PATIENT ACCESS POLICY & USER MANUAL

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1. EXECUTIVE SUMMARY & POLICY STATEMENT

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

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

- that waiting lists are managed effectively
- a high quality of service to patients is maintained
- optimum use is made of resources at all locations within the Trust.

This document is intended to be used by all staff in the local health economy dealing with waiting list management. It will ensure that patients will be treated in order of clinical priority, and that patients of the same clinical priority will be seen in turn. It will also help provide equity of access within specialties across sites throughout the Trust.

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

The Director of Performance is accountable for ensuring services have the frameworks, policies and processes to support delivery of operational standards relating to the provision of elective care, diagnostic and cancer services. Divisional General Managers, Assistant Divisional Managers, outpatient and inpatient scheduling staff, Head of RTT Access and the RTT Access team have overall responsibility for implementing and ensuring adherence to the policy within their areas.

Where issues arise with any member of staff complying with the policy, the issue will be resolved between that individual’s line manager, the relevant Assistant Divisional Manager and Divisional General Manager and the individual concerned. Any failure to reach agreement will be referred to the Director of Performance. Any failure to reach agreement at that stage will be referred to the Chief Operating Officer.

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

This Patient Access & Waiting Times Policy for West Hertfordshire Hospitals NHS Trust has been developed and reviewed following investigation of best practice together with consultation and good practice throughout the local health economy. This has included partnership working with Clinical Commissioning Groups (CCGs), and the Patient Access Team.

The aim of this document is

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

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

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

3.1 The NHS Constitution for England

From April 2010 patients have had the right to:
- start their consultant led treatment within a maximum of 18 weeks from referral for non-urgent conditions.
- Be seen by a cancer specialist within a maximum of 2 weeks from a GP referral for urgent access where cancer is suspected.

For English Patients (from an individual patient perspective) the current maximum waiting times for elective care are set out in the NHS Constitution and the handbook to the NHS Constitution. This can be found at:


Handbook to the NHS Constitution for England (July 2015)


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

These measures are set out in the current NHS England document: Everyone Counts: Planning for Patients 2014/15 to 2018/19. This can be found at:


3.2 NHS Operational Planning & Guidance 2016/17 – 2018/19

This document describes nine “must do” national priorities, covering the following:

- STPs
- Finance
- Primary Care
- Urgent & Emergency Care
- Referral to treatment times and elective care
- Cancer
- Mental Health
- People with learning disabilities
- Improving quality in organisations

The guidance states that Commissioners and Providers must have plans to demonstrate how they will deliver these priorities.
It also describes the seven NHS England 2020 goals, one of which is to maintain and improve performance against core standards, including the RTT 92% incomplete pathway standard.

4. NATIONAL PERFORMANCE MEASURES

4.1 REFERRAL TO TREATMENT (RTT)

In June 2015 NHS England announced changes to the tracking of RTT waiting times, with a focus on open pathways. Therefore the only national reporting of RTT waiting times will be as follows:

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

The current (October 2015) Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care rules and guidance can be found at


Further information can be obtained from the updated (May 2016) Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care: Frequently Asked Questions, which can be found at


4.2 CANCER WAITING TIMES

The headline performance measures are against a minimum threshold of

- 93% of patients referred by a GP (GMP or GDP) for suspected cancer will be seen within 2 weeks from referral

- 93% of patients referred with breast symptoms (where cancer is not suspected) will be seen within 2 weeks from referral

- 96% of patients will receive first definitive treatment within 31 days of the decision to treat (DTT)

- 94% of patients will receive treatment within 31 days of the DTT where that is a second or subsequent treatment(s), including those diagnosed with a recurrence, where the subsequent treatment is surgery.

- 98% of patients will receive treatment within 31 days of the DTT where that is a second or subsequent treatment(s), including those diagnosed with a recurrence, where the subsequent treatment is drug treatment.
• 94% of patients will receive treatment within 31 days of the DTT where that is a second or subsequent treatment(s), including those diagnosed with a recurrence, where the subsequent treatment is radiotherapy.

• 85% of patients will receive first definitive treatment within 62 days of urgent GP (GMP or GDP) referral for suspected cancer.

• 90% of patients will receive first definitive treatment within 62 days of urgent referral from an NHS Cancer Screening programme (breast, cervical and bowel) for suspected cancer.

• Patients will wait a maximum of 62 days from a consultant upgrade of urgency of a referral to first treatment – currently no operational performance standard.

• Patients will wait a maximum of 31 days from urgent GP referral to first treatment for children’s cancer, testicular cancer and acute leukaemia (monitored within the 62 day standard but no separate operational standard).

The National Cancer Waiting Times Monitoring Dataset Guidance – version 9.0 (October 2015), can be found at


Further detailed information can be obtained from the Delivering Cancer Waiting Times, A Good Practice Guide (updated July 2016), which can be found at


4.3 DIAGNOSTIC WAITING TIMES

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

99% of patients will have a maximum wait of 6 weeks for a diagnostic test (see section 8). National guidance can be found at

https://nhsenglandfilestore.s3.amazonaws.com/stats/DM01-guidance-v-5.32.doc

Details of frequently asked questions can be found at

https://nhsenglandfilestore.s3.amazonaws.com/stats/DM01-FAQs-v-3.0.doc

4.4 NON-CLINICAL ON THE DAY CANCELLATIONS

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

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

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

All staff employed by West Hertfordshire Hospitals NHS Trust will adhere to the Waiting Times and Patient Access Policy.

All stakeholders including, CCG’s, Area Teams, patient representatives, patients and others will have access to this policy.

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

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

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

- **This symbol indicates a CLOCK START / STOP event**

- **This symbol indicates a DATA ENTRY requirement**

5.1 **REFERRAL TO TREATMENT PRINCIPLES**

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

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

5.2 **REASONABLE OFFERS**

A reasonable offer is an offer of a time and date three or more weeks from the time the offer was made. If a patient accepts an offer with less than 3 weeks’ notice, that will be considered a reasonable offer should the patient subsequently cancel.
5.3 RTT CLOCK STARTS

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

The RTT clock start date is the date that the Trust receives the referral. For referrals received through NHS e-Referral, the RTT clock starts on the patient converts their unique booking reference number (UBRN).

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

5.4 RTT CLOCK STOPS FOR TREATMENT

An 18-week clock stops when:

- A patient receives treatment in an outpatient setting; this could be medication, advice, fitting of a brace or appliance, or the initiation of a therapy treatment plan
- The patient is admitted for treatment.

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

A diagnostic procedure that turns in to a therapeutic procedure or the fitting of a medical device also stops the RTT Clock.

CLOCK STOP: First definitive treatment

DATA ENTRY – Use code 30 date of admission/treatment

5.5 RTT CLOCK STOPS FOR NON-TREATMENT

An RTT clock stops when the patient and subsequently their GP are informed that:

It is clinically appropriate to return the patient to primary care for non-consultant-led treatment in primary care.

A clinical decision is made not to treat.

A patient DNA (did not attend) results in the patient being discharged.

A patient declines treatment having been offered it.
A decision is made to start the patient on a period of watchful wait / active monitoring.

