or by other means with the expectation that they will remain in hospital for at least one night, including any patient admitted with this intention who leaves hospital for any reason without staying overnight.

The definition of a day case is “A patient admitted electively during the course of a day with the intention of receiving care who does not require the use of a hospital bed overnight and who returns home as scheduled. If this original intention is not fulfilled and the patient stays overnight, such a patient should be counted as an ordinary admission.”

- A day case must be an elective admission
- A Consultant is responsible for the patient’s medical care
- The patient uses a hospital bed for recovery purposes. If a bed or trolley is used for a specific short procedure rather than because of the patient’s condition, this does not count as a hospital bed.
- The patient is not intended to occupy a hospital bed overnight, and does not actually occupy a bed overnight.

7.3 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

If more than one procedure is to be performed at one time by the same surgeon the patient should be added to the waiting list with additional procedures noted.

DATA ENTRY:
List the additional procedures on the waiting list entry

If different surgeons will be working together to perform more than one procedure the patient should be added to the waiting list of the Consultant Surgeon for the priority procedure with additional procedures noted.

DATA ENTRY:
List the additional procedures and the other consultant required to assist with the joint procedure

If a patient requires more than one procedure performed on separate occasions by different (or the same) surgeon(s):

- The patient should be added to the active waiting list for the primary (first) procedure.
- The patient should not be added to the waiting list for any subsequent procedures, as they are not “fit or willing” to proceed with any additional treatment at this stage.
- When the first procedure is complete and the patient is fit, willing and able to undergo the second procedure the patient should be added to the waiting list.

CLOCK START: First activity in an RTT period

DATA ENTRY: Use code 10
Date patient added to waiting list for second procedure

7.4 THE PLANNED WAITING LIST

Patients should only be added to a planned list where clinically they need to wait for a period of time. This includes planned diagnostic tests (e.g. check cystoscopy) or treatments or a series of procedures carried out as part of a treatment plan - which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Patients identified for addition to the planned waiting list should have a target admission date specified by the clinician. This target date should be added when adding the patient to the waiting list or a provisional date entered on PAS.

Patients on planned lists should be booked at the clinically appropriate time and they should not have to wait a further period after this time has elapsed. For example, a patient due to have a re-test in six months’ time should be booked six months later and they should not get to six months, then have to wait again for non-clinical reasons. This is not an acceptable use of a planned list.

When patients on planned lists are clinically ready for their care to commence and reach the date for their planned appointment, they should either receive that appointment or be transferred to an active waiting list and an RTT waiting time clock should start (and be reported in the relevant waiting time return).

The key principle is that where patients' treatment can be started immediately, then they should start treatment or be added to an active waiting list.

7.4.1 Endoscopy pathways

Elective Planned patients need to have repeat endoscopies at clinically indicated intervals. The Endoscopy Booking Clerk enters the date for repeat endoscopy on the PAS system. A 'bring forward' system is then used by the Endoscopy Booking Clerk to ensure patients are contacted at the appropriate interval. Dedicated surveillance lists are run, and each patient is allowed to choose their date of attendance on one of these lists.

Further details regarding the management of these surveillance patients can be found in the Department’s Policy “Booking Policy in Endoscopy”.

The booking clerk and Endoscopy Manager will review regularly any planned lists for their service to ensure that patient safety and standards of care are not compromised to the detriment of outcomes for patients. Patients should also be given written confirmation if they are placed on such lists, including the review date.

7.5 MAINTAINING THE WAITING LIST

Waiting Lists should be kept up to date by waiting list coordinators and identified staff managing individual lists using the 18 week RTT Patient Tracking List (PTL). They need to ensure that patients are listed promptly and that the list does not contain patients who no longer need their procedures.

All waiting lists are to be maintained in the PAS system. A full audit trail of all offers made to patients and all contact made with patients and other clinical or administrative staff must be kept updated on the system.

Details of listed patients must be entered onto the computer system within 24 hours of the decision to admit being made for patients on cancer pathways, and 48 hours for all other priorities. Patients will be added to the waiting list with the date the decision to admit was made. The waiting list episode needs to be attached to the correct 18 week RTT pathway.

7.5.1 Non-Clinical on the day cancellations

Where a patient is cancelled on the day of admission of day of surgery, he/she must be rebooked within 28 days of the original admission date. Two reasonable offers must be made to the patient within 28 days of the date of cancellation. The patient may choose not to accept a date within 28 days.

If the Trust cannot offer the patient a date within 28 days of the cancellation, the Trust must offer to fund the patient's treatment at the time and hospital of the patient's choice where appropriate.

7.6 PATIENT CONTACT

7.6.1 Booking Admissions

All patients will be offered admission dates within the current guidelines for patient choice and in line with the national guidance for waiting times.

Wherever possible, patients must be contacted by telephone to agree their admission date.

Three attempts are to be made to contact the patient over a 24 hour period, on at least two different days and at different times of day, with one attempt being after 5pm. If the patient cannot be contact, their contact details are to be checked with the GP/referrer, or the National Spine. If the details are not correct, they are to be updated on PAS and the patient contacted via the correct details. If the details are correct, the patient will then be sent a letter requesting that they make contact with the relevant booking team.

