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SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE SUMMARY

REPORT TO BOARD OF DIRECTORS

HELD ON 15 APRIL 2015

Subject:	Revised Access Policy
Supporting Director:	Kirsten Major, Director of Strategy & Operations
Author:	Annette Peck / Michael Harper
Status (see footnote):	D

PURPOSE OF THE REPORT:

To approve the Revised Access Policy

KEY POINTS:

The policy has been updated to reflect comments received following its implementation in February 2014.

The key changes are:

- Addition of specific guidance relating to patients under the age of 18
- Revision of sections 7.2.3 relating to patients who fail to attend for a diagnostic test and 10.2 relating to patient pauses
- Additional information in section 11.2 on hospital cancellation of admissions
- A link to FAQ has been added to Appendix 1

The implementation of the policy will be monitored on an ongoing basis.

IMPLICATIONS:

		TICK AS APPROPRIATE
1	Deliver the best clinical outcomes	✓
2	Provide patient centred services	✓
3	Employ caring and cared for staff	
4	Spend public money wisely	✓
5	Deliver excellent research, education & innovation	

APPROVAL PROCESS:

Meeting	**Presented**	**Approved**	**Date**
TEG	DSO	✓	8 April 2015
Board of Directors	DSO		

[1]Status:	A = Approval
	A* = Approval & Requiring Board Approval
	D = Debate
	N = Note
[2] Against the five aims of the STHFT Corporate Strategy 2012-2017	

ACCESS POLICY

Managing the 18 Weeks Referral to Treatment Waiting Times

Revised February 2015

Reference Number	Version	Status	Executive Lead(s) Name and Job Title	Author(s) Name and Job Title
	3.0	Current	Kirsten Major, Director of Strategy & Operations	Annette Peck, Head of Information

Approval Body	Trust Executive Group	**Date Approved**	08/04/2015
Ratified by	Board of Directors	**Date Ratified**	
Date Issued	13/02/2015	**Review Date**	February 2016
Contact for Review Name and Job Title: Annette Peck, Head of Information			

Associated Documentation:

Trust Controlled Documents

Safeguarding Children Policy (June 2011)
Safeguarding Vulnerable Adults Policy (April 2012)
Equality Impact Analysis Policy (January 2012)

External Documentation

https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks
https://www.gov.uk/government/publications/the-handbook-to-the-nhs-constitution-for-england

Legal Framework

NHS Constitution

For more information on this document please contact:-

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Version History

Version	Date Issued	Brief Summary of amendments	Owner's Name:
1.0	September 2009	Comprehensive Review	Annette Peck
2.0	27/02/2014		Annette Peck
3.0	February 2015		Annette Peck

(Please note that if there is insufficient space on this page to show all versions, it is only necessary to show the previous 2 versions)

Executive Summary

ACCESS POLICY - Managing the 18 Weeks Referral to Treatment Waiting Times

Document Objectives:	To ensure that all patients that are referred and treated within the Trust receive high quality care, fair and equitable access and services in line with 18 week Referral to Treatment, the Cancer Waiting Time Standards, and the NHS Constitution. To provide the Trust with a coherent approach to the management of waiting lists, scheduling and booking across the organisation.
Group/Persons Consulted:	All Clinical Directors All Operational Directors Trust Executive Group All Service Managers NHS Sheffield
Monitoring Arrangements and Indicators:	Annual Review of policy Quarterly Review of adherence to the policy
Training Implications:	All staff involved in the 18 weeks Referral to Treatment Time pathway will receive training on 18 week pathways through a e-learning package Further training on the application of the policy will be provided to Service Managers, who will be required to train staff within directorates
Equality Impact Assessment:	Completed Equality Impact Assessment is included in the policy at Appendix 4
Resource implications:	Staff time for training and monitoring
Intended Recipients:	
Who should:-	
➢ be **aware** of the document and where to access it	All Clinical Staff All Operational Directors and Service Managers All administrative and managerial staff involved in the recording and management of patient pathways All staff involved in arranging appointments and admission dates for patients
➢ **understand** the document	As above
➢ have a **good working knowledge** of the document	As above

1.0 INTRODUCTION

This Access Policy is intended to ensure that all patients that are referred and treated within the Trust receive high quality care, fair and equitable access and services in line with 18 week Referral to Treatment, the Cancer Waiting Time Standards, and the NHS Constitution.

This policy will provide the Trust with a coherent approach to the management of waiting lists, scheduling and booking across the organisation. It will ensure that patients are treated in line with local and National Policies regarding Vulnerable Adults, Patients with Learning Disabilities, Safeguarding Children Policies and War Veteran Guidance.

It is essential that all staff involved in the management of patients waiting elective treatment have a clear understanding of their roles and responsibilities in this process. This includes clinical, managerial and administrative staff. Every process in the management of patients who are waiting for treatment must be clear and transparent to the patients and to partner organisations and will be open to inspection, monitoring and audit. The Trust will give priority to clinically urgent patients and treat everyone else in turn and will share correspondence that is sent between clinicians with patients regarding their care.

The policy reflects the key access targets for Outpatient, Inpatient, Diagnostic and Planned Waiting List Management, 18 Week Referral to Treatment, and Cancer Waiting Time Standards, in line with the NHS Constitution.

The NHS Constitution brings together in one place for the first time in the history of the NHS, what staff, patients and public can expect from the NHS. As well as capturing the purpose, principles and values of the NHS, The Constitution brings together a number of rights, pledges and responsibilities for staff and patients alike. These rights and responsibilities are the result of extensive discussions and consultations with staff, patients and public and it reflects what matters to them.

This policy will be continuously reviewed reflecting any changes in light of patient feedback, the commissioning intentions of the local Commissioners and NHS Constitutional rights and pledges.

It provides a framework within which detailed operational procedures can be formed at Directorate level to ensure access to services for out-patients, in-patients and day cases in the context of the 18 week referral to treatment (RTT) standard. The policy combines an interpretation of national guidance with local standards of productivity and equity such that waiting is minimised and activity is maximised.

Compliance with this policy will ensure:

- A streamlined patient pathway with minimum waits
- Trust adherence to mandated milestones and standards of measurement relating to elective patient pathways
- Consistent and equitable treatment of patients on elective pathways
- Effective use of Trust resources

Hospital Clinical Staff, Managers, Secretarial and Clerical Staff all have an important role in managing the process of referral to treatment effectively. The core responsibilities of the Trust and wider health community include:

- Treating patients in a timely manner
- Keeping hospital visits to the minimum required
- Delivering high quality, efficient and responsive services
- Prompt and informative communications with patients

This policy details how elective patients will be managed administratively at all points of contact with the Sheffield Teaching Hospitals NHS Foundation Trust (STHFT). It is the responsibility of all associated members of staff to understand the RTT principles and definitions.

Separate detailed guidance is available for Cancer pathways. Specific references to Cancer pathways are included in this document where relevant.

2.0 KEY PRINCIPLES

The principle underlying the maximum 18 week referral to treatment standard is that patients should receive excellent care without unnecessary delay. The Trust will meet and improve on the maximum waiting times set by the DH for all groups of patients. This policy is intended to cover all non-emergency services provided by the Trust.

Every process in the management of patients who are waiting for treatment must be clear and transparent to staff, to patients and to partner organisations, and must be open to inspection, monitoring and audit, as required.

Patients should not be referred for acute services unless they are fit, ready and willing to access services within a maximum of 18 weeks. The only exception to this is if the patient requires urgent treatment.

The Trust, whenever possible, will negotiate appointment and admission dates and times with patients.

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

All patients must be seen primarily in order of length of wait, with the exception of war pensioners and service personnel injured in conflict, who must receive priority treatment if their condition is directly attributable to injuries sustained in conflict. Clinically urgent patients are defined as those who, for clinical reasons, cannot wait for the current maximum waiting times and need to be seen by the Consultant in no more than 2 weeks from referral for out-patients and operated on within 31 days from decision to treat for inpatients. Those patients prioritised as clinically urgent by the Consultant will be seen within these timescales rather than the standard maximum 18 week pathway in place for patients clinically prioritised as routine.

All referrals, additions and removals from all waiting lists will be made in accordance with this policy.

All waiting lists for outpatient appointments and hospital admission should be held on and managed through the Patient Administration System (PAS). Waiting lists for diagnostic tests and Allied Health Professionals can be held on local Information Technology (IT) systems but the principles of this policy must be applied. Manual (paper) waiting list management systems are not acceptable for any stage of the pathway.

The accuracy and reliability of waiting list and diagnostic information is the responsibility of **all staff** who are involved in the processing and management of outpatient referrals, diagnostics and admissions to the hospital.

A clinician will only refer directly to another clinician in urgent cases (e.g. cancer) or where there is an agreed pathway. In all other instances if a patient requires a referral to another consultant within the Trust or another service provider they should be referred back to their GP and the GP advised that a further referral is required.

