The Shrewsbury and Telford Hospital NHS Trust

Shropshire Clinical Commissioning Group
Telford and Wrekin Clinical Commissioning Group

Local Health Economy Elective Care Access Policy

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CONTENTS

Click on a category below to be taken directly to that section of the document. To return to this page click on the icon in the bottom corner of the page you are viewing.

SECTION 1 – GENERAL PRINCIPLES

1. *Statement of Intent* 11
2. *Scope of Policy* 11
3. *Structure of Policy* 11
4. *Key Policy Principles* 11
5. *Roles & Responsibilities* 12
   a) *LHE Collectively* 12
   b) *CCG's* 12
   c) *SaTH* 12
6. *National Elective Care Standard* 13
7. *Overview of National RTT Rules* 15
   a) *Clock Starts* 15
   b) *Clock Stops* 15
   c) *Patients Who DNA (Do Not Attend)* 16
   d) *Patient Reschedules Their Outpatient & Diagnostic Appointments* 16
   e) *Patient Reschedules Their Admission Dates* 16
   f) *Active Monitoring* 16
8. *Demand & Capacity* 17
9. *Pathway Milestones* 17
10. *Procedures of Limited Clinical Value (PLCV)* 17
11. *Access to Health Services for Military Veterans* 18
12. *Private Patients* 18
13. *Prisoners* 18
14. *Vulnerable Patients* 18
15. *Leave Notification* 18
16. *Communication With Patients* 18
17. *Elective Care Governance Structure* 19
18. *Information, Monitoring & Reporting* 19

SECTION 2 – PATIENT SPECIFIC PATHWAYS

NON ADMITTED PATHWAYS 23

1. *Referral Management* 24
   a) *Pre-Requisites Prior to Referral* 24
   b) *Referral Sources* 24
   c) *Referral Methods* 27
   d) *Referral Criteria/Minimum Data Sets* 28
   e) *Clinical Triage/Review of Referrals* 28

2. *First Appointment* 28
   a) *e-Referrals Appointment Slot Issues (ASI's)* 28
   b) *Paper Based Referrals* 29
3. *Hospital Initiated Appointment Changes* 29
4. *Patient Initiated Appointment Cancellations* 30
5. *Patient Initiated Appointment Changes* 30
6. *Clinic Attendance* 31
   a) *Arrival of Patients* 31
   b) *Clinic Outcomes* 31
   c) *Follow-up Appointments* 31
7. *Non Attendance* 32
   Children Who Fail to Attend First Appointments 32
   Follow-ups Who Fail to Attend 32
8. *Clinic Management* 33
   a) *Clinic Templates* 33
   b) *Ad Hoc Clinic Cancellation & Reductions* 33
   c) *Booking Rules* 34
9. *Outpatient Clinic Accommodation* 34

DIAGNOSTIC PATHWAYS 35

1. *Diagnostic Patients on an RTT Pathway* 36
   Patients Who Decline Two Reasonable Appointment Offers 36
   Patients Who Fail To Attend 36
2. *Subsequent Diagnostics* 37
3. *Straight to Test* 37
4. *Direct Access* 37

ADMITTED PATHWAYS 38

1. *Decision to Admit* 39
2. *Completion of Waiting List To Come In (TCI) Forms* 39
3. *Pre-Anaesthetic & Pre-Operative Assessment* 39
4. *Adding Patients to the Admitted Waiting List* 40
5. *Listing Patients/Offering TCI Dates* 40
6. *Patient Cancellation/Declining of TCI Offers* 41
7. *The TCI Letter* 42
8. *Patients Listed for More Than One Procedure* 42
9. *Patients Who Become Medically Unfit Whilst on the Admitted Waiting List* 42
10. *Validation Patients of Patients on the Admitted Waiting List* 43
11. *Reinstating Patients on the Admitted Waiting List* 43
12. *Subsequent Treatments Same Condition* 43
13. *Hospital Cancellation of TCIs* 43
14. *28 Day Readmission of Hospital Initiated Cancellations* 45
15. *Planned Waiting List* 45
16. *Patients Who Do Not Attend (DNA) Admission* 46

17. *Bilateral Procedures* 46
18. *Admitting Patients* 46
19. *Emergency Admissions for an Elective Procedure* 46
20. *Removals Other Than Treatment* 46

SECTION 3 – REFERENCE INFORMATION

1. *Definitions* 49
2. *Useful Information* 53
   a) *Patients' Right to Treatment (RTT) Rules* 53
   b) *Recording and Reporting Referral to Treatment (RTT) Waiting Times For Consultant-led Elective Care* 53
   c) *RTT Frequently Asked Questions 2012* 53
   d) *Maximum Waiting Times – Guidance for Commissioners* 54
   e) *Planned Patients* 54
   f) *Referral to Treatment Consultant-led Waiting Times – Reviewing Patient Pathways Who Have Waited Longer Than 18 Weeks* 54
3. *Contact Information* 55
   a) *Patient Access Team* 55
   b) *Contact Details* 55

SECTION 4 – STANDARD OPERATING PROCEDURES (SOPs)

1. *Booking Centre SOP's* 59
2. *Two Week Wait SOP's* 60

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Section One

General Principles

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1. STATEMENT OF INTENT

The Shrewsbury and Telford Hospital NHS Trust (SaTH), Shropshire Clinical Commissioning Group and Telford & Wrekin Clinical Commissioning Group (CCG) are united in its commitment as a Local Health Economy (LHE) to ensure patients receive treatment in accordance with national standards and objectives. The purpose of this policy is to outline the LHE's expectations and requirements in terms of managing patients along all non-emergencies, referred to as elective care pathways.

2. SCOPE OF POLICY

This policy applies to the principles and procedures for the management of the different groups of patients encompassing elective pathways. These are categorised as follows:

- **Patients on a Referral to Treatment (RTT) pathway awaiting treatment.**
- **Patients not on an RTT pathway but still under review by SaTH Clinicians.**
- **Patients on a cancer pathway.**
- **Patients who have been referred for a diagnostic investigation either by their GP or by a SaTH Clinician.**

3. STRUCTURE OF POLICY

The policy is structured in such a way which makes it easy to navigate in both hard copy and electronically. Where a separate Standard Operating Procedure (SOP) or document is referenced, a hyperlink will be shown allowing the reader to be taken directly to it if desired. It is split into the following four sections:

1. **General Principles.**
2. **Pathway Specific Principles – following a logical chronological patient journey. Where there is a SOP providing a detailed process to be followed at a given stage, this is referenced at the relevant point. Readers can use the link information contained in Section Four Standard Operating Procedures to view any supporting documentation.**
3. **Reference Information.**
4. **Standard Operating Procedures.**

4. KEY POLICY PRINICPLES

a) This policy covers the way in which Shrewsbury and Telford Hospital NHS Trust, Shropshire CCG and Telford & Wrekin CCG will as a Local Health Community (LHC) collectively manage administration for patients who are waiting for or undergoing treatment on an admitted, non-admitted or diagnostic pathway.

b) As set out in both **Everyone Counts** and the **NHS Constitution**, patients have the right to start Consultant led treatment within maximum waiting times. The policies and procedures comprising this policy adhere to national best practice and provide a framework to ensure that patients are treated transparently, fairly and reasonably.

c) The Trust will give priority to clinically urgent patients and treat everyone else in turn.

d) The Trust will work to meet and better the maximum waiting times set by NHS England for all groups of patients.

e) The Trust will at all times negotiate appointment and admission dates and times with patients.

f) The Trust will work to ensure fair and equal access to services for all patients.

5. ROLES & RESPONSIBILITIES

a) LHE Collectively

The Local Health Economy is collectively responsible for the production, review and revision of this policy on at least an annual basis. Each of the three organisations will have a designated lead in this respect.

b) CCG's

CCGs are responsible for ensuring that GPs and all other primary care staff adhere to the principles set out in this policy.

c) SaTH

i. Chief Executive / Chief Operating Officer /Deputy Chief Operating Officer/ Assistant Chief Operating Officer (Scheduled Care)

The Chief Operating Officer (COO) on behalf of the Chief Executive has overall responsibility for the implementation of this policy and Board level accountability for the delivery of elective access standards. The COO is responsible for ensuring the delivery of targets and monitoring compliance of elective access standards. The Assistant Chief Operating Officer for Scheduled Care will be responsible as designated by the Chief Operating Officer.

ii. Clinicians

Clinicians have a responsibility for adhering to key internal procedures in the proactive management of patients along their RTT journey. Key examples are the timely and accurate completion of the clinic outcome form and swift review of referrals.

iii. Patient Access Team

The Patient Access Manager is SaTH's designated lead in respect of the review and revision of this policy on at least an annual basis in collaboration with the CCG designated leads. The Patient Access Team provides SaTH's central point of expertise, advice, training and support in respect of referral to treatment rules, standards and processes.

iv. Centres

Centre Managers are responsible for the overall delivery of RTT standards and for ensuring that staff is competent and compliant in the application of this policy and associated standard operating procedures.

v. Administration Staff

All administration staff must abide by the principles in this policy and the supporting standard operating procedures.

6. NATIONAL ELECTIVE CARE STANDARD

The table below provides a summary of the current national care elective standard.

National Referral to Treatment Reported Standard	
Incompletes	92% of patients on an incomplete pathway (i.e. still waiting for treatment) to be waiting no more than 18 weeks (or 126 days).
Diagnostics	
Applicable to the following **diagnostic investigations**	99% of patients to undergo the relevant diagnostic investigation within 5 weeks and 6 days (or 41 days) from the date of decision to refer to appointment date.
Cancer	
Two Week Wait	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).
Decision to Treat to Treatment (31 Day Wait)	96% of patients to receive their first definitive treatment (FDT) 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. 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 a course of radiotherapy. Maximum wait of 31 days from urgent GP referral to first treatment for children's cancer, testicular cancer and acute leukaemia - no performance measure set for this – monitoring as a part of the 62 day wait for first treatment.
Referral to Treatment (62 Day Wait)	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). Maximum wait of 62 days for patients to receive their first definitive treatment for cancer where their Consultant has upgraded their referral to urgent – no national performance measure set for this at present but a local performance measure of 85% has been set.

