

Patient Access Policy
V6.1

Document Information

Trust Policy No: : ULH-C&A-AP03
Version: : 6.0
New or Replacement: : Replacement
Original Approved by: : ULHT 18 week Delivery Team
ULHT End Waiting Change Lives Programme
Board
ULHT Executive Board
ULHT Trust Board (for information)
Patient Council
LPCT Professional Executive Committee (PEC)
Date approved: :
Name of author: : Julie Judd
Name of executive sponsor: : Michelle Rhodes
Name of responsible committee : Executive Team
Date issued: :
Review date: :

Change Control

| | |
|----------------------|--|
| Previous versions | : ULH-C&A-AP02 |
| Changes: | All relevant job titles have been changed to reflect new structures |
| Additions | |
| Modification | 1.3 Special Exemptions: Revised guidance. 2.1 Referrals: Revised Choose & Book Guidance on named consultant referrals. 3.1 Target for Emergency Care: Revised Target 4.5.13 Prior Approval revised. 4.7 26 Week Inpatient Target Overview – removed 4.8 Application of 26 week rules – removed 4.11 Overview Principles: 18 week website link deleted – no longer exists. 7.7 Cannot attend – changed to Did not attend (DNA) |
| Deletions | : |
| Date of issue | : July 2011 |
| Review date | : May 2012 |
| Referenced documents | : |
| Relevant legislation | : |
| Relevant standards | : |

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1 Introduction

This policy describes how the Trust will manage access to its services and ensure fair treatment to all patients. The successful management of waiting lists in particular is covered in this policy as well as general principles for patient access. It is vital that these principles are applied for the Trust to achieve the national objectives to reduce waiting times and improve patient choice

1.1 Scope

Everyone involved in patient access should have a clear understanding of his or her roles and responsibilities. This policy defines those roles and responsibilities and establishes a number of good practice guidelines to assist staff with the effective management of patients requiring outpatient, diagnostics, inpatient and/or day case treatment.

This policy will be applied consistently and fairly across the Trust. The Deputy Director and Business Manager and Clinical Director for each directorate/specialty have the overall responsibility for implementing the policy within their area.

1.2 Objectives

This policy aims to achieve the following within the Trust:

- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.
- Support the reduction in waiting times, cancelled operations, and the achievement of the national patient access targets (as described in Section 3).
- Increase the number of patients with a booked outpatient, diagnostic and/or inpatient/day case appointment, thereby reducing the number of patients who Do Not Attend (DNAs), cancellations and improving the patient experience.
- Provide a practical and easy to follow 'guide' for those charged with managing the day-to-day administration and clinical management of waiting lists. Although the document cannot predict every eventuality, common sense will be required for cases that fall outside the policy. Decisions made outside the policy will need to be justified and documented in the patient's notes.
- Ensure that all the information relating to the number of patients waiting, seen and treated is accurate and recorded on ULHT clinical information systems including the main Patient Administration System (PAS).

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- The advice given in this policy is, at all times, consistent with: the NHSE Good practice Guide and Guidelines for Good Administrative Practice, the NHS Data Model & Dictionary, and the Royal College of Surgeons.¹

1.3 Special Exemptions

Where the patient is content for their veteran status to be included, this should be clearly stated by GP's when drafting referral letters including, in their clinical opinion, that the condition may be related to military service.

When utilising Choose & Book, GP's are asked to referral normally and select the correct appointment priority based upon the patient's medical condition (routine/urgent or 2 week wait) including veteran details in the referral letter. Ref: <http://www.chooseandbook.nhs.uk/staff/communications/fact/Armed-Forces.pdf>

Where a United Lincolnshire Hospitals NHS Trust clinician agrees that a veteran's condition is likely to be service-related, they are to prioritise the veteran over other patients with the same level of clinical need. However, veterans should not be given priority over other patients with more urgent clinical needs.

1.4 Overseas Visitors

Overseas visitors should be referred in accordance with agreed procedures. The regulations concerning charges to overseas visitors are identified in 'Overseas Visitors Guidance' on the Trust intranet under Finance/Financial Procedure Notes/Income.

1.5 Audit

To ensure compliance with the policy the Trust will be audited routinely by the Audit Commission and/or District Audit. The Trust will also conduct regular reviews to ensure that policy is being adhered to.

1.6 Accessibility

If you would like to receive a copy of this document in another format e.g. Braille or large print please contact:

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¹ Guidelines for the Management of Surgical Waiting Lists, Royal College of Surgeons (1991)

2 Key Principles

2.1 Referrals

- Choose and Book will be the primary referral method to ensure the patient receives Choice of provider, date and time of 1st appointment.
- The Trust's Directory of Services (DoS) enables GP's to refer by Consultant Team, if requested by the patient. The Trust will accept referrals to a named consultant led team, as long as the referral is clinically appropriate.
- Referrals should be sent on the standardised referral pro-forma where these exist.

2.2 Demographics

- It is the responsibility of the referring GP to ensure that the referral pro-forma contains accurate and up-to-date demographic information regarding the patient, including NHS number and both daytime and evening contact numbers.
- It is ULHT's responsibility to ensure that these demographic details are used when making appointments and that ULHT's clinical information systems including PAS are amended accordingly. It is also ULHT staff responsibility to check those details using the NHS Summary Care Record Service (SCRS) and to check that reasonable notice has been given if the patient does not attend.
- Patients will have their demographic details checked and updated on the relevant clinical information system including PAS by the clinic receptionist at every outpatient and inpatient attendance.