3.0 WAITING TIME GUARANTEES

The current national waiting time guarantees fall into three areas:-

Referral to treatment time (maximum18 weeks)
Waiting times for Cancer treatment

In addition the Trust has local standards for the waiting time for the stages of treatment.

3.1 18 Week Referral to Treatment

All patients should receive their first definitive treatment within 18 weeks of referral to secondary care.

The performance of the Trust against this standard is required to be:-

- **A minimum of 90% of admitted patients complete their pathway within 18 weeks**
- **A minimum of 95% of non-admitted patients complete their pathway within 18 weeks**
- **A minimum of 92% of patients who are still waiting for treatment in any period (incomplete pathways) should have waited less than 18 weeks**

The targets are not 100% because the nature of the clinical condition of some patients will mean that treatment within 18 weeks is not appropriate or possible. Also, some patients will request a delay in their treatment so that treatment within 18 weeks is not possible. These two groups of patients are the only patients who may wait longer than 18 weeks.

3.2 Stages of Treatment

The above guarantee sets out the time frame for patients receiving their first definitive treatment. The stage of treatment guarantees apply to all patients regardless of whether or not they are on an 18 week pathway.

The Trust needs to be more ambitious in its plans to reduce the time it takes to complete the RTT pathway, to be competitive with other Trusts; to ensure it is working efficiently; and, most importantly, to provide the best possible service to patients.

For 2015/16, STHFT maximum waiting times have been set as follows:

i) No patient should wait longer than 5 weeks for a first outpatient appointment
ii) No patient should wait longer than 4 weeks for a diagnostic test to be carried out and the results reported
iii) No patient should wait longer than 2 weeks for pre-operative assessment (with the aim to be to offer pre-operative assessment to patients on the same day as the decision to admit (DTA) is made)
iv) No patient should wait longer than 4 weeks following pre-operative assessment, for admission to STH (maximum 15 weeks total pathway)

These timescales will be reviewed annually, with the aim of reducing the overall patient pathway year on year.

3.3 Cancer Waiting Times

The target waiting times for patients where cancer is suspected, diagnosed or being treated are as follows:

i) All referrals from GP/GDPs (General Dental Practitioners) that are marked 'urgent suspicious of malignancy' must be seen by a specialist within 14 days of the date that the referral is received by the Trust. These are known as '2 week waits' (2ww).

ii) All referrals from GP/GDPs that are marked 'urgent suspicious of malignancy' where the diagnosis of cancer is confirmed will receive their first definitive treatment within 62 days of the date that the referral is received by the Trust.

iii) All other patients diagnosed with cancer who require treatment must receive that treatment within 31 days of the decision to treat being made.

iv) All patients diagnosed cancer patients will wait no more than 31 days from decision to treat to the start of treatment for second and subsequent treatment (surgery and chemotherapy).

v) All patients with suspected cancer, detected through national screening programmes must not wait more than 62 days from referral to treatment.

vi) All patients where cancer is detected during their hospital care must not wait more than 62 days for treatment (Consultant upgrade) from the date that it is decided that cancer is a possible diagnosis.

3.4 Straight to test diagnostics

Where a GP/AHP requests a diagnostic test to determine whether onward referral to secondary care or management in primary care is appropriate, then the patient is not on an 18 week RTT pathway and the RTT clock does not start.

The patient must have the diagnostic procedure within six weeks of referral. If the patient is subsequently referred to secondary care, then an RTT pathway will commence on the date the referral for that care is received.

Where a GP refers a patient for a diagnostic prior to an Outpatient appointment with a Consultant as part of an agreed pathway, i.e. it is known that the patient will require a Consultant appointment, then the patient is on an 18 week RTT pathway and the clock starts on receipt of the referral to the Consultant. The national standard is that a patient must wait no longer than six weeks for their diagnostic procedure. The local standard is 4 weeks.

3.5 Patients requiring commissioner approval

Once the patient has been referred to secondary care and a RTT pathway started, clock stops can only be made to a patient's RTT pathway when treatment occurs or a decision not to treat is made. No adjustments or clock stops can be made to a pathway whilst a panel or approval board assesses commissioner approval requests. Patients who require treatment which must have commissioner approval prior to commencement must not be disadvantaged by having their referral returned to primary care. Therefore, the referrer to the Trust must seek prior approval before referring the patient. The approval must accompany the referral.

In some instances it will not be apparent until the outpatient consultation or on completion of diagnostic testing, that the patient requires an excluded procedure. Commissioners should hold

approval panels in line with the 18 week timeframes for any patient referred for assessment who has already commenced an RTT pathway.

For cancer referrals, Commissioners should hold approval panels in line with the cancer waiting times framework.

4.0 18 WEEK REFERRAL TO TREATMENT (RTT)

It is the responsibility of all members of staff to understand the 18 week principles and definitions. They must be applied to all aspects of the patient's pathway. More detailed guidance on the 18 week referral to treatment time measurement is contained in Appendix 1. A document containing the answers to some frequently asked questions (FAQ) is also available at http://sharepoint.sth.nhs.uk/Dept/StrategyAndOperations/18%20Weeks%20FAQs/Forms/AllItems.aspx

4.1 Start of the 18 Week Pathway

4.1.1 An 18 week clock starts when any healthcare professional refers to:-

(i) A consultant led service, regardless of location, with the intention that the patient will be assessed and if appropriate, treated before responsibility is transferred back to the referring healthcare professional (usually GP or GDP).

(ii) A referral management or assessment service, that may result in an onward referral to a consultant led service before responsibility is transferred back to the referring healthcare professional (usually GP or GDP).

4.1.2 An 18 week clock also starts when:-

(i) A new decision to treat is made for a patient currently receiving ongoing care at the hospital. For example, a patient has been prescribed medication that is intended to treat their condition and is followed up in an outpatient setting. When the patient attends for a routine review their condition has changed and an intervention is required. A new 18 week pathway period starts when the decision to admit (DTA) is made.

(ii) A referral is made by a consultant either within the hospital or from another provider to a consultant led service for a new course of treatment. For example, a patient has been managed conservatively in a medical specialty but their condition deteriorates and surgical intervention is required. A new 18 week pathway starts when the referral to the surgical specialty is made.

(iii) When a patient becomes fit and ready for the second of a bilateral procedure, for example a cataract operation on the second eye. A new 18 week pathway starts when the patient is fit to be treated and returned to the 'active' waiting list.

4.2 End of the 18 Week Pathway

The 18 week pathway ends when:-

(i) The patient receives their first definitive treatment that is 'treatment that is intended to manage their disease, condition or injury'. The clock stops if the treatment given is intended to avoid

further intervention. Treatment will often continue beyond the first definitive treatment and after the clock has stopped.

(ii) The patient declines treatment.

(iii) When a diagnosis has been reached but either the patient or the clinician decide that rather than treatment a period of time where the condition is monitored on a regular basis in secondary care is appropriate. This is termed 'active monitoring'. The patient remains under the care of the hospital during this period and must be actively followed up. A patient on active monitoring should either, be on a 'planned' waiting list, be on the outpatient review list with a scheduled review date, or have a future outpatient appointment booked. If a decision is made that treatment is now appropriate then a new period on the 18 week pathway is created and a new 18 week clock is started.

(iv) A patient is added to a transplant waiting list.

(v) A decision is made that no treatment is required or the patient is not ready for treatment and the patient is discharged back to primary care (usually GP or GDP).

(vi) Patient has treatment as an emergency which was previously intended to be done electively.

5.0 REFERRALS

The primary route for the receipt of referrals will be electronically through Choose and Book (C&B). However, in the short term referrals will also be received:-

(ii) Electronically through NHS mail for tertiary referrals (inter provider transfers)
(iii) On paper for referral from GPs
(iv) On paper for tertiary referrals (inter provider transfers)

All inter provider transfers (IPTs) should contain or be accompanied by the minimum data set for IPTs. This applies to both those received from another provider and those made between clinicians within the Trust. Details of the minimum data set are in Appendix 2. If the information is not provided then the referrer should be contacted asking them to provide the required information as soon as possible. If the start date is not available then a date 8 weeks before the date the referral is received should be used.

5.1 Referrals received through Choose and Book

A detailed procedure document is available that sets out the processes to be used for Choose and Book referrals and appointments. This includes the procedures for dealing with Appointment Slot Issues (ASI). Appointment Slot Issues arise when the referrer or patient cannot find an available appointment slot on C&B. These appointment requests are then 'deferred to provider'. Then, in line with the national requirement, STHT has to contact the patient within 4 working days to agree an appointment date and time with them.

5.2 Inter Provider Transfers received through NHS mail

The appropriate NHS mail box should be accessed at least once a day and the referrals processed in the same way as paper referrals.

5.3 Paper Referrals

All referral letters both those from GPs and tertiary referrals should be stamped with the date of receipt and entered onto PAS within 24 hours (1 working day) of receipt. To ensure that this is the case, all mail regardless of the addressee or any 'medical in confidence' status should be opened and processed within 1 working day of receipt. All directorates must develop standard operating procedures that ensure that all relevant mail is opened within 1 working day. Only mail addressed 'Personal – addressee only' is exempt from this requirement.

