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SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE SUMMARY
REPORT TO THE BOARD OF DIRECTORS MEETING
HELD ON 20 APRIL 2016

Subject:	Update of Trust Access Policy
Supporting TEG Member:	Kirsten Major, Director of Strategy and Operations
Authors:	Balbir Bhogal, Performance and Information Director Annette Peck, Head of Information
Status[1]	A & D

PURPOSE OF THE REPORT:

To the update the Trust Board on the revised Trust Access Policy.

KEY POINTS:

- The current Trust Access Policy was agreed and issued in May 2015
- The Trust Access Policy is a key document, used by all clinical services, to ensure that the way in which we manage pathways and processes for elective patients is fair and consistent, both internally and with national waiting time standards, including the NHS Constitution.
- National guidance was issued in Autumn last year and proposed a number of changes:
    - From October 2015 the key national measure for Referral to Treatment (RTT) Waiting Times will be the incomplete target. The target remains unchanged at 92% of patients waiting for treatment should not have waited longer than 18 weeks.
    - That a patient pause will no longer be used to adjust the patients waiting time.
    - For patients wishing to delay treatment, a blanket rule should not be applied when discharging patients back to the referrer and that clinical input is required when considering whether to retain the patient on the waiting list or return the patient to the referrer.
- The Trust Access Policy requires an update to accommodate these National changes.
- Procedural guidance relating to the management of waiting times has been removed from the Policy with a view to developing a set of supporting Standard Operating Procedures which provide practical guidelines for local staff to follow.
- Terminology in the policy has been updated to reflect the implementation of new systems such Lorenzo and the E-Referrals Service.
- Consultation has taken place across the Trust and with the CCG to review the proposed updates to the policy.
- Feedback from the consultation has been captured and the policy updated where appropriate

IMPLICATIONS[2]**:**

AIM OF THE STHFT CORPORATE STRATEGY 2012-2017		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	

RECOMMENDATION(S):

The Board of Directors is asked to:

a) Review and note the changes proposed, accepting the Policy for implementations
b) Note the proposal of a shortened version for GPs and patients.

Review of Trust Access Policy

1. Introduction

In October 2015 the Department of Health updated the national rules on the measurement of the RTT waiting times standard. The paper outlines the changes to the policy in response to the national guidance issued and also describes further changes to the policy in light of feedback from key stakeholders. The purpose of this paper is to seek approval for the proposed changes to the Trust Access Policy.

2. Summary of the Key Changes

The changes to the policy fall into two broad categories; the first set of changes relate directly to the change in national guidance. The second category is local changes based on feedback from key stakeholders.

National Guidance;

From October 2015 the key national measure for Referral to Treatment (RTT) Waiting Times will be the incomplete target (i.e. although key indicators of internal performance, the Trust is no longer required to report nationally on performance against the Admitted (90%) and Non-Admitted (95%) completed pathway standards). The incomplete target remains unchanged at 92% of patients waiting for treatment should not have waited longer than 18 weeks.

Also from the 1st October 2015 a patient pause will no longer be used to adjust the patients waiting time.

For patients wishing to delay treatment, a blanket rule should not be applied when discharging them back to the referrer and clinical input is required when considering whether to retain the patient on the waiting list or return the patient to the referrer.

Local Changes;

Procedural guidance relating to the management of waiting times has been removed from the Policy with a view to developing a set of supporting standard operating procedures.

Terminology in the Policy has been updated to reflect the implementation of new systems such Lorenzo and the E-Referrals Service.

Further detail on the measurement of diagnostic waiting times has been added to the Policy to provide clarity.

Appendix 1 sets out the changes made with a reference to the relevant section.

3. Feedback from Consultation

The Trust Access Policy Advisory Group met in January 2016 to review the changes and also, identify areas where the policy required further refinement. Advisory group members circulated the policy changes within their directorates to secure further feedback.

The policy was also shared with CMB members, ODs and the CCG. Feedback from the consultation is described in Appendix 2 accompanied with the associated action taken.