CLOCK STOP: DNA (33) / Decision not to treat (34) / Patient declined treatment (35)

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

5.6 ACTIVE MONITORING / WATCHFUL WAITING

In many pathways there will be times when it is clinically appropriate to start a period of active monitoring without further clinical intervention or diagnostic procedure.

The clock stops when this decision is made and communicated to the patient.

CLOCK STOP: Active monitoring / watchful waiting

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

Some clinical pathways require patients to undergo regular monitoring/review diagnostics as part of an agreed programme of care. These events would not of themselves indicate a decision to treat or a new clock start.

It is not appropriate to stop a clock for a period of active monitoring if some form of diagnostic or clinical intervention is required in a couple of days’ time, but it is appropriate if a longer period of active monitoring is required before further action is needed.

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

CLOCK START: Active monitoring end

DATA ENTRY – Use code 11 the date the decision to treat is made
5.7 CLINICALLY INITIATED DELAYS (Patient not fit for treatment)

If a patient is listed for surgery but is identified, or self-reports, as unfit for that procedure, the nature and duration of the clinical issue should be ascertained. If the clinical issue is short term (3 weeks or less) and has no impact on the original clinical decision to undertake the procedure (eg cough, cold), the patient must be offered a new TCI date within their 18 week breach date. The clock will continue running during this time.

If the clinical issue is expected to last for 4 weeks or more the patient must be removed from the waiting list and advised accordingly. This will be a clock stop event.

CLOCK STOP: Active monitoring / watchful waiting

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

The patient should be re-listed and a new clock started when confirmation is received from either the GP or the relevant clinician, that the patient is fit to undertake the procedure. The treating consultant must review the case and indicate whether the patient needs to be reviewed in outpatients or whether they can be added directly to the inpatient waiting list.

CLOCK START: Active monitoring end

DATA ENTRY – Use code 11 the date the patient is added to the waiting list or the date of the new referral if the patient requires outpatient review first

5.8 NEW CLOCK STARTS

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

CLOCK START: First activity in RTT period

DATA ENTRY – Use code 10 the date the decision is made and communicated to the patient and GP
This will include all patients whose pathway has been stopped previously but who are then added to an elective waiting list for surgery or other therapeutic intervention.
6. OUTPATIENT WAITING LISTS

6.1 REFERRAL LETTERS

All routine and urgent referral letters should be sent to the outpatient booking office. Referrals are received by the Trust in either paper form or electronically in the form of an NHS e-referral. Both fall into two categories:

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

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

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

6.2 MANAGEMENT OF REFERRALS

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

6.2.1 Paper Referrals

All paper referrals must be date stamped upon receipt at point of entry to the Trust.

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

![CLOCK START](image)

**CLOCK START**

date referral received by the Trust

![DATA ENTRY](image)

**DATA ENTRY**

Referral details entered on PAS

Referrals will be sent to Clinical teams for prioritisation. Prioritisation should be recorded as “Cancer” (where a 2ww pro forma has not been used), ‘Urgent’ or ‘Routine’.
Patients should be given appointments within the agreed maximum timeframe for each specialty (agreed by clinical specialties and at Executive Level).

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

### 6.2.2 NHS e-Referrals

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

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

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

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

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

If there are no slots available for the selected service, the patient will appear on the Appointment Slot Issue (ASI) work list. Patients on this list must be contacted within 14 days and offered an appointment as soon as one becomes available. If they cannot accept the appointment offered they will stay on the list until another is available.

If the patient cannot accept the second appointment offered the patient should be advised that the relevant clinician will review the referral and confirm whether a further appointment should be offered or if the patient should be discharged back to their GP.

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

**CLOCK STOP**

the pathway is nullified on the date the patient advises the referral is no longer required
6.3 CANCER 2 WEEK WAIT REFERRALS (INC BREAST SYMPTOMATIC)

GPs and GDPs must use the Trust’s 2 week wait (2WW) pro forma which can be found at:

http://nww.westhertshospitals.nhs.uk/referrals/cancer_two_week_wait_referrals.asp

Referrers will ensure that patients are given the information sheet attached to all 2WW referral pro forma that explains the urgency of the referral.

Referrals must be faxed by the GP/GDP to the Trust (within 24 hours of the patient being seen) to Central Booking Office at St Albans City Hospital (fax: 01727 897492). The Central Booking Office staff will liaise with the Consultant to ensure that all patients will be offered a date within 14 days.

GPs who send referrals under this protocol will receive a faxed back confirmation of receipt of the referral.

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

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

Patients should not be referred back to their GP because they are unable to accept an appointment within 2 weeks, ie once a referral has been received it should not be returned due to patient unavailability.

If difficulty in meeting the booking guidelines is encountered, this must be escalated through the relevant Assistant Divisional Manager and Divisional Manager for action and resolution. The Cancer Unit Manager must also be kept informed. This should remain as it is down to the division to advise on capacity in these circumstances

Two week wait referrals can only be downgraded by the GP - if a consultant thinks the 2 week wait referral is inappropriate, it should be discussed with the GP and the GP asked to withdraw the two week wait referral status. GPs should not be asked to downgrade a patient (or withdraw the referral) simply because they are unavailable to accept an appointment within two weeks.
6.3.1 2 week wait first appointment DNAs

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

**DATA ENTRY**

Log the DNA on PAS and re-book another appointment – log this on PAS

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

If a patient DNAs their first outpatient appointment for the second time, the responsible clinician will review the patient notes at end of clinic with a view to discharging the patient providing that:

- Discharging the patient is not contrary to their best clinical interest.

- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected. If the decision is made not to rebook, the patient will be removed from the outpatient waiting list and an automated PAS letter will be sent to the GP and the patient notifying them of this removal. The patient will be discharged from PAS, and cancelled on NHS e-Referral if appropriate.

6.3.2 2 week wait first appointment cancellations

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

**DATA ENTRY**

Log the cancellation and book another appointment – log this on PAS

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

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

If there is evidence of training needs in general practice in relation to Cancer referrals, or that this route is being misused to secure fast-track appointments, appropriate action will be agreed with the CCG.
6.4 RAPID ACCESS CHEST PAIN CLINIC (RACPC) REFERRALS

To meet NHS standards, RACPC referrals must be seen by a specialist within 14 days of the Trust receiving the referral. To ensure that this is achieved:

Referrals from GPs will be by referral protocol only.

GPs will ensure that appropriate information regarding the RACPC referral is provided to the patient and the importance of being seen quickly communicated to the patient as well.

Referrals must be sent by the GP (within 24 hours of the patient being seen) to the RACPC who will liaise with the Consultant to ensure that all patients are offered a date within 14 days.

NHS e-Referral referrals for RACPC will be booked into an appointment slot within 14 days by the GP or patient. In the unlikely event that no slots are available on NHS e-Referral, the GP must send the referral to the appropriate receiving point, who will liaise with the Consultant to ensure that all patients will be offered a date within 14 days.

If a patient cannot make themselves available within 2 weeks for an appointment, the GP should delay making the referral until the patient is available to be seen within 2 weeks.

DATA ENTRY
Log the appointment on PAS, record the cancellation.
Offer an appointment the patient can attend and record on PAS

If the patient cannot accept the second appointment offered the patient should be advised that the relevant clinician will review the referral and advise whether a further appointment should be offered or if the patient should be discharged back to their GP.