The referral should be graded by clinical staff, if required, and returned to clinic booking staff within 2 days of receipt of the referral. Where partial booking is in operation, the patient must then be sent a 'partial booking' letter within 4 working days of receipt of the referral in the Trust. The patient should be given 7 days in which to respond and arrange their appointment. Otherwise, the patient should be contacted by telephone within 4 working days of receipt of the referral in the Trust, to agree their appointment date and time. All patients should be given at least 7 days notice of their appointment, unless, in discussion, they agree to attend at shorter notice, should there be an appointment available. It should be made clear to the patient that they can change the appointment any time up to 24 hours before the date and time they have been allocated, but that if they fail to attend for the appointment they will be referred back to their GP and a new referral will be required.

5.4 Misdirected Referrals

If a referral has been made to a named consultant and the special interest of the consultant does not match the needs of the patient, the consultant should not see the patient but pass the referral on to an appropriate colleague. A new referral should not be created on the PAS but the consultant changed to the appropriate one. If the referral is for a service not provided by the Trust then the referral letter will be returned to the referrer with a note advising that the patient needs to be referred elsewhere. GP/GDPs should address general referrals to the hospital speciality rather than named individual consultants. The Trust reserves the right to re-allocate referrals appropriately within a specialty to ensure fair and equitable access to patients.

If a patient has booked an appointment using the C&B system but the receiving consultant or service judge that it would be better if the patient was seen in a different clinic/service then the appointment will be re-scheduled into an appropriate clinic with the minimum possible inconvenience to the patient. The patient will be contacted and an alternative appointment will be booked for the patient using the C&B system. Only in exceptional circumstances should the appointment be booked outside of C&B. The referrer will be informed of the change via the C&B work lists.

6.0 OUTPATIENT APPOINTMENTS

6.1 Referrals for Cancer Services

To meet the required NHS standards, all referrals from GP/GDPs that are marked 'urgent and suspicious of malignancy' must be seen by a specialist **within 14 days of the referral being received by the Trust.** All specialties should have procedures in place to ensure that this standard is met.

The 'quality' of suspected cancer referrals needs to be subject to regular audit by clinicians, with appropriate feedback to individual GP/GDPs and as necessary to commissioners. If there is evidence of training needs in general practice in relation to cancer symptoms, or that this route is being abused to secure fast-track appointments for inappropriate patients, appropriate measures will be agreed with the commissioners.

Any concerns related to urgent cancer referrals should be pursued with the Operational Director and Cancer Management Group who will agree a course of action with the GP Lead Clinician for Cancer.

For urgent cancer referrals, where the appointment has not been made through Choose and Book the patient should be contacted as soon as possible, preferably by phone and an appointment date agreed.

If it is necessary to rearrange the appointment then the patient must be contacted by phone and a new date agreed. Appointments must not be rearranged without agreeing the new date with the patient.

6.2 Referrals other than Cancer

All referrals other than cancer and those made using the C&B system will be date stamped with the date the letter is received in the Directorate and entered on to PAS within 24 hours (1 day) of receipt . This must be done before the letter is forwarded for clinical grading. When a clinician determines that an urgent appointment is needed attempts should be made to agree a date with the patient within 14 days of the referral being received. All other referrals should be seen in chronological order.

An appointment date will then be agreed with the patient. The date of all new appointments must be agreed with the patient and recorded as such on the hospital's PAS system. This also applies to appointments rearranged by the hospital. All patients must receive at least 7 days notice of all appointments. If it is necessary to rearrange the appointment then the patient must be contacted by phone and a new date agreed. Appointments must not be rearranged without agreeing the new date with the patient.

6.3 Patients who do not attend an Outpatient Appointment

6.3.1 Cancer Referrals – New Appointment

Patients referred under the cancer two-week wait standard who are given an appointment but who DNA must be contacted as soon as possible and one further urgent appointment agreed. The process outlined below for checking the patient's address should be followed. If the patient fails to attend the second appointment, the GP should be notified as soon as possible. No further appointments will be offered until advised by the GP. If the referral is from another acute provider then the referring clinician will also be informed.

6.3.2 Cancer Referrals – Follow up (subsequent) Appointment

If a patient referred under the cancer two-week wait standard does not attend a follow up outpatient appointment then they should be contacted and given another appointment as soon as possible. If they DNA this second appointment then they should be referred back to their GP and no further appointments offered until advised by the GP. If the referral is from another acute provider then the referring clinician will also be informed.

6.3.3 Referrals for patients under the age of 18 years – New and Follow up Appointment

As part of safeguarding and multi agency working, any child or young person aged 0 to 17 years (up to their 18th birthday) who fails to attend a designated appointment will have this communicated to the named consultant, and if appropriate to the Health Visitor/ School Nurse/Social Worker, by the clinic nurse or allied health professional

When a child or young person does not attend an appointment in an outpatient clinic/department/ diagnostic or therapeutic services, the clinic nurse, allied health professional or designated member of

the team must make a follow up phone call to the parent/carer on the same working day when possible or within 24 hours to establish the reason for non attendance. If the young person is aged 16 years and above the contact should be made with the patient directly (except if the patient has a recognised disability). The detailed requirements are set out in the 'Guidance for the Follow Up of Children and Young People who Fail to Attend an Out Patient Appointment' (Children's DNA policy).

6.3.4 Other Referrals – New Appointment

Patients who do not attend (DNA) a new appointment should, except in exceptional circumstances, be discharged back to the care of their GP. The clinician concerned will write to the patient's GP and formally discharge the care back to the GP.

Any correspondence or conversations from the hospital concerning an outpatient appointment must clearly state that if the patient fails to attend they will be referred back to their GP/GDP.

If a patient does not attend a new appointment then the patient's address that is held on PatientCentre should be verified, either by contacting the patient's GP or by accessing their record on the Summary Care Record. If the address on PatientCentre is not the most up to date one then the patient should be contacted and a further appointment made within 7 days.

If the patient's address is correct then the patient should be informed that they have been discharged and returned to the care of their GP. They should be asked to contact their GP practice if they have any problems or still require the referral. The General Practitioner will be informed that the patient did not attend and will not be offered another appointment. In exceptional circumstances the Consultant may ask for a second outpatient appointment to be arranged without referring back to the GP/GDP.
If a patient does not attend their first outpatient appointment then the 18 week clock is nullified (i.e. cancelled).

6.3.4 Other Referrals - Follow up (subsequent) Appointment

Patients who do not attend (DNA) a follow up (subsequent) appointment should be discharged. The clinician concerned will write to the patient's GP and formally discharge the care back to the GP.

Any correspondence or conversations from the hospital concerning an outpatient appointment must clearly state that if the patient fails to attend they will be referred back to their GP/GDP.

If a patient does not attend a follow up appointment then the patient's address that is held on PatientCentre should be verified, either by contacting the patient's GP or by accessing their record on the Summary Care Record. If the address on PatientCentre is not the most up to date one then the patient should be contacted and a further appointment made within 7 days.

If the patient's address is correct then the patient should be informed that they have been discharged and returned to the care of their GP. They should be asked to contact their GP practice if they have any problems or still require the referral. The General Practitioner will be informed that the patient did not attend and will not be offered another appointment. In exceptional circumstances the Consultant may ask for a second outpatient appointment to be arranged without referring back to the GP/GDP.

When informing the patient's GP/GDP of the failure to attend it is important to point out any risks or vulnerabilities that the patient may be subject to and that the GP/GDP may be unaware of that could be exacerbated by the non-attendance. Where necessary this should extend to a request for intervention by the GP/GDP which may lead to a further referral. This is a clinical responsibility of the Consultant responsible for their care.

6.4 Patients Who Change an Outpatient Appointment

6.4.1 Cancer Referrals

Patients who contact the hospital to change their outpatient appointment should agree an alternative appointment at the time of cancellation. If the patient cancels their appointment on more than 2 occasions then they should be told that if they cancel the appointment again then they will be discharged back to the care of their GP i.e. if they cancel three consecutive appointments. If the referral is from another acute provider then the referring clinician will also be informed.

6.4.2 Referrals for patients under the age of 18 years

If a parent/carer or the young person cancels a clinic appointment this must be documented in the patients notes by the clinic nurse or allied health professional or recorded electronically via Computerised Radiology Information System (CRIS) for diagnostic services. Clerical staff must be made aware to report any cancelled or outstanding appointments on Choose and Book to the clinic nurse or allied health professional. The notes must be shown to, or discussed with the patient's named consultant who will make the decision for reappointment. The detailed requirements are set out in the 'Guidance for the Follow Up of Children and Young People who Fail to Attend an Out Patient Appointment' (Children's DNA policy).