The CCG has requested that a shortened version of the policy is developed for GPs and patients focussing on the areas that affect these two discreet groups. There is a national requirement for the Access Policy to published on the Trust website and be accessible for patients. It is proposed that a shortened version is developed but that it contains a link to the full policy.

Appendix 3 sets out the proposed Policy for approval.

4. Recommendation

TEG is asked to;

c) review and note the changes proposed
d) consider the proposal of a shortened version for GPs and patients.
e) endorse the policy for approval by the Trust Board

Appendix 1 - **Access Policy Review Summary of Changes**

Section	Proposed Change	Reason for change
Title Page	Change title of policy from - Managing the 18 weeks Referral to Treatment Waiting Times to Management of Waiting Times including referral to treatment, cancer and diagnostic waits	To ensure that users are clear of the scope of the policy
External Documentation	Added link to new guidance	To enable users to directly access national guidance
Document objectives	Added in reference to diagnostic waiting times	To ensure that users are clear of the scope of the policy
Monitoring arrangements	Annual to Bi – Annual review	Waiting times national guidance established and regular changes are not expected
Training implications	Changed e-learning packages to a variety of learning packages	A recognition that different types of training material will be required to support the implementation of the policy
1 Introduction	Added in reference to diagnostic waiting times	To ensure that users are clear of the scope of the policy
1 Introduction	Sharing of correspondence between clinicians and patients removed	This will be referenced in the Standard Operating Procedure (SOP) supporting the policy
1 Introduction	Sentence inserted to reference Standard Operating Procedures	To provide users with detailed process information that supports the implementation of the policy
1 Introduction	Sentence removed re: detailed guidance cancer pathways	Users will be guided to the broader set of Standard Operating Procedures
2 Key Principles	Example of agreed pathway – e.g. onward referral for the same condition	Provide clarity for clinicians
3.1 18 Week Referral to Treatment	Standard for incomplete waits identified as the nationally reported standard Non admitted and admitted standard identified as Trust local standards	To reflect the new national guidance where the Incomplete standard is now the only nationally reported measure for 18 Weeks
3.2 Stages of Treatment	Removed	To be incorporated into SOP
3.2 Cancer Waiting Times	Re-numbered as section 3.2	To replace the section that has been removed
4 18 Week Referral to Treatment (RTT)	Reference to Appendix removed	Appendix to be moved to SOP
4 18 Week Referral	Link to FAQ's added	To enable users to directly

to Treatment (RTT)		access national guidance
5 Referrals	Details regarding minimum dataset removed	Users will be guided to the broader set of Standard Operating Procedures
5.1 -5.2	Sections shortened	Users will be guided to the broader set of Standard Operating Procedures
6.3.4 Other referrals	Process for cancelling section removed	Users will be guided to the broader set of Standard Operating Procedures
7.1 Diagnostic waits	Clock start for diagnostic time defined	To provide clarity for users
7.2 Patients who fail to attend for a diagnostic test	Patient cancellation added to heading	To provide clarity for users
7.2.1 Cancer patients	Patient cancellation rules added to section including impact on diagnostic waiting time start	To provide clarity for users
7.2.3 Other patients	Patient cancellation rules added to section including impact on diagnostic waiting time start	To provide clarity for users
8.3 Information about the patient	Section removed	Users will be guided to the broader set of Standard Operating Procedures
10.2 Patient Pause	Clarification that pauses no longer adjust the waiting time but still should be recorded for administrative purposes. To clarify that the pause cannot be limited to 12 weeks and should be reviewed on a case by case basis	To reflect the new national guidance
10.3 Active monitoring	Reference to appendix 3 removed	Users will be guided to the broader set of Standard Operating Procedures
Appendix 1,2,3	Removed	Users will be guided to the broader set of Standard Operating Procedures