The management of patient DNAs will be in line with section 6.15.

Where difficulty in meeting the booking guidelines is encountered, this must be escalated to the relevant Assistant Divisional Manager and Divisional Manager for action and resolution.

The quality of RACPC referrals will be the subject of regular audit, (with appropriate feedback to individual GPs and the CCG). If there is evidence of training needs in general practice in relation to RACPC referrals, or that this route is being misused to secure fast-track appointments for inappropriate patients, appropriate action will be agreed with the CCG. Guidance is contained in a separate policy.
6.5 TRANSIENT ISCHAEMIC ATTACK (TIA) CLINIC REFERRALS

To meet NHS standards all high risk TIA patients should be seen and treated as a medical emergency within 24 hours of the first contact with a healthcare professional.

All low risk TIA patients should be seen and treated within 7 days of the first contact with a healthcare professional.

Referrals from GPs will be by referral protocol only and must be accompanied by a completed ABCD2 score pro-forma.

Patient scoring 4 or above on the ABCD2 should be referred to the high risk clinic within 24 hours of the first contact.

GPs must contact the TIA referral hotline and an urgent appropriate appointment will be agreed for the patient whilst still in consultation with the GP.

Patients who score below 4 on the ABCD2 should be referred as low risk and will be given an appointment in the TIA clinic within 7 calendar days of contact.

GPs must fax referrals to the Stroke Office and the patient will be contacted to agree an appropriate appointment date and time.

The quality of TIA referrals will be the subject of regular audit, (with appropriate feedback to individual GPs and the CCG). If there is evidence of training needs in general practice in relation to TIA referrals, or evidence that this route is being misused to secure fast-track appointments for inappropriate patients, action will be agreed with the CCG.

6.6 REFERRALS FOR LOW PRIORITY TREATMENTS

Requests for admission for some conditions which are classed as low priority treatments are not generally funded by commissioners. These patients must not be added to the inpatient waiting list unless explicit approval has been received on a named patient basis from the commissioning CCG. Once approval has been obtained, the request for admission can be processed in the normal way. The RTT clock will continue while approval for treatment is sought.

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

Separate guidance should be referred to when managing the treatment of overseas visitors, as access to the Health Service may be limited. Department of Heath guidance on overseas visitors may be found at: www.dh.gov/overseasvisitors

6.8 MILITARY VETERANS

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

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

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

6.9 CONSULTANT TO CONSULTANT REFERRALS

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

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

- Consultant to consultant outpatient referral or Accident & Emergency to consultant outpatient referral is considered of benefit to the patient when a different specialist consultant opinion is needed to advance the management of the presenting or associated condition
- When the referral is for investigation, management or treatment of cancer, or a suspected cancer
- Symptoms or signs suggest a life threatening or urgent condition
- Surgical assessment of an established medical condition with a view to surgical treatment
- Medical assessment of an established surgical condition with a view to medical management
- Anaesthetic risk assessment
- A&E referrals to fracture clinic
• Referrals that are part of the continuation of investigation/treatment of the condition for which the patient was referred. These will continue their existing pathway.

• Suspected cancer referral. This will be vetted and dated by the receiving consultant and upgraded if deemed necessary. Once upgraded the patient will be treated within 62 days of the date the referral was received by consultant.

• Management of pain where surgical intervention is not yet appropriate.

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

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

6.10 INAPPROPRIATE REFERRALS

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

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

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

6.11 REFERRALS FROM AAU & WARDS

Patients who require an outpatient appointment with the Consultant Team that was responsible for their care during their inpatient stay will be booked as “follow-up appointments”.

These patients do not need to be placed on an 18 week RTT pathway. Appointments should be agreed with the patient and booked by the ward before the patient is discharged.

Patients who require an outpatient appointment with a different specialty or new Consultant Team following an inpatient admission will be booked as “New appointments”. These patients fall under the 18 week RTT requirements, and a RTT clock will start at this point.
Waiting times standards as detailed in section 2.1 and 4.3.2 will apply to these patients. Appointments should be agreed with the patient and booked by the ward before the patient is discharged.

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

The guidance on consultant to consultant referrals (section 5.5.6) must be applied when booking appointments for this group of patients.

6.12 FURTHER APPOINTMENT REQUESTS AFTER DISCHARGE

Patients requesting an appointment with the same clinical team after being discharged must seek a new referral from their GP.

6.13 REFERRALS FROM CLINICAL ASSESSMENT & TRIAGE SERVICES (CATS)

These services provide intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care. At the Trust there are CATS for dermatology and musculoskeletal conditions. A referral to CATS starts an 18 week RTT clock.

If the patient is referred on to the Trust having not received any treatment or non-treatment clock stop in the service the Trust inherits the 18 week RTT wait for the patient.
Minimum Data Set forms must be used to transfer 18 week information about the patient to the Trust. The Trust will ensure these are in place to manage the patient’s care.

6.14 PATIENT CONTACT

6.14.1 Booking Outpatient Appointments

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

Wherever possible, patients are to be contacted by telephone to agree their first outpatient appointment.

Three attempts are to be made to contact the patient over a 24 hour period (one attempt to be after 5.00pm). If this is unsuccessful the patient will then be sent a letter requesting that they make contact with the relevant booking team. This is known as partial booking. Where this is not in place, the patient will be sent an appointment.

If the patient does not make contact with the relevant team within two weeks (as per the letter), the patient should be removed from the outpatient waiting list and a standard PAS letter sent to the patient and GP confirming the patient’s removal. The RTT clock will be nullified.

A written appointment to a patient must be deemed reasonable.

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

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

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

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

6.14.2 Patients requesting time to consider treatment options (thinking time)

Patients may wish to spend time thinking about the recommended treatment options before confirming they are willing and able to proceed. It would not be appropriate to stop the 18 week RTT clock where this amounts to only a few days however, it may be appropriate to stop the 18 week RTT clock (patient active monitoring) where the patient requests a delay of two or more weeks.
before coming to a decision, provided the clinician responsible for the patient’s care confirms that:

- that a delay it is not contrary to their best clinical interest.

- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected.

CLOCK STOP: Patient active monitoring

DATA ENTRY – Use code 31
date patient requested thinking time (and there is a delay of 2 or more weeks before coming to a decision)

If the patient subsequently decides to go ahead with the recommended treatment he/she can be added to the waiting list and a new clock started when the patient confirms they willing to proceed. They can be added directly to the waiting list again within a 12-week period. Any delay over 12 weeks will require a new referral from the GP. The consultant in charge of the patient’s care may decide to add the patient straight on to the waiting list, or may offer the patient an outpatient appointment.

CLOCK START: Active monitoring end

DATA ENTRY – Use code 11
date patient confirms they are willing to proceed or date new referral received

6.15 DID NOT ATTEND (DNA)

6.15.1 New appointment DNA

For patients who DNA their first outpatient appointment for the first time, the responsible clinician and/or outpatient nurse will review the patient notes at end of clinic with a view to discharging the patient providing that:

- Discharging the patient is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected.

If the decision is made not to rebook, the patient will be removed from the outpatient waiting list and an automated PAS letter will be sent to the GP and the patient notifying them of this removal. The patient will be discharged from PAS, and cancelled on NHS e-Referral if appropriate. The 18 week RTT clock is nullified.