6.4.3 Other Referrals

Patients who contact the hospital to change their outpatient appointment should agree an alternative appointment at the time of cancellation. They should be informed that if they cancel this rearranged appointment they will be referred back to their GP/GDP i.e. if they cancel two consecutive appointments.

Patients who contact the Trust on the day of their appointment will be advised that the Consultant will review the patient's records and make a decision regarding further management. A letter will be sent to the patient and GP/GDP informing them of the decision.

Patients who book their appointments through Choose and Book can cancel and rebook these at any time, other than by contacting the hospital, in any of three ways:-

- Using the internet
- Via their GP
- Via The Appointment Line (TAL)

If they cancel an appointment they do not have to rebook it immediately. If they do not rebook within 7 days then they should be contacted and asked if they still require the appointment. If a patient cannot be contacted then a letter should be sent to him/her and their GP informing that the appointment request will be removed from the system and if he/she still requires an appointment, the GP will need to make another appointment request. If STHFT is not the only choice of provider that the patient has made then the request should not be deleted.

If a patient cancels two appointments that he/she has agreed then he/she should be contacted immediately and informed that if he/she cancels again he/she will be referred back to their GP.

6.5 Clinic Cancellation or Reduction

It is hoped that **all staff holding clinics** (including consultants) would provide as much notice as possible of any planned leave. Clinics will now be booked to 12 weeks and patient inconvenience and

distress are minimised by staff providing as much notice of leave as possible. Consultants must give a minimum of 6 weeks' notice for planned leave and for any other staff holding clinics, the exigencies of the service will be interpreted as a minimum of 6 weeks' notice. There should not be any clinic cancellations or reductions for this reason without at least 6 weeks' notice. All clinic cancellations that are not the result of an authorised planned absence or are within less than 6 weeks must be reported by the Out-patient Manager/Supervisor to the Operational Director who will be expected to investigate the reason in consultation with the Clinical Director. It is important that clinic staff do not cancel or reduce clinics that are less than 6 weeks away without the authorisation of the Operational Director or Clinical Director.

- Where patients have to be cancelled, the case notes should be reviewed by the clinician concerned.

- Patients that have been previously cancelled by the hospital should not be cancelled a second time.

- An alternative appointment must be agreed with the patients who would have attended the cancelled or reduced clinic as soon as possible in line with clinical need.

Short notice cancellations must be an exceptional event as they are inconvenient for patients and could possibly lead to deterioration in their health. Clinical Directors and Operational Directors will be expected to monitor the cancellation reasons and to intervene if avoidable cancellations are indicated. Where cancellations are a regular feature, actions to reduce the frequency will be agreed for each specialty and progressive reductions over time will need to be demonstrated.

Any other changes to patients' appointments must be agreed with the patient and where possible 7 days notice of the alternative given.

The practice of sending the patient a revised appointment without agreeing it with them or without making it clear that they can rearrange this appointment is not acceptable.

6.6 Follow up appointments

Many patients will not require a follow up appointment and will be discharged back to their referrer following their first assessment. When the clinician decides that a follow up appointment is necessary the GP should be informed and the letter should clearly state why the follow up is necessary.

If patients have not yet started treatments (i.e. they are on an open pathway) and a clinician indicates that a patient requires a follow up appointment then this date and time should be arranged and agreed with the patient before he/she leaves the outpatient clinic. This appointment must be such that the patient can still commence their treatment within 18 weeks.

If the patient has already started their treatment (i.e. is on a closed pathway) and the appointment is required within 12 weeks then this should be arranged with the patient before he/she leaves the outpatient clinic so that, the date and time can be agreed with the patient. If the appointment is required after 12 weeks then it can be arranged with the patient before they leave the outpatient clinic or the patient can be placed on a follow up outpatient waiting list with a date by when they should be seen. Patients should then be contacted at least 3 weeks before their due date and an appointment date agreed with them. All patients should be given at least 7 days notice of their appointment, unless in discussion they agree to attend at shorter notice, should an appointment be available.

If it becomes necessary to rearrange any appointments then the patient should be contacted and a new date and time agreed. The practice of sending the patient a revised appointment without

agreeing it with them or without making it clear that they can rearrange this appointment is not acceptable.

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

6.7 Outcome of Outpatient Appointments

The outcome of all outpatient appointments should be recorded on PAS at the time of the clinic and the appropriate action should be taken (e.g. patient added to the inpatient or day case waiting list). The standard clinic outcome form is provided in Appendix 4. Patients should not be recorded as having an outcome of 'Open Appointment' but should be discharged back to their GP/GDP, unless there are exceptional clinical circumstances (e.g. patients in the terminal phase of their illness), which should be fully recorded in the patient record by the treating hospital clinician. There are patients (such as those with spinal injuries) who require annual follow up. These should be placed on outpatient review lists and managed accordingly.

7.0 DIAGNOSTIC TEST

7.1 Waiting times for diagnostic tests

Patients referred for diagnostic tests should have these within 4 weeks of the date of referral. It is the intention that patients should be sent from outpatient clinics directly to diagnostic imaging for some investigations to be carried out on the day of the outpatient appointment.

7.2 Patients who fail to attend for diagnostic tests

7.2.1 Cancer Patients

Cancer patients who DNA a diagnostic appointment should be offered a second appointment. If they DNA this appointment they should be referred back to the lead consultant / MDT coordinator.

7.2.2 Patients under the age of 18 years

When a child or young person does not attend an appointment in a diagnostic service, the clinic nurse, allied health professional or designated member of the team must make a follow up phone call to the parent/carer on the same working day when possible or within 24 hours to establish the reason for non attendance. If the young person is aged 16 years and above the contact should be made with the patient directly (except if the patient has a recognised disability).

7.2.3 Other Patients

For all other patients who DNA an appointment for a diagnostic test a second appointment will be offered and the patient advised that if they do not attend that appointment they will not be offered another one. If the patient does not attend the second appointment, the diagnostics department will inform the referring clinician. The referring clinician will then, depending on the individual patient clinical condition, discharge the patient back to the care of their GP/GDP.

Any correspondence or conversations from the hospital concerning an appointment for a diagnostic test must clearly state that if the patient fails to attend they will be referred back to their GP/GDP.

The process outlined in 6.3.4 for validating the patient's address should be followed.

8.0 INPATIENT WAITING LISTS

8.1 Adding Patients to the Waiting List for Admission

The decision to add a patient to a Waiting List must be made by a Consultant or a Clinician authorised to do so.

Patients who are added to the waiting list including booked admissions **must be,** in the opinion of the clinician, **clinically ready for admission on the day the decision to admit is made**. The clinician must determine that the patient is available and prepared to be admitted at any point within the remaining time to ensure that the 18 week RTT is honoured and that the patient would be well enough to proceed with the operation/procedure at any point within that time frame. The overriding principle should be if there was a bed available tomorrow for the patient, they would be fit, ready, and able to come in.

8.2 Booked Patients

Whenever possible, a date for admission should be agreed with the patient at the time the decision to admit is made. If the patient requires pre-operative assessment then the appointment for the pre-assessment clinic should be made at the time the decision to admit is made. Patients who have an agreed date for admission will have their details added to the active waiting list with a booked TCI (to come in) date and they will be included in all statistical returns and monitoring. The agreed date should be within the 18 weeks RTT unless the patient chooses otherwise. If the patient chooses to delay their treatment then a patient pause should be recorded as described in section 10.2.

8.3 Information about the Patient

When the patient arrives at the clinic the following information should be obtained:

- Confirmation of all the patient's details i.e. patient's address (including postcode), date of birth and registered General Practitioner and ethnic origin (if not already present)
- Patient's telephone numbers (home and work; daytime and mobile telephone) or a number through which they can be contacted Availability to come in at short notice (less than 48 hours) if an unexpected vacancy arises and if the patient has not been given an admission date.
- Any special circumstances requiring longer notice than usual for admission (e.g. caring for elderly relative, transport arrangements etc.)

8.4 Confirmation to the Patient

Every patient should receive a letter confirming that they have been put on a waiting list or have agreed to a booked admission date. This should include details of how the patient can contact the Trust if they will not be able to accept an admission date during a particular time period.

If a Patient Information leaflet is available for the intended procedure this should be given to the patient in clinic or included with the letter (not both).

9.0 STRUCTURE OF WAITING LISTS

To aid both the clinical and administrative management of the waiting list, it is recommended that lists should be sub-divided into a limited number of smaller lists, differentiating between active lists and others.

9.1 Active Waiting Lists

The active waiting list should consist of patients awaiting admission who are available to come in or who have accepted a booked admission date.

Clinicians should decide how they wish to sub-divide their active waiting lists to assist them with the clinical management of patients, but these sub-divisions should be as few as possible.

9.2 Planned Waiting Lists

Planned waiting list patients are those who are waiting to be recalled to hospital for a known further stage in their course of treatment or investigation/intervention. These patients are not waiting for a first treatment date - they have commenced their treatment and there is a plan for the subsequent stages of that treatment.