All the standards within the table above are set at less than 100% to allow for tolerances which apply in the following scenarios:

Exceptions –

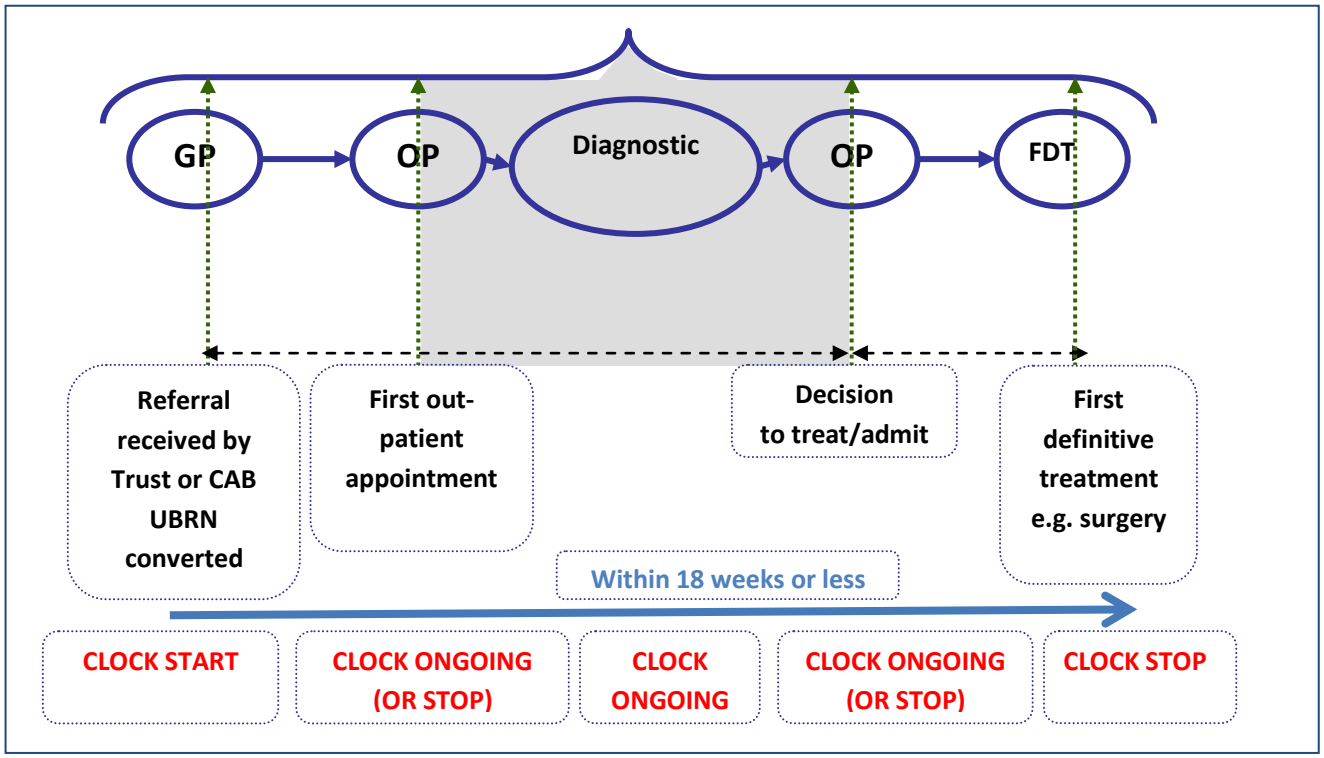
a) **Clinical - Applicable to RTT pathways where it is in the patient's best clinical interest to extend treatment beyond the standard.**
b) **Choice – applicable where patients choose to extend their pathways via rescheduling previously agreed appointment dates or admission offers.**
c) **Co-operation – applicable where patients do not attend previously agreed appointment dates or admission offers.**

Whilst 92% Incompletes standard is the nationally reported standard, the Trust is still required to monitor 95% Non-Admitted Standard and 90% Admitted Standard as illustrated below:

Non Admitted	95% of patients to be treated within 18 weeks (or 126 days) from receipt of referral to treatment (or decision not to treat).
Admitted	90% of patients to be treated within 18 weeks (or 126 days) from receipt of referral to treatment.

7. OVERVIEW OF NATIONAL RTT RULES

The full national RTT rules suite can be accessed by clicking **here**. Detailed local application of the rules is provided in the standard operating procedures within section five the end of this policy **click here to go to Section Four**. An overview of the rules however is shown using the diagram and narrative below.



a) Clock Starts

The RTT clock starts when:

- A referral is received into a Consultant led service, regardless of setting, with the intention that that patient will be assessed and if appropriate, treated before clinical responsibility is transferred back to the referrer.
- A referral is received into an interface or referral management assessment centre which may result in an onward referral to a Consultant led service before clinical responsibility is transferred back to the referrer.

  A patient self refers into a Consultant led service for pre-agreed services agreed by the LHC.

b) Clock Stops

The RTT clock stops upon first definitive treatment (FDT), if a decision is made that treatment is not required or if the patient declines treatment. FDT is defined as:

An intervention intended to manage the patient's condition, disease or injury in order to avoid further intervention.

If a patient requires a procedure or surgery as a day case or inpatient, the clock stops upon admission and forms part of the admitted standard of 90% (standard monitored by Trust).

If the patient's treatment is medication prescribed in outpatients or if a decision not to treat is made in outpatients, this information is captured on the Clinic Outcome Form (COF) and forms part of the non admitted standard of 95% (standard monitored by Trust). There may

also be occasions where a decision not to treat is made in an 'ad hoc' setting, for example following review of diagnostic results by a Clinician in the office. Clock stops such as these are captured and also form part of the non admitted standard of 95% (standard monitored by Trust).

c) Patients Who Do Not Attend (DNA)

These rules are applicable only if the patient has had the opportunity to agree their appointment or admission date in advance. Patients will be contacted via the Central Booking Office and offered an appointment or admission date, where a fixed appointment/admission date is given the patient will be telephoned or given the opportunity via letter to rearrange.

i. First Appointment Following Initial Referral

- If a patient DNAs their first appointment following the initial referral which started their RTT clock, their RTT clock should be nullified (i.e. not stopped and reported).
- Should the patient be offered another date, a new RTT clock will start on the date that the patient agrees their appointment. For example, if the patient DNAs their appointment on 4th July and a conversation with the patient happens on 4th July to agree another appointment for 18th July, the new clock starts on 4th July.

ii. Any Other Outpatient Appointment, Diagnostic Appointment or Admission Along the Patient's Pathway

- Patient offered another appointment / admission date – the RTT clock continues.
- Patient discharged back to GP – the RTT clock stops (following confirmation that it is not contrary to the patient's clinical interests).

d) Patient Reschedules Their Outpatient & Diagnostic Appointments

If a patient reschedules their outpatient or diagnostic appointment, their RTT should continue to tick, even if they wish to reschedule their first appointment following initial referral.

e) Patient Reschedules Their Admission Dates

If a patient has previously agreed to a reasonable admission offer (see Section 2 for definition) which they subsequently wish to change; the cancellation does not stop the RTT clock.

f) Active Monitoring

Active monitoring is where a decision is made that the patient does not require any form of treatment currently but is to be monitored in secondary care. When a decision to commence a period of active monitoring is made and communicated with the patient, the RTT clock stops. 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.

g) Patients may initiate the start of a period of active monitoring themselves (for example by choosing to decline treatment to see how they cope with their symptoms). However, it would not be appropriate to use patient initiated active monitoring to stop patients' clocks where a patient does want to have a particular diagnostic test, appointment or other intervention, but wants to delay the appointment. Where such patient initiated delays prior to admission mean that 18 weeks cannot be delivered for that patient, then the minimum operational standards for 18 weeks allow for patients for whom starting treatment in 18 weeks would not be appropriate.

8. DEMAND & CAPACITY

Regular and robust demand and capacity analysis is a critical success factor in understanding individual services, forward planning and the delivery of elective care standards. Demand and capacity analysis should be undertaken on at least an annual basis, aligned to the annual planning process, by all specialties.

9. PATHWAY MILESTONES

The agreement and measurement of performance against pathway specific milestones is an important aspect successful RTT sustainability. Pathway specific milestones should be agreed for each specialty (in line with robust demand and capacity analysis) in terms of the point of the pathway by which the following should occur:

- First outpatient appointment
- Treatment decision
- Treatment

As a minimum, the following differentiation should be applied to all routine patients under the care of surgical and medical specialties where an admission is rarely necessary for treatment.

Pathway Milestone	Surgical Specialties (no later than)	Medical Specialties (no later than)
First Outpatient Appointment	Week 4	Week 8
Treatment Decision	Week 10	Week 14
Treatment	Week 18	Week 18

10. PROCEDURES OF LIMITED CLINICAL VALUE (PLCV)

Procedures of Limited Clinical Value Policy for SCCG and TWCCG must be adhered to – any procedures undertaken without prior authorisation, will not be funded by the Commissioners. A GP should request an opinion prior to referral to secondary care for conditions that are normally within this exclusion group. In these circumstances the RTT clock will begin when approval for referral to secondary care has been received by the GP and the GP proceeds to make a formal referral. Where appropriate, GPs are encouraged by Commissioners to use generic 'Dear Doctor' letters which can be allocated by the Trust to an appropriate Consultant with the shortest waiting time. GPs must retain flexibility to refer to a named Consultant team.

As a general principle, before a referral for treatment is made, the Trust expects the patient to be both clinically fit for assessment and possible treatment of their condition, and ready to start their pathway within 2 weeks of the initial referral. The criterion for assessment includes (but is not limited to):

- Patients who smoke should have been referred to their local smoking cessation service and ideally should have stopped smoking prior to referral.
- Patients who are overweight should have lost weight by the time they are referred. Specifically, patients with a BMI>40 are unlikely to be suitable for hip and knee replacement surgery at this hospital.
- Teeth and gums should be healthy and free from infection.
- Pre-existing medical conditions (e.g. hypertension) should be well managed and controlled.
- The patient's skin should be intact and free from infection.
- For likely hip and knee joint replacement procedures the Oxford Hip and Knee Scores should be within best practice, Commissioner Tolerances and based on clinical decision.

- The patient meets all criteria associated with Procedures of Limited Clinical Value in accordance with specific Commissioner Policies.

The Trust will work with its lead Commissioner, GPs and other primary care services to ensure patients understand the above requirements before beginning an elective pathway.

11. ACCESS TO HEALTH SERVICES FOR MILITARY VETERANS

In line with December 2007 guidance from the Department of Health 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. 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.

12. PRIVATE PATIENTS

If a patient has been seen privately, either in the Trust or at another hospital and wishes to be treated at SaTH by the same Consultant as an NHS Patient; the patient must first obtain an NHS referral letter from their GP or referring Consultant. On receipt of this letter the patient may then be treated as a new referral in outpatients or placed on a waiting list for investigations or treatment but will be treated according to their NHS medical priority. The RTT clock starts at receipt of referral to the NHS.

13. PRISONERS

The Department of Health expects prisoners to be treated within the same waiting time as all other NHS patients. However, they accept that in some cases there will be circumstances unique to the prison population which may lead to longer waits. The Trust must ensure that prisoners are treated equally and subject to reasonable offers of appointments. In spite of this prisoners will be returned back to the care of their referrer should three reasonable offers be declined or cancelled.

14. VULNERABLE PATIENTS

It is essential that patients who are vulnerable for whatever reason have their needs identified at the point of referral. This group of patients includes but is not limited to:

a) Patients with learning difficulties, psychiatric problems or dementia.
b) Patients with physical abilities or mobility problems.
c) Children (under 18) for whom there is a safeguarding concern.

15. LEAVE NOTIFICATION

All specialties and departments must comply with the Trust's notice of leave policy. Medical staff and related rotas must be ideally completed at least eight weeks in advance to ensure that six weeks notice is given to maximise the effectiveness of booking procedures and protocols.

16. COMMUNICATION WITH PATIENTS

The rules and principles within which the LHE will operate to deliver elective care to all patients; whether they be urgent suspected cancer referrals, 18 week pathway patients or patients on planned

waiting lists; must be made clear and transparent to patients at each stage of their pathway. All communications with patients, whether verbal or written, must be informative, clear and concise and MUST be recorded within the PAS system. The Trust will use the PAS system to identify patients with specific communication needs and will, where possible and when notified, may make reasonable adjustments – i.e. larger font letters/voicemail and/or text reminders of appointments/utilising communication addresses for carers as requested.

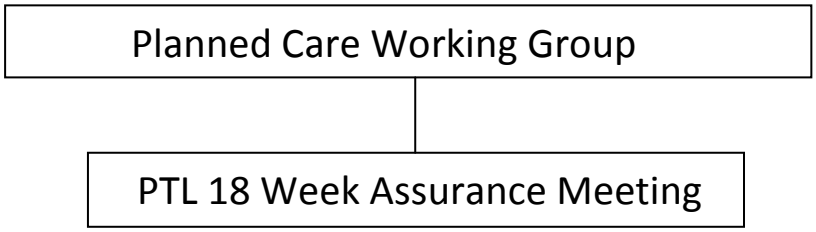
A key principle for 18 weeks is that any decision to accept that a patient will not receive their treatment in 18 weeks, however legitimate this is, should be explicitly communicated to the patient and subsequently to their GP or the original referrer if not the GP:

Exceptions –

- **Clinical - Applicable to RTT pathways where it is in the patient's best clinical interest to extend treatment beyond the standard**
- **Choice – applicable where patients choose to extend their pathways via rescheduling previously agreed appointment dates or admission offers.**
- **Co-operation – applicable where patients do not attend previously agreed appointment dates or admission offers.**

Commissioners and providers will need to be able to demonstrate (to an auditor or the CQC or in the event of a patient complaint) that cases that take longer than 18 weeks to reach the start of first definitive treatment are legitimate exceptions.