Appendix 2 - Trust Access Policy Review – Feedback from Consultation Exercise

Reviewer	Policy Section	Comment	Action taken
Operations Director	Various	Patientcentre reference in policy needs to be updated	Patientcentre reference replaced with Lorenzo
Operations Director	Various	Further guidance is required to support the management of patients with long term conditions that persistently DNA and cancel appointments.	To be addressed through the SOP and training for staff
Private Patients Office	12. Private patients	Statement required to remind users that all private patient activity must be recorded on Lorenzo EPR	Bullet point added
CMB	8.1 Adding patients to an inpatient waiting list	Patients on a cancer pathway may not be fit and ready before added to the list. This should not prevent them from being added to the waiting list.	Paragraph updated to recognise the cancer pathway
CMB	Various	Patients who DNA appointments should not be referred back to the GP if they were not given reasonable notice or had the opportunity to agree their appointment	Sections clarified to ensure that automatic DNA and discharge should not happen
Service Improvement	Various	Choose and Book references need to be updated in the policy	Choose and Book references updated with E-referrals service
CCG	General comment	The Trust should consider producing a short summary of the policy for GPs and Patients.	To be proposed to the Trust Executive Group
CCG	Various	Clarity of the impact of the RTT status for patients that DNA and are re-appointed	Clarified that first DNA will nullify the clock subsequent DNA's have no impact on RTT status if not discharged
CCG	11.2 Hospital cancellations	The policy does not reflect that cancellations should be re-admitted within 28 days if the admission has been cancelled on the day for non-clinical reasons	Policy reflects this in first paragraph for section 11.2

CCG	Various	Access and Waiting Times rules for mental health patients should be cross referenced in the policy more explicitly	To be addressed through the SOP and training for staff
CCG	2.0 Key principles	The CCG are looking audit consultant to consultant referrals and there may a CQUIN	Noted
CCG	2.0 Key principles	CASES not referenced in policy	To be addressed through the SOP and training for staff
CCG	3.2 Stages of treatment	Pathway milestones may not be affordable	Noted
	4.1.1 Start of the 18 week pathway	CASES not referenced in policy	These examples are taken directly from national measurement rules
CCG	4.1.1 Start of the 18 week pathway	Query regarding pathways that commence following internal consultant referrals	This has always been the case if the referrals is for a new treatment
CCG	5.0 Referrals	Policy should consider an advice and guidance section	Section 5.5 added on advice and guidance referrals
CCG	5.0 Referrals	Policy makes no reference to receiving referrals via Fax	This will be referenced in the updated accompanying Standard Operating Procedure (SOP) as much of the detail of this section has been marked to move to the SOP
CCG	Various	Choose and Book references remain in policy	Choose and Book references updated with E-referrals service
CCG	5.3 Grading of referrals	Consistency of consultant grading process taking place in two days	The Trust will consider how this will be audited
CCG	6.2 Referrals for cancer services 6.4 Referrals other than cancer	Ensuring that quality of referrals is appropriate for the referral route. CCG wanting a stronger statement in ensuring that happens	To be addressed through the training and implementation of the policy
CCG	6.3.1 Cancer patients – new appointments	The guidelines for contacting patients who DNA appointments for cancer needs to be more specific	To be addressed through the SOP and training for staff
CCG	6.3.3 Referrals for patients under the age of 18 years – New and Follow up	Need a section that covers the process for vulnerable adults e.g.	To be addressed through the SOP and training for staff