Examples include:

- "Check" endoscopic procedures
- Age/growth related surgery
- Chemotherapy

Patients should only be on a planned list if there are clinical reasons why the patient cannot have the procedure or treatment until a specified time. Patients on planned waiting lists should not be on open 18 week pathways. There should be no patients on a planned waiting list for social reasons. All patients must have an expected admit date recorded on the PAS.

When a patient on a planned list does not have their consultant-led treatment procedure on or around the planned date they should be transferred to an active list and an RTT clock should start i.e. an RTT clock should start if the due date for the planned consultant-led procedure is reached and the patient has not yet received treatment. Thereafter, 'normal' RTT rules should apply.

10.0 MAINTAINING THE WAITING LIST

Waiting lists should be kept up to date by the responsible person using data received from various sources. They need to ensure that patients are listed promptly and that the list does not contain patients who no longer need their operations at the hospital.

10.1 Computer Systems (PAS data entry)

To ensure consistency and the standardisation of reporting with Commissioners and the NHS Executive, **all waiting lists are to be maintained and managed using the Patient Administration System (PAS). In no circumstances should duplicate manual waiting list records be held.**

Details of listed patients must be entered onto the computer system within 2 working days of the decision to admit. Failure to do this will lead to incorrect assessment of where the patient is on the 18

week RTT and incorrect reporting of the waiting list size. The date of decision to admit must be the same as the clinic attendance date or the date the test results were received.

The waiting list module shares information with other PAS modules and alerts users if a patient is already listed on any other waiting lists and automatically updates any changes to names, addresses or GP information. It alerts the user if patients are in the hospital when they generate any correspondence and prevents letters being produced if a death notification has been made on the system.

10.2 Patient Pauses

The process of suspending a patient on the waiting list is no longer appropriate. The only pauses in the 18 week RTT periods are those requested by the patient – known as patient pauses.

Some patients are not currently available for admission due to social/personal reasons, e.g. holidays, work commitments and may request that their admission be delayed. For the measurement of the 18 week RTT this is classified as a patient pause and the waiting time is adjusted to take this into account.

A patient pause can only be recorded if decision to admit has been made and the patient has declined at least 2 reasonable appointment offers for admission. This is defined as offering the patient two alternative dates with at least three weeks notice. The pause starts on the date of the first reasonable offer and ends on the date from which the patient makes themselves available again for admission.

Clock pauses cannot be applied within the diagnostic phase of the pathway.

All patient pauses must have an end date. Patient pauses should be no longer than 12 weeks in total. If the patient is unable to give a date by which they will be available or request a pause of longer than 12 weeks, then they must be removed from the waiting list and returned to the care of their GP until they become available for treatment.

Once the patient is available for treatment, the GP should refer them back for reconsideration of the intended treatment. A new 18 week clock will start at that point. If clinically appropriate, the patient should re-enter their clinical pathway at the point from which they left it, e.g. straight to pre-op assessment.

There are some patients who will request that their treatment is carried out in a particular time period. In these cases it is acceptable to record a patient pause before any offers are made as long as the pause does not exceed the maximum time allowed of 12 weeks. The pause should start on the date of the first reasonable offer that could have been made by the Trust. The reason for the patient pause must be entered clearly in the case notes and recorded on the PAS waiting list entry. It is recommended that a provisional TCI date be agreed with the patient and recorded on PAS in the comment field. The clock re-start date is the date the patient says they will be available for treatment, even if the Trust cannot offer that exact date to the patient.

10.3 Patients Who Are Unfit

The overriding principle is that a patient should not be on the waiting list for admission unless they are fit, ready, and able to come in. Where a patient is clinically assessed as unfit for receiving treatment because of an existing condition or a previously undiagnosed or untreated condition the patient should be referred back to their General Practitioner. The GP is responsible for that patient's care until such time as the patient is ready for treatment.

Once the patient is fit for treatment, the GP should refer them back for reconsideration of the intended treatment. The patient should re-enter the care pathway at the point from which they left it but a new 18 week clock would begin.

The only exception to this is when the unfit status is short-term (less than 2 weeks), for example, if the patient has a cold. In this case the patient should not be returned to the care of their GP and should still be treated within 18 weeks. The 18 week clock does not stop because the patient is unfit.

A patient who is MRSA+ may continue to be managed by the Trust but the 18 week clock continues until the patient either receives their surgery or is referred back to their GP.

10.3 Active Monitoring

Active monitoring is where it is clinically appropriate to monitor the patient in secondary care without clinical intervention or further diagnostic procedures. Active monitoring can be initiated by either the patient or the Clinician. The start of a period of active monitoring stops the RTT waiting time, a new clock starts from zero weeks wait at the end of the active monitoring period and the Trust has a further 18 weeks to treat the patient

Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made. If such a decision has been made but subsequently it becomes apparent that there is a clinical reason to delay treatment/admission then a waiting time clock would usually continue.

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. For example, stopping a clock to actively monitor a patient knowing full well that some form of diagnostic or clinical intervention would be required in a couple of days' time, is unlikely to make sense to a patient, as they are likely to perceive their wait as being one continuous period from the time of their initial referral. Its use may be more appropriate where a longer period of active monitoring is required before any further action is needed.

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.

Examples of where it is and where it is not appropriate to use active monitoring are given in Appendix 3.

11.0 ARRANGING DATES FOR ADMISSION

11.1 Offers of Admission Dates

All dates for admission will be agreed with the patient. This can be either by agreeing the admission date with the patient at the time that the decision to admit him/her is made (full booking) or by asking the patient to contact us to arrange his/her admission (partial booking).

It is expected that:-

- Patients will be made a reasonable offer – that is an offer of two alternative dates with at least 3 weeks' notice

- Patients will be selected from the waiting list in accordance with the individuals' 18 week pathway.
- All patients will undergo pre-operative assessment, where required, in advance of admission.
- Wherever possible an admission date will be negotiated with the patient at the time the decision to admit is made.

11.2 Hospital Cancellations

Patient admissions should not be cancelled for non-clinical reasons at any stage. If, in unavoidable circumstances, a patient admission is cancelled on the day of admission for a non-clinical reason then they must be admitted within 28 days from the date of cancellation.

It is hoped that **all staff holding theatre sessions** would provide as much notice as possible of any planned leave. Consultants must give a minimum of 6 weeks' notice for planned leave and for any other staff theatre lists, the exigencies of the service will be interpreted as a minimum of 6 weeks' notice. There should not be any theatre cancellations or reductions for this reason without at least 6 weeks' notice. All cancellations of theatre lists that are not the result of an authorised planned absence or are within less than 6 weeks must be reported to the Operational Director who will be expected to investigate the reason in consultation with the Clinical Director. It is important that theatre staff/schedulers do not cancel or reduce lists that are less than 6 weeks away without the authorisation of the Operational Director or Clinical Director.

- Where patients have to be cancelled, the case notes should be reviewed by the clinician concerned.
- Patients that have been previously cancelled by the hospital should not be cancelled a second time.
- An alternative TCI must be agreed with the patients who would have been treated on the cancelled or reduced list as soon as possible in line with clinical need.

Short notice cancellations must be an exceptional event as they are inconvenient for patients and could possibly lead to deterioration in their health. Clinical Directors and Operational Directors will be expected to monitor the cancellation reasons and to intervene if avoidable cancellations are indicated. Where cancellations are a regular feature, actions to reduce the frequency will be agreed for each specialty and progressive reductions over time will need to be demonstrated.

Any other changes to patients' TCIs must be agreed with the patient and where possible 7 days' notice of the alternative given.

The practice of sending the patient a revised TCI without agreeing it with them or without making it clear that they can rearrange this TCI is not acceptable.

11.3 Patient Cancellations

If a patient cancels an offer of admission then an alternative date should be agreed with them at the time the cancellation is made. The cancellation has no effect on the patient's 18 week pathway, as the clock remains ticking, and the patient should still be treated within 18 weeks of their referral. If a patient is unable to agree an alternative date then a 'patient pause' may be applied.
If the patient cancels a second admission date then they should be referred back to their GP.

11.4 Cancer Patients

If a cancer patient cancels and rearranges three admission dates then they should be returned to the care of their GP.

11.5 Patients Who Do Not Attend

If a patient does not attend for their admission then the following steps should be taken:-

- If the treatment is urgent/cancer then the patient should be contacted immediately and a new admission date agreed. A cancer patient will be allowed to DNA two admission dates before they are returned to the care of their GP.
- If the treatment is not urgent then the patient's details, in particular their address should be verified. The consultant should be informed and the patient should then be removed from the waiting list and a letter sent to the patient and their GP/GDP informing them of this.
- When a child or young person does not attend for an admission this must be discussed with the patient's named consultant who will make the decision for reappointment and documented in the patient's notes.

12.0 PRIVATE PATIENTS

The following guidance is taken from 'A Code of Conduct for Private Practice' published by the Department of Health in 2004 and the 'Commissioning Policy: Defining the boundaries between NHS and Private Healthcare' Reference NHSCB/CP/12 published in April 2013.