17. ELECTIVE CARE GOVERNANCE STRUCTURE



18. INFORMATION, MONITORING & REPORTING

Information and monitoring Reports are available on the Trust intranet via the SQL Reporting Service:

- New RAG PTL.
- Inpatient Waiting List.
- RTT Delivery Summary Dashboard & 18 week Dashboards.
- Demand and Capacity Models.
- Data Quality Reports.
- New Active Booking List.
- Follow-up Booking List.
- Referral On-hold referral report.
- Stopped Clock Report.

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Section Two

Pathway Specific Principles

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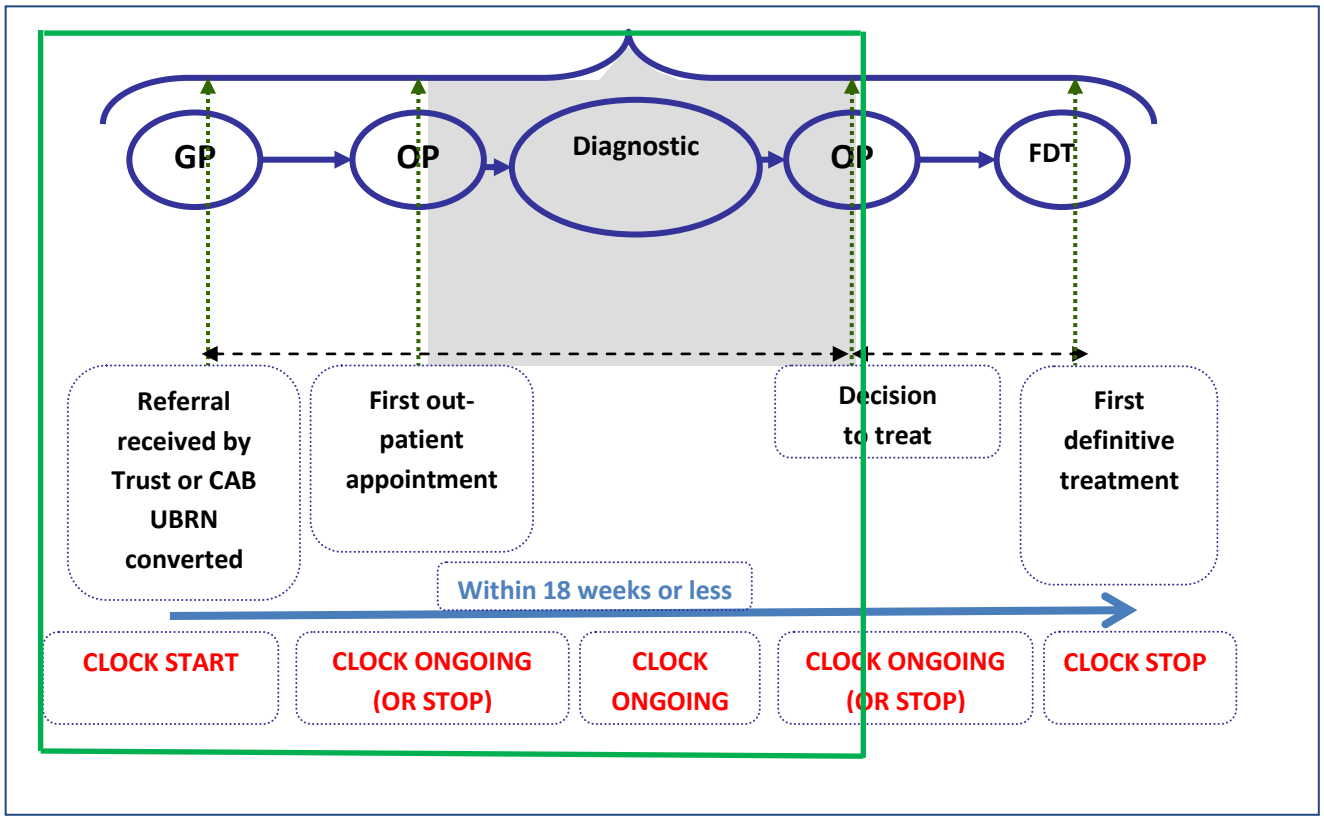
NON-ADMITTED PATHWAYS

The non-admitted stages of the patient's pathway comprise both outpatients and the diagnostic stages, as highlighted by the section with the green border around it in the diagram below. It starts from the clock start date (i.e. the date the referral is received) and ends when either a clock stop happens in outpatients (this could be the first, second or a further appointment).



The following pages detail the agreed policies and principles, starting with Referral Management. Where there is a Standard Operating Procedure (SOP) to support a particular point, a link is shown in **Section Four** of this document.

1. REFERRAL MANAGEMENT

a) Pre-Requisites Prior to Referral

i. Primary Care

In line with national RTT rules, before patients are referred the GPs and other referrers should ensure that patients are ready, willing and able to attend for any necessary outpatient appointments and / or treatment and that they fully understand, where possible, the implications of any surgery or other treatment which may be necessary.

ii. Secondary Care

It is the responsibility of the Centre management teams in conjunction with Clinicians to ensure that the Directory of Services (DoS) is up to date in terms of the service specific criteria and that the clinics are mapped to the relevant services. This gives the best chance of the patient being booked into the correct clinic at the first visit and reduces the rejection rate. Centre Management teams should review and update their DoS on at least an annual basis in parallel with revision dates to the Access Policy.

b) Referral Sources

i. GP

The vast majority of referrals should be made from primary to secondary Care (GP to Consultant) for the following reasons:

- To maximise the choice opportunities for patients in terms of provider, date and time of appointment.
- To provide care closer to home wherever possible by ensuring management of patients within primary care where appropriate.
- To contribute to the management of secondary care capacity by ensuring only those genuinely needing secondary care receive it, and in a more timely way as part of an RTT pathway.

ii. Internal Consultant to Consultant Referrals

The vast majority of referrals should be made from Primary to Secondary Care ("GP to Consultant") for the following reasons:

- To offer patient choice for each different episode of care. Patients should be offered the opportunity for 'Choice' in relation to referral for and opinion or management of a condition.
- To provide care closer to home wherever possible by ensuring management of patients within primary care where appropriate.
- To contribute to the management of secondary care capacity by ensuring only those genuinely needing secondary care receive it, and in a more timely way as part of 18 weeks pathway.

For these reasons, when a Consultant decides that the opinion of another Consultant/service should be sought, in the majority of cases he/she will write back to the referring GP detailing this opinion so that the patient and their GP can agree on further management. There are circumstances in which a "Consultant to Consultant" referral is clinically appropriate, described as follows:

No matter how well defined these circumstances are, there will always be occasional exceptions where Consultants and Commissioners will have to take a view based on individual patients and clinical circumstances.

A Consultant may refer directly to another Consultant when:

- In the opinion of the Consultant at the time of the first appointment, the patient's condition is clinically urgent and is most appropriately dealt with by direct urgent or "2 week" referral to a Secondary Care colleague/service.
- If the original referral is for 2 conditions, e.g. glaucoma and cataract and one needs to be treated prior to the other.
- The presenting referral symptom involves a different speciality – e.g. Referred to dermatology with facial skin lesion but with involvement of adjacent buccal mucosa where orthodontic opinion sought, or referral for back pain, where investigation excludes an orthopaedic cause but identified the cause as elsewhere e.g. vascular or gynaecological.
- Where the referral is for the investigation or further treatment either medical or surgical, of the condition for which the original referral was made.
- Where diagnostics and investigations e.g. an endoscopy is required as part of the patient pathway for the original presenting condition.
- When a patient specifically asks that the diagnosis is not shared with their GP (e.g. some sexual health cases).
- Where sub-acute tertiary referral is needed, i.e. an inpatient waiting to go to a specialist unit.

Examples to Consider

- A chest physician concludes that the patient requires an endoscopy as part of the investigation into their breathlessness and cough. If the Consultant plans to review the patient after the endoscopy and intends to continue the management of that patient, then Consultant to Consultant referral is appropriate. If the Consultant intends to hand over the management of the patient to the gastroenterologist, and the problem is not urgent, then referral back to the GP is likely to be most appropriate.
- A Gastroenterologist sees a patient with abdominal pain, and is subsequently found to have gallstones (in line with PLCV Policy), a referral to the upper GI surgical team would be appropriate.
- A dermatologist concludes that skin lesions are vascular and should be assessed by a vascular surgeon. If longstanding and non-urgent, then referral back to the GP may be the most appropriate course of action. If the condition is more acute or urgent, then Consultant to Consultant referral may be appropriate.

Circumstances in which Consultant to Consultant referrals are NOT appropriate

- The GP referral does not contain enough information to ensure that the patient will see the right Consultant at their first appointment.
- Referrals from A & E to other Consultants, unless part of immediate emergency or urgent care episode.
- The referral triage process has not been adequately applied (where this is the case, commissioners reserve the right to refuse payment for a consultation with 'the wrong' Consultant).
- A non urgent incidental finding is made during the course of assessment or investigation that is unrelated to the reason for referral.
- A patient discloses symptoms to the Consultant that indicate a diagnosis unrelated to the reason for referral.

- The Consultant is considering a designated 'procedure of low clinical value' as the next management option for the patient.

In all these circumstances, the patient (with a letter from the Consultant or the original GP referral letter) should be directed back to their GP with adequate information and guidance to allow the patient and GP to agree an appropriate course of action. Primarily it is considered that some Consultant to Consultant referrals may be requests for clinical management that could be carried out in a primary care setting.

iii. <u>External Consultant to Consultant Referrals / Inter Provider Transfers</u>

Consultant to Consultant (Tertiary) Referrals

- Consultants wishing to make an outpatient referral to another Trust should complete a standard referral form and Inter Provider Transfer pro-forma with the necessary Minimum Data Set (MDS).
- The Inter Provider Transfer (MDS) pro-forma should include all relevant information including any clock starts/stops and whether or not the patient has received any definitive first treatment. The RTT clock will continue to tick if the onward referral is for the same condition and/or symptoms, is to another Consultant led service and no definitive first treatment has been received by the patient.

Transfers between providers (Inter Provider Transfers Minimum Datasets)

- Patients may be transferred from the Trust to another provider, or may be transferred into the Trust from another provider, including primary care intermediate services; the standard minimum data set (MDS) must accompany the referral.
- The principle need for using the MDS form is to ensure all service providers involved in a patient's pathway have adequate information about clock starts and other associated information to enable the patient's management to be conducted within appropriate time frames.
- When a patient is transferred for treatment or diagnostic investigation in the middle of a pathway, the clock will continue and it will be the joint responsibility of involved providers to ensure that the patient is managed within 18 weeks. There will also be occasions when a patient is transferred for management after the original clock has stopped. This information will also need to be shared with the onward provider, hence an MDS form will still be required and the patient's pathway will need to be recorded as appropriate.
- Hospital-initiated or CCG-initiated transfers to alternative providers after referral to the Trust must always involve the consent of the patient, their GP, and the Consultant must be informed of the transfer of any of their patients. This is a transfer of clinical responsibility and acceptance.

iv. <u>Referral Management Centres (RAS & TRAQS)</u>

Referrals from Shropshire CCG and Telford & Wrekin CCG GP practices are directed through the Referral Assessment Service (RAS) and Telford Referral and Quality Service (TRAQS) respectively. The RTT clock is activated by receipt of the referral at RAS/TRAQS. RAS/TRAQS offer choice to patients and book appointments at chosen providers where possible. Both services work collaboratively with the Trust to ensure that there are smooth patient pathways in place.

c) Referral Methods

The LHE jointly supports and is working towards all referrals being made directly via e-Referrals (with the exception of Welsh patients who do not use e-Referrals). Paper referrals in the future will only be accepted for referrals from referring CCGs outside of Shropshire CCG and Telford & Wrekin CCG. Faxed referrals on the appropriate pro-forma for Rapid Access Chest Pain (RACP), for symptomatic breast referrals, Rapid Access gynaecology colposcopies and for Cancer Two Week Waits will be accepted. Inappropriate or paper referrals from GP practices within Shropshire or Telford &Wrekin CCGs will be dealt with as clinically appropriate. The Trust should notify RAS and TRAQS when paper referrals are received for this to be managed through primary care support teams at each CCG. There are currently three recognised methods of referral for non cancer referrals as described below (see Addendum to Elective Care Access Policy – Cancer Pathways).

i. e-Referrals

Directly Bookable Services

Directly Bookable Services (DBS) via e-Referrals enables the patient to book a first outpatient appointment slot at the Hospital of their choice. SaTH will ensure that sufficient capacity is available for patients to directly book their first appointment within 24 hours of referral. Patients who have been directly booked will have a referral auto created on PAS by the e-Referrals software. The RTT clock start will be auto triggered when the referral is received by RAS/TRAQS for SCCG and TWCCG patients. For out of county patients the RTT clock start is triggered when the Unique Booking Reference Number (UBRN) on e-Referrals is converted to an appointment or ASI.