If the patient contacts the hospital within 10 working days of the letter being received, they are to be given a TCI offer and booked as per normal processes. If they are on an Incomplete 18 week pathway, their clock is not affected.

If the patient fails to contact the hospital within 10 working days, they are to be escalated to the Consultant in charge of their care. It is the responsibility of the consultant to determine if it is in the patient's best interest to be discharged back to the care of their GP. In exceptional circumstances, the clinician may decide that the patient should proceed with the treatment plan the patient will be reinstated at the same point of their RTT pathway on to the waiting list.

If the patient contacts the hospital after the 10 working day deadline, they will need a new referral from their GP.

If the patient advises that the appointment is no longer required, they will be removed from the waiting list and discharged back to the GP. The 18 week clock will be stopped.

CLOCK STOP: Patient declined treatment

DATA ENTRY: Use code 35
Date patient removed from the waiting list and notification to GP

7.6.2 Reasonable offers

A reasonable offer is when a time and date is allocated to the patient with 3 or more week (15 working days) from the time the offer was made.

The Elective Access Officer will ensure that all TCIs offered are recorded on PAS.

A written appointment to a patient must be deemed reasonable.

It is accepted that while all offers have to be reasonable it is possible some patients may be willing to attend at short notice. However if a patient declines such an offer the patient's 18 week RTT waiting time must continue.

Should a patient accept an admission date with less than three weeks' notice (15 working days), this will become a reasonable offer.

If more than one reasonable offer is cancelled or declined by the patient there should be a clinical review and a clinical decision made based on the patients best clinical interest and on an individual patient basis. A trigger point for escalation to the clinician should be based on the length of delay that occurs from the point of referral and not from the number of appointments cancelled or declined. Patients can chose to delay their procedure for as long as they wish, it is only if the clinician feels that it is in the patient's best clinical interest that they should be referred back to their GP and the clock stopped.

CLOCK STOP: Decision not to treat.

DATA ENTRY: Use code 34
Date decision made by consultant to discharge back to GP.

7.6.3 Patient request for review of treatment decision/plan

All patients should confirm that they are happy to proceed with their agreed treatment plan before being added to the inpatient/day case waiting list.

In some cases, a patient may change their mind when they are already on the waiting list and wish to discuss their intended procedure with their consultant before continuing. If this happens, they should remain on the waiting list with an active ticking clock and offered a follow-

up appointment. If they are happy to continue with the procedure, no changes need to be made to the pathway other than adding a note to explain what has happened.

If the patient wishes to then wait and see if their symptoms change before proceeding to surgery, they are to be removed from the waiting list and their clock stopped for Active Monitoring. A review appointment must be scheduled to review progress. At this review appointment, the patient is to be either added to the waiting list and a new clock started, or discharged back to the care of their GP.

If the patient wishes to proceed with current treatment plan, or an amended treatment plan:

CLOCK CONTINUES: New Treatment Plan.

DATA ENTRY: Use code 20
When adding patient to waiting list

If the patient does not wish to proceed with any treatment, they are to be either placed on Active Monitoring or discharged back to their GP.

CLOCK STOP: Active/Monitoring; patient declined treatment

DATA ENTRY: Use code 31 or 35
Date patient communicated that they do not wish to proceed with treatment

7.6.4 Patient non-compliance with admission instructions

When a patient does not comply with clearly communicated pre-operative advice i.e. the cessation of medication before surgery or not eating or drinking, then this should be treated as a cancellation and should be given an alternative date at the time of the non-compliance.

If a patient is non-compliant again or cancels the next admission date, a clinical review and a clinical decision made on the individual patient level about whether to offer the patient another appointment or whether discharging them is in their best clinical interest.

CLOCK STOP: Decision not to treat.

DATA ENTRY: Use code 34
Date decision made by consultant to discharge back to GP.

7.7 DID NOT ATTEND (DNA)

Where a patient does not attend a reasonably offered admission date a clinician will review the request with a view to discharging the patient providing that:

- the appointment was clearly communicated to the patient;

- discharging the patient is not contrary to their best clinical interests;
- discharging the patient is carried out according to local publically available policies on patients who do not attend an appointment;
- These local policies are clearly defined and specifically protect the clinical interests of at risk patients (for example children) and are agreed with care, commissioners, patients and other relevant stakeholders.

Discharge back to the GP shall be confirmed by the responsible clinician, the patient and the GP will be sent a letter informing them that this decision has been made.

CLOCK STOP: Decision not to treat

DATA ENTRY: Use code 34
Date of discharge confirmed by clinician

7.8 PATIENT CANCELLATIONS

Patients who cancel their admission for non-medical reasons should be given an alternative date at the time of the cancellation.

If a patient cancels an admission on more than one occasion there should be a clinical review and a clinical decision made on the individual patient level about whether to offer the patient another appointment or whether discharging them is in their best clinical interest.

7.9 PATIENTS WHO BECOME MEDICALLY UNFIT PRIOR TO ADMISSION

If a patient is listed for surgery but is identified, or self-reports, as unfit for that procedure, the nature and duration of the clinical issue should be ascertained.

If the clinical issue is short term (guideline - 3 weeks or less) and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold), the patient must be offered a new TCI date within their 18 week breach date. The clock will continue running during this time.