UK residents and others eligible for NHS treatment that choose to be treated privately are entitled to re-enter NHS services on exactly the same basis of clinical need as any other patient. The maximum waiting time guarantee applies to these patients as they re-enter the NHS service. Where a patient wishes to change from private to NHS status, consultants should ensure that the following principles apply: -

- Any eligible patient seen privately is entitled to subsequently change their status and seek treatment as a NHS patient.
- Any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status.
- Patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients.
- If a patient is admitted to an NHS hospital as a private inpatient, but subsequently decide to change to NHS status before having received treatment, there should be an assessment to determine the patient's priority for NHS care.
- A private outpatient consultation should not lead to earlier treatment within the NHS or earlier access to NHS diagnostic services than their clinical priority requires.

- Patients referred for NHS services following a private consultation or private treatment should be treated in the same way as a referral from any other source.

- The 18 week RTT pathway starts at the point at which the patient was referred into the NHS, not at the point they were seen privately.

- NHS patients opting to have private treatment must be removed from the NHS waiting list, their 18 week RTT clock stopped and the referral and pathway ended.

13.0 PRIORITY TREAMENT FOR WAR VETERANS

When a referral for a war veteran is received, the clinicians involved their care must be made aware of this and their obligation to give the patient priority throughout their treatment. This is in line with the guidance on the treatment of war pensioners and military veterans (HSG(97)31) and 'The Armed Forces Covenant'

The guidance states that 'NHS hospitals should give priority to war pensioners, both as out patients and inpatients, for examination or treatment that relates to the condition or conditions for which they receive a gratuity, unless there is an emergency case or another case that demands clinical priority'. This covers all military veterans who require treatment for service-related conditions and not just those in receipt of a war pension. Every effort must be made by hospital staff involved in these pathways to ensure that any particular requirement for these patients is met, such as afternoon appointments or appointments on specific days.

A veteran is someone who has served in the armed forces for a least one day. When service men and women leave the armed forces, their health care is the responsibility of the NHS.

The guidance is that:-

'Where a person has a health problem as a result of their service to their country, it is right that they should get priority access to NHS treatment, based on clinical need. They should not need first to have applied and become eligible for a war pension'.

It is suggested that veterans are most likely to present with service-related conditions requiring:

- Audiology services – as a result of noise related hearing loss

- Mental Health services – these conditions may present some time after the patient has left the service

- Orthopaedic services – because of injuries during a person's time in the armed forces that begin to present problems some time after discharge from the service.

GPs are asked to identify such patients at referral. Secondary care clinicians are to prioritise these veterans over other patients *of the same level of clinical need*. Veterans should not be given priority over other patients with more urgent clinical needs.

14.0 MANAGEMENT INFORMATION

14.1 Information for Managers

Detailed information on the waiting lists is published every month as part of routine contract monitoring. More up to date information is available on the Information Services web site.

Information on the 18 week RTT pathways for specialties and individual patients is also available on the Information Services web site.

14.2 Information for Clinical Commissioning Groups (CCGs), NHS England and Department of Health

Statistical information is submitted to the Department of Health to meet statutory requirements as published in the Data Manual. The information is currently submitted via the UNIFY web based system. The information is also available to CCGs via this route. A minimum data set of all the patients on the waiting list at the end of each month is sent to CCGs.

DEFINITIONS

For the purposes of this policy, the following terms have the meanings given below:

Active Monitoring/Watchful Waiting	A clinical/patient decision is made that no treatment or further intervention is required for the time being whilst development of the patient's condition is assessed over time. The patient remains under the clinical responsibility of the consultant during this period. The clinician has to have agreed this active monitoring with the patient.
Admitted Pathway	A pathway that ends in a clock stop for admission (day case or in-patient).
Active Waiting List	Patients who are awaiting elective admission for treatment and are currently available to be called for admission.
Booked Patients	Patients awaiting elective admission who have been given an admission date which was arranged and agreed with the patient at the time of the decision to admit. These patients form part of the active waiting list.
Choose & Book	A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital clinic.
Clinical Assessment Service	A service that does not provide treatment, but assesses referrals from GP's and others to advise on the most appropriate next steps for the place or treatment of the patient.
Clinical Commissioning Groups	A group of General Practitioners who have the responsibility of commissioning care for their practice populations.
Clinician/Healthcare Professional	Allied Health Professionals (e.g. physiotherapists, dietitians etc.) Consultant and other hospital-based medical staff General Practitioners General Dental Practitioners Nurse Practitioners
Contracted Activity	The levels of patient treatments to be provided by healthcare providers, such as NHS Trusts, purchased by service commissioners, and set in the form of a legal contract.
Day cases	Patients who require admission to the hospital for treatment and will need a period of recovery, but who are not intended to stay in hospital overnight.
Decision to Admit (DTA)	Where a clinical decision is taken to admit the patient for either day case or inpatient treatment

Diagnostic Procedure	A procedure undertaken to help diagnose the patient's condition and inform the future treatment and management of that condition
Did Not Attend (DNA)	Patients who have been informed of their date of admission or pre-assessment (inpatients/day cases) or appointment date (outpatients) and who without notifying the hospital did not attend for admission/pre-assessment or OP appointment.
Elective care	A procedure or treatment chosen (elected) by the patient or doctor that is of benefit to the patient but not urgent
First Definitive Treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention.
Full Booking	Full booking is where the offer of appointment or admission date is agreed with the patient at the time the offer is made.
Incomplete Pathway	A pathway where patients are waiting to start treatment and where the 18 week clock is still running at the end of any reporting period
Inpatients	Patients who require admission to hospital for treatment and are intended to remain in hospital for at least one night.
Inter-Provider Transfers	A referral from another healthcare provider other than STHFT
Medical Suspension	Patients who have become medically unfit for surgery whilst on the waiting list.
Minimum Data Set	National data sets which define a standard set of individual data items from information generated from patient care records
Monitor	Independent regulator of NHS Foundation Trusts
Non-admitted Pathway	A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment'.
Outpatients	Patients referred for clinical advice or treatment.
Partial Booking	Partial booking is where we ask the patient to contact the hospital to agree an appointment date and time or admission date.
PAS	Patient Administration System – currently known as PatientCentre
Patient Pause	An allowable pause in the patient pathway in certain circumstances, initiated by the patient.

Planned Admissions	Patients who are to be admitted as part of a planned sequence of treatment or investigation. The patient has been given a date, or approximate date at the time a decision to admit was made. These patients do not form part of the active waiting list.
Pre-documentation (Pre-doc)	Entry of patient details onto hospital computer system at the time of receipt of referral in advance of patient appointment offer.
Referral Management Centre	A service that does not provide treatment, but assesses referrals from GP's and others to advise on the most appropriate next steps for the place or treatment of the patient.
Referral to Treatment Time (RTT)	The time from referral to first definitive treatment for a single condition.
Service Commissioner	Organisations responsible for purchasing healthcare services for the local or national populations.
Social/Personal Suspension	Patients who have asked for their admission to be delayed for social/personal reasons
Service Provider	Organisations responsible for providing healthcare services for local or national populations.
TAL (The Appointment Line)	A telephone booking service for patients to book, check, change or cancel their appointments via Choose & Book
TCI (To Come In) Date	Date set for patient's admission to hospital
Therapeutic Procedure	A procedure undertaken to help treat the patient's condition

ACCESS POLICY **APPENDIX 1**

18 WEEK PATIENT PATHWAY

GUIDE TO 18 WEEK CLOCK RULES

Purpose

The 18 week pathway standard is that:

No patient should wait more than 18 weeks for treatment to start following referral to a new care pathway.

Patients on the 18 week pathway have a clock start date once they are referred and a clock stop date once treatment has started or the pathway ends for other reasons.

This local guidance explains these definitions and is in three sections:

1. Clock start
2. Clock stop
3. Exceptions

1. Clock start

1.1 What starts the 18 week clock?

1.1.1 Referrals from primary care (usually GPs/GDPs) to services led by a consultant. For example:

- Outpatient clinics
- Satellite or outreach clinics
- One stop services
- Diagnostic services intended to lead on to treatment within a consultant-led service.

1.1.2 Self-referrals by patients to consultant led services start a clock once the referral has been ratified by a consultant or other healthcare professional. This includes long term patients who refer themselves back into the service.

1.1.3 Referrals from primary care to cancer services.

- The two week, 31 day and 62 day cancer standards continue to apply
- An 18 week clock also starts and overrides these targets if the 18 week point comes first
- If cancer is later excluded, 18 weeks continues to apply to any treatment that is required
- Patients who are treated for cancer which then recurs will start a new 18 week clock.