Indirectly Bookable Services

RAS and TRAQS will send out reminder letters to patients who have yet to book their appointment after a UBRN has been generated. The Trust will endeavour to give patients their choice of site within the Trust but as a single provider, patient appointments may be offered a different site if appropriate treatment is available. Referrals that have been booked under the Indirect Booking rules will need to have a referral added to PAS. The referral received date (i.e. the RTT clock start date) must be the date when RAS/TRAQS received the referral.

ii. Paper Based Referrals

All paper based referral letters should be sent directly to the Central Booking Office which is based at the Royal Shrewsbury Hospital. If any other specialty or department be directly in receipt of a paper based referral letter, the date it was received should be clearly indicated in top right hand corner of the referral. An email should be sent to the Central Booking Office indicating that a referral has been received email address: sth-tr.SaTH-Referrals@nhs.net with a MDS of information in order for the referral to be entered onto PAS without delay. The referral letter will then be collected by a member of Patient Access staff. If SCCG and TWCCG referrals are received in paper form the CCGs will be notified.

d) Referral Criteria/Minimum Data Sets

i. The referrer is responsible for ensuring that the referral letter contains the essential minimum data set. This includes the patient's NHS number, full patient demographics, and a preferred day, evening or mobile telephone number that the patient would like to be contacted on as well as sufficient clinical data to enable the appropriate

appointment to be made. The letter should also state the patient's current drug regime, clinical question to be answered and significant past medical history. An incomplete referral will be returned to the originating referrer. Referrals that are deemed to be misdirected to the wrong Consultant specialist will be returned to the referrer with a letter.

ii. Referrals should be addressed to a speciality rather than a named Consultant and referrals will be allocated to the Consultant with the shortest waiting time. Named referrals will be allocated to the relevant Consultant but if they do not have sufficient capacity to accept the referral then a decision will be made in conjunction with the Consultant and the speciality operational / service manager to allocate the referral to an appropriate alternative Consultant. Exceptions to this would be where denying access to a sub speciality opinion would compromise clinical care.

e) Clinical Triage/Review of Referrals

i. e-Referrals

Consultants within the e-referrals service that the patient has been referred to will review e-referrals online and either accepts, redirects or rejects the referral as necessary. Any rejected referrals are instantly reported on to the referring GP via e-Referrals, this will enable the GP to contact the patient in a timely fashion and discuss next steps with the patient.

ii. Paper Based Referrals

If the referral is clinically inappropriate, the Consultant may not accept the referral. If this is the case, the reason for the decision will be communicated to the referrer, with a patient copy of the letter being sent within 15 working days of receipt by the Trust.

2. FIRST APPOINTMENT

Each specialty group should agree milestones for first outpatient appointments. In general terms, medical specialties should aim for the first outpatient appointment to be no later than week eight of the pathway and surgical specialties no later than week four. Urgent patient appointments must be made for no later than week two.

A reasonable offer for outpatients is an offer of a date and time three or more weeks from the time that the offer was made at any of the Trust's sites. Should a patient accept an appointment less than three weeks into the future, this becomes a reasonable offer.

a) e-Referrals Appointment Slot Issues (ASI's)

If no appointments are available due to lack of capacity, the UBRN will be directed to the Trust via the 'Defer to Provider' function on the e-Referrals application for local management to resolve. This is referred to as an ASI (appointment slot issue). The RTT clock is ticking from the point at which RAS/TRAQS received the referrals for SCCG and TWCCG patients, or for out of county patients when the patient attempted to book their appointment even though they will not be visible on the Trust's patient administration system at this point. The Central Booking Team or team co-ordinator will then call the patient to offer an appointment within two working days of the patient attempting to book.

ASIs result in a poor patient experience and time consuming administrative workarounds. Sufficient capacity must therefore be made available via e-Referrals to ensure patients can book directly into services. This is the responsibility of the operational / service management team responsible for the speciality. Any issues associated with this will be escalated to the

appropriate operational / service managers so they can be discussed at the weekly PTL Meetings.

b) Paper Based Referrals

Patients should be appointed firstly by their clinical priority (i.e. urgent patients first) and then within chronological order of their RTT clock start date.

It is essential the sufficient appointment capacity is available to book patients within their clinical priorities and specialty specific milestones for first appointments. Central Booking Office staff should check that this is available prior to contacting patients or sending invitation to call letters.

i. Urgent Referrals

Urgent patients that are referred via the paper referral process will be placed on the outpatient waiting list and will be contacted via the telephone within two working days of receipt of referral to agree an appointment date. A letter should be sent to confirm the appointment which must also include details of how to cancel and reschedule appointments.

ii. Routine Referrals

Routine patients that are referred via the paper referral process will be placed on the outpatient waiting list and sent an invitation to call letter in order to book their appointment within pathway specific milestones OR Central Booking Office to contact the patient. Patients should be offered a choice of dates and an appointment made which is mutually convenient. The patient's details including daytime contact number must be checked and corrected at this time and all appointment offers must be recorded on PAS. A letter should be sent to confirm the appointment which must also include details of how to cancel and reschedule appointments.

If the patient fails to call within 14 days of the letter being sent out the outpatient waiting list entry is removed. A letter is sent to the patient's GP and the referral is closed. The code for the patient RTT pathway will be patient declined treatment.

Where a patient is referred to a pooled service, they are to be offered an appointment with the Consultant with the shortest waiting time either Trust site.

iii. RACP (Rapid Access Chest Pain Clinic), Rapid Access Colposcopy Referrals & Urgent Symptomatic Breast Referrals

To meet required NHS standards, rapid access chest pain referrals & urgent symptomatic breast referrals must be seen by a specialist within 14 days of the GP faxing the referral through or by the referral being received via e-Referrals. Rapid Access Colposcopy referrals must been seen within 28 days.

In order to achieve this standard the Trust requires the GP to use the referral pro-forma and fax the proforma to an assigned urgent fax number.

The patient has to be able to attend an appointment within the 14 days or they will need to be re-referred by the GP.

3. HOSPITAL INITIATED APPOINTMENT CHANGES

a) In the event of a hospital initiated cancellation, the patient's RTT clock continues to tick from the original referred received date.

b) The patient will be contacted to arrange an alternative appointment date and time. Both an apology and a reason for cancellation will be given. The Trust will make every effort to ensure that they do not cancel patient's appointments.

c) If the cancellation is within two weeks of the appointment date, the patient will be telephoned. If the cancellation is outside of the timeframe, the patient will be contacted by letter. Appointments will be made as close to the original appointment as possible. This is particularly important when patients need to re-attend for test results or to review medication.

d) If a patient is cancelled or rescheduled twice by the Trust this will need to be escalated immediately to the appropriate Centre Manager to take immediate action.

4. PATIENT INITIATED APPOINTMENT CANCELLATIONS

Patients who wish to cancel their appointment and do not require a further appointment or treatment should be removed from the waiting list, their RTT clock stopped and a letter should be sent to the patient and their GP confirming their decision.

5. PATIENT INITIATED APPOINTMENT CHANGES/DELAYS

a) Patients will have the opportunity to change appointments during the agreed maximum timeframe for each specialty. Patients who cancel their appointment should be given an alternative date at the time of the cancellation if required.

b) If a patient cancels an appointment on two or more consecutive occasions (and causes delay to their appointment by more than two weeks) or they are unable to re-book their appointment within their breach date, their case should be reviewed by a Clinician to ensure there is no clinical risk in not treating the patient and it is agreed that the patient is not considered to be vulnerable. Where no risk is identified, patients should be discharged back to their GP.

A clock stop should be considered if the patient is unwilling to accept a date within six weeks or before their 18 week RTT breach date, under which circumstances clinical advice must be sought to confirm:

- That the delay is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Children Policy or Safeguarding Vulnerable Adults Policy and Procedure) are protected.

Providing the above has been confirmed, the patient may be offered a date beyond six weeks or their 18 week RTT breach date. If the Clinician is satisfied that the proposed delay is appropriate, this should be allowed. A new clock start (of the date the offer was made/accepted) should be recorded on PAS.

c) Patients who cancel their outpatient or diagnostic appointment for reasons other than sickness or for extreme personal circumstances with less than 2 days notice, after receiving reasonable notice of this date (three weeks) will be referred back to their Clinician for review and a decision made as to whether or not the patient should be discharged back to the care of their GP if it is in the patient's best clinical interests to do so. The RTT clock continues to tick during the appointment reschedule but should be stopped if the patient is being discharged back to their GP.

d) If a patient wishes to change their appointment following a previous hospital cancellation at short notice within the same speciality, a further appointment will be offered to the patient;

however their RTT status will remain. Patients who have been referred as urgent suspected cancer, Rapid Access Chest Pain cannot cancel their agreed appointment, as the two week pathway is then unlikely to be met. The Centres must take ownership of reinforcing to the patient the need for attendance.

e) Patients will be informed of the rules around cancelling appointments in the letter confirming their appointment.

6. CLINIC ATTENDANCE

a) Arrival of Patients

i. Patient demographic details should be checked at every clinic attendance and amended as necessary on the Trust's PAS system. The status of overseas visitors will be checked at this time. The responsible overseas manager must be notified where it is suspected that there is an overseas visitor.

ii. All patients must have an attendance / arrival status recorded, i.e. Attended or Did Not Attend.

b) Clinic Outcomes

i. All patients must have an outcome (e.g. follow-up or discharge) and an updated RTT status record on the clinic on PAS. This includes patients who have already started treatment and have had a previous clock stop as they may need to start a new clock due to a new treatment plan or continue being monitored.

ii. Clinicians must indicate both the outcome and the RTT status on the paper based clinic outcome form (COF) which the receptionist is then responsible for transferring to PAS.

iii. The vast majority of non admitted RTT performance is derived from the data transferred to PAS from the COF so it is critical that the data is recorded in an accurate and timely manner.

c) Follow-up Appointments

i. Patients who require an appointment within six weeks should be fully booked as they leave the outpatient appointment.

ii. Patients who require an outpatient follow-up appointment in more than six weeks' time will be telephoned and offered an appointment date.

iii. Patients requiring a further appointment outside six months will require a Consultant only request to the Clinical Lead/Clinical Director as well as the Outpatient Department. Pathway exceptions will include Glaucoma, Rheumatology and Long Term Conditions including MS, Parkinsons, Epilepsy, Heart Failure, Long term Diabetes or Endocrine disorders.

iv. Long term follow-up appointments will be agreed between Consultant and the patient's GP around the clinical needs of the patient.

v. Any patients who require a further appointment outside six months will be flagged to the speciality management and Clinicians for further investigation with a view to establishing the appropriateness of the further follow-up appointment. However, if the speciality Clinician deems that this is not in the best clinical interests of the patients care, they can be offered a further follow -up appointment outside the six month rule.