2.3 Private Patients

Patients referred to ULHT for an NHS service following a private consultation or private treatment will join the 18 week pathway at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list will be determined by the same criteria applied to NHS patients. It is the responsibility of the referring clinician to ensure that sufficient information is provided including the Referral to Treatment status to ensure that the patient joins the 18 week RTT pathway at the appropriate point for treatment. Referrals should clearly identify that this is a private patient transferring over to the care of the NHS.

2.3.1 Outpatients

- Where a private patient wishes to become an NHS patient, they should be seen in accordance with clinical priority and in chronological order.
- All private patient referrals will be logged on PAS.

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- The 18 week clock will start at the point at which the clinical responsibility for the patient's care transfers to the NHS. This will be the date when the Trust accepts the referral for the patient.

2.3.2 Waiting List

- Where a patient is added to an NHS waiting list following a private consultation, they should be added according to their clinical priority.
- The 18 week clock will start at the point at which the clinical responsibility for the patient's care transfers to the NHS. This will be the date when the Trust accepts the referral for the patient.

2.3.3 Cancer Patients

- Private cancer patients can be directly referred within 3 days of decision to transfer from the Private Provider to ULHT. In addition to joining the 18 week pathway the patient will also join the 31 day cancer pathway.
- It should be noted that the 31 day cancer pathway clock does not start when the referral is received like the 18 week RTT Clock. The 31 day cancer clock begins from the date of the "decision to treat", which is the date that the patient and consultant agree the treatment plan.

2.4 Cancer Waits

- Urgent referrals from GPs for suspected cancer should be submitted using a specific 2 week wait pro-forma and be seen within 2 weeks of the referral being received at ULHT for consultation.
- Once a decision to treat is made, a patient must be treated within 31 days, or the soonest target date if for example the 62 day target is before the 31st day target.
- The overall pathway will be reduced to 62 days for cancer patients from receipt of the 2 week wait referral at the Trust to the 1st definitive treatment.

2.5 Management Process and Information

- Communications with patients should be timely, informative, clear and concise and the process of waiting list management should be transparent to the public.
- All staff will ensure that any data created, edited, used, or recorded on ULHT information systems within their area of responsibility is accurate and recorded within ULHT Policy timescale in order to maintain the highest standards of data quality.
- All waiting lists must be managed on ULHT's clinical and patient information systems including PAS and all information relating to patient activity must be recorded accurately and in a timely manner.

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- The date a paper referral letter is received will be recorded on the Patient Administration System (PAS) as being the date the 18 week RTT clock starts (including private patients transferring to NHS care). If the patient's pathway started at an alternative provider within the NHS, i.e. CAS, RMC or other Trust etc, then the clock start will be the date received at original provider.
- The date when the patient converts the Unique Booking Reference Number (UBRN) is the start of the waiting period for a Choose and Book referral.
- At least 6 weeks notice should be given by consultants and their firms if an outpatient clinic or theatre list is to be cancelled for annual leave, study leave or for any other foreseeable reason. At least 6 weeks notice should be given by ULHT when consultants are required to attend meetings.
- A patient who is on an 18 week RTT pathway who cancels their outpatient appointment for the 2nd time or does not attend (DNA) an outpatient appointment, will be referred back to the care of the GP for re-referral unless the clinician decides otherwise. (Action Cards 2, 4 & 27)
- A patient who is on an 18 week RTT pathway who cancels their admission for the third time or does not attend (DNA) an appointment/admission/pre-operative assessment, will be referred back to the care of the GP for re-referral unless the clinician decides otherwise. (Action Cards 16 & 27A)
- Patients who are on the 62 day suspected cancer pathway will be referred back to the GP if they DNA their new appointment on 2 occasions. Patients on the 62 day suspected cancer pathway who cancel their appointment on more than 1 occasion at any stage in the pathway will be referred back to the GP or referrer only if the patient agrees to be referred back to the referrer. ULHT cannot refer patients on the suspected or diagnosed cancer pathways back to the referrer if they continue to show interest in still being seen, and if they do not agree to be referred back to the GP or referrer.
- Nothing should be done to limit treatment for patients who have a need for it (e.g. by adopting administrative practices designed to defer treatment). ULHT also has a responsibility to ensure no one is added to a list inappropriately.
- No inpatient/day case will normally be 18 Week Paused for more than an accumulative 3 months. (Action Cards 17 & 18).
- The policy will be reviewed at least annually and will accurately reflect changing local, regional and national priorities and plans.
- The Clinical Directors, with Deputy Directors and Business Managers are responsible for ensuring that this policy is implemented and adhered to.

2.6 Patients' Responsibilities

Patients have responsibilities e.g. for keeping appointments, and giving reasonable notice if unable to attend (provided appropriate notice has been given by ULHT).

2.7 Ready, Willing and Able

Patients must only be added to the waiting list for outpatient, diagnostic appointments or inpatient/day case treatment if they are ready, willing and able to attend. (Patients will be screened, according to the Trust's Screening Policy prior to addition to the Elective Waiting List).

Patients who are not ready, willing and able for a period of four or more weeks, must not normally be added e.g. extended holidays, working abroad (excluding the Services), need to lose weight prior to operation, pregnant, or a medical condition that needs controlling by GP prior to operation.

These patients should be referred to their GP for care until they are ready, willing and able to have the procedure. A letter with reply proforma will be sent to the patient's GP or referrer (if different) at this time. The patient can then be fast-tracked directly back onto the Waiting List when the proforma is received back from the GP or referrer stating the patient is ready and available to be re-listed.

Patients on an active 18 Week Pathway who are added to the waiting list and then become unready, unwilling or unavailable for a period of four weeks or more, should also be referred back to their GP care. Paediatric patients' case notes will be reviewed by the consultant prior to the referral of the patient to their GP care.

2.8 Training

All staff involved in the implementation of this policy, clinical, administrative, and clerical will undertake initial training and regular annual updating. Appropriate training programmes will support staff with special regard given to newly recruited staff and bank staff.

2.9 Quality Assurance

In order to establish that the policy and procedures are appropriately carried out, and reflect current standards, an audit of the processes will be undertaken on a yearly basis.

Waiting lists will also be subject to rolling validation programmes according to current best practice.

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2.10 Communication

This policy will be available to NHS staff and the general public via the Intranet and Internet. All appropriate ULHT staff will be kept informed of any updates.

2.11 Security & Confidentiality

All staff engaged in the application of this policy are bound by the ULHT's Security and Confidentiality policies and the NHS Code of Confidentiality.(
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253)

3 National Priorities

3.1 Targets for Patient Access

From December 2008, for 90% of admitted patients and 95% of non-admitted patients, the maximum waiting time from GP Referral to Treatment is 18 weeks, including any diagnostic tests.

Actions to deliver 18 weeks Referral to Treatment (RTT)

- Reduction in the maximum wait for an outpatient appointment with the aim to achieve the shortest possible waiting times for all patients in accordance with national maximum waiting times guidance.
- Every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs.

Targets for Emergency Care

- 95% of patients to be seen, admitted, transferred or discharged in less than 4 hours in A&E. No patient to wait more than 4 hours with maximum of 12 hours on a trolley.

Targets for Planned Care

- Reduction in the maximum wait for an outpatient appointment with the aim to achieve the shortest possible waiting times for all patients in accordance with national maximum waiting times guidance.

Targets for Diagnostics

- A maximum wait of 6 weeks with the aim to achieve the shortest possible waiting times for all patients in accordance with national maximum waiting times guidance.

National Capacity Assumption

- Day case rate increased to 75%
- Increased amount of activity taking place in primary and community settings to contribute to the national assumption of at least one million more outpatients appointments (around 10%) take place in the community rather than in hospital.
- Sufficient bed capacity (including critical care) to ensure that bed occupancy drops to a level consistent with admitting emergency cases without delay.
- Support and incentives for routine delivery of fast and convenient access to primary care services for all patients by increasing and targeting resources in those practices or other service providers with particular resource, management or other developmental needs.
- Increase the amount of elective activity undertaken in dedicated facilities (including Treatment Centres (TCs) and non-NHS providers (including the private sector).

Targets for Cancer and “Cancer Vital Signs”

- Sustain existing cancer waiting time standards and set local waiting time targets so that there is a maximum of 31 days from Decision to Treat to Treatment, and 62 days from urgent referral to treatment for all cancers under a “no pauses” approach for patients treated on or after January 1 2009. (Action Card 36 for clock start and clock stop definitions).
- Reduce the rate of smoking, contributing to the national target of: reducing the rate in manual groups from 32% in 1998 to 26% by 2010; 800,000 smokers from all groups successfully quitting at the 4 week stage by 2006.
- **Second and subsequent treatments to be delivered within 31 days for newly diagnosed cancer patients and patients presenting with a recurrence of disease – Vital sign 11a and 11b.** This applies to all patients treated on or after January 1 2009 having surgical or drug therapy treatments, and to all patients treated on or after January 1 2011 having radiotherapy and/or other treatments. (Action Card 37)
- **Breast Screening Vital Sign 13a** - Sustain provision of breast screening to all women aged between 50 -73 from 2008 onward.
- Provide treatment within 62 days for patients added to the 62 day suspected cancer pathway following an abnormal breast screening result who go on to be diagnosed with cancer. This applies to all patients treated on or after January 1 2009. (Action Card 38).
- **Bowel Screening Vital Sign 13a** - Provision of bowel screening opportunities to patients within eligible age range.
- Provide treatment within 62 days for patients added to the 62 day suspected cancer pathway following an abnormal FOB bowel screening result, who go on to be diagnosed with cancer. This applies to all patients treated on or after January 1 2009. (Action Card 39).
- **Cervical Screening Vital Sign 13a** - Provide treatment within 62 days for patients added to the 62 day suspected cancer pathway following an abnormal cervical screening result, who go on to be diagnosed with cancer. This applies to all patients treated on or after January 1 2009. (Action Card 40).
- **62 day – Consultant Upgrades – Vital Sign 13b.** Consultants or a member of their team may upgrade patients from routine pathways onto the 62 day suspected cancer pathway if cancer is suspected. Simply dial Lincoln County extension 3887 and follow the directions (Action Card 65).
- **All breast symptoms to be seen within 14 days of referral – Vital Sign 08. From December 2009 2 week wait – all patients referred with breast symptoms** (whether or not cancer is suspected) will be seen by a Consultant led service within 14 days of the referral being

received by the Trust. Compliancy to this vital sign is required by December 2009. (Action Card 38).

- **Clinical Data Capture:** Set local targets to achieve compliance to the national timescales for mandatory and optional Clinical Data Capture.
- **Peer Review:** Set local targets to achieve compliance to the national Peer Review standards and timescales
- **2ww Turnaround of Cervical Screening results:** From January 2010 women undergoing cervical smear tests are to receive their results within 2 weeks of the date the smear test was taken.
- Set local targets to achieve compliance with forthcoming national standards on supportive and palliative care (to be derived from National Institute for Clinical Excellence (NICE) supportive and palliative care guidance).
- Agree, implement and monitor local plans to improve the outcomes of cancer treatment, as evidenced by increasing compliance with NICE Improving Outcomes guidance and the associated national cancer standards.

Targets for Coronary Heart Disease (CHD)

- Improve access to services across the patient pathway and increase patient choice by achieving the two week wait standard for Rapid Access Chest Pain Clinics; setting local targets to a 6 week maximum wait for angiography; and delivering a maximum wait time of 3 months for local PCI revascularisation.
- Continue to deliver the National Target for patients suffering from a heart attack of 'call to needle' time for at least 68% of patients within 60 minutes of calling for professional help, where thrombolysis is the preferred local treatment for heart attacks.
- In primary care, update practice-based-registers so that patients with CHD and diabetes continue to receive appropriate advice and treatment in line with National Service Frameworks (NSF) standards and by March 2006, ensure practice-based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a BMI greater than 30.
- Improve the management of patients with heart failure in line with the NICE Guidelines, and set local targets for the consequent reduction in patients admitted to hospital with a diagnosis of heart failure

Targets for Older People

- Each year NHS Lincolnshire estimates that there will be 1.37% growth in emergency hospital admissions and no growth in re-admissions.
- From 2006, a minimum of 80% of people with diabetes should be offered screening for the early detection (and treatment if needed) of diabetic retinopathy as part of a systematic programme that meets national standards, rising to 100% coverage of those at risk of retinopathy by end 2007.

Targets for Audiology

- Audiology Services are included in the national target for 18 weeks RTT and will be measured as per the national diagnostic test standards.
- Local agreement will be made with NHS Lincolnshire for direct referrals to 1st definitive treatment within Audiology ie where this includes the fitting of the hearing aid.

Targets for Accelerated Stroke Improvement Standards

- % High Risk TIA seen and scanned within 24 hours: Target 60%
- % Patients who spend 90% of time on stroke unit: Target 80%
- % Access to a scan within 24 hours: Target 100%
- %Access to a scan within 60 minutes: Target 50%
- For eligible patients; % Thrombolysed within 3 hours: Target 12%
- Outcome of death from Stroke inpatient stay: Target No greater than 21%
- % of patients admitted to Stroke Unit within 4 hours of hospital arrival: Target 90%

NHS Constitution & Maximum Waiting Times (Revised April 2010)

With effect from 1st April 2010 all patients have the right to start consultant-led treatment within 18 weeks from referral, and be seen by a specialist within 2 weeks of GP referral for suspected cancer or, where this is not possible, for the NHS to take all reasonable steps to offer the patient a quicker appointment at a range of alternative providers if the patient makes such a request.

****Please note this applies to all patients referred on or after 1st April 2010****

The Right to Access Services within the maximum waiting times forms part of the NHS Constitution and is detailed below:

Right

“You have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution”

What this right means for patients

This is a new right and there is new legislation to support it. From 1 April 2010, you will have the right to:

- Start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions; and
- Be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.

If this is not possible, the Primary Care Trust (PCT) or Strategic Health Authority (SHA) which commissions your treatment must investigate offering you a range of suitable alternative providers that would be able to see or treat you more quickly than the original provider. You will need to contact the provider you have been referred to or your local PCT before alternatives can be investigated for you. Your PCT or SHA must take all reasonable steps to meet your request.

Your right to treatment within 18 weeks from referral will include treatments where a consultant retains overall clinical responsibility for the service or team, or for your treatment. This means the consultant will not necessarily be physically

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present for each appointment, but will take overall responsibility for your care. The setting of your consultant-led treatment, for example whether hospital based or in a GP-based clinic, will not affect your right to treatment within 18 weeks.

Exceptions

The right will cease to apply in circumstances where:

- You choose to wait longer;
- Delaying the start of your treatment is in your best clinical interests, for example where smoking cessation or weight management is likely to improve the outcome of the treatment;
- It is clinically appropriate for your condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage;
- You fail to attend appointments which you had chosen from a set of reasonable options; or
- The treatment is no longer necessary.

The following services are not covered by the right:

- Non-medical consultant-led mental health services; and
- Maternity services.

A copy of the NHS Constitution is available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613

If you were referred for treatment on or after 1st April 2010 and you would like to discuss the length of time you have been waiting in accordance with the NHS Constitution, in the first instance please contact:

18 week Maximum Wait

Julie Judd, General Manager, Access Booking & Choice

United Lincolnshire Hospitals NHS Trust

Greetwell Road

Lincoln LN2 5QY

Contact Tel: 01522 573713

Email: Julie.judd@ulh.nhs.uk

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2 week wait (suspected cancer)

Julie Judd, General Manager, Access, Booking & Choice

Cancer Services Manager

United Lincolnshire Hospitals NHS Trust

Greetwell Road

Lincoln LN2 5QY

Contact Tel: 01522 573713

Email: Julie.judd@ulh.nhs.uk

PCT

Andy Hill,

Commissioning Manager,

NHS Lincolnshire

Venture House

Endeavour Park

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PE21 7TW

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4 Strategic Approach to Patient Access

4.1 The Referral to Treatment (RTT) Patient Pathway

Delivering an 18 week patient pathway from GP referral to the start of treatment is a key objective for the NHS.

4.1.1 Overview principles:

- Underlying 18 weeks is the principle that patients should receive excellent care without unnecessary delay.
- The target focuses closely on pathways that do or might involve medical or surgical consultant-led care, setting a maximum time of 18 weeks from the point of initial referral to the start of any treatment necessary for all patients who want it, and for whom it is clinically appropriate.
- Referral to Treatment (RTT) pathways can be categorised as admitted or non-admitted, complete or incomplete. RTT reporting is required for complete and incomplete waits, with completed waits split by admitted and non-admitted pathways.
- All pathways start as non-admitted pathways, but some of those pathways convert to admitted pathways at a decision to admit for treatment, rather than diagnosis.
- If in doubt, the principle of providing excellent care without unnecessary delay should be followed, together with those of reasonableness, honesty and good communication.
- Consultants will review vulnerable patients, ie children, cancer patients, very urgent patients, who choose to continue to delay their treatment. The Consultant will contact the patient/carer to discuss and plan their care, because it may be appropriate not to refer these patients back to their GP for care.

4.2 Referral to Treatment Policy

4.2.1 Introduction

The principles and definitions for 18 weeks RTT are detailed below, including the 18 week pathway. Whilst 18 weeks will become the maximum normal wait for non-urgent patients, most patients will be seen more quickly. As with previous targets, the average wait on the 18 week pathway can be much less than the maximum.

This 18 week target is different from previous waiting time targets. Instead of focusing on a single stage of treatment (such as outpatients or inpatients) the 18 week pathway addresses the whole patient pathway from referral to the start of treatment. In doing so, it is the first to illuminate so-called 'hidden waits' – the diagnostic and follow-up outpatient stages which historically have taken weeks or months to complete and have never been measured systematically. The 18 week pathway requires the NHS to measure the total period each patient waits for

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treatment and to manage each patient's journey from referral to treatment in a timely and efficient manner. Also, for the first time, the commissioning PCTs will be held directly accountable for the achievement of this pathway.

Data on all elements of the RTT pathway waiting times has been collected since September 2008.

Achieving an 18 week RTT pathway for all requires a contribution from everyone working in the NHS. It will not be enough to simply tackle long waits as done historically. The principle of 18 weeks requires all staff to *work* differently to deliver this fundamental change in waiting list management.

The 18 week RTT pathway does not replace existing shorter waiting time guarantees, for example cancer and heart disease. As cancer and heart disease were the first end-to-end pathways, the experience gained in implementing these targets has been and will continue to be applied to the 18 week RTT pathway.

4.3 Referral to Treatment Key Principles

The policy describes how the Trust will manage access to its services and ensure fair treatment to all patients. The successful management of RTT pathways is covered in this policy as well as general principles for all patient access issues. It is vital that these principles are applied for the ULHT to achieve the national objectives to reduce waiting times, improve patient care and patient choice.

Everyone involved in patient access should have a clear understanding of his or her roles and responsibilities. The policy defines a number of good practice guidelines to assist staff with the effective management of patients requiring outpatient, diagnostic or inpatient/day case treatment.

The policy aims to achieve the following across the ULHT and Primary Care clinical pathways:

- Ensure that patients receive treatment according to their clinical priority, with patients of the same clinical priority treated in chronological order.
- Support the reduction in waiting times in line with the DH guidance, and the achievement of the Trust's locally agreed stages of treatment targets, alongside national access targets.
- Provide a practical and easy to follow 'guide' for those charged with managing the day-to-day administration and clinical management of the patient pathway. Although the document cannot predict every eventuality, common sense will be required for cases that fall outside the policy. However, decisions made outside the policy will need to be justified and documented in the patient notes.
- Ensure that all the information relating to the number of patients waiting, seen and treated is accurate and recorded on PAS.

The patient's experience of these rules will depend significantly on how reasonableness is defined and operated and this will need to consider both the reasonableness to the patient and to ULHT.

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The advice given in this policy is, at all times, consistent with: the NHSE Good Practice Guide and Guidelines for Good Administrative Practice, the NHS Data Model and Dictionary, the Royal College of Surgeons and follows the RTT guidance.

This policy will be applied consistently and fairly across ULHT. The Assistant Director and Clinical Director for each directorate/specialty have the overall responsibility for implementing the policy within their area.

Special exemptions exist for war pensioners:

‘Persons in receipt of a War Pension (Please see Point 1.3 above for further information)

To ensure compliance with the policy the Trust will be audited routinely by the Audit Commission and/or District Audit. The Trust will also conduct reviews to ensure adherence to policy.

4.4 18 week Referral to Treatment (RTT) Pathway Overview

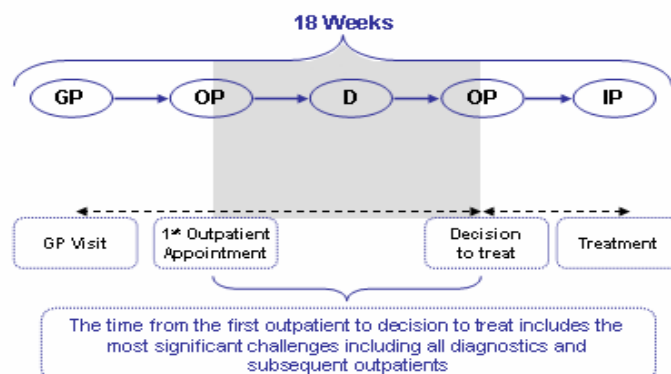
Delivering an 18 week patient pathway from GP referral to the start of treatment is a key objective for the NHS.

Overview principles:

- Underlying 18 weeks is the principle that patients should receive excellent care without unnecessary delay.
- The target focuses closely on RTT pathways that do or might involve consultant-led care, setting a maximum time of 18 weeks from the point of initial referral to the start of any treatment necessary for all patients who want it, and for whom it is clinically appropriate.
- RTT pathways can be categorised as admitted or non-admitted, complete or incomplete. RTT reporting is required for complete and incomplete waits, and completed waits need to be split by admitted and non-admitted pathways.
- All pathways start as non-admitted pathways, but some of those pathways convert to ‘admitted’ pathways at a decision to admit for treatment, rather than diagnosis.
- If in doubt, the principle of providing excellent care without unnecessary delay should be followed, together with those of reasonableness, honesty and good communication.

The challenge of 18 weeks

The NHS needs to continue to reduce waits to first outpatient and from decision to treat to treatment. This will require more activity and reform than ever before. In addition the NHS needs to focus on the time from first outpatient to decision to treat which historically has not been a major focus.



4.5 Referral to Treatment (RTT) Pathway Definitions

4.5.1 18 Week Clock Start Definition

An 18 week clock starts when any health care professional or service permitted by a Primary Care Trust to make such a referral refers to:

- A medical or surgical consultant led service, regardless of setting, with the intention that the patient will be assessed and if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner;
- An interface or referral management or assessment service, which may result in an onward referral to a medical or surgical consultant led service before responsibility is transferred back to the referring health professional or general practitioner.

These services include:

- Consultant-led services irrespective of setting.
- Cancer services (for which a 62-day cancer-target clock also starts).
- Obstetrics, although pregnancy referrals should only start a clock when there is a separate condition or complication requiring medical or surgical consultant-led attention.
- Diagnostics services, provided the patient will be assessed and if appropriate, be treated by a medical or surgical consultant-led service, before responsibility is transferred back to the referring health professional (i.e. 'straight-to-test')
- Practitioners with special interests (GPwSI) if they are part of a referral-management arrangement as defined.

4.5.2 Other Clock Starts

Upon completion of an 18 week RTT period, a new 18 week clock starts:

- when a patient becomes fit and ready for the 2nd of a consultant led bilateral procedure, defined as 'a procedure that is carried out on both sides of the body at matching anatomical sites' eg cataracts;
- upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan;
- upon a patient being re-referred in to a consultant led, interface, or referral management or assessment service as a new referral. An interface service is defined as "All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care";
- when a decision to treat is made following a period of active monitoring;
- when a patient rebooks their appointment following a first appointment DNA that stopped and nullified their earlier clock.

4.5.3 Whose Referrals can Start the 18 Week Clock

- Professions/services accepted by the primary care trust may commission 18- week pathways and start the clock, including:
 - General practitioners (GPs)
 - General dental practitioners (GDPs)
 - General practitioners (and other practitioners) with a special interest (GPwSI)
 - Optometrists and Orthoptists
 - Minor Injuries Units (MIU)
 - Walk-in Centres (WiC)
 - Genito-Urinary Medicine clinics (GUM)
 - National screening programmes
 - Specialist nurses or allied health professionals with explicit PCT authorisation
 - Prison health services
 - Consultants (or consultant-led services) but specifically:
 - for urgent non-related conditions newly identified by the consultant in which case this may cause a second clock to start (and a 31-day clock if cancer is the new condition) with any first clock still ticking.
 - in cases where a decision to treat is made (at follow-up outpatients) for a patient whose programme of long-term care needs to be medical or surgical consultant-led and who does not currently have an 18-week clock;
- The 18-week commitment is made to all patients of Primary Care Trusts including prisoners and military personnel to the extent that the PCT commissions their care. 18 weeks does not apply to MOD-commissioned care unless stated in commissioning agreements with providers.

4.5.4 What Defines the 18 Week Clock-start Date?

- The clock-start date is the date on which the provider receives the patient's referral, or, in the case of clocks legitimately started by consultants, the date of the consultant's decision to start the clock. Non-Choose and Book referrals (including those from GDPs, A&E, Walk-in Centres (WiCs) and others not currently connected to Choose and Book) the clock starts on the date on which the referral letter is received by the provider and initiates the start of the pathway.
- For referrals made through Choose and Book the clock starts on the date on which the patient converts their unique booking reference number (UBRN) either directly from the referral point (e.g. GP practice) or via the Telephone Appointments Line service.
- If a patient is referred or booked into the wrong specialty clinic and needs to be re-referred to the correct service, the original UBRN will continue to be used and the clock start is from the original received date.
- When a patient is referred to another Consultant, for the same condition, either externally or internally, the Original Referral Date is the date the 18 week pathway commenced. The same applies when the patient's pathway commences in primary care e.g. Orthopaedic triage or GPwSI (GP with Special Interest).

4.5.5 What defines the 62 day Cancer Clock start Date

- From January 1 2009, the 62 day cancer target clock starts from receipt of referral rather than from the Decision to Refer as it has been up until January 1 2009.
- Referrals made through Choose and Book will have a clock start on the date on which the patient converts their unique booking reference number (UBRN) either directly or from the referral point (eg GP practice) or via the Appointments Line Service.

4.5.6 What Does Not Start the 18 Week Clock?

- Consultants (or consultant-led services) referrals for routine cross-conditions newly identified by the consultant.
- Therapy, healthcare science or mental health services that are not consultant-led (including multi-disciplinary teams and community teams run by mental health trusts) irrespective of setting.
- Diagnostic services (i.e. direct to x-ray) if the referral is for the GP to make a decision about onwards referral for treatment.

4.5.7 18 Week Clock Stop Definition

The clock stops on an 18 week RTT pathway when a clinical decision is made that treatment is not required, when first definitive treatment begins or when a period of active monitoring begins.

4.5.8 31 and 62 day Cancer Clock Stop Definition

For diagnosed cancer patients on the 31 and 62 day pathways, the clock stops when a clinical decision is made not to provide treatment, when first definitive treatment begins or when a period of active monitoring begins. For patients on the 62 day suspected cancer pathway who are diagnosed as not having cancer, the clock stops at this point and the patient will follow the 18 week pathway clock which started ticking at the same time as the 31 or 62 day pathway.

4.5.9 What Stops the 18 Week Clock?

The following clinical decisions stop the clock on the date the decision is communicated to the patient and GP and original referrer if not the GP.

- Decision not to treat.
- Decision to embark on a period of active monitoring.
- Decision to add a patient to a transplant list (Planned List)
- Decision to return the patient to primary care for non-medical/surgical consultant-led treatment in primary care.
- Decision to return the patient to a RMC/CAS etc for treatment if the treatment is not to be medical or surgical consultant-led treatment.
- Patient declines offered treatment.
- Patient DNAs 1st outpatient appointment (the clock is reset to null and a new clock is started from the date that the patient contacts the Trust and rebooks a new appointment).

4.5.10 What Stops the 31 and 62 day Cancer Clock

The following clinical decisions stop the clock on the date the decision is communicated to the patient and GP and original referrer if not the GP:

- Patient declines all treatment.
- Treatment starts.
- Patient dies before treatment.
- Patient goes for private treatment.
- No cancer diagnosed.
- Patient is admitted as emergency prior to 2ww first Outpatient Appointment (for the same condition).

4.5.11 First Definitive Treatment Definition

First definitive treatment is defined as an intervention intended to manage a patient's disease, condition, or injury and avoid further intervention. (Treatment will often continue beyond the first definitive treatment and after the clock has stopped).

4.5.12 First Definitive Treatment Can Be:

- Inpatient or day-case therapeutic treatment; the clock stops on the date of admission.
- Diagnostic tests turned into therapeutic procedures during the investigation; for example, a colonoscopy which reveals a polyp that can be removed there and then.

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- The fitting of a medical device, with the clock stopping on the date on which definitive fitting or trial fitting begins, and with no undue delay in subsequent fitting sessions.
- Outpatient treatment (or consultant-led treatment irrespective of setting) if no subsequent inpatient or day-case admission is expected, with the clock stopping on the date of attendance.
- First-line treatment – less intensive treatments or medical management attempted with the intention of avoiding more invasive procedures or treatment, with a new clock starting if a decision is later taken to provide more aggressive treatment; for example intra-uterine insemination could constitute first definitive infertility treatment and clock-stop, with consultant referral for IVF at a later date starting a new clock subject to communication with primary care and possible primary care veto.
- Receipt of first definitive advice from a consultant geneticist may reasonably stop the clock if treatment by the genetics service (e.g. counselling) is not required and if the original referral was direct to the consultant geneticist; however, this rule will be kept under review as genetics services and treatments develop.
- Therapy (e.g. physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science interventions (e.g. hearing-aid fitting) if that is what the medical or surgical consultant-led service decides is the intervention intended to manage the patient's disease, condition or injury and avoid further intervention.

4.5.13 Prior Approval Patients

The definition of prior approval for the purpose of this policy is 'the prior approval by the Primary Care Trust (PCT) for an individual patient or a group of patients, for whom the PCT is the Responsible Commissioner, to access care or treatment, including diagnostics,

For an individual patient this applies to a treatment where the PCT has taken a decision and communicated to the Acute Trust that prior approval is required by the PCT to the Acute Trust before treatment of a defined type is to be carried out by the Trust.

Clinicians **must** seek funding approval before treatment can start for a particular patient. Funding will be approved if the patient meets the criteria set out in the commissioning policy.

The PCT will not pay the Trust in instances where the patient has been initiated on treatment before funding approval has been granted, unless extenuating circumstances can be demonstrated

Patients, General Practitioners (GP's) & Clinicians should ensure that they have checked any relevant treatment specific policy on their PCT's website as the treatment may not be routinely commissioned by the PCT.

4.5.14 What does not stop the 18 week clock?

The following examples do not stop the clock:

- Administration of pain relief before a surgical procedure takes place, or other steps to manage a patient's condition in advance of definitive treatment.
- Consultant-to-consultant referrals where the underlying condition remains unchanged.
- The mere act of making a tertiary referral or a referral from one provider to another.
- Patient admitted for diagnostic test or procedure only.
- Patient admitted for pre-treatment prior to 1st definitive treatment.
- Patient admitted for pre-op assessment only.
- Patient admitted for 1st definitive treatment but treatment is not carried out during admission.
- Patient admitted for a planned procedure/diagnostic test after 1st definitive treatment.

4.5.15 What does not stop the 31 and 62 day cancer clocks?

All of the above plus:

- The first DNA does not stop the 62 day suspected cancer pathway, a pause is allowed for the first DNA, but the clock is not nullified and restarted as in the 18 week pathway.
- If the patient has to undergo emergency treatment for another condition prior to starting their cancer treatment.

4.5.16 Dealing with Legitimate Exceptions or Delay (18 Week Pauses)

- There will always be patients for whom the 18 week schedule is inconvenient or clinically inappropriate. The rules need to cater for this.
- Patients who cancel their first appointment in advance will not have their 18 week clock stopped unless they wish to delay for a period of time which makes it unreasonable or impossible for 18 weeks to be achieved for that patient. I.e. a patient may cancel their first appointment with any period of notice and the 18 week clock will not be reset.
- A nationally agreed tolerance for the 18-week target has been set as 10% admitted patients and 5% non-admitted patients as of December 2008. PCTs and providers will need to be able to demonstrate (to an auditor or the Healthcare Commission or in the event of a patient complaint) that cases that take longer than 18 weeks to reach the start of first definitive treatment are legitimate exceptions.
- The inpatient system of 'pausing' the 18 Week RTT clock will not be extended to outpatients or diagnostics.
- Tolerances for the 62 day and 31 day cancer pathway have been set nationally. For the 62 day pathway, providers have to treat 85% of

patients within 62 days of receipt of the initial 2ww referral, thus giving a tolerance of 15%. For the 31 day pathway, providers have to treat 96% of patients within 31 days of the decision to treat being agreed between the consultant and the patient, thus giving a tolerance of 4%

- **18 Week Clock Pause:**

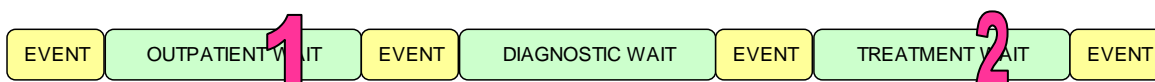
When a patient is on an 18 week pathway a Pause to the pathway can be instigated providing the following guidance is adhered to:

- the patient must be on an Elective Therapeutic Waiting List
- the patient must normally be offered 2 dates with at least 3 weeks notice
- the patient is not willing or able to accept either date but can accept a further offered date Note: an 18 Week Pause can only be applied once this new TCI has been agreed
- An 18 Week Pause period must only be added to PAS following authorisation by the General Manager (Access Booking & Choice) or his/her representative'
- An 18 Week Pause period will apply from the earliest offered reasonable TCI date to the date the patient states he/she is available for treatment (Action Card 17)

Exception: If a patient states they are unavailable for a set period of time due to work (for example a patient who is a teacher who wishes to delay their admission until the summer holidays) before two reasonable dates for admission have been offered to the patient, this may mean that offering dates which meet the reasonableness criteria would be inappropriate (as the patient would be offered dates that ULHT already knew he/she couldn't make). In these circumstances, the clock should be paused from the date of the earliest reasonable offer that ULHT would have been able to offer the patient.

- **Cancer Pathways Clock Pause(s)**

Pauses are allowed (and therefore adjustments for these pauses can be made) in 2 places:



- If a patient DNAs their initial outpatient appointment – this would allow for a clock pause from the receipt of the referral (recorded as the cancer referral to treatment period start date) to the date upon which the patient rebooks their appointment. This pause is relevant to the cancer two week wait and the 62-day standard. DNA's other

than the initial outpatient /straight to test appointment do not initiate a clock pause.

- If a patient declines a treatment in an inpatient (ordinary admission or day case) setting provided the offer of admission was “reasonable”. For cancer patients under the 31 or 62 day standard ‘reasonable’ is classed as any offered appointment between the start and end point of 31 or 62 day standards (ie. any appointment within a cancer treatment period or cancer referral to treatment period. The pause would be the time between the date of the declined appointment to the point when the patient could make themselves available for an alternative appointment.

Why is the definition of ‘reasonable’ for an admitted cancer treatment different to that used for 18 weeks?

Under 18 weeks rules ‘reasonable’ is classed as two appointments with at least 3 weeks notice. However, 3 weeks notice is not feasible for cancer patients who are on a much shorter pathway due to the potential seriousness of their condition.

Is there a minimum amount of time that needs to elapse to allow something to be reasonable ie is a TCI date on the same day reasonable?

A patient’s wishes and views do need to be taken into account and patient’s will be offered a TCI date with 1 one day’s notice or sooner if agreed with the patient.

4.5.17 Clinical Exceptions

A maximum of 18 weeks RTT is the goal for every patient. In some cases, however, treatment within 18 weeks may prove not to be possible for clinical reasons.

For instance:

- if a series of tests must be done in sequence, or
- where the patient and consultant have agreed that the patient should receive a second opinion which despite best efforts adds a critical delay;

There may also be patients for whom there is genuine clinical uncertainty about the diagnosis but where active monitoring (and clock stop) is inappropriate. However 18 weeks should remain the clear goal for every patient.

4.5.18 Patient Initiated Delay

The nationally set tolerance (10% admitted patients and 5% non-admitted patients) will allow for patient-initiated delay in outpatients and diagnostics.

4.5.19 Referrals Back to GP/Referrer for Care

Patients will be referred back to the care of their GP/referrer and the 18 week RTT clock stopped when:

- treatment is declined,

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- a patient requests 18 Week social Pauses for more than an accumulative 12 weeks, or
- the patient is unfit and care within the primary sector will take more than 14 days (except MRSA)

A new 18 week RTT clock will start when the patient is re-referred. The patient will rejoin the 18 week RTT pathway at the point of exit if it is clinically appropriate and within 6 months.

4.5.20 Concurrent Waits and One Stop Clinics

A patient may be waiting for an outpatient appointment and diagnostic test at the same time.

If a diagnostic test is identified at the point of referral or prioritisation, then this should be requested at the same time as the outpatient appointment is booked. The sequence of events will be determined by the clinical staff, and the diagnostics booked according to ULHT's stages of treatment milestones e.g. if the diagnostic is required first, then this should be booked within 4 weeks and the outpatient appointment should then be booked in weeks 5-8 weeks. Where clinical pathways allow, the diagnostic and outpatient appointment should occur on the same day.

4.5.21 Any Exclusion from an 18 week RTT patient pathway

Patients who are not part of an 18 week RTT Pathway include:

- Emergency Admissions
- Obstetric Patients (referrals will start a clock when there is a separate condition or complication requiring medical or surgical consultant-led attention)
- Elective Planned Patients (in sequence of treatment, where 1st treatment is definitive treatment)
- Patients receiving on-going care where first definitive treatment has occurred, i.e. regular outpatient appointments or subsequent elective treatment.
- Patients on Active Monitoring
- See Referral to Treatment Pathway Definitions Section 3 – What does not Start a Clock

4.6 Application of 18 weeks RTT Rules

ULHT has been working