Refer to section 6.3.1 for Cancer referral DNAs.
6.15.2 Follow up appointment DNA

Patients who DNA their follow up outpatient appointment will be discharged back to their GP providing that:

- Discharging the patient is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected.

This is to be confirmed by the consultant at the end of the clinic and a letter sent to this effect to the patient and their GP. Where the patient is on an active/open pathway a clock stop needs to be recorded on PAS at time of the patient DNA.

See section 6.3.2 for guidance on the management of cancer pathway patients who cancel their appointment.

CLOCK STOP: DNA

DATA ENTRY – Use code 33
date of the DNA’s appointment and notification to GP

6.16 PATIENT CANCELLATIONS (CNA – Could not attend)

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

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

CLOCK STOP: Patient not treated but discharged

DATA ENTRY – Use code 35
date of the second consecutive patient cancellation

See section 6.3.2 for guidance on the management of cancer pathway patients who cancel their appointment.
6.17 HOSPITAL CANCELLATIONS

Patients who are cancelled by the hospital must be offered an alternative date which is within the following two weeks and/or within their 18 week RTT breach date.

The only acceptable reason for clinic cancellations is absence of medical staff as a result of planned annual / study leave, audit activities, on call commitments or unplanned sickness absence. A minimum of six weeks’ notice of planned leave should be given. Clinics should not be cancelled for any other reason unless there are exceptional circumstances and the cancellation has been authorised by the Director of Performance or the Chief Operating Officer or a nominated deputy.

6.17.1 Cancellations with six weeks’ or more notice

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

6.17.2 Cancellations with less than six weeks’ notice

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

No clinic should be cancelled without the authorisation of the Director of Performance or the Chief Operating Officer or a nominated deputy.

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

7.1 PRINCIPLES OF WAITING LIST MANAGEMENT

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

Patients should not be added to the waiting list unless they are fit, ie if a bed was available the following day the patient is medically fit to proceed.

Patients who are considered to be insufficiently fit/well enough to proceed must be discharged back to their GP with a full explanation and clear details of the criteria that need to be met in order for the patient to be reconsidered for treatment at a later date.

The consultant may choose to continue to review them in outpatient department but take them off the waiting list for surgery. This includes patients with a high BMI, smokers, drug users and heavy drinkers. A decision not to treat or active monitoring clock stop should be applied following the clinician’s decision to the patient’s 18 week RTT pathway.

CLOCK STOP: Decision not to treat

DATA ENTRY – Use code 34
date of decision not to treat

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

7.2 THE ACTIVE WAITING LIST (PTL)

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

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

- Clinical priority should be defined as urgent or routine only.
To aid both the clinical and administrative management of the waiting list, elective waiting lists and planned lists will be listed separately but must be managed in line with this policy guidance and the intended management.

7.2.1 Patients requiring Commissioner funding approval

When funding prior approval for treatment is required this must be obtained before adding a patient to the active waiting list. The 18 week RTT clock will continue to tick whilst approval is sort. The process for obtaining approval to treat must be followed as outlined in Appendix 3. This applies to NHS Hertfordshire patients only, but may be extended to other Commissioners following negotiation.

7.2.2 Adding Patients to Active Inpatient / Day case Waiting Lists

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

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

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

7.3 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

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

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

If different surgeons will be working together to perform more than one procedure the patient should be added to the waiting list of the Consultant Surgeon for the priority procedure with additional procedures noted.
If a patient requires more than one procedure performed on separate occasions by different (or the same) surgeon(s):

- The patient should be added to the active waiting list for the primary (1st) procedure.
- The patient should not be added to the waiting list for any subsequent procedures, as they are not “fit or willing” to proceed with any additional treatment at this stage.
- When the first procedure is complete and the patient is fit, willing and able to undergo the second procedure the patient should be added to the waiting list.

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

**CLOCK START:** First activity in an RTT period

**DATA ENTRY – Use code 10**
date patient added to waiting list for second procedure

### 7.4 THE PLANNED WAITING LIST

Patients should only be added to a planned list where clinically they need to wait for a period of time. This includes planned diagnostic tests (e.g. check cystoscopy) or treatments or a series of procedures carried out as part of a treatment plan - which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.

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

When patients on planned lists are clinically ready for their care to commence and reach the date for their planned appointment, they should either receive that appointment or be transferred to an active waiting list and an RTT waiting time clock should start (and be reported in the relevant waiting time return). The key principle is that where patients’ treatment can be started immediately, then they should start treatment or be added to an active waiting list.
7.4.1 Endoscopy pathways

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

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

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

7.5 MAINTAINING THE WAITING LIST

Waiting Lists should be kept up to date by waiting list co-ordinators or identified staff managing individual lists using the 18 week RTT Patient Tracking List (PTL). They need to ensure that patients are listed promptly and that the list does not contain patients who no longer need their procedures. Telephone validation of the PTL should be undertaken on a regular basis, e.g., bi-monthly, to ensure the list is up to date and accurate, ensuring good data quality standards are maintained.

All waiting lists are to be maintained in the PAS system. Manual card based systems remain only as a backup to the main database. A full audit trail must be kept updated on the system.

Details of listed patients must be entered onto the computer system within 24 hours of the decision to admit being made. Patients will be added to the waiting list with the date the decision to admit was made. The waiting list episode needs to be attached to the correct 18 week RTT pathway.

7.6 PATIENT CONTACT

7.6.1 Booking Admissions

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

Wherever possible patients must be contacted by telephone to agree their admission date.
Three attempts are to be made to contact the patient over a 24 hour period. If this is unsuccessful the patient will then be sent a letter requesting that they make contact with the relevant booking team.

If the patient does not make contact with the relevant team within 10 days (of the date of the letter), the patient should be removed from the inpatient waiting list and a standard PAS letter sent to the patient and GP confirming the patient’s removal providing the following can be confirmed:

- that this is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected.

**CLOCK STOP: Patient declined treatment**

**DATA ENTRY – Use code 35**

date patient removed from waiting list and notification to GP

### 7.6.2 Reasonable offers

A reasonable offer is “an offer of a time and date 3 or more weeks from the time that the offer is made”. If a patient accepts an offer with less than 3 weeks’ notice, that will be considered a reasonable offer should the patient subsequently cancel. The Admissions Office will ensure that all appointments offered are recorded on Clinicom.

**DATA ENTRY**

Log the offers made to the patient

Patients who decline one reasonable offer must be offered at least one further reasonable offer. Patients should be warned that after declining the first reasonable offer only one other date will be offered.

If a second reasonable offer is declined and the patient elects to defer surgery advice must be sought from the clinical team to ascertain

- that the delay is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected.

Providing the above has been confirmed, the patient may be offered a further date.
If the clinician feels the delay is inappropriate and not in the best clinical interests of the patient, a follow up clinical review must be arranged. If the patient does not accept the advice of the clinician, the patient must be discharged back to the care of their GP provided:

- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected.

CLOCK STOP: Patient declined treatment

DATA ENTRY – Use code 35
date patient removed from waiting list and notification to GP

A written appointment to a patient must be deemed reasonable.

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

Should a patient accept an admission date with less than three weeks’ notice, this will become a reasonable offer.