7. NON ATTENDANCE

a) Any patient who does not attend their agreed appointment (new or follow-up) will be reviewed by the relevant Clinician and a clinical decision will be made as to whether a further appointment is required or to discharge the patient back to the care of their GP if it is in the patient's best clinical interests to do so. Both patient and GP will be notified of this in writing to ensure the referring GP is aware and can action further management of the patient if necessary. The patient's RTT clock will be stopped. Exceptions to this are but not limited to:

- **i.** When a clinical decision is taken that discharging the patient is contrary to the patient's clinical interests;
- **ii.** Clinically very urgent referrals including cancer, or active surveillance for cancer, rapid access chest pain, and other critical illnesses;
- **iii.** Children of 16 years and under or vulnerable adults.

b) Where circumstances were beyond the patient's control the Trust will endeavour to be as flexible as possible. The patient must first be contacted to ascertain the reasons for DNA and ensure compliance to attend a rescheduled appointment.

c) e-Referral patients who do not attend their chosen appointment will be reviewed by the relevant Clinician and a clinical decision will be made as to whether a further appointment is required or to discharge the patient back to the care of their GP if it is in the patient's best clinical interests to do so. The GP may re-instate the referral by re-referring the patient. In these circumstances a new 18 week RTT pathway will commence.

d) DNAs found following investigation of the Trust systems found to be as a result of an administrative error will be reappointed to a date as soon as possible to limit any potential delay/disadvantage to the patient.

Children Who Fail to Attend First Appointments

- Will usually be offered a second appointment. Should this also be missed a letter will be sent to the G.P, copied to the parents, and the Paediatric Liaison Health Visitor informing them of two DNAs and suggesting that they re-refer if the problem persists.
- If the initial referral states a problem that is likely to be short lived, or seems driven by parental anxiety, a second appointment may not be sent, but a letter should be sent to the GP and parents informing them of this, and saying we assume the problem has now resolved, and asking for a re-referral if needed.
- If the initial referral letter states a potentially serious problem a phone call to the parents might be more appropriate.
- If the GP mentions Social Worker or Health Visitor concerns in the letter then a second appointment is offered, and contact with those professionals may be sensible.

Follow-ups Who Fail to Attend

- Will normally be offered a second appointment. If that is also missed, the Consultant will write to the GP , Paediatric Liaison Health Visitor and the family discharging them unless:
- They've had multiple DNAs in the past, when maybe one DNA will warrant such a letter.
- If the Consultant knows the family well, may offer a third appointment or make contact with family via phone / letter.
- If child is at risk, the Consultant should try to make contact with family expressing concerns before contacting Social Care.
- If the child has a chronic illness and is therefore likely to be well known, input from the Specialist nurse may be helpful, or ask GP to make contact via the repeat prescription mechanism.

Action to be taken where there are concerns

Following review of the notes by the Consultant, if the practitioner considers the parents' behavior to possibly be neglectful, action should be taken.

- Contact the parents to rearrange the appointment.
- Discuss with the Named Doctor or Named Nurse.
- Refer to Trust Safeguarding Policy and if required refer to Social Care if child thought to be at risk of significant harm.

8. CLINIC MANAGEMENT

a) Clinic Templates

Clinic templates define the number of each type of patient that can be seen in a clinic based on the number and grade of Clinicians in the clinic. Centre Managers and Clinical Directors will review Consultant clinic templates as part of the annual job planning process and demand / capacity profiling. Any changes to clinic templates should be forwarded to the Central Booking Office to be processed on PAS once agreed. Access rights to the functionality on PAS to make changes to clinic templates will be restricted to Central Booking Office staff only.

b) Ad Hoc Clinic Cancellation & Reductions

i. Changes to Clinic templates will be clearly communicated to the Central Booking Office. A minimum of six weeks written notice of planned annual, study or professional leave must be given when a doctor or other professional requires a clinic to be cancelled or reduced.

ii. Consultants, medical staff and other health professional staff must give at least six weeks notice of annual leave. Where this is not given, the Consultants team or alternative health professional must cover the clinic. Leave should be given as early as possible to minimise the effect on clinics. This is the responsibility of the operational/business manager for the speciality. Known annual bank holidays (Christmas, Easter….) can be planned for with significant notice.

iii. Approved cancelled clinics due to leave should be taken up by other Consultants/Specialities wherever possible to ensure maximum utilisation.

iv. Requests at less than 6 weeks notice will need to be presented to the Centre Manager, signed off by the Clinical Director with a clear justification as to why the request could not be made sooner and evidence that alternative cover arrangements are in place to ensure continuation of the service.

v. The Trust is committed to offering certainty to patients as well as choice in arranging care. As such, every effort will be made to avoid cancelling patient's appointments. Every effort will be made to backfill absent Clinicians by the speciality. Cancellation will be a last resort.

vi. Clinics should not be cancelled or reduced for any purpose unless there are exceptional circumstances.

vii. Ideally eight weeks with a minimum of six weeks written notice of planned annual, study or professional leave must be given when a doctor or other professional requires a clinic to be cancelled or reduced. Wherever possible patients that have been previously cancelled should not be cancelled a second time. Such occurrences require immediate escalation to the Centre Manager to take immediate action.

viii. When clinics have to be unavoidably cancelled/reduced at short notice this must be approved by the Centre Manager. Liaison with Nursing staff, Booking & Records Manager, Central Booking Office and Clinic Preparation is essential.

ix. On receipt of a request to cancel or reduce a clinic, the Booking Team will avoid cancelling the following patients:

- Urgent Cancer or Urgent Two Week Wait Referrals
- RACPC & Urgent Symptomatic Breast Patients
- Long term follow-up flagged cancer patients
- Urgent appointments
- Those patients with a time dependent appointment
- Those patients cancelled previously.

x. The patients will be contacted by the Central Booking Office to arrange a new appointment. Every effort will be made to ensure that patients are contacted including the use of first class post and telephone calls when cancellations are being made for clinics within two weeks of the patient's appointment.

xi. When a patient has hospital transport or an interpreter booked the relevant department must be notified of any amendments to the patient's appointment.

c) Booking Rules

Booking instructions for all specialties will be given to the Central Booking Office. These will be signed off by the Centre / Business Managers and Consultants and sent to the Central Booking Office. Each Centre must produce a comprehensive version controlled set of Booking Rules which must be clear and concise. These will be reviewed on an appropriate basis and any changes required will be clearly identified.

9. OUTPATIENT CLINIC ACCOMMODATION

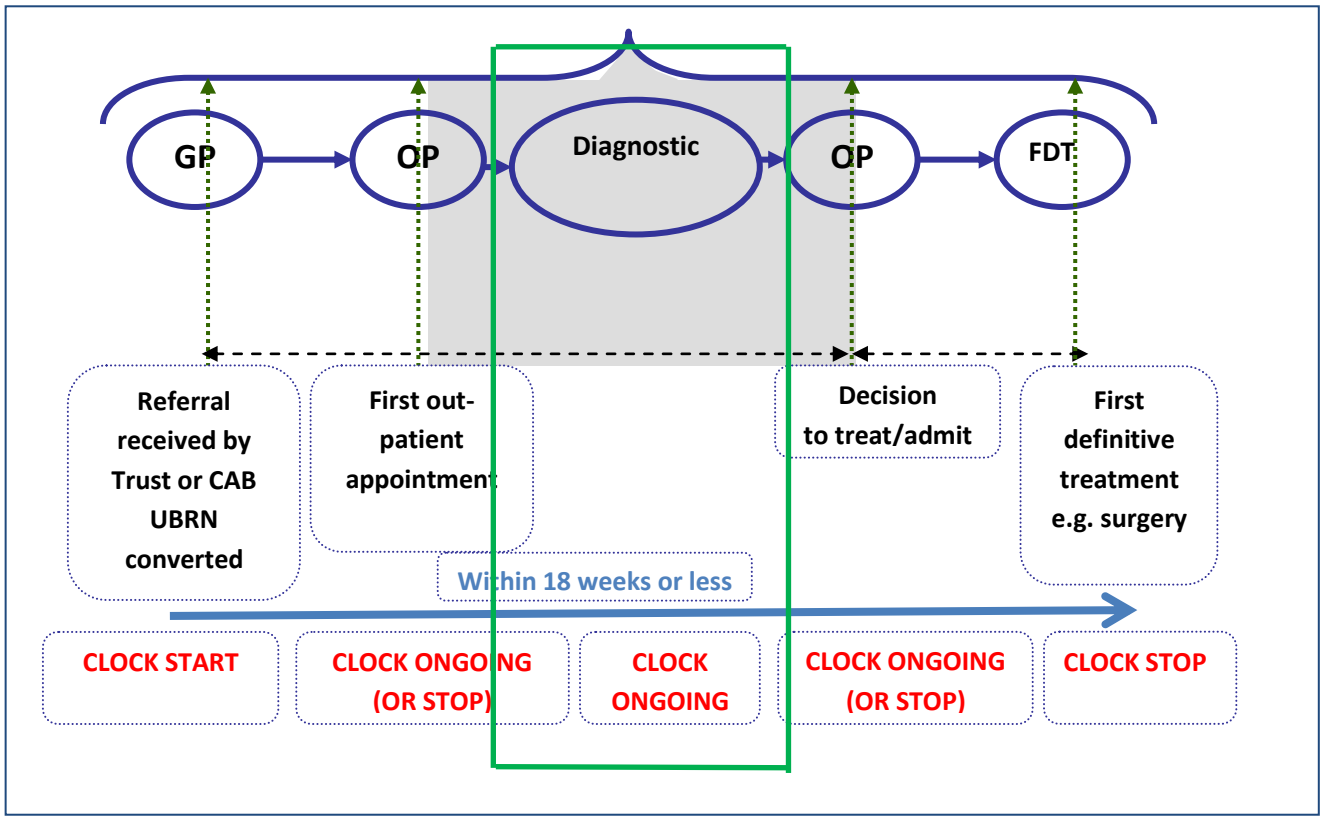
a) The Trust will ensure that outpatient clinic capacity is fully utilised. Any cancelled scheduled clinic sessions due to annual or study leave will be communicated to Centres.

b) Clinic templates will be reviewed on a six monthly basis by the appropriate Operational / Business Manager and the Consultant to ensure that there is adequate capacity available to deliver the required volumes of patients to meet the Trust's business plan. This monthly review will need to reflect the demand fluctuations for the service and plan revision accordingly.

DIAGNOSTIC PATHWAYS

The section within the green border on the diagram below represents the diagnostic stage of the RTT pathway which forms part of the non-admitted pathways. It starts at the point of a decision to refer and ends upon the diagnostic procedure being reported on.

It is important to note however, that patients can also be referred for diagnostic investigations directly by their GP where they will not be on an 18 RTT pathway.



The following pages detail the agreed diagnostic policies and principles .Where there is a Standard Operating Procedure (SOP) to support a particular point, a link is shown in Section Four of this document.

1. DIAGNOSTIC PATIENTS ON AN RTT PATHWAY

A reasonable offer for diagnostic tests is an offer of a date and time of three or more weeks from the time that the offer was made at any of the Trust's sites. Should a patient accept an appointment less than two weeks into the future, this becomes a reasonable offer. All offered and declined appointments will be recorded on CRIS.

Some diagnostic tests will be undertaken on an admitted basis.

Patients Who Decline Two Reasonable Appointment Offers

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

Patients Who Fail to Attend

Standard Radiology DNA protocol will apply (in line with Trust policy on outpatient appointment DNAs - see section 2), 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 providing that:

- That the delay is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Children Policy or Safeguarding Vulnerable Adults Policy and Procedure) are protected.