1.1.4 Referrals from primary care to Obstetrics

- Referrals for healthy pregnant women do not start a clock
- However, a clock starts for pregnant women if there is a separate condition or complication requiring medical or surgical consultant-led attention
- If it is not possible to carry out treatment because the patient is pregnant, the patient should be referred back to primary care until the patient is fit, ready and able to commence treatment for their non-pregnancy related condition

1.1.5 Referrals from other hospital services such as Accident and Emergency to a hospital consultant start a clock unless the patient is being admitted as an emergency or attending fracture clinic.

1.1.6 A decision made by a consultant following emergency admission to start a new elective treatment pathway will start a clock.

1.1.7 Referral by a hospital consultant (within or outside the Trust) to another hospital consultant for an unrelated new condition starts a new pathway while the original pathway remains open. Consultant to consultant referrals within the Trust for unrelated conditions will only be for urgent cases, with routine referrals going back to the GP.

1.1.8 Upon completion of an 18-week referral to treatment period a further new clock only starts in the following circumstances:

- A decision made by the consultant at outpatient follow up to initiate a new treatment plan which is not part of the patient's existing care plan will start a clock. This will apply particularly in the case of the management of long term conditions.

- A decision made by the consultant that a patient on a planned waiting list is clinically ready for a procedure will start a clock when this is a new treatment plan. For example, it is decided that a patient who has had a number of 'check scopes' requires surgical intervention.

- When a patient becomes fit and ready for the second of a consultant-led bilateral procedure.

- When a decision to treat is made following a period of active monitoring.

- If a patient is allocated another appointment following a first appointment DNA that stopped and nullified their earlier clock.

1.1.9 Referrals from primary care to intermediate services such as:

- Referral Management Centres
- Clinical Assessment Services
- Primary Care practitioners with specialist interests start a clock which continues to tick if the patient is then referred on to the Trust.

1.2 What does not start the clock?

1.2.1 Referrals from primary care to services that are not led by a consultant, for example to:

- Nurse led clinics not under the responsibility of a medical or surgical consultant
- Allied healthcare professionals (for example Therapy services)
- Midwives
- Healthcare sciences (for example Hearing services)
- Direct access diagnostic services not intended to lead to treatment
- Primary dental services provided by dental students
- Orthodontic services which are not led by a consultant orthodontist
- Community multi-disciplinary teams.

1.2.2 Referral by a hospital consultant (within or outside the Trust) to another hospital consultant for treatment which is related to the original condition does not start a new clock, and the original clock continues to tick.

1.2.3 Referral following an emergency admission to a follow-up clinic for related care

1.2.4 Self referrals by patient (for example to GUM clinics), which have not been ratified by a consultant or healthcare professional

1.2.5 Routine dialysis appointments are not part of the 18 week pathway.

1.3 Whose referrals start the clock?

1.3.1 From primary care:

- General practitioners
- General dental practitioners
- Optometrists opticians, and Orthoptists
- Walk in Centre
- Specialist nurses or allied health professionals with PCT authorisation to refer (unless the clock has already started within an intermediate service)
- National screening services
- Prison health services.

1.3.2 From hospital services when the patient is not being admitted as an emergency:

- Accident and Emergency (except referrals to fracture clinic)
- Minor Injuries Unit
- Eye casualty
- GUM Clinical staff (not self referrals by patient)

1.3.3 Hospital consultants or other authorised Allied Health Professionals (AHP) for a separate or unrelated condition or for a new treatment plan.

1.3.4 Self referrals, once ratified by a consultant.

1.4 **What defines the clock start date?**

1.4.1 For referral letters received from primary care: the date of receipt of the referral.

1.4.2 For referrals made through Choose and Book: the date on which the appointment request is converted into a booking by the patient. This date continues to apply even if the patient is booked into the wrong clinic initially.

1.4.3 For referrals received from other hospital services or intermediate care services for a new care pathway: the date of receipt of the referral. An inter provider/inter specialty transfer is required for these patients.

1.4.4 For referrals received from intermediate care services, such as the Musculoskeletal Service, the date on which that service received the referral from primary care, where a treatment has not already been given. An inter provider/inter specialty transfer is required for these patients.

1.4.5 For referrals received from consultants (within or outside the Trust) for an unrelated condition: the date of receipt of the referral. An inter provider/inter specialty transfer is required for these patients.

1.4.6 For referrals received from consultants (within or outside the Trust) for treatment for the original condition: the date that the original referral was received from primary care. An inter provider/inter specialty transfer is required for these patients.

1.4.7 For new treatment decisions made by a consultant: the date of the decision.

1.4.8 For patients being seen privately, if the decision is made to transfer to NHS care: the date the Trust accepts the referral to the NHS.

1.4.9 For self referrals the clock starts on the date that the referral is ratified by a clinician

2. Clock Stop

2.1 What stops the 18 week clock?

2.1.1 First definitive treatment (see 2.2 below)

2.1.2 A clinical decision that consultant led NHS treatment is not required, at the date that this decision is communicated to the patient and referrer:

- Decision that treatment is not required or the patient is not ready for treatment, and therefore to discharge the patient to primary care.
- Decision to discharge a patient to primary care for treatment in primary care.
- Decision to discharge a patient to a Referral Management Centre for treatment if the treatment is not to be a consultant led surgical or medical treatment.
- Decision to refer out of the NHS (e.g. for private treatment).

2.1.3 Decision to embark on a period of active monitoring (often known as watchful waiting).

2.1.4 Decision to place a patient on a transplant list.

2.1.5 Patient declines treatment having been offered it.

2.1.6 Patient has treatment as an emergency which was previously intended to be done electively.

2.2 What defines first definitive treatment?

2.2.1 This is the first treatment that is intended to manage a patient's disease, condition, or injury. It may include first line treatment when this is intended to manage a condition and avoid more invasive procedures.

2.2.2 First definitive treatment can include:

- Inpatient or day case treatment: the clock stops on the date of admission
- Outpatient treatment or consultant-led treatment in other settings: the clock stops on the date of attendance
- Diagnostic tests that turn into therapeutic procedures during the investigation: the clock stops on the date of attendance or admission
- The fitting of a medical device: the clock stops on the date of the definitive fitting (or the date of trial fitting with no undue delay in subsequent fitting sessions).
- Prescribing of medication intended to treat the condition

2.3 What defines active monitoring?

2.3.1 If a clinical decision is made that no treatment or further intervention is required at this time but the patient's condition needs to be monitored in secondary care. The clock stops on the date that this decision is made and communicated to the patient. The patient remains under the clinical responsibility of the consultant and it is possible that there will be regular follow up appointments.

2.3.2 When at a future date a decision to treat or otherwise intervene is made, this starts a new 18 week clock on the date that this decision is made and communicated to the patient.

2.4 Planned patients and series of procedures

2.4.1 Patients on planned waiting lists are outside the scope of 18 weeks, but if a patient on a planned list does not have their consultant-led treatment procedure on or around the planned date they should be transferred to an active list and an RTT clock should start i.e. an RTT clock should start if the due date for the planned consultant-led procedure is reached and the patient has not yet received treatment. Thereafter, 'normal' RTT rules should apply.

2.4.2 When a series of procedures is intended from the outset (for example two stage or bilateral procedures) the clock stops at the date of the first definitive procedure. Subsequent stages should be completed without undue delay.

2.4.3 When the decision for subsequent treatment is made at a later date and separately from the first, this starts a new 18 week clock.

2.5 What does not stop the clock?

2.5.1 Any steps taken to manage a patient's condition in advance of a definitive treatment, including pain relief or physiotherapy prior to a surgical intervention.

2.5.2 Referral by a hospital consultant (within or outside the Trust) to another hospital consultant for the same or a related condition.

2.5.4 Inpatient or day case admission for a diagnostic procedure only, unless it results in a therapeutic procedure. For example, if during a colonoscopy that was intended to be diagnostic only a resection of a lesion is carried out.

3.1 Exceptions

3.1.1 What are exceptions?

3.1.2 There will always be patients for whom the 18 week timescale to the start of treatment is clinically inappropriate or against the patient's wishes.

3.1.3 A nationally agreed percentage tolerance has been set for patients whose pathway end date is later than 18 weeks for these reasons. The tolerances are 5% for non-admitted pathways and 10% for admitted pathways.

3.1.4 There are limited circumstances in which the clock can be "paused" as set out in 3.2 below. The reason for an exception or clock pause must be documented, legitimate and auditable, and must be explicitly communicated to the patient and the referrer.

3.2 Clock Pauses

A clock may be paused only where a decision to admit has been made, and the patient has declined at least 2 reasonable appointment offers for admission i.e. two alternative dates with at least 3 weeks' notice. The clock is paused for the duration of the time between the earliest reasonable offer and the date from which the patient becomes available again for admission. If the offer does not meet the criteria of reasonableness then the refusal of the appointment by the patient cannot be viewed as a patient choice and therefore they cannot be suspended and a patient pause cannot be added.

A clock pause cannot be applied to the diagnostic phase of the pathway.