	Appointment	easy read letters, next of kin, mental capacity	
CCG	6.3.4 Other Referrals – New Appointment	DNA letters to GP should be copied to patient	Patients get their own letter
CCG	6.3.4 Other Referrals – New Appointment	CCG asking if DNA patients are advised to contact GP for re-referral	DNA letter is not explicit and will be changed
CCG	6.4.3 Other referrals	Want the cancellation and DNA process to be consistent and not sure that the current statement is robust enough	To be addressed through the SOP and training for staff
CCG	6.5 Clinic Cancellation or Reduction	Want to see explicit rules regarding notice for cancellations of clinics	Statement updated
CCG	6.6 Follow up appointments	The practice of informing the GP that a follow up is required is not embedded practice across the Trust	To be addressed through the training and implementation of the policy
CCG	6.6 Follow up appointments	Definition of vulnerable adult should be specified	Definition added
CCG	7.1 Waiting times for diagnostic tests	Policy should reference the national target in addition to local target	National standard referenced in paragraph 7.1
CCG	8.1 Adding Patients to the Waiting List for Admission	Clarity on fitness before listing for surgery	Statement updated
CCG	8.3 Information about the patient	Capture special needs in addition to special circumstances	To be addressed in the SOP
CCG	8.4 Conformation to the patient	Proposal that patient literacy level should be checked before sending the letter. Also identification of next of kin	To be addressed in the SOP
CCG	9.1 Active waiting lists	Should ensure that the number of sub waiting lists are kept to a minimum and do not compromise the ability to treat patients in chronological order	To be addressed through the SOP and training for staff
CCG	10.3 Patients who are unfit	Clarity required for GPs on who they should notify when patient is fit for surgery. Also, a reminder to GPs not to refer if patients are not fit for treatment	Will be made clearer when unfit patient returned to GP

CCG	11.2 Hospital cancellations	Can't see statement describing the management of multiple cancellations	Second bullet in this section states that patients should not be cancelled for a second time
CCG	11.2 Hospital cancellations	Statement regarding consultant leave needs to be stronger	Statement updated
CCG	11.5 Patient DNA	Need further checks to be added regarding patient cognitive impairments and reasonable adjustments	The SOP will provide detail on the checks that should be implemented when a patient DNA's
CCG	13.0 Priority treatment for War Veterans	Needs to be communicated to General Practice	Noted

Appendix 3 – Proposed Trust Access Policy

ACCESS POLICY

Management of Waiting Times including referral to treatment, cancer and diagnostic waits

Reference Number	Version	Status	Executive Lead(s) Name and Job Title	Author(s) Name and Job Title
216	4.0	Current	Kirsten Major, Director of Strategy & Operations	Annette Peck, Head of Information

Approval Body	Trust Executive Group	**Date Approved**	
Ratified by	Board of Directors	**Date Ratified**	
Date Issued		**Review Date**	
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/uploads/system/uploads/attachment_data/file/464956/RTT_Rules_Suite_October_2015.pdf
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:
3.0	21/04/2015		Annette Peck
4.0	April 2016	National guidance changes reflected and procedural detail removed to be incorporated into a supporting Standard Operating Procedure	Balbir Bhogal/ 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, diagnostic waiting times 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:	**Bi -**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 variety of learning packages 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 2
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, diagnostic waiting times 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.

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.

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.

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.

There are a series of standard operating procedures to support this policy.

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 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 Lorenzo Electronic Patient Record. 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.

Patient information will be checked at every visit to ensure that Lorenzo EPR has the most up to date demographic information.

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
Waiting time for diagnostic tests

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

3.1 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 92% of patients who are still waiting for treatment in any period (incomplete pathways) should have waited less than 18 weeks – Nationally reported standard**

- **A minimum of 90% of admitted patients complete their pathway within 18 weeks – Locally reported standard**

- **A minimum of 95% of non-admitted patients complete their pathway within 18 weeks – Locally reported standard**

3.2 Waiting time for Cancer Treatment

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.

The performance of the Trust against these standards is required to be:-

- **93% of referrals from GP/GDPs that are marked 'urgent suspicious of malignancy' will be seen within 2 weeks**

- **85% of 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**

- **96% of all other patients diagnosed with cancer who require treatment must receive that treatment within 31 days of the decision to treat being made.**

- **94% of 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 of surgery or radiotherapy.**

- **98% of 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 of chemotherapy.**

- **90% of patients with suspected cancer, detected through national screening programmes will wait no more than 62 days from referral to treatment.**

- **85% of patients where cancer is detected during their hospital care will wait no more than 62 days for treatment (Consultant upgrade) from the date that it is decided that cancer is a possible diagnosis.**

3.3 Waiting Times for Diagnostic Tests

The overall diagnostic waiting times performance is made up of a total of 15 different diagnostic tests.