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

- A copy of the request form plus the CRIS generated DNA letter will be sent to the referring Consultant/GP.
- The request will be cancelled on CRIS.
- For patients on an 18 week RTT pathway, the 18-week non-clinic clock stop pro-forma must be completed and forwarded to the Central Booking Office.
- If a further appointment is to be offered the request should be treated as a new referral and re-entered onto CRIS as a new event, ensuring a new request received date is entered accordingly.
- 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.

2. SUBSEQUENT DIAGNOSTICS

Where the patient has received first definitive treatment for condition they were referred for and subsequent new treatment plan is agreed following the result of a 'check' diagnostic, a new RTT should commence.

3. STRAIGHT TO TEST

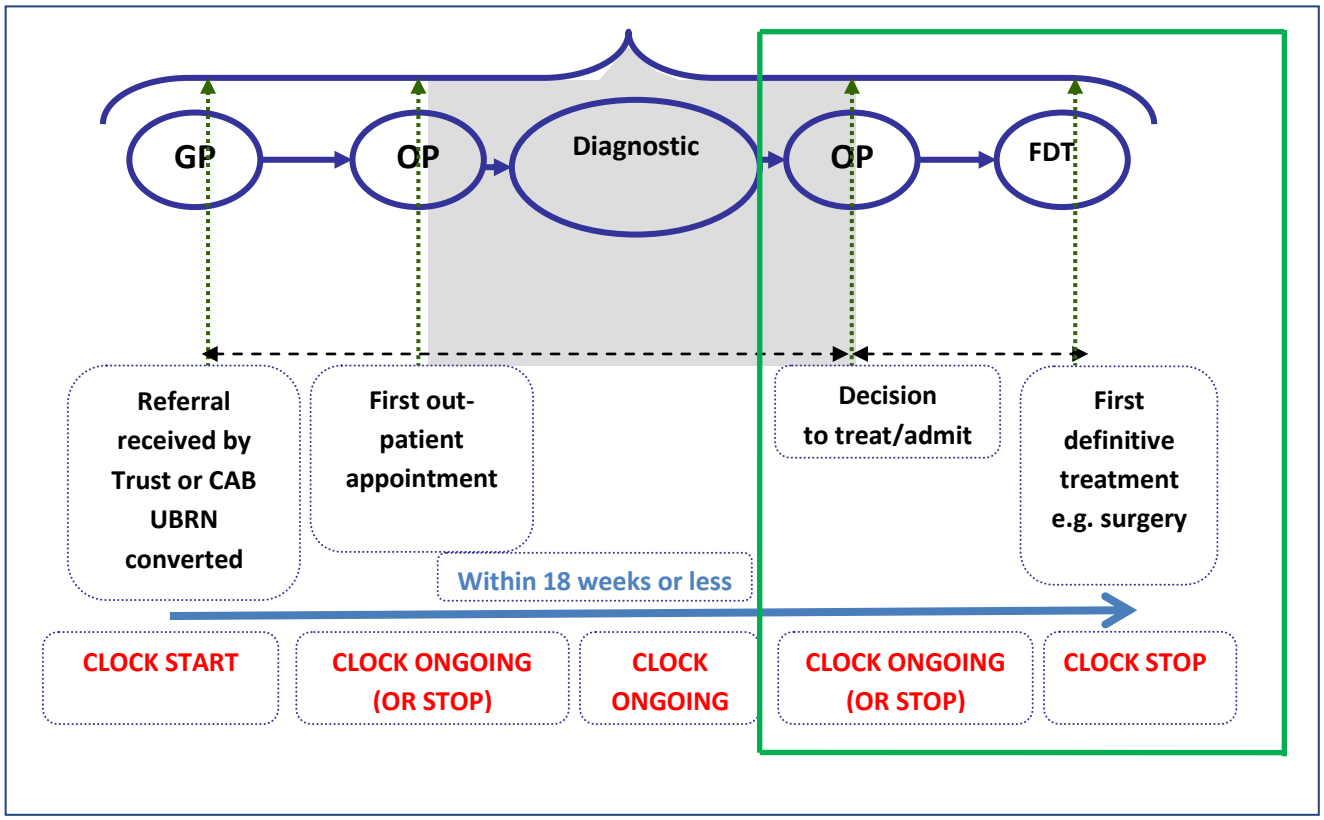
In the event of a GP referring a patient straight to diagnostics and the patient might be treated by a medical or Consultant led service prior to clinical responsibility being transferred back to the GP, this constitutes an RTT pathway.

4. DIRECT ACCESS

Where a GP refers a patient for a diagnostic test but retains clinical responsibility for the patient and makes a decision regarding referral on the basis of the results; this does NOT constitute an RTT pathway. An RTT clock only commences if the GP subsequently makes a referral to a Consultant led service.

ADMITTED PATHWAYS

The section within the green border on the diagram below represents the admitted stage of the pathway. It starts at the point of a decision to admit and ends upon admission for first definitive treatment.



The following pages detail the agreed policies and principles, starting with the Decision to Admit. Where there is a Standard Operating Procedure (SOP) to support a particular point, a link is shown in Section Four of this document.

1. DECISION TO ADMIT

The decision to admit a patient for surgery (as a daycase or inpatient) must be made by a Consultant or another Clinician who has been given delegated authority. A patient should only be added to an active waiting list for surgery if:

a) There is a sound clinical indication for surgery.

b) The patient is clinically fit, ready and available to undergo surgery. Patients who are added must be clinically and socially ready for admission on the day the decision to admit is made.

c) Following pre-anaesthetic assessment, patients who are not fit for treatment should not be listed and either placed on a period of active monitoring if appropriate with the patient's understanding and agreement or if clinically appropriate referred back to the care of their GP or

d) There is a real expectation of performing the operation within a reasonable time in relation to the patient's clinical priority.

e) The intended procedure is not on the PLCV policy which should only be carried out with prior authorisation from the CCG. A number of procedures have been deemed of limited clinical value by the CCG's. For these procedures there must be evidence that the correct pathway has been followed and an approved prior approval form must have been received. It is the responsibility of the management team in the Centre where the surgeon works to gain prior approval for the procedure. All patients must be added to the waiting list at the time a Decision to Treat is made and prior approval must be sought thereafter (please note that the RTT clock continues during the time approval is sought). A decision is required from the CCG's within seven days of the request for approval being received. If approval is rejected, the patient must be removed from the waiting list and referred back to the GP with a letter documenting that prior approval was rejected. A copy of the letter must also be sent to the patient.

2. COMPLETION OF WAITING LIST TO COME IN (TCI) FORMS

a) A waiting list TCI form will be completed at the time of the decision to admit, in full by the Clinician making the decision to admit for all patients added to the waiting list.

b) Waiting list TCI forms will be collected from the Outpatient clinics by a nominated member of the Patient Access Team on a daily basis. Urgent TCIs will be added to the waiting list on the site of the outpatient appointment irrespective of where the surgery takes place. Routine TCIs will be sent directly to the Central Booking Office. All waiting list entries must be put onto PAS within 48 hours or two working days of the outpatient appointment.

3. PRE-ANAESTHETIC & PRE-OPERATIVE ASSESSMENT

a) Patients should be pre-anaesthetically assessed as soon as possible following the decision to admit, preferably immediately following the decision to admit.

b) The purpose of this assessment is to ensure all patients are fit for treatment, that they are listed for the appropriate type of admission (day case, short stay or inpatient care).

c) Patients who are not fit for treatment should not be listed and either placed on a period of active monitoring if appropriate with the patient's understanding and agreement or if clinically appropriate referred back to the care of their GP for optimisation. This needs to be a clinical decision based on the time it will take to optimise the patient and the likely gap between decision to admit and date of admission. Examples of conditions requiring a longer period of optimisation could be:

- Patients with high blood pressure.
- Patients needing to lose weight.
- Patients with cardiac or respiratory problems.
- Patients requiring a diagnostic test before a definitive decision to admit can be made.

d) The decision to proceed with these types of patients lies entirely with the Consultant anaesthetist/Consultant surgeon who following a review will make a decision whether to proceed.

e) Patients who are not presently fit will be fully investigated and an individual management plan agreed with the Clinician. If optimisation is likely to take a short period of time, their RTT pathway will continue. If it is likely to take a longer period of time then their RTT pathway will be stopped either with active monitoring or decision not to treat depending on the clinical management plan.

4. ADDING PATIENTS TO THE ADMITTED WAITING LIST

a) Patients must be added to the admitted waiting list within one working day of the decision to admit.

b) From the point of adding the patient to the admitted waiting list, the patient transfers from a non-admitted pathway to an admitted pathway.

c) When logging a patient on the waiting list module of PAS, the Booking team must ensure that:

- Patients are not already listed for the same condition.
- The entry is recorded correctly as either active or planned.
- Full treatment text and an accurate procedure code are noted.
- That the patient is not already scheduled for surgery for another procedure under a General Anaesthetic.
- Any communication with the patient should be recorded on PAS in the Pathway validation section of the system.

5. LISTING PATIENTS/OFFERING TCI DATES

To maximise the patient experience and minimise unnecessary delays along the pathway, the LHE is committed to working towards patient being fully booked on the same day as the decision to admit.

a) Where patients are not fully booked The Trust's in-patient Waiting list report must be used as the data source for scheduling admitted patients.

b) Listing must be undertaken by selecting patients firstly by their clinical priority and then within chronological order of RTT wait time.

c) Patients must be contacted by telephone to have the opportunity to agree their TCI date.

d) Patients should be offered two separate dates with at least three weeks notice for day case or inpatient admissions.

e) Where available, patients can be offered dates with less than three weeks notice and if they accept, this then becomes a 'reasonable' offer.

f) Patients will be telephoned on two occasions, one in the day time and one in the evening. If unable to make contact with the patient following the two telephone calls, a letter will be sent asking the patient to telephone the department to arrange an admission within five working days.

g) If the patient fails to call within ten working days of the letter being sent, the Trust will endeavour to contact the patient via telephone on two separate occasions at different times of the day. If the Trust is still unable to contact the patient then the Patient's GP will be contacted to verify the Patient's contact details. If the Trust is still unable to contact the patient then the patient will be referred back to their Clinician for review and a decision made as to whether or not the patient should be discharged back to the care of their GP if it is in the patient's best clinical interests to do so. The waiting list entry will be removed as the patient has declined treatment. A letter is sent to the patients GP and the patients RTT pathway will be closed.

6. PATIENT CANCELLATION/DECLINING OF TCI OFFERS

a) When offering TCI dates, patients may need to decline for social reasons due to other commitments which cause them to be unavailable, e.g. holidays or exams. Patients could decline offers immediately during the telephone conversation or cancel / decline at any point between initially accepting and the admission date itself.

b) 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 date on two or more consecutive occasions (and causes delay of more than two weeks) or they are unable to re-book their appointment within their 18 week breach date, their case should be reviewed by medical staff to ensure there is no clinical risk in not treating the patient and it is agreed that the patient is not considered to be vulnerable (see the Safeguarding Children Policy or Safeguarding Vulnerable Adults Policy and Procedure).

A clock stop should be considered if the patient is unwilling to accept a date within six weeks or before their 18 week RTT breach date, under which circumstances clinical advice must be sought to confirm:

- That the delay is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Children Policy or Safeguarding Vulnerable Adults Policy and Procedure) are protected.

Providing the above has been confirmed, the patient may be offered a date beyond six weeks or their 18 week RTT breach date. If the Clinician is satisfied that the proposed delay is appropriate, this should be allowed. A new clock start (of the date the offer was made/accepted) should be recorded on PAS.

Patients wishing to defer surgery for more than twelve weeks should be discharged back to the care of their GP provided:

- That the delay is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Children Policy or Safeguarding Vulnerable Adults Policy and Procedure) are protected.