If the clinical issue is expected to last for 3 weeks or more there should be a clinical review and a clinical decision made on an individual patient level about whether to offer the patient another appointment or whether discharging them back to their GP for monitoring is in their best clinical interest.

CLOCK STOP: Decision not to treat

DATA ENTRY: Use code 34
Date patient identified as not fit to proceed with surgery

Once the patient is deemed fit by their GP the patient will be re-listed and a new clock started when confirmation is received that the patient is fit to undertake the procedure. They can be added directly to the waiting list again.

CLOCK START: First activity in an RTT period

DATA ENTRY: Use code 10
Date patient identified as fit to proceed with surgery or date new referral is received

7.10 ON THE DAY CANCELLATIONS

7.10.1 Non-Clinical reasons (hospital initiated)

On the day cancellations are defined as occurring “on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. For example, the patient is to be admitted to hospital on a Monday for an operation scheduled for the following day (Tuesday). If the hospital cancels the operation for non-clinical reasons on the Monday then this would count as a last-minute cancellation. This includes patients who have not actually arrived in hospital and have been telephoned at home prior to their arrival” on the day they were due to arrive.

Where theatre lists or patients are cancelled on the day of admission or day of surgery, patients must be booked as close to their original appointment as possible, and within a maximum of 28 days of the cancellation date.

Two reasonable offers must be made to the patient within 28 days of the date of cancellation. The patient may choose not to accept a date within 28 days.

If the Trust cannot offer the patient a date within 28 days of the cancellation, the Trust must offer to fund the patient’s treatment at the time and hospital of the patient’s choice where appropriate.

7.10.2 Clinical reasons (hospital initiated)

Where a patient is cancelled on the day of admission or day of surgery for clinical reasons, the nature and duration of the clinical issue should be ascertained.

If the clinical issue is short term (3 weeks or less) and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold), the patient must be offered a new TCI date within their 18 week breach date. The clock will continue running during this time.

If the clinical issue is expected to last for 3 weeks or more there should be a clinical review and a clinical decision made on an individual patient level about whether to offer the patient another appointment or whether discharging them back to their GP for monitoring is in their best clinical interest.

CLOCK STOP: Decision not to treat

DATA ENTRY: Use code 34
Date patient identified as not fit to proceed with surgery

Once the patient is deemed fit by their GP the patient will be re-listed and a new clock started when confirmation is received that the patient is fit to undertake the procedure. They can be added directly to the waiting list again.

CLOCK START: First activity in an RTT period

DATA ENTRY: Use code 10
Date patient identified as fit to proceed with surgery or date new referral is received

7.11 CANCELLATION OF SESSION BY HOSPITAL

Patients who are cancelled by the hospital prior to the day of admission must be offered an alternative date which is within their 18 week RTT breach date.

The only acceptable reason for theatre list cancellation is absence of medical staff as a result of planned annual / study leave, audit activities, on call commitments or unplanned sickness absence. A minimum of six weeks' notice of planned leave should be given. Theatre lists should not be cancelled for any other reason unless there are exceptional circumstances and the cancellation has been authorised by the Divisional Director.

7.11.1 Session Cancellation with six weeks or more notice

- Only leave approved by the relevant clinical lead will be actioned.
- Session cancellation notifications will only be accepted if submitted on the appropriate form, unless there are exceptional circumstances.
- Session cancellation notification must be passed to the relevant administrative manager for action.
- Session cancellation requests will be actioned at the earliest opportunity and within a maximum of five working days.
- Where patients have to be cancelled, the relevant clinician should review clinical priorities and waiting times and identify the rebooking requirement.
- Patients who have previously been cancelled should not be cancelled a second time.

7.11.2 Session Cancellation with less than six weeks' notice

Sessions should not be cancelled with less than six weeks' notice unless there are exceptional circumstances.

No session should be cancelled without the authorisation of the General Manager or a nominated deputy.

When theatre lists have to be unavoidably cancelled at short notice, liaison with the Divisional Director, Deputy Divisional Director for Theatre and Theatre Manager is essential. Identifying appropriate capacity remains the responsibility of the consultants and the division.

7.12 WAITING LIST VALIDATION & REVIEW

All Patient Tracking Lists including Planned must be validated on a weekly basis by the Elective Access Officers and Patient Pathway Manager in conjunction with the validators. This process 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. This process ensures that any changes to the patient's circumstances and condition are captured and action taken as necessary.

7.13 PATIENT INITIATED PAUSES (PIPs)

There is no longer provision to pause an RTT waiting time clock under any circumstances. However, the following should be noted:

- It is still important that the booking team know if a patient is going to be unavailable for an extended period of time, both start and finish dates. This still needs to be clearly recorded on Medway
- For each specialty and patient condition there will be a point beyond which it would not be safe to admit the patient for surgery without further review by the treating clinician as the presentation may have changed. It is the role of each consultant to have that discussion before any patient is listed for surgery.
- Where the patient is requesting that their operation can only be within a particular time period – for example during school holiday periods – the patient needs to be advised that this cannot be guaranteed.