7.7 DID NOT ATTEND (DNA)

Where a patient does not attend a reasonably offered admission date they should be removed from the waiting list and returned to the care of their GP provided the following can be confirmed:

- that it is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected.

CLOCK STOP: DNA

DATA ENTRY – Use code 33
date patient removed from waiting list and notification to GP

Clinical teams must be notified of any patients on a cancer pathway who do not attend. The clinical team must contact the patient and/or the patient’s GP to ascertain the reason for non-attendance. The clinical team will liaise with
the scheduler when rebook ing the admission to ensure the most clinically appropriate date is offered to the patient.

7.8 PATIENT CANCELLATIONS (CNA – Could not attend)

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

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

DATA ENTRY – Use code 35
date second admission date cancelled by patient

CLOCK START: First activity in RTT period

DATA ENTRY – Use code 10
date alternative offer made and accepted by patient

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

7.9 PATIENTS WHO BECOME MEDICALLY UNFIT PRIOR TO ADMISSION

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

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

If the illness/condition is expected to last for 4 weeks or more the patient should be removed from the waiting list and advised accordingly and where appropriate, discharged back to primary care or referred to another specialty
for any further management/treatment that is required before admission can be rearranged. This will be a clock stop event.

**CLOCK STOP: Decision not to treat**

**DATA ENTRY – Use code 34**
date the patient is identified as not fit to proceed with surgery

The patient will be re-listed and a new clock started when confirmation is received from either the GP or the relevant clinician, that the patient is fit to undertake the procedure, the treating consultant must review the case and indicate whether the patient needs to be reviewed in outpatients or whether they can be added directly to the inpatient waiting list.

**CLOCK START: First activity in an RTT period**

**DATA ENTRY – Use code 10**
date patient is identified as fit to proceed with surgery or date that new referral is received

### 7.10 ON THE DAY CANCELLATION

#### 7.10.1 Non-clinical reasons (hospital initiated)

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

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

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

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

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

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

If the reason for cancellation is expected to last for 4 weeks or more, or there is a clinical reason to defer surgery for 4 weeks or more, the patient must be removed from the waiting list and advised accordingly. This will be a clock stop event.

**CLOCK STOP: Decision not to treat**

**DATA ENTRY – Use code 34**

*date the patient is identified as not fit to proceed with surgery*

A treatment plan must be agreed for the patient, or the patient discharged back to the care of their GP. The patient will be re-listed and a new clock started when confirmation is received that the patient is fit to undertake the procedure. They can be added directly to the waiting list again within a 12-week period. Any delay over 12 weeks will require a new referral from the GP.

**CLOCK START: First activity in an RTT period**

**DATA ENTRY – Use code 10**

*date patient is identified as fit to proceed with surgery or date that new referral is received*

7.11 CANCELLATION OF SESSION BY HOSPITAL

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

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

7.11.1 Session Cancellation with six weeks’ or more notice

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

7.11.2 Session Cancellation with less than six weeks’ notice

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

No session should be cancelled without the authorisation of the Director of Performance or Chief Operating Officer or a nominated deputy.

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

7.12 WAITING LIST VALIDATION & REVIEW

All waiting lists must be validated at least once a month by the waiting list co-ordinators. This process will ensure that lists are always as up-to-date as possible, and that the most efficient use is made of the Trust’s inpatient and day case resources. This process ensures that any changes to the patient’s circumstances and condition are captured and action taken as necessary.

Telephone validation of the PTL should be undertaken on a regular basis, eg bi-monthly, to ensure the list is up to date and accurate, ensuring good data quality standards are maintained.
8. PRE-OPERATIVE ASSESSMENT (POA)

Full guidance on the pathway to Pre-Operative Assessment process can be found within the “Policy for Patient Preparation of adult patients due to undergo Elective Surgery”.

8.1 ADULT POA

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

8.1.2 POA Appointment DNA

Patients who DNA a first or any subsequent pre-operative assessment appointment will be discharged if a further review appointment is assessed as not clinically important providing the following can be confirmed:

- that discharge is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected.

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

CLOCK STOP: DNA

DATA ENTRY – Use code 33
date patient removed from waiting list and notification to GP

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

8.1.3 Patient assessed as fit to proceed

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

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

If the clinical issue is expected to last for 4 weeks or more the patient must be removed from the waiting list. This will be a clock stop event. See section 6.9 for further information.

CLOCK STOP: Decision not to treat

DATA ENTRY – Use code 34
date the patient is identified as not fit to proceed with surgery

The patient will be re-listed and a new clock started when confirmation is received that the patient is fit to undertake the procedure. They can be added directly to the waiting list again within a 12-week period. Any delay over 12 weeks will require a new referral from the GP.

CLOCK START: First activity in an RTT period

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

Over 12 weeks, the patient will need a new referral to out-patients. They will only be added to the waiting list again when they are fit, willing and available for treatment.

Any patient on a cancer pathway who is considered not fit for treatment must be referred back to the consultant in charge of their care urgently for further consideration.

8.2 PAEDIATRIC POA

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

Paediatric patients who DNA (are not brought to the appointment) a first or any subsequent pre-operative assessment appointment will be discharged if a further review appointment is assessed as not clinically important providing the following can be confirmed:

- that discharge is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Child Protection Policy) are protected.

Should there be any Safeguarding concerns about the child who has missed an appointment; Safeguarding Practice Guidelines will be followed. With children who do not attend (were not brought), the GP will be asked to consider why the child did not attend and to include safeguarding concerns within this. For children who already have safeguarding issues, the failure to attend will be highlighted to the appropriate professionals.

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

CLOCK STOP: DNA

DATA ENTRY – Use code 33 date of DNAd appointment and notification to GP

8.2.3 Patient assessed as fit to proceed

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

8.2.4 Patients assessed as not fit to proceed

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

If the clinical issue is expected to last for 4 weeks or more the patient must be removed from the waiting list. This will be a clock stop event. See section 6.9
for further information.

CLOCK STOP: Decision not to treat

DATA ENTRY – Use code 34
date the patient is identified as not fit to proceed with surgery

The patient will be re-listed and a new clock started when confirmation is received that the patient is fit to undertake the procedure. They can be added directly to the waiting list again within a 12-week period. Any delay over 12 weeks will require a new referral from the GP.

CLOCK START: First activity in an RTT period

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

Over 12 weeks, the patient will need a new referral to out-patients. They will only be added to the waiting list again when they are fit, willing and available for treatment.
9. DIAGNOSTICS AND IMAGING APPOINTMENTS

9.1 DIAGNOSTIC WAITING LISTS

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

9.1.1 Active Waiting List

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

9.1.2 Planned Waiting List

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

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

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

9.1.3 Therapeutic Procedures

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

- Radiologically guided steroid injections
- Angioplasty

9.1.4 Diagnostic Referrals/Requests

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

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

**DATA ENTRY**
Record the request on CRIS as received with the status as “awaiting clinical information”

A dedicated form should be used for MRI – including the patient safety questionnaire. Wherever possible “Order Comms” should be used to refer all patients for radiology tests.

### 9.1.5 Receipt & recording of requests

Referral forms should be addressed to either the Radiology department and/or appropriate modality. They will be date stamped on receipt, the request form scanned and added to the CRIS request received list. This process is automated for requests received via Order Comms.