Clinicians must be notified of any patients on a cancer pathway who wishes to cancel their admission. If the Clinician feels the delay is inappropriate and not in the best clinical interests of the patient a member of the clinical team must contact the patient to discuss this further.

c) Patients who cancel their own elective admission date for reasons other than sickness / or extreme personal circumstances with less than 2 days notice, after receiving reasonable notice of this date (at least three weeks) will be referred back to their Clinician for review and a decision made as to whether or not the patient should be discharged back to the care of their GP if it is in the patient's best clinical interests to do so. The RTT clock continues to tick during the appointment reschedule but should be stopped if the patient is being discharged back to their GP.

7. THE TCI LETTER

A letter must be generated immediately following the agreement of a TCI date. The TCI letter must contain the following core details:

- Patient's name.
- NHS Number & Hospital Number.
- Date letter sent to patient.
- Date and time of admission.
- Details of necessary pre-assessment before admission.
- Where to report on arrival.
- Named contact for queries relating to admission.
- Reference to instructions for admission and / or booklet.
- Request to check bed is available on day of admission.
- Reasons for checking bed availability.
- Specific information about the treatment.
- General information about the patient's stay in hospital and discharge.

8. PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

A patient referred for two separate conditions resulting in the requirement for two admissions for different procedures could be managed in the following ways. On completion of the first procedure the clock is stopped for that particular pathway. If the patient is unfit as a result of the first surgery to undergo the second surgery and there is no prospect of the patient becoming fit then the patient's clock can be stopped (decision not to treat) and patient should be discharged back to the care of their GP or alternatively the patient could be placed on a period of active monitoring by the Clinician until the patient becomes fit, ready and available to proceed with the second procedure.
Under no circumstances should a patient be on more than one waiting list within the Trust for general anaesthetic. Such patients must be given the opportunity to recover from one procedure under anaesthetic before opting to undergo another. If a patient requires more than one procedure at the same point in time, a clinical decision must be made which procedure is clinically more urgent. The key is that this should be a clinical decision to facilitate the most appropriate management of the patient.

9. PATIENTS WHO BECOME MEDICALLY UNFIT WHILST ON THE ADMITTED WAITING LIST

Patients awaiting admission who become medically unfit for surgery due to a short-term condition in nature (e.g. cold, stomach bug) will remain on the schedule and the clock will continue to tick. However, if there are serious co-morbidities found on pre-assessment which requires treatment in itself or if the patient requires optimisation (e.g. weight loss) before surgery, it may be appropriate to

keep the patient under active monitoring at the Trust or alternatively if clinically appropriate discharge the patient back into the care of the GP for work up / optimisation.

10. VALIDATION PATIENTS OF PATIENTS ON THE ADMITTED WAITING LIST

a) Some patients on the elective waiting list may no longer need their treatment (e.g. if they have been treated elsewhere) or need their operation to be performed by a different Trust (e.g. where a patient moves to another part of the country). To ensure that only those patients still needing their treatment are on the waiting list and to comply with the Data Protection Act, the Trust will validate the waiting list on a regular basis.

b) The Central Booking Office will contact patients on the elective waiting list to ask if they still need their treatment. Patients who reply that they still need their treatment will remain on the waiting list. Patients who reply that they no longer need their treatment will be removed from the waiting list. Patients who are unobtainable by letter or telephone and whom do not reply within 3 weeks of a letter being sent will also be removed from the waiting list. A patient may reinstate themselves on the schedule (Waiting list) within four months of the discharge date by contacting the Central Booking Office. The Central Booking Office will contact the Consultant to agree the patient's request for a decision to proceed or request a further outpatient clinic appointment. If more than four months has elapsed, the patient must be referred by the GP to the appropriate Consultant via outpatients, in both cases a new RTT clock begins.

c) Such validation will usually be performed once a month and there should be a focus on patients waiting four weeks or more from decision to admit. However the Trust may choose to do this more frequently and on a wider patient group.

11. REINSTATING PATIENTS ON THE ADMITTED WAITING LIST

The Trust aims to pre-operatively assess 100% of patients on the day the decision to admit is made. However, if this was not possible on the day the patient may have been invited to attend a pre-operative assessment subsequently to being added to the admitted waiting list. If at pre-assessment stage the patient is removed from the admitted waiting list due to serious co-morbidities which requires treatment in itself or if the patient requires optimisation before surgery, it may be appropriate to keep the patient under active monitoring at the Trust and therefore the patient may need to be re-instated. In the case the RTT clock will have a new start date.

12. SUBSEQUENT TREATMENTS SAME CONDITION

If following active monitoring a patient is added to waiting a new clock will start on the day Decision to Admit is made and communicated with the patient. This also applies to a patient on a previous emergency pathway.

Patients who are removed from the waiting list will need to be reviewed in outpatients first before being re-instated unless based on clinical judgement this is decided against by the Consultant. The new clock start date will be either the date of the GPs request or the date of the review in outpatients.

13. HOSPITAL CANCELLATION OF TCI'S

a) There are various reasons why an operation may have to be cancelled which fall into three main categories – cancellation by the Trust for clinical reasons, cancellation by the Trust for

non-clinical reasons and cancellation by the patient. These should be included on any subsequent electronic discharge letter or in the patient's notes. All reasons for cancellation will be added to PAS by the Central Booking Office.

b) **Cancellation by the Trust for clinical reasons;** if the operation is cancelled because the patient is unfit for surgery or the operation is no longer required the clock stops and the patient should be referred back to their GP. The exception to this is patients who develop colds, D&V prior to admission and would be expected to recover in 7-10 days, the clock continues for these patients.

c) **Cancellation by the Trust for non-clinical reasons;** The Trust will only cancel a patient's admission when it is not possible to carry out the procedure (e.g. bed capacity, unplanned leave, emergency cases). Before any cancellation is made, this must be discussed with the Centre Manager for that speciality. Everything must be done to try and avoid a hospital cancellation as it causes distress to the patient and an operational problem to the hospital.

d) If it is absolutely necessary for the hospital to cancel a patients surgery, the patient will normally be given a new admission date at the time of cancellation. If this is not possible it is the responsibility of the Senior Manager who authorised the cancellation to ensure that the patient has a new date of admission within 28 days if the patient is cancelled on the day of surgery or as soon as possible if cancelled prior to this.

e) Should it be necessary to cancel elective admissions, priority will be given to clinically urgent cases and long waiters. The new date also has to be within the 18 week patient target. Every effort should be made to avoid cancelling a patient's admission: Theatre lists should not be cancelled except under exceptional circumstances.

- Ideally eight weeks but with a minimum of six weeks written notice of planned annual, professional or study leave must be given when a doctor requires a theatre list to be cancelled, and where a colleague is unable to cover the list, to avoid patients being cancelled needlessly.
- Requests for theatre list cancellations with less than six weeks notice must be escalated to the appropriate Operational/Business Manager. Requests with less than six weeks notice must then be agreed by the Assistant Chief Operating Officer or nominated Deputy. Such requests will only be agreed in exceptional circumstances.

f) **Cancellations on the day of surgery**

- On a daily basis the On Call Scheduled Care Operational Manager or nominated Deputy will review TCI admissions for the following day and identify any difficulties expected at the 3.45pm Site Safety Meeting. In conjunction with the Clinical Site Manager and Head of Capacity a plan for the next days TCI patients must be made.
- At the 8.45am Site Safety Meeting the On Call Scheduled Care Operational Manager and Matron will review the elective admissions for the day. Difficulties in capacity preventing all TCIs being placed must be escalated to the Assistant Chief Operating Officer or nominated deputy who will make the decision as to whether patients should be cancelled or not.
- Any cancellations required for non-clinical reasons not notified at and agreed as a result of the 08.45 Site safety Meeting must be escalated to the operational manager within the Clinical Centre to discuss the potential cancellation and explore all available options to avoid cancellation.

- In **ALL** cases, **ANY** cancellation on the day of surgery for non-clinical reasons will only be authorised by The Assistant Chief Operating Officer or nominated deputy.
- All cancellation must be accurately recorded in SEMA and reappointed within agreed targets and timeframes.
- Patients who have been previously cancelled should not be cancelled a second time if at all possible. If this is unavoidable, the Chief Operating Officer or nominated Deputy must authorise such a cancellation.
- No patient should ever be cancelled three times.

Patients that are cancelled at any point in time prior to surgery will always be notified by telephone and offered a new date. A notification of cancellation letter will be sent to the patient's GP.

14. 28 DAY READMISSION OF HOSPITAL INITIATED CANCELLATIONS

a) The Trust's objective is to have a zero on the day cancellation rate. It is inevitable however that for a variety of reasons some operations will be cancelled.

b) Patients cancelled on the day of surgery for a non-clinical reason need to be kept to a minimum, with patients readmitted within 28 days.

c) Patients who are cancelled on the day will be contacted by Central Booking Office and offered a new admission date within 48 hours of their cancellation.

15. PLANNED WAITING LIST

a) Patients who are waiting to be recalled to hospital for a further stage in their course of treatment are classed as Planned Admissions. This is an admission where the date of admission is determined by the clinical needs to the treatment. Examples of these would be follow-up chemotherapy sessions, or a removal of internal fixation, three months post operation, check cystoscopy or repeat colonoscopies. These patients will be held on a 'planned waiting list', separate from the other waiting list, however will be subject to the same monitoring and validation process.

b) The Operational / Business Managers are responsible for reviewing the planned list on a weekly basis to ensure compliance. This review will include checking that patients are being brought in, in accordance with their planned review dates and have been listed appropriately to the planned list definition.

c) Patients on a planned schedule are outside the scope of RTT rules. Planned procedures are part of an agreed programme of care, which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Planned activity is also sometimes known as 'surveillance'. Examples of procedures which should be on a surveillance list are:

- **i.** Check procedures such as cystoscopies, colonoscopies etc.
- **ii.** Patients proceeding to the next stage of treatment e.g. patients undergoing chemotherapy or removal of metal work.

d) Patients must only be included on planned schedule if there are clinical reasons why the patient cannot have the procedure or treatment until a specified time. Examples can be age related procedures in children or where protracted conservative management is require prior to the surgery.

e) 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.

f) 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.

16. PATIENTS WHO DO NOT ATTEND (DNA) ADMISSION

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

b) Patients who fail to attend their agreed operation date will be reviewed by the Clinician and a clinical decision made to remove the patient from the waiting list and referred back to their GP if it is in the patient's best clinical interest to do so.

c) The RTT clock will stop. Exceptions to this rule are:

- **i.** Patients undergoing cancer treatments.
- **ii.** Urgent referrals based on clinical judgement.

17. BILATERAL PROCEDURES

Patients will only be put onto the admitted waiting list for one side at a time.

The RTT clock will stop when the first definitive treatment begins (i.e. when the procedure is carried out). A second new clock starts once the patient is fit and ready to proceed with the second procedure.

If the decision to admit involves two procedures as part of the single pathway of treatment the clock stops when the first treatment begins. The subsequent procedure is undertaken based on clinical need as part of the same pathway but the clock has already stopped. This is a process for planned patients who are managed according to clinical need.

18. ADMITTING PATIENTS

Where a patient's admission is a procedure or operation constituting first definitive treatment as part of an RTT pathway, the admission on PAS will stop the patient's clock.

19. EMERGENCY ADMISSIONS FOR AN ELECTIVE PROCEDURE

Where patients are admitted as an emergency for an elective procedure the patient will be removed from the waiting list and their RTT clock stopped.

20. REMOVALS OTHER THAN TREATMENT

Patients who state that they do not wish to receive treatment will have their waiting list entry removed and their clock stopped.

Section Three

Reference Information

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1. Definitions

A

Active Monitoring A waiting time clock may be stopped where it is clinically appropriate to start a period of active monitoring in secondary care without clinical intervention or diagnostic procedures at that stage.
A new waiting time clock would start when a decision to treat is made following a period of active monitoring (also known as watchful wait)
Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to refer the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such and also stops a waiting time clock.
If a patient is subsequently referred back to a Consultant led service, then this referral starts a new waiting time clock.

Admission The act of admitting a patient for a day case or inpatient procedure.

Admitted Pathway A pathway that ends in a clock stop for admission (day case or inpatient).