- **The national target is that 99% of patients will have their diagnostic test within 6 weeks of referral. The local standard is 4 weeks.**

All referrals for diagnostic tests must wait no longer than the national standard of 6 weeks with the majority being seen within the local standard of 4 weeks.

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)

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 e-Referral Service (eRS), formerly Choose and Book (C&B). However, in the short term referrals will also be received:-

- Electronically through NHS mail for tertiary referrals (inter provider transfers)
- On paper for referral from GPs (post or fax)
- 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. 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 e-Referral Service (eRS)

A detailed procedure document is available that sets out the processes to be used for eRS referrals and appointments. This includes the procedures for dealing with Appointment Slot Issues (ASI). ASIs arise when the referrer or patient cannot find an available appointment slot on eRS. 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 Lorenzo EPR within 24 hours (1 working day) of receipt.

The referral should be graded by clinical staff, if required, and returned to clinic booking staff within 2 days of receipt of the referral.

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. 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 eRS 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 using the eRS system with the minimum possible inconvenience to the patient. Only in exceptional circumstances should the appointment be booked outside of eRS. The referrer will be informed of the change via the eRS work lists.

5.5 Advice and Guidance

GPs may contact the Trust to seek advice and guidance. This may result in clinical teams advising tests, a formal referral or other advice. A referral for advice and guidance does not start an 18 week pathway. Referrals for advice and guidance must be made via eRS and actioned within 48 hours of receipt of the request.

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 eRS 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 eRS will be date stamped with the date the letter is received in the Directorate and entered on to Lorenzo EPR 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 Lorenzo EPR. 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 Lorenzo EPR should be verified, either by contacting the patient's GP or by accessing their record on the Summary Care Record. If the address on Lorenzo EPR 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.
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 Lorenzo EPR should be verified, either by contacting the patient's GP or by accessing their record on the Summary Care Record. If the address on Lorenzo EPR 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. 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 Radiology Information System (CRIS) for diagnostic services. Clerical staff must be made aware to report any cancelled or outstanding appointments on eRS 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.

6.5 Clinic Cancellation or Reduction

All staff holding clinics (including consultants) should 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 Lorenzo EPR 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 1. 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

The clock start for a patient waiting for a diagnostic test is when the request for the test is made. Patients referred for diagnostic tests should have these within 4 weeks of the date of referral (local standard), where this standard is not achieved the patient must be seen within 6 weeks (National standard).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 cancel or fail to attend for diagnostic tests

7.2.1 Cancer Patients

Cancer patients who cancel or DNA a diagnostic appointment should be offered a second appointment. The clock start for the cancelled or missed appointment is set to zero and the waiting time starts again form the date of the missed/cancelled appointment. The RTT clock start remains unchanged. If they cancel or 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 cancel or DNA an appointment for a diagnostic test a second appointment will be offered and the patient advised that if they cancel or do not attend that appointment they will not be offered another one. The clock start for the cancelled or missed appointment is set to zero and the waiting time starts again form the date of the missed/cancelled appointment. The RTT clock start remains unchanged. 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 (Access Plans)

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. The exception to this statement is patients on a cancer pathway.

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 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 Lorenzo EPR.

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

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

Details of patients' who require inpatient or daycase admission 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.

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 and recorded under 'availability' on Lorenzo EPR.

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 The pause 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.

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. If the patient is unable to give a date by which they will be available or request a pause significantly longer than 12 weeks, then this must be discussed with the consultant and a decision made whether they should 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.

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.

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.

All staff holding theatre sessions should 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.

- All private patient activity must be recorded on Lorenzo EPR

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 (Access Plan)	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.
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
E-referral service (eRS)	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.
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.
Lorenzo EPR	Trust electronic patient record system incorporating administration functions
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
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'.
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 Lorenzo EPR
Patient Pause	An allowable pause in the patient pathway in certain circumstances, initiated by the patient. Please note this no longer adjusts the RTT waiting time and the clock remains ticking

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	Documentation used to seek clinical advice or treatment for a patient.
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

Appendix 1

Outpatient Clinic Outcome Form

APPENDIX 2

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

	- 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