8. PRE-OPERATIVE ASSESSMENT (POA)

8.1 ADULT POA

The patient will be pre-screened and a decision made as to the type of pre-operative assessment required i.e. telephone or booked assessment. Where possible, patients will be offered pre-operative assessment on the day that they are added to the waiting list in outpatients. In the event that this is not possible the patient will be offered a subsequent appointment to attend for pre-operative assessment.

8.1.1 POA Appointment DNA

Patients who DNA a first or any subsequent pre-operative assessment will have a clinical review and a clinical decision made on the individual patient level about whether to offer the patient another pre-operative assessment appointment or whether discharging them is in their best clinical interest.

The patient and GP will be notified of this by letter. It will then be the responsibility of the GP to manage the patient's condition.

CLOCK STOP: Decision not to treat

DATA ENTRY:
Use code 34
Date patient removed from the waiting list and notification to the GP

See section 6.3.1 for guidance on the management of cancer pathway patients who fail to keep their appointment.

8.1.2 Patients assessed as fit to proceed

If the patient is considered fit for treatment and prior approval is not required, the admissions department will negotiate a date for treatment with the patient in due course. The patient will be treated within their 18-week pathway unless this is not clinically appropriate or the patient chooses to wait longer for treatment.

8.1.3 Patients assessed as not fit to proceed

If the patient is not fit for treatment but the clinical issue is short term (3 weeks or less) and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold), confirmation that the clinical issue has resolved must be obtained before the patient is considered fit to proceed. The clock will continue running during this time.

If the clinical issue is expected to last for 3 weeks the patient should be removed from the waiting list and where appropriate discharged back to primary care or referred to another specialty for any further management/treatment that is required before admission can be rearranged. The Pre-Operative Assessment Nurse will send a letter to the clinician to advise of this decision. This will be a clock stop event. The exception to this rule is patients who have been listed as urgent or who are on a cancer pathway; these patients should be discussed with the consultant to determine the most appropriate action to take.

CLOCK STOP: Decision not to treat

DATA ENTRY: Use code 34
Date patient identified as not fit to proceed with surgery

The patient will be re-listed and a new clock started when confirmation is received that the patient is fit to undertake the procedure. They can be added directly to the waiting list again.

CLOCK START: First activity in an RTT period

DATA ENTRY: Use code 10
Date patient identified as fit to proceed with surgery or date that new decision made

8.2 PAEDIATRIC POA

Where possible, patients will be offered pre-operative assessment on the day that they are added to the waiting list in outpatients. In the event that this is not possible the patient will be offered a subsequent appointment to attend for pre-operative assessment.

8.3 Patient assessed as fit to proceed

If the patient is considered fit for treatment and prior approval is not required, the admissions department will negotiate a date for treatment with the patient in due course. The patient will

be treated within their 18-week pathway unless this is not clinically appropriate or the patient chooses to wait longer for treatment.

9. DIAGNOSTIC AND IMAGING APPOINTMENTS

9.1 DIAGNOSTIC WAITING LIST

To aid both the clinical and administrative management of the waiting list, this is sub-divided into a limited number of smaller lists, differentiating between active lists and others. Care and consideration must be given to the procedures set to manage these lists in line with departmental policy and this guidance.

9.1.1 Active Waiting List

The active waiting list should consist of patients awaiting diagnostic tests/procedures, who are available to attend within the waiting time standard.

9.1.2 Planned Waiting List

For some patients, the timing of their diagnostic test is dependent upon other clinical factors. In these circumstances patients are called for an appointment at a clinically indicated time and these requests are classed as planned.

Patients who require follow-up imaging should be classed as planned attendances and should not be added to the active waiting list.

When patients on planned lists are clinically ready for their test to commence and reach the date for their planned appointment, they should either receive that appointment or be transferred to an active waiting list and a waiting time clock should start (and be reported in the relevant waiting time return).

9.1.3 Therapeutic Procedures

The following procedures carried out within the Radiology Department are therapeutic procedures and not diagnostic procedures and as such, the 6 week diagnostic waiting times standards do not apply. These procedures are governed by the 18 Week RTT rules.

- Radiologically guided steroid injections
- Angioplasty

9.1.4 Diagnostic Referrals/Requests

Referrals received from both primary and secondary care clinicians for diagnostic investigations must be received on the appropriate request forms, completed correctly and signed electronically or on paper.

Any form that is incomplete or unsigned will be returned to the requester. These requests must be entered on the diagnostic system, if patient demographics allow, as request received and the status up-dated to record “awaiting clinical information”, this provides a clear audit trail if required.

DATA ENTRY:
Record the request as received with the status as “awaiting clinical information”

9.1.5 Receipt & recording of requests

Referral forms should be addressed to either the Radiology department and/or appropriate modality. They will be date stamped on receipt, the request form scanned and added to the request received list.

The diagnostic waiting time clock starts when the request for a diagnostic test or procedure is made. This is when the request for a diagnostic procedure is entered or by using the date written on the diagnostic request form by the referring clinician.

6 week diagnostic CLOCK START

DATA ENTRY:
Date of request for diagnostic test

The appropriate administration process for prioritisation will follow. Incomplete forms should be returned to the referrer for correct completion.

For direct access referrals, where it is the responsibility of the patient to arrange booking of the diagnostic appointment, the diagnostic waiting time will start at the point when the request is received for the Trust to arrange the diagnostic appointment.