B

Bilateral (Procedure) A procedure that is performed on both sides of the body, at matching anatomical sites. For example, removal of cataracts from both eyes.

C

Care professional A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professionals Act 2002.

Clinical Decision A decision taken by a Clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements.

Consultant A person contracted by a healthcare provider who has been appointed by a Consultant appointment committee. He or she must be a member of a Royal College or Faculty. Consultant led waiting times exclude non-medical scientists of equivalent standing (to a Consultant) within diagnostic departments.

Consultant led A Consultant retains overall clinical responsibility for the service, team or treatment. The Consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.

Converts a UBRN	When an appointment has been booked via Choose and Book, the UBRN is converted (Please see definition of UBRN).

D

DNA (Did Not Attend)	DNA (sometimes known as an FTA – Failed to attend). In the context of Consultant led waiting times, this is defined as where a patient fails to attend an appointment/admission without prior notice.
Decision to admit	Where a clinical decision is taken to admit the patient for either day case or inpatient treatment.
Decision to treat	Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatment performed in other setting e.g. as an outpatient.
Direct Access	Where a GP refers a patient for a diagnostic test but retains clinical responsibility for the patient and makes a decision regarding referral on the basis of the results, this does NOT constitute an RTT pathway. An RTT clock only commences if the GP subsequently makes a referral to a Consultant led service.

F

First definitive Treatment	An intervention intended to manage the patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient
Fit (and ready)	A new RTT clock should start once the patient is fit and ready for a subsequent bilateral procedure. In this context, fit and ready means that the clock should start from the date that it is clinically appropriate for the patient to undergo that procedure, and from when the patient confirms they are available.

H

Healthcare Science Intervention	*See Therapy.*

I

Interface service	All arrangements that incorporate any interventions any intermediary levels of clinical triage, assessment and treatment between primary and secondary care.
Interface service (non-Consultant-led)	Consultant-led referral to treatment relates to Hospital/Consultant led care. Therefore, the definition of the term 'interface service' for the purpose of Consultant led waiting times does not apply to similar 'interface' arrangements established to deliver traditionally primary care or community provides services, outside of their traditional (practice or community based) setting. The definition of the term does not also apply to:

- Non Consultant led mental health services run by Mental Health Trusts.
- Referrals to 'practitioners with a special interest' for triage, assessment and possible treatment, except where they are working as part of a wider interface service type arrangements as described above.

N

Non-admitted pathway — A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment'.

Non Consultant led — Where a Consultant does not take overall clinical responsibility for the patient.

Non Consultant led Interface service — *See interface service.*

R

Reasonable offer — A reasonable offer is an offer of time and date three weeks or more from the time that the offer was made.

Referral Management or Assessment Service — Referral management or assessment services are those that do not provide treatment, but accept GP (or other) referrals and provide advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient.
Referral Management and Assessment Services should only be in place where they carry clinical support and abide by clear protocols that provide benefits to patients. They must not be devices either to delay treatment or to avoid local clinical discussions about good referral practice.
A waiting time clock only starts in referral to a referral management and assessment service where that service may onward-refer the patient to a surgical or medical Consultant led service before responsibility is transferred back to the referring health professional.

S

Straight to test — A specific type of direct access diagnostic service whereby a patient will be assessed and might, if appropriate, be treated by a medical or surgical Consultant led service before responsibility is transferred back to the referring health professional.

Substantively new different treatment — Upon completion of a Consultant led referral to treatment period, a new waiting **or** time clock starts upon the decision to start a substantively new or different treatment that does not already form part of the patient's care plan.
It is recognised that a patient's care often extends beyond the Consultant led referral to treatment period, and that there may be a number a number of planned treatments beyond first definitive treatment.
However, where a further treatment is required that was not already planned; a new waiting time clock should start at the point the decision to treat was made.

Scenarios where this might apply include:

- Where less 'invasive/intensive' forms of treatment been unsuccessful and more 'aggressive/intensive' treatment is required (e.g. where intra uterine insemination (IUI) has been unsuccessful and a decision is made to refer for IVF treatment;
- Patients attending regular follow-up appointments, where a decision to try a substantively new or different treatment. In this context, a change to the dosage of existing medication may not count as a substantively new or different treatment, whereas a change to medication combined with a decision to refer the patient for therapy might.
  Ultimately, the decision about whether the treatment is substantively new or different form the patient's agreed care plan is one that must be made locally by a care professional in consultation with the patient.

T

Therapy or Healthcare Science Intervention	Where a Consultant led or interface service decides that therapy (for example physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science (e.g. hearing aid fitting) is the best way to manage the patient's disease, condition or injury and avoid further interventions.

U

UBRN (Unique Booking Reference Number)	The reference number that a patient receives on their appointment request letter when generated by the referrer through Choose and Book. The UBRN is used in conjunction with the patient password to make or change an appointment.

2. Useful Information

a) PATIENTS' RIGHT TO TREATMENT (RTT) RULES

Patients' right to treatment (RTT) rules and definitions for ensuring the waiting-time clock starts and stops fairly and consistently. The rules suite aims to set out clearly and succinctly the rules and definitions for referral to treatment Consultant led waiting times to ensure that each patient's waiting time clock starts and stops fairly and consistently. It does not attempt to provide detailed guidance on how the rules should apply in every situation, but to provide the NHS with a framework to work within to make clinically sound decisions locally about applying them, in consultation between Clinicians, providers, commissioners and, of course, patients.

For more information follow this link:
https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks

b) RECORDING AND REPORTING REFERRAL TO TREATMENT (RTT) WAITING TIMES FOR CONSULTANT-LED ELECTIVE CARE

The accurate recording and reporting of referral to treatment (RTT) waiting times information is extremely important. Patients can and do use this information to inform their choice of where to be referred and also to understand how long they might expect to wait before starting their treatment. NHS providers and commissioners also need to use this information to ensure they are meeting their patients' legal right to start Consultant led non-emergency treatment within a maximum of 18 weeks from referral1 – and to identify where action is needed to reduce inappropriately long waiting times.

For more information follow this link:
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting-RTT-guidance-v24-2-PDF-703K.pdf

c) RTT FREQUENTLY ASKED QUESTIONS

This document contains answers to frequently asked questions on RTT measurement and the RTT data collection. It does not attempt to provide guidance on how RTT should apply or be measured in every situation.

For more information follow this link:
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Accompanying-FAQs-v7.2.pdf

d) MAXIMUM WAITING TIMES – GUIDANCE FOR COMMISSIONERS

The NHS Constitution sets out statutory rights for all NHS patients. One of the factors taken into account in determining Quality Premium payments for clinical commissioning groups (CCGs) will be discharging their patients' statutory rights on waiting times. Annex A summarises these.
Equality and diversity are at the heart of the NHS strategy. Due regard to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it, has been given throughout the development of the policies and processes cited in this document.

For more information follow this link:
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/12/Maximum-Waiting-Times-guidance-revised-November-2013.pdf

e) PLANNED PATIENTS

Commissioners and providers need to plan and manage their services so that new and planned patients are treated at the right time and in order of clinical priority. Patients requiring initial or follow-up appointments for clinical assessment, review, monitoring, procedures, or treatment must be given a specific date and time, as required by best clinical evidence.

For more information follow this link:
https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

f) REFERRAL TO TREATMENT CONSULTANT-LED WAITING TIMES – REVIEWING PATIENT PATHWAYS WHO HAVE WAITED LONGER THAN 18 WEEKS

Reviewing the pathways of patients who have waited longer than 18 weeks before starting their treatment
As set out in the NHS Operating Framework and NHS Constitution patients have a right to start Consultant led treatment within a maximum of 18 weeks. To minimise unnecessary waits, commissioners need to understand and act upon the reasons for any unnecessary waits over 18 weeks. This guidance suggests methods for reviewing and reporting waits longer than 18 weeks in order to understand the causes and drive further improvements in patient experience.

For more information follow this link:
http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

3. Shrewsbury and Telford Hospital Contact Information

a) PATIENT ACCESS TEAM

The Patient Access Manager is SaTH's designated lead in respect of the review and revision of this policy on at least an annual basis in collaboration with the CCG designated leads. The Patient Access Team provides SaTH's central point of expertise, advice, training and support in respect of referral to treatment rules, standards and processes.

b) CONTACT DETAILS

Centre Manager for Patient Access and Outpatient Nursing Support is based at The Princess Royal Hospital and can be contacted on telephone number: 01952 641222 extension 5736.

Patient Access Manager is based at The Princess Royal Hospital and can be contacted on telephone number: 01952 641222 extension 5653.

PA for Patient Access is based at The Princess Royal Hospital and can be contacted on telephone number: 01952 641222 extension 5730.

Booking and Records Manager is based at The Royal Shrewsbury Hospital and can be contacted on telephone number: 01743 261000 extension 1411.

Booking Support Services Manager is based at The Royal Shrewsbury Hospital and can be contacted on telephone number: 01743 261000 extension 1411.

The Patient Access booking team are responsible for booking outpatient appointments and the scheduling of both day case and inpatient admissions.

For the Central Booking Office please contact:
01952 282810 or 01743 261044
Offices are open Monday to Friday 8.00am until 8.00pm and Saturday mornings 9.00am until 12.00pm.

If you would like more information about our booking and appointments service, please follow this link or scan the QR code:
http://www.sath.nhs.uk/patients-and-visitors/Booking_and_Appointments.aspx

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Section Four

Standard Operating Procedures

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Patient Access Centre Standard Operating Procedures

All of the Patient Access S.O.P.'s are available on the Trust's intranet page **here** (internal link only).

1. **BOOKING CENTRE**

BC01 – Registering New Referrals
BC02 – Grading New Referrals
BC03 – Reconciling New Referrals
BC04 – Validation of On-Hold Referrals
BC05 – Booking New Appointments
BC06 – Booking Follow-up Appointments from the Active Booking List (ABL)
BC07 – Cancelling Clinics
BC08 – Registering New Referrals for Powys Patients
BC09 – How to Reschedule a Clinic
BC10 – Inter Provider Transfer (IPT) Referrals
BC11 – Additional Clinic Requests
BC12 – Arranging for an Interpreter for Patients
BC13 – How to Create a Temporary Rule and Freeze Clinics
BC14 – Requesting a Ward Follow-up
BC15 – Directory of Services Review
BC16 – Hospital Cancellations of Outpatient Appointments
BC17 – Adding a Patient to the Waiting List
BC18 – Validating the Waiting List
BC19 – Patients with Long or Short Term Medical Conditions
BC20 – Offering a TCI Date
BC21 – Patients Who DNA Their TCI Date
BC22 – Patients Who DNA Their Pre-Operative Assessment
BC23 – Pre-Operative Assessment for Gynaecology
BC24 – Booking a Pre-Operative Assessment Appointment
BC25 – Patients Who Wish to Cancel Their Admission
BC26 – Process of Accepting, Redirecting and Rejecting Referrals
BC27 – Process of Actioning the Appointment Slot Issue Worklist
BC28 – Cancellation of TCI's
BC29 – Booking a Flexi Cystoscopy
BC30 – Process of Actioning the Appointments for Booking Worklist
BC31 – Communication with Patients Who Have an Outpatient Referrals or Appointment
BC32 – Communication with Patients Who Have Been Added to the Waiting List
BC33 – Dealing with Data Received From Netcall
BC34 – Registering a New Identity

2. TWO WEEK WAIT

TW01 – Booking Two Week Wait New Appointments

TW02 – Grading Two Week Wait Referrals

TW03 – Two Week Wait Patients Being Contacted Via Netcall

TW04 – Entering Data onto Somerset

TW05 – Booking Two Week Wait Patients to Breach

TW06 – Somerset vs Sema Report

TW07 – Two Week Wait Gynaecology Referrals

TW08 – Two Week Wait Paediatric Referrals

TW09 – Registering a New Two Week Wait Referral

TW10 – Two Week Wait Dermatology Referrals