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

**6 week diagnostic CLOCK START**

**DATA ENTRY**
*date of request for a diagnostic test*

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

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

**6 week diagnostic CLOCK START**

**DATA ENTRY**
*date patient contacts the Trust to arrange appointment for the diagnostic test*
9.1.6 Prioritisation

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

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

**DATA ENTRY**
Update CRIS to record “request accepted”

It should be noted that outpatient imaging may be offered to a patient at any site within the Trust, although consideration will be given to the patient’s place of residence where possible.

9.1.7 Inappropriate Referrals

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

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

**DATA ENTRY**
Update CRIS to record “request unjustified” or “request rejected”

9.2 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)

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

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

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

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

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

6 week diagnostic CLOCK START

DATA ENTRY
date of request for a diagnostic test

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

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

9.4 APPOINTMENTS

9.4.1 Urgent Referrals

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

9.4.2 Routine Referrals

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

9.4.3 Imaging Appointments

Following prioritisation, patients will be contacted by telephone to arrange a convenient appointment or an appointment letter will be sent directly to the patient confirming the appointment.

All offered and declined appointments will be recorded on CRIS.
9.4.4 Reasonable Offers

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

9.4.5 Patient Declines reasonable appointment offers

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

CLOCK START

DATA ENTRY
date of last appointment offered to the patient

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

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

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

9.4.6 Did not attend

Standard Radiology DNA protocol will apply (in line with Trust policy on outpatient appointment DNAs - see section 5.15), when a patient does not attend for the first time. A radiology clinician will review the diagnostic request with a view to discharging the patient providing that:

- This is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected.

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

- A copy of the request form plus the CRIS generated DNA letter will be sent to the referring Consultant/GP.
• The request will be cancelled on CRIS.

DATA ENTRY
Update the examination status on CRIS to cancelled

• For patients on an 18 week RTT pathway, the 18-week non-clinic clock stop pro-forma must be completed and forwarded to RTT Access team.

CLOCK STOP – Use code 33: DNA

DATA ENTRY
date of appointment

If a further appointment is to be offered the request should be treated as a new referral and re-entered on to CRIS as a new event, ensuring a new request received date is entered accordingly.

CLOCK START: First activity in an RTT period

DATA ENTRY – Use code 10
date of last appointment offered to the patient

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

If a patient does not attend their diagnostic appointment but is then rebooked under the instruction of the consultant, the diagnostic waiting time for that test/procedure is set to zero and the waiting time starts again from the date of the appointment that the patient missed. This adjustment has no effect on the patient’s 18 week RTT pathway.

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

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

If a patient cancels their appointment more than twice, the imaging request should be returned to the referring clinician and the patient discharged providing the referral is not for a suspected/confirmed cancer.

The patient should be removed from the waiting list and cancelled on CRIS, noting the appropriate reason.

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

DATA ENTRY
Record the cancellation and follow the cancellation process on CRIS

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

9.4.8 Patient Discharged - Treatment not Taken Place

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

DATA ENTRY
Record the outcome and reasons on CRIS

9.5 SESSION CANCELLATION

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

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

When a session has to be unavoidably cancelled, rebooking should take place within 5 working days.
9.5.1 Session Cancellation with six weeks’ or more notice

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

9.5.2 Session Cancellation with less than six weeks’ notice

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

No session should be cancelled without the authorisation of the Deputy Chief Executive or a nominated deputy.
10. **ACUTE THERAPY SERVICES including**
    **Outpatient Physiotherapy, Dietetics, Orthotics & Surgical Appliances**

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

10.1 **Referrals**

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

10.2 **Triage & vetting of referrals**

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

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

10.3 **Reasonable Offers**

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

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

**DATA ENTRY**

Log the offers made to the patient

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

10.4 **Hospital appointment cancellations**

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

If a patient cancels their appointment and does not wish to have another appointment notification must be sent to the responsible clinician and the patient informing them that the offer of an appointment has been withdrawn.

CLOCK STOP: Patient declined treatment

DATA ENTRY – Use code 35
date of cancelled appointment and notification to referrer

The responsible clinician should consider whether the patient should be discharged back to their GP, unless it is agreed that this is contrary to their best clinical interest, or it is agreed that the patient is considered to be vulnerable or is a child.

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

Patients who cancel their appointment and wish to re-book, should be re-appointed as close to their original appointment as possible. Patients should be reminded that if they cancel this appointment for a second time the responsible clinician will be informed and the offer of the appointment will be withdrawn, unless the patient is a paediatric patient or has been identified as a vulnerable adult or the patient has supplied a valid reason for the cancellation.

Patients who cancel their appointment for a second time must be referred back to their responsible clinician with a view to the patient being discharged back to their GP, unless it is agreed that this is contrary to their best clinical interest, or it is agreed that the patient is considered to be vulnerable or is a child.

CLOCK STOP: Patient declined treatment

DATA ENTRY – Use code 35
date of second cancelled appointment and notification to referrer

Discharge back to the GP shall be confirmed by the responsible clinician, and if the decision is made to discharge the patient, a letter must be sent to the patient and their GP informing them that this decision has been made.
10.6 Did Not Attend (DNA)

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

- This is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected.

Patients will be referred back to their responsible clinician with a view to the patient being discharged back to their GP. Discharge back to the GP shall be confirmed by the responsible clinician, and if the decision is made to discharge the patient a letter will be sent to the patient and their GP informing them that this decision has been made.

CLOCK STOP: DNA

DATA ENTRY – Use code 33
date of DNA appointment and notification to referrer
11. PATIENT LETTERS

11.1 Outpatient Letters

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

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

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

11.2 Admission Letters

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

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

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

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

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

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

11.3 Reasonable offers – letters

A reasonable offer is “an offer of a time and date 3 or more weeks from the time that the offer is made”.

For a written appointment or admission offer to be considered reasonable, the patient must be offered a date with a minimum of three weeks’ notice.
## 12. APPENDICES

### 12.1 GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASI (appointment Slot Issues)</td>
<td>List of patients who were not able to book an appointment through the NHS e-Referral system because there were no appointment slots available</td>
</tr>
<tr>
<td>Active Waiting List</td>
<td>Patients awaiting elective admission and are currently available i.e. fit, able and ready, to be called for admission at entry to waiting list.</td>
</tr>
<tr>
<td>Area Team</td>
<td>Replaced SHAs – manage care and provide assurance on services commissioned by CCGs</td>
</tr>
<tr>
<td>Booked Admissions</td>
<td>Patients who are have the opportunity to book their admission or treatment date immediately following their clinic appointment or very shortly after.</td>
</tr>
<tr>
<td>Booked Patients</td>
<td>Patients awaiting elective admission who have been given an admission date at the time of the decision to admit. These patients form part of the active waiting list. Elective Booked.</td>
</tr>
<tr>
<td>Choice</td>
<td>Patients Value Choice to be offered to all patients waiting for 6 months for elective care by summer 2004. Choice at point of referral for elective care by December 2005.</td>
</tr>
<tr>
<td>CATS</td>
<td>Clinical Assessment and Treatment Services – interface services providing an intermediate level of clinical assessment and triage/treatment of patients which sit in between primary and secondary care.</td>
</tr>
<tr>
<td>Cancer Waiting Times (CWT)</td>
<td>NHS cancer plan 2000 has set a specific goal of reducing cancer-waiting times (CWT) in UK.</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group – replaced PCTs with the local commissioning of services and acute care</td>
</tr>
<tr>
<td>Day cases</td>
<td>Patients who required admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.</td>
</tr>
<tr>
<td>DTA</td>
<td>Decision to Admit.</td>
</tr>
<tr>
<td>DTC’S</td>
<td>Diagnostic Treatment Centres</td>
</tr>
<tr>
<td>Did Not Attend (DNA)</td>
<td>Patients who have been informed of their admission date (inpatients/day cases) or appointment date (outpatients) and who without notifying the hospital did not attend admission/outpatient appointment.</td>
</tr>
<tr>
<td>Inpatients</td>
<td>Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night.</td>
</tr>
<tr>
<td>Outpatients</td>
<td>Patients referred by a General Practitioner, General Dental Practitioner or another Consultant for clinical advice or treatment.</td>
</tr>
<tr>
<td>Partial Booking List or waiting list</td>
<td>A holding list for patients waiting for an Outpatient Appointment. This process ensures patients are seen in chronological order and have the opportunity to choose a convenient date.</td>
</tr>
<tr>
<td>Planned Admissions</td>
<td>Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment/investigation. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18 week RTT pathway.</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>PAS</td>
<td>Patient Administration System – Clinicom.</td>
</tr>
<tr>
<td>PTL</td>
<td>Patient Tracking List a tactical tool used to deliver 18 week RTT national operational standards. The Trust’s current tool is iReporter.</td>
</tr>
<tr>
<td>Referral to Treatment (RTT)</td>
<td>18-week pathway from referral from GP to commencement of treatment in secondary care.</td>
</tr>
<tr>
<td>Self-deferrals</td>
<td>Patients, who, on receipt offer of admission, notify the hospital that they are unable to come in.</td>
</tr>
<tr>
<td>SITREPS</td>
<td>Situation Reports made to Area Teams on current indicators.</td>
</tr>
<tr>
<td>TCI</td>
<td>To come in date or letter.</td>
</tr>
</tbody>
</table>
### 12.2 18 WEEK REFERRAL TO TREATMENT CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Status Code</th>
<th>Patient Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>Start of first definitive treatment</td>
<td>Patient has received first definitive treatment that is intended to manage their disease, condition or injury</td>
</tr>
<tr>
<td>32</td>
<td>Active Monitoring / Watchful Waiting</td>
<td>Start of active monitoring initiated by the clinician – not to be used for thinking time</td>
</tr>
<tr>
<td>33</td>
<td>DNA (did not attend)</td>
<td>The patient failed to attend the appointment / admission</td>
</tr>
<tr>
<td>34</td>
<td>Decision not to treat</td>
<td>Patient does not require treatment</td>
</tr>
<tr>
<td>35</td>
<td>Patient declined treatment</td>
<td>Patient not treated but discharged</td>
</tr>
<tr>
<td>90</td>
<td>Activity following First Treatment</td>
<td>First treatment occurred previously (eg admitted as an emergency from A&amp;E or the activity is after the start of treatment). Ongoing management post treatment.</td>
</tr>
<tr>
<td>91</td>
<td>Activity following a clock stop during active monitoring / watchful waiting</td>
<td>Activity during period of active monitoring</td>
</tr>
<tr>
<td>10</td>
<td>First activity in RTT period</td>
<td>Not yet treated (awaiting test results/add to waiting list/refer for outpatient treatment or diagnostics)</td>
</tr>
<tr>
<td>20</td>
<td>Transfer to another WHHT Clinician</td>
<td>Subsequent activity during RTT period - further activities anticipated</td>
</tr>
<tr>
<td>21</td>
<td>Transfer to another provider</td>
<td>Not yet treated - subsequent activity RTT period anticipated by another Health Care Provider - clock still ticks</td>
</tr>
<tr>
<td>97</td>
<td>Form returned - wrongly completed</td>
<td>Patient not treated (as far as PAS is aware)</td>
</tr>
<tr>
<td>98</td>
<td>Not Applicable</td>
<td>Activity not applicable to RTT period</td>
</tr>
<tr>
<td>99</td>
<td>Form not returned</td>
<td>Patient not treated (as far as PAS is aware)</td>
</tr>
<tr>
<td>11</td>
<td>Active monitoring end</td>
<td>First activity at the start of a new RTT period following active monitoring</td>
</tr>
<tr>
<td>12</td>
<td>Consultant referral</td>
<td>First activity at the start of a new RTT period following a decision to refer directly to a new consultant for separate condition</td>
</tr>
<tr>
<td>31</td>
<td>Active monitoring (Patient initiated)</td>
<td>Start of active monitoring initiated by the patient – can be used for thinking time</td>
</tr>
</tbody>
</table>
12.3 PROCESS FOR PAEDIATRIC DNAs

CHILD MISSES APPOINTMENT

No medical need for further appointment

No Safeguarding issues identified

Discharge GP Follow up

Letter 1

Safeguarding concerns raised in referral

Discuss with/refer to safeguarding team and CSF (social services)

Letter 2

Safeguarding concerns raised in referral

No Safeguarding issues identified

Discuss with/refer to safeguarding team and CSF (social services)

Appointment made Letter 4

Family do not want another appointment

Family do not want another appointment

Letter 3

Second appointment missed Letter 5

Safeguarding Children Team
Named Nurse: Michelle Mulvaney - 07747 792 742
Safeguarding Children Nurse: Jo Scott - 07990551647

Offer follow up appointment

Secretary or clinic clerk to phone/contact

Appointment made Letter 4

Second appointment missed Discharge Letter 5

Discharge letter to GP Letter 6

Letter 4

Family do not want another appointment

Letter 4

Second appointment missed Letter 5
Letter 1: DNA first appointment – no medical social concerns.

Dear Patient/Parent

We did not see you/name/ in clinic today. We hope that this means that your problems have resolved. We are unable to offer you a further appointment at present. If you feel that you do need to be seen, we would recommend that you make an appointment with your GP.

Copy to GP

Letter 2: DNA Safeguarding concerns

Dear GP

X did not attend clinic today. There have been previous safeguarding concerns raised. We are unable to offer a further appointment unless we receive a further referral letter. Please could we ask you to ensure that safeguarding issues are being addressed.

Copy Safeguarding Team WHHT
HV/School Nurse
CSF (social services)
Consider Parents

Letter 3: DNA Medical and safeguarding concerns but further appointment not wanted.

Dear GP

X did not attend clinic today. We have contacted the family who do not want an appointment at this time. Please could you try to ensure that all medical and safeguarding issues are being addressed. We would be happy to send a further appointment at your request.

Copy Safeguarding Team WHHT
HV/School Nurse
CSF (social services)
Consider Parents

Letter 4: DNA Medical concerns, no safeguarding concerns, repeat appointment offered.

Dear GP

X did not attend clinic today. We have contacted his/her parents/carers and have made a further appointment for. If He/She does not attend this we will not send a further appointment unless you make a further referral.
Letter 5: DNA Second appointment.

Dear GP

X did not attend his/her clinic appointment today. The appointment was made directly by the parents/carers who expressed concerns about X. We are unable to offer a further appointment unless we receive a new referral.

Please could we ask you to ensure that there are no health or social concerns regarding X.

Copy Safeguarding Team WHHT
HV/School Nurse
Consider copy to CSF- Social Services

Letter 6: DNA – Medical Concerns. Phoned & resolved.

To GP

X did not attend clinic today. We have contacted the family who do not want an appointment at this time. Please could you try to ensure that all medical issues are being addressed. We would be happy to send a further appointment at your request.
## EVALUATION MEASURES

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead</th>
<th>Tool</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding of events that constitute clock start / stop by all staff with administrative responsibility for pathway management</td>
<td>Head of RTT Access team</td>
<td>18 week pathway multiple choice quiz</td>
<td>Bi annually</td>
<td>Access meeting</td>
</tr>
<tr>
<td>Reasonable notice offers of appointments and admission dates.</td>
<td>Head of RTT Access team</td>
<td>Pathway audits (random selection of 20 non-admitted and 20 admitted pathways with a clock stop event)</td>
<td>Bi monthly</td>
<td>Access Meeting</td>
</tr>
<tr>
<td>Correct application of policy when recording pathway events, eg process for patients who DNA.</td>
<td>Head of RTT Access team</td>
<td>Pathway audits (random selection of 20 non-admitted and 20 admitted pathways with a clock stop event)</td>
<td>Bi monthly</td>
<td>Access Meeting</td>
</tr>
<tr>
<td>Accurate and valid recording of offers and patient choice on relevant system with appropriate pathway management</td>
<td>Head of RTT Access team</td>
<td>Pathway audits (random selection of 20 non-admitted and 20 admitted pathways with a clock stop event)</td>
<td>Bi monthly</td>
<td>Access Meeting</td>
</tr>
</tbody>
</table>
14. RELATED POLICIES

None.

15. EQUALITY IMPACT ASSESSMENT

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does the policy/guidance affect one group less or more favourably than another on the basis of:</td>
<td>Yes/No</td>
</tr>
<tr>
<td></td>
<td>Race</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Nationality</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Gender</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Culture</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Religion or belief</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Marriage &amp; Civil partnership</td>
<td>No</td>
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<tr>
<td></td>
<td>Pregnancy &amp; maternity</td>
<td>No</td>
</tr>
<tr>
<td>2.</td>
<td>Is there any evidence that some groups are affected differently?</td>
<td>No</td>
</tr>
<tr>
<td>3.</td>
<td>If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>N/A</td>
</tr>
<tr>
<td>4.</td>
<td>Is the impact of the policy/guidance likely to be negative?</td>
<td>N/A</td>
</tr>
<tr>
<td>5.</td>
<td>If so can the impact be avoided?</td>
<td>N/A</td>
</tr>
<tr>
<td>6.</td>
<td>What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
</tr>
<tr>
<td>7.</td>
<td>Can we reduce the impact by taking different action?</td>
<td>N/A</td>
</tr>
</tbody>
</table>

If you have identified a potential discriminatory impact of this procedural document, please refer it to Jane Shentall, Director of Performance, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Jane Shentall, Director of Performance.
16. POLICY AND PROCEDURE SIGN-OFF SHEET

<table>
<thead>
<tr>
<th>Policy Name and Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version Number and Date: No:</td>
</tr>
<tr>
<td>Service Location: PLEASE INSERT SERVICE LOCATION</td>
</tr>
</tbody>
</table>

All staff members must sign to confirm they have read and understood this policy.

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
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<th>Signature</th>
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</tbody>
</table>
Policy Ratification Form

Ratification Date: 

<table>
<thead>
<tr>
<th>Name of Persons</th>
<th>Job Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divisional Support (Direct Line Manager / Matron / Consultant / Divisional Manager)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Consultation Process (list of stakeholders consulted / staff groups presented to)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTT Programme Board membership</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sue Daniels</td>
<td>Radiology Services Manager</td>
<td>16/06/2017</td>
</tr>
<tr>
<td>Smita Ganatra</td>
<td>Acute Therapy Services Manager</td>
<td>16/06/2017</td>
</tr>
</tbody>
</table>

Endorsement By Panel/Group

<table>
<thead>
<tr>
<th>Name of Committee</th>
<th>Chair of Committee</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT Programme Board</td>
<td>Sally Tucker, COO</td>
<td>29/06/2017</td>
</tr>
</tbody>
</table>

Document Checklist

1. **Style & Format**
   - Is the title clear and unambiguous?
   - Is the font in Arial?
   - Is the format for the front sheet as per Appendix 1 of the policy framework?
   - Has the Trust Logo been added to the Front sheet of the policy?
   - Is it clear whether the document is a guideline, policy, protocol or standard operating procedure?

2. **Rationale**
   - Are reasons for development of the document stated?

3. **Content**
   - Is there an introduction?
   - Is the objective of the document clear?
   - Does the policy describe how it will be implemented?
   - Are the statements clear and unambiguous?
   - Are definitions included?
   - Are the responsibilities of individuals outlined?

4. **Evidence Base**
   - Is the type of evidence to support the document identified explicitly?
   - Are key references cited?
   - Are supporting documents referenced?

5. **Approval**
<table>
<thead>
<tr>
<th>Document Checklist</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the document identify which committee/group will approve it?</td>
<td></td>
</tr>
<tr>
<td><strong>6. Review Date</strong></td>
<td></td>
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<tr>
<td>Is the review date identified?</td>
<td></td>
</tr>
<tr>
<td>Is the frequency of review identified? If so is it acceptable?</td>
<td></td>
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<tr>
<td><strong>7. Process to Monitor Compliance and Effectiveness</strong></td>
<td></td>
</tr>
<tr>
<td>Are there measurable standards or Key Performance Indicators to support the monitoring of compliance with and effectiveness of the document?</td>
<td></td>
</tr>
<tr>
<td>Is there a plan to review or audit compliance with the document?</td>
<td></td>
</tr>
</tbody>
</table>

**Standard Equality Impact Assessment Tool**

<table>
<thead>
<tr>
<th>Persons likely to be affected by policy change / implementation</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Are there concerns that the proposed documentation / change could have an adverse impact on:</strong></td>
<td></td>
</tr>
<tr>
<td>Race, Ethnicity, National Origin, Culture, Heritage</td>
<td></td>
</tr>
<tr>
<td>Religion, Faith, Philosophical Belief</td>
<td></td>
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<tr>
<td>Gender, Marital Status, Pregnancy</td>
<td></td>
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<tr>
<td>Physical or Learning Disabilities</td>
<td></td>
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<tr>
<td>Mental Health</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation / Gender Reassignment</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Homelessness, Gypsy / Travellers, Refugees / Asylum Seekers</td>
<td></td>
</tr>
<tr>
<td><strong>Please give details of any adverse impact identified:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>If adverse impacts are identified, are these considered justifiable? (Please give reasoning)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>There is unlikely to be an adverse impact on different minority groups</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Person completing Ratification Form</th>
<th>Job Title</th>
<th>Date</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Ratification Group/Committee</th>
<th>Chair</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>