6 week diagnostic CLOCK START

DATA ENTRY:
Date patient contacts the Trust to arrange appointment for the diagnostic test

9.1.6 Prioritisation

Referral requests will be allocated to the appropriate person for prioritization according to the protocol for each modality. Once requests have been allocated to a specific person, patients will be treated equally.

Following acceptance of the request the status requires up dating to record “Request Accepted”. This applies to both GP and Consultant-to-Consultant referrals, where they exist.

DATA ENTRY:
Update system to record “request accepted”

9.1.7 Inappropriate referrals

If a referral has been made that does not follow referral protocols the radiologist must add comments on the system detailing the reasons why the referral is considered inappropriate.

The request status requires up-dating by entering “Requested Unjustified” or “Request Rejected” ensuring that the reason for rejection is recorded in the comments box, providing a clear audit trail should the reason for rejection be required in the future.

DATA ENTRY:
Update system to record "request unjustified" or "request rejected"

9.2 IONISING RADIATION (MEDICAL EXPOSURE) REGULATIONS IR(ME)R

If the referral does not comply with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R, the request will be returned to the referring clinician.

For MRI and ultrasound the same principles will apply and the request will be rejected if not clinically warranted.

A non-justification pro forma letter will be attached to the request form detailing the reason for rejection.

9.3 CANCER REFERRALS

Cancer referrals are received from hospital consultants into the Radiology department in the same way as all other referrals but should be clearly marked as a cancer referral.

The diagnostic waiting time clock starts when the request for a diagnostic test or procedure is made. This is when the request for a diagnostic procedure is entered or by using the date written on the diagnostic request form by the referring clinician and confirmed as a cancer referral by the vetting Radiologist.

6 week diagnostic CLOCK START

DATA ENTRY:
Date of request for a diagnostic test

An urgent appointment is made for the patient in order to meet the 31 day National Cancer Waiting Times Target. This appointment should be made within a maximum of 14 days from receipt of the imaging request.

Should insufficient capacity exist in order to meet the target, immediate escalation is required to the Radiology Services Manager.

9.4 APPOINTMENTS

9.4.1 Urgent Referrals

Referrals justified as urgent by a Radiologist, Radiographer or Sonographer must be given priority. Regular review of session templates must take place to ensure best use of available slots.

9.4.2 Routine Referrals

Routine referrals should be given appointments in turn, providing equity of access.

9.4.3 Imaging Appointments

Following prioritisation, patients will be contacted by telephone to arrange a convenient appointment or an appointment letter will be sent directly to the patient confirming the appointment. All offered and declined appointments will be recorded.

DATA ENTRY:
Log the appointment, record the cancellation. Offer the patient an alternative appointment and record

9.4.4 Reasonable Offers

The definition of a reasonable offer is an offer of an appointment with at least 3 weeks' notice of the appointment date.

9.4.5 Patient declines reasonable appointment offers

If a patient declines two reasonable offers, the clock for the 6 week diagnostic standard can be re-set from the date of first appointment offered.

6 week diagnostic CLOCK START

DATA ENTRY:
Date of last appointment offered to the patient

The clock cannot be reset if there is no evidence that the appointments offered to and declined by the patient were reasonable.

Adjustments to the 6 week diagnostic standard as outlined above do not affect the patient's 18 week RTT waiting time.

It is therefore important that staff are aware of patients who are on both a diagnostic 6 week and 18 week RTT pathway and that their care is delivered in line with both national standards.

9.4.6 Did Not Attend

Standard Radiology DNA protocol will apply (in line with Trust policy on outpatient appointment DNAs), when a patient does not attend for the first time. A radiology clinician will review the diagnostic request with a view to discharging the patient back to the requesting clinician providing that:

- the appointment was clearly communicated to the patient;
- discharging the patient is not contrary to their best clinical interests;
- discharging the patient is carried out according to local publically available policies on patients who do not attend an appointment;
- These local policies are clearly defined and specifically protect the clinical interests of at risk patients (for example children) and are agreed with care, commissioners, patients and other relevant stakeholders.

It is the responsibility of the consultant responsible for the patient's care pathway to decide whether or not to then discharge the patient back to the care of their GP. If the patient is on an Incomplete RTT pathway i.e. the 18 week clock is ticking, this clock will be stopped by the act of discharging the patient back to the care of their GP and not by the DNA itself unless it is the first appointment that the patient has with the trust and they have not yet been seen in clinic.

If the patient is to be discharged the following process must be followed:

- A copy of the request form plus the DNA letter will be sent to the referring Consultant/GP.

- The request will be cancelled on the system

If the patient is to be rebooked, they are to be given another date and this does not affect their 18 week RTT clock.

DATA ENTRY:
Update the status to cancelled

Patients who DNA should not be offered a further appointment unless requested by a consultant or where there are exceptional circumstances (see below).

If a patient does not attend their diagnostic appointment but is then rebooked under the instruction of the consultant, 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. This adjustment has no effect on the patient's 18 week RTT pathway.

Failure to attend an agreed appointment date will result in the patient being discharged. The referrer will be informed of the failure to attend and removal. The patient may be re-referred at the General Practitioner's/referrer's discretion.

9.4.7 Patient Cancellations

Patients who cancel their appointment once should be given an alternative date at the time of cancellation.

If a patient cancels their appointment more than twice the imaging request should be returned to the referring clinician who should undertake a clinical review and make a decision of a rebook or discharge back to the GP based on the patients individual circumstances.

All patient cancellations should be recorded by following the diagnostic cancellation process.

DATA ENTRY:
Record the cancellation and follow the cancellation process

Suspected cancer patients who DNA will be offered one further appointment before the above process is followed.

9.4.8 Patient Discharged – Procedure not taken place

In the event of a patient being unable to tolerate the examination and this being abandoned (eg as a result of claustrophobia), details must entered (including the reason) and the referrer notified. Where possible, consideration will be given to an alternative imaging procedure.

DATA ENTRY:
Record the outcome and reason

9.5 SESSION CANCELLATION

The only acceptable reason for session cancellation is absence of medical staff as a result of planned annual / study leave (following the Consultant Radiologist and Radiology Associate Specialist Annual/Study Leave Guidelines), audit activities, on call commitments or unplanned sickness absence. A minimum of six weeks' notice of planned leave should be given.

Sessions should not be cancelled for any other purpose unless there are exceptional circumstances.

When a session has to be unavoidably cancelled, rebooking should take place within 5 working days.

9.5.1 Session Cancellation with six weeks' or more notice

- Only leave approved by the relevant clinical lead will be actioned.
- Session cancellation notification must be passed to the relevant clerical officer for action.
- Session cancellation requests will be actioned at the earliest opportunity and within a maximum of five working days.
- Where patients have to be cancelled, the relevant clinician should review clinical priorities and waiting times and identify the rebooking requirement.
- Patients who have previously been cancelled should not be cancelled a second time.

9.5.2 Session Cancellation with less than six weeks' notice

Sessions should not be cancelled with less than six weeks' notice unless there are exceptional circumstances.

No session should be cancelled without the authorisation of the Divisional Director or Chief of Division.

10. ACUTE THERAPY SERVICES

This includes outpatient physiotherapy, dietetics, orthotics and surgical appliances.

All appointments must be booked within the timeframes and guidelines of the RTT 18 weeks rules.

10.1 Referrals

Requests must include all relevant clinical information and denote clinical urgency.

10.2 Triage and vetting of referrals

All requests will be vetted in the relevant department within 24 hours of the request being made. Requests with missing clinical information or considered to be inappropriate will be returned to the responsible clinician within this timescale and the patient will not be added to the waiting list.

The patient is informed by letter that the referral has been rejected with the reason why, and is asked to make contact with their consultant.

10.3 Reasonable Offers

The definition of a reasonable offer is an offer of an appointment with at least 3 weeks' notice of the appointment date.

Patients must be contacted by telephone to arrange their appointment date and times. Three attempts must be made to make contact with the patient over a 48 hour period including one attempt after 5pm. If telephone contact cannot be made the patient must be sent a letter with a date and time for their appointment and asked to confirm their attendance.

DATA ENTRY:
Log the offers made to the patient

Patients must be sent a confirmation letter within 24 hours of their appointment being booked. The letter should be clear and informative and should include a point of contact and telephone number to call if they have any queries. The letter should explain clearly the process should

the patient wish to cancel the appointment and the consequences should they fail to attend their appointment at the designated time.

10.4 Hospital appointment cancellations

Where appointments are cancelled by the Trust, patients should be booked as close to their original appointment as possible in the next available slot.

10.5 Patient cancellations

Patients who cancel their appointment and wish to re-book, should be re-appointed as close to their original appointment as possible. Patients should be reminded that if they cancel this appointment for a second time the responsible clinician will be informed for a clinical decision on their future treatment plan.

Discharge back to the GP shall be confirmed by the responsible clinician, and if the decision is made to discharge the patient, a letter must be sent to the patient and their GP informing them that this decision has been made.

CLOCK STOP: Decision not to treat

DATA ENTRY: Use code 34
Date of discharge confirmed by clinician

10.6 Did Not Attend (DNA)

A clinician will review the request with a view to discharging the patient providing that:

- the appointment was clearly communicated to the patient;
- discharging the patient is not contrary to their best clinical interests;
- discharging the patient is carried out according to local publically available policies on patients who do not attend an appointment;
- These local policies are clearly defined and specifically protect the clinical interests of at risk patients (for example children) and are agreed with care, commissioners, patients and other relevant stakeholders.

Discharge back to the GP shall be confirmed by the responsible clinician, the patient and the GP will be sent a letter informing them that this decision has been made.

CLOCK STOP: Decision not to treat

DATA ENTRY: Use code 34
Date of discharge confirmed by clinician

11. PATIENT LETTERS

11.1 Outpatient Letters

A letter inviting the patient to contact the Trust to agree an appointment date will contain the following information:

- Patient name and case note / hospital number
- Date of letter
- Who to contact (named contact where possible)
- Response required from patient and timeframe
- Details of what will happen if no contact is made (removed from list; GP or referrer informed)

After the patient makes contact and an appointment date has been agreed, this conversation should be followed up with a confirmation letter providing explicit instructions.

11.2 Admission Letters

A letter inviting the patient to contact the Trust to agree an admission date will contain the following information:

- Patient name and case note / hospital number
- Date of letter
- Who to contact (named contact where possible)
- Response required from patient and timeframe
- Details of what will happen if no contact is made (removed from list; GP or referrer informed)

After the patient makes contact and an admission date has been agreed, this conversation should be followed up with a confirmation letter providing explicit instructions.

This letter is known as the “to come in letter” and should contain the following details:

- Patient name and case note / hospital number
- Date of letter
- Day, date and time of admission
- Where to report to on arrival
- Response required from the patient (if any since this confirms a previously agreed date)
- Clear named contact telephone number for queries relating to admission or to advise of unavailability or late cancellation
- Reference to instructions for admission and / or booklet if not already advised at POA.
- Request to check bed is available on day of admission (if appropriate)
- Reasons for checking bed availability (if appropriate)
- Information about the planned treatment if not already advised

This letter should be sent out in the name of the Consultant or contain the Consultant's name.

11.3 Reasonable offers – letters

A reasonable offer is an offer of a time and date 3 or more weeks (15 working days) from the time that the offer is made either written or verbal.

12. ADDITIONAL INFORMATION

12.1 MANAGEMENT INFORMATION & REPORTING

The Information Team makes available a wide range of detailed and summary information to management and operational staff in the Trust, to help manage and monitor performance against internal and external waiting targets. Information is either emailed directly to staff or published via web-based reporting tool. Training is available through Learning and Development.

12.1.1 External Information & Reports

18 Weeks Referral to Treatment (RTT)

Monthly returns are uploaded to the DH via Unify2 as per the national timetables.

Weekly returns are provided to the CCG and TDA.

Diagnostic Waiting Times

Monthly and quarterly returns are uploaded to the DH via Unify2 as per the national timetables.

An Elective Admission List (EAL) CDS showing the waiting list at month end is sent to the CCGs by the last day of the following month.

12.2 RTT TRAINING

12.2.1 Introduction to RTT Training (Mandatory)

Mandatory training will be provided on attendance of yearly training course. Mandatory E-learning training must be completed by all Trust Staff who are considered to have involvement with the patient pathway. Please consult your manager to confirm if you need to complete.

Non-compliance with mandatory training will be monitored and non-attended escalated to General Managers / Associate General Managers and/or Service Managers.

12.2.2 Super User RTT Training

For Associate General Managers, Patient Pathway Managers, Validators and identified super users; additional training is provided to enable them to be classed as super users. This training involves an explanation of the complexities of validation as well as training on the Trust's Patient Management Module.

12.2.3 Clinician RTT Training

For clinicians who see patients in outpatient clinics, or who are involved in elective care. Training is provided on the use of the Clinical Outcome Form, an overview of RTT rules and principles and why it is important to patients

12.3 MONITORING COMPLIANCE AND EFFECTIVENESS

Papers relating to the RTT processes will be submitted to the Operational Management Group for monitoring.

The Elective Care Patient Access Policy will be published on KGH Intranet.

12.3.1 Data Quality

To ensure the Standard Operating Policies relating to RTT are adhered to and the rules outlined within this policy are followed, a series of data quality checks will be made on a regular basis. These data quality KPIs form part of the RTT governance process and will

be used to highlight areas or individuals who require additional training and may be used as a tool for performance management if non-adherence continues.

12.3.2 Policy Updates

This document will be reviewed every year to ensure it is reflective of national and local guidance. If no changes to guidance are made the policy should be reviewed every 3 years, as set out in the *Policy for Procedural Documents (D10).*

12.4 EQUALITY IMPACT ASSESSMENT

As part of its development, this policy and its impact on equality has been reviewed. the purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation or religious belief.

13. PROCESS FOR IMPLEMENTATION AND DISSEMINATION

13.1 Awareness

The Elective Care Patient Access Policy will be published on KGH Intranet.

To build awareness of the changes in this Policy, training will be given to those directly affected by the Policy. Details of training will be published on KGH intranet. Also an addition will be made in the KGH newsletter to advise of the updated policy being available to view online.

Awareness will also be raised via KGH screensavers and posters around the trust and offsite at Robinson Way, Nene Park and Isebrook.

14. APPENDICES

14.1 GLOSSARY OF TERMS

ASI (appointment Slot Issues)	List of patients who were not able to book an appointment through the NHS e-Referral system because there were no appointment slots available
Active Waiting List	Patients awaiting elective admission and are currently available i.e. fit, able and ready, to be called for admission at entry to waiting list.
Area Team	Replaced SHAs – manage care and provide assurance on services commissioned by CCGs
Booked Admissions	Patients who have the opportunity to book their admission or treatment date immediately following their clinic appointment or very shortly after.
Booked Patients	Patients awaiting elective admission who have been given an admission date at the time of the decision to admit. These patients form part of the active waiting list. Elective Booked.
Choice	Patients Value Choice to be offered to all patients waiting for 6 months for elective care by summer 2004. Choice at point of referral for elective care by December 2005.
Cancer Waiting Times (CWT)	NHS cancer plan 2000 has set a specific goal of reducing cancer-waiting times (CWT) in UK.
CCG	Clinical Commissioning Group – replaced PCTs with the local commissioning of services and acute care
Day cases	Patients who required admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.
DTA	Decision to Admit.
DTC'S	Diagnostic Treatment Centres
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 did not attend admission /outpatient appointment.
PAS	Patient Administration System – Medway.
PTL	Patient Tracking List a tactical tool used to deliver 18 week RTT national operational standards.
Referral to Treatment (RTT)	18-week pathway from referral from GP to commencement of treatment in secondary care.
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night
Outpatients	Patients referred by a General Practitioner, General Dental Practitioner or another Consultant for clinical advice or treatment.
Partial Booking List or waiting list	A holding list for patients waiting for an Outpatient Appointment. This process ensures patients are seen in chronological order and have the opportunity to choose a convenient date.

Planned Admissions	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment/investigation. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18 week RTT pathway
PAS	Patient Administration System – Medway
Self-deferrals	Patients, who, on receipt offer of admission, notify the hospital that they are unable to come in.
SITREPS	Situation Reports made to Area Teams on current indicators.
TCI	To come in date or letter.

14.2 18 WEEK REFERRAL TO TREATMENT CODES

Code	Status Code	Patient Status
10	First activity in RTT period	Not yet treated *(awaiting test results/add to waiting list/refer for outpatient treatment or diagnostics)* **OR** new decision to treat following previous treatment
11	Active monitoring end	First activity at the start of a new RTT period following active monitoring
12	Consultant referral	First activity at the start of a new RTT period following a decision to refer directly to a new consultant for separate condition
20	Pathway is ongoing – treatment not yet started	Subsequent activity during RTT period - further activities anticipated
21	Transfer to another provider	Not yet treated - subsequent activity RTT period anticipated by another Health Care Provider - clock still ticks
30	Start of first definitive treatment	Patient has started/received first definitive treatment that is intended to manage their disease, condition or injury
31	Active monitoring/Watchful Waiting (Patient initiated)	Start of active monitoring initiated by the patient – can be used for thinking time
32	Active Monitoring / Watchful Waiting	Start of active monitoring initiated by the clinician – not to be used for thinking time
33	DNA – Patient did not attend first appointment	Clock nullified
34	Decision not to treat	Patient does not require treatment or treatment is not necessary
35	Patient declined treatment	Patient not treated but discharged
36	Patient Died before treatment	Deceased
90	Activity following First Treatment	First treatment occurred previously (e.g. admitted as an emergency from A&E or the activity is after the start of treatment). Ongoing management post-treatment.
91	Activity following a clock stop during active monitoring / watchful waiting	Activity during period of active monitoring
98	Not Applicable	Activity not applicable to RTT period

INTERPROVIDER TRANSFER FORM

FOR REFERRING ORGANISATION	
Referring organisation name:	Referring organisation code:
Referring clinician:	Referring clinician registration code:
Contact name:	Contact phone: Contact e-mail:
Patient Details	
Surname:	Forename:
Title:	Date of Birth:
NHS Number:	Local Patient Identifier:
Correspondence Address:	Contact Details: Home: Work: Mobile: E-mail:
Correspondence Postcode:	Name of contact (if not patient):
GP Name:	GP Practice Code:
Is the patient eligible under the definition of an 18 Weeks RTT pathway?	Yes ☐ No ☐ (move to Receiving Organisation Details)
If yes - is this referral part of an existing pathway or the start of a new pathway?	Existing ☐ New ☐
Unique Pathway Identifier:	Clock Start Date:
Allocated by (organisational code): (Organisation who received original referral – clock start)	Date existing pathway started: (Referral date if starts new pathway)
Date of decision to refer to other organisation: (Existing pathways only)	For existing pathways: Not yet treated ☐ Treated ☐ Active monitoring ☐
Receiving Organisation Details	
Receiving Organisation Name:	Receiving Clinician:
Receiving treatment function: (speciality/department)	Date and time MDS sent:
For Receiving Organisation	
Date/time received:	

14.4 Standard Operating Procedures

There are numerous Standard Operating Procedures available on the Trust Intranet RTT Pages

http://kghintranet/directorates/QG/RTT/pages/home.aspx

14.5 Paper Switch-off Exclusions

Paper Switch-off Exclusions		
Specialty/type		Any organisation specific detail
1	Obstetrics	Applies to both NGH / KGH
2	Infertility	Applies to both NGH / KGH
3	Termination of pregnancy	Applies to both NGH / KGH
4	Maxillofacial	Applies to both NGH / KGH
5	Diagnostic Services	Applies to both NGH / KGH
6	Emergency clinics – all seen on symptom clinics	Applies to both NGH / KGH
7	Ophthalmology	Applies to both NGH / KGH
8	Genetics	Applies to both NGH only
9	System to system requests e.g. Systm1 NHFT	For NGH - Community Paediatrics and Childrens Physiotherapy
10	Prison requests	Applies to both NGH / KGH
11	Mental Health Trust requests	Applies to both NGH / KGH
12	Patients with no NHS numbers	Applies to both NGH / KGH
13	Patients with NHS numbers that don't want their details added to the Spine	Applies to both NGH / KGH

14.6 RTT Framework