All patient pauses must have an end date. Patient pauses should be no longer than 12 weeks in total. If the patient is unable to give a date by which they will be available or request a pause of longer than 12 weeks, then they must be removed from the waiting list and returned to the care of their GP until they become available for treatment.

Once the patient is available for treatment, the GP should refer them back for reconsideration of the intended treatment. A new 18 week clock will start at that point. If clinically appropriate, the patient should re-enter their clinical pathway at the point from which they left it, e.g. straight to pre-op assessment.

3.3 Clinical Exceptions

Exceptions may occur where treatment within 18 weeks may not prove possible. For example:

- When a series of tests needs to be carried out in sequence
- When a second condition presents that requires treatment before the first
- Where a patient and consultant have agreed that a second opinion is required and despite best efforts this adds a critical delay
- Where there is genuine clinical uncertainty regarding a diagnosis, but active monitoring is inappropriate.

3.4 Do Not Attends (DNA's)

There are limited circumstances in which DNA's nullify the 18 week clock:
Any patient who DNA their **first** appointment after initial referral will have their clock nullified and their referral returned to the referrer

- Patients who cancel their first appointment in advance will not have their clock stopped
- DNA's and cancellations do not stop the clock at any other point on the 18 week pathway.

3.5 Frequently Asked Questions

A document containing the answers to Frequently Asked Questions (FAQ) is available at http://sharepoint.sth.nhs.uk/Dept/StrategyAndOperations/18%20Weeks%20FAQs/Forms/AllItems.aspx

18 WEEK PATIENT PATHWAY

INTER PROVIDER AND INTER SPECIALITY TRANSFERS

1. Definition

1.1 Inter Provider Transfer

This is when a patient is referred from another provider trust e.g. Barnsley Hospital NHS Foundation Trust to Sheffield Teaching Hospitals NHS Foundation Trust for advice and treatment.

1.2 Inter Specialty Transfer

This is when a patient is referred from one specialty at Sheffield Teaching Hospitals NHS Foundation Trust to another specialty at STH for advice and treatment.

2. Information required

The referrer is required to provide as a minimum, in addition to any relevant clinical information the following:-

Pathway Identifier
Pathway Start Date
Current Treatment Status
Pathway End Date – if applicable

3. Provision of the Information

The information is available from the PAS/PFI systems and can be incorporated into the referral letter.

4. Obtaining the Information

If the information is not provided on the referral letter then it is the responsibility of the receiving hospital to contact the referrer to obtain this information as soon as possible. In the meantime the clock start date should be recorded as 8 weeks earlier than the date the referral was received.

ACCESS POLICY **APPENDIX 3**

EXAMPLES OF ACTIVE MONITORING

The following are examples of when active monitoring may and may not be used:-

Case 1

Mr D is seen by the Cardiologist and given a diagnosis of an aortic aneurysm. Mr D and the Consultant discuss the possibility of surgery, but it is agreed that at this stage it is too small for surgery. The patient is therefore put on a period of active monitoring. During this time regular ultrasound tests will be carried out to measure the size of the aneurysm and life style changes (weight, exercise) are addressed to minimise the risk of rupture to the patient (which would then result in emergency surgery). As the risk of death from surgery is higher than the risk of death from a rupture, not all aneurysms result in surgery and this patient may be monitored and then perhaps discharged back to the GP, or if the aneurysm increases in size then surgery will be required.

Case 2

Mrs R is referred to general medicine with undefined respiratory disease. The consultant has no clear plan of treatment and wants to monitor the patient before any intervention. There are two options, to discharge back to the GP for monitoring (clock stop) or to start a period of active monitoring, with the patient having a follow up appointment in 3 months' time, but to contact the hospital before if her condition deteriorates.

Case 3

Mrs B is referred by her GP to an orthopaedic consultant. The consultant undertakes a number of diagnostic tests which indicate that the patient requires surgery. However as the patient also has angina they are referred for a cardiac opinion to assess their fitness for surgery. The cardiac opinion comes back 4 weeks later that the patient is fit for surgery. Surgery takes place three weeks later. In this scenario the use of Active Monitoring may not be appropriate, as the referral for cardiac opinion indicates that clinical interventions or diagnostic procedures may be appropriate at that stage. Therefore, Mrs B's clock should stop when the patient is admitted for surgery. The clock carries on ticking while the cardiac opinion is being obtained.

THIS PAGE CAN ONLY BE EDITED BY STH ACCESS POLICY GROUP

OUTPATIENT CLINIC OUTCOME FORM

Tick as Appropriate: New ☐ / Follow-up ☐ Attended ☐ / DNA ☐

Patient Details:

Surname:	**Clinic Date:**	**Arrival Time:**
First name:	**Clinic Code:**	**Appt Time:**
Hospital ID:	**Consultant:**	**Time Seen:**
NHS Number:		**Time Left:**

If patient DNA'd specify action required: Discharge: ☐ Book another appointment: ☐

For all patients who attend the following sections are to be completed by clinician:

Clinical Outcome

		Please tick only one box	
		S Code	✓
Definitive treatment	Treatment started previously , e.g. prescription, advice, procedure	**90 (f/up only)**	
	Treatment started today, e.g. prescription, advice, procedure	**30**	
	Add to waiting list for inpatient procedure (*further form required*)	**10/20**	
	Add to waiting list for day case procedure (*further form required*)	**10/20**	
	Admit to a ward today	**20**	
Treatment undecided	Further investigation required	**20**	
	Patient wants to think about treatment	**31**	
	Patient already being monitored, monitoring to continue	**91 (f/up only)**	
	Start ongoing monitoring today	**32**	
Definite decision not to treat	Patient declined treatment	**35**	
	Clinical decision not to treat	**34**	
Change in management	Decision to treat after active monitoring	**11**	
	Add to waiting list after active monitoring	**11**	
Refer patient	Internally, for opinion or management.	**20**	
	To another provider for diagnosis only – *tick most appropriate category above*		
	To another provider for ongoing management or treatment	**21**	
	Specify where being referred to:		

Further Instructions

	Please tick one box only ✓
Patient to be discharged - clinician decision	
Patient to be discharged - patient decision	
Follow-up appointment required	
Details of follow-up booking:	

Months:		**Weeks: .....**		**Date:**	
Overbook if necessary?		'Face to face' interpreter required?		Refer to Smoking Cessation Service?	

If an outpatient procedure has been carried out please ensure this is recorded overleaf:

Please ensure you complete the reverse of this form
Please ensure the clinic receptionist receives this form today

DIRECTORATE SPECIFIC REQUIREMENT

To include: Outpatient procedures carried out
Details of any tests required
Any further instructions about ongoing care

APPENDIX 5

INITIAL EQUALITY IMPACT ASSESSMENT PROFORMA FOR POLICY

POLICY: ACCESS POLICY - Managing the 18 Weeks Referral to Treatment Waiting Times

Who has been consulted?

Clinical Management Board
Operational Board
Service Managers
Trust Executive Group
NHS Sheffield

Describe the aims, objectives and purpose of the policy service being assessed:

Who is intended to benefit?

Patients and Staff

Equality Impact Analysis Screening Tool – Written Policy or Guidance

	- Is there a potential or actual negative impact associated with this policy on people or individuals who share a 'protected characteristic'? i.e. does this policy directly or indirectly discriminate? - Can this policy be used to promote equality between people who share a protected characteristic and people who do not	**NOTES** changes/additions/ further information or advice needed
RACE	Neutral impact.	This policy applies equally to all patients, their carer's and staff.
SEX **(I.E. MALE / FEMALE)**	Neutral impact.	This policy applies equally to all patients, their carer's and staff.
GENDER REASSIGNMENT	Neutral impact.	This policy applies equally to all patients, their carer's and staff.
DISABILITY(including consideration of the impact on carers of a disabled person)	Neutral impact.	This policy applies equally to all patients, their carer's and staff.
RELIGION OR BELIEF	Neutral impact.	This policy applies equally to all patients, their carer's and staff.
SEXUAL ORIENTATION	Neutral impact.	This policy applies equally to all patients, their carer's and staff.
AGE	Neutral impact.	This policy applies equally to all patients, their carer's and staff.
PREGNANCY or MATERNITY	Neutral impact	This policy applies equally to all patients, their carer's and staff.

	Does this Written Policy or Guidance impact on the following areas?	NOTES changes/additions/ further information or advice needed
HUMAN RIGHTS i.e. **Fairness** **Respect** **Equality** **Dignity** **Autonomy**	The policy implicitly and explicitly supports all of these principles and promotes equality of access throughout.	
SOCIAL DEPRIVATION / TACKLING HEALTH INEQUALITY	Neutral impact	This policy applies equally to all patients, their carer's and staff.

ACTION

Have you identified any action that is required in addition to any changes made to the policy during policy development? Please note in brief below for reference

ACTION	LEAD	DEADLINE
Review of information available to support the policy	Annette Peck	May 2015
Development of standard operating procedures to support the policy	Operational Directors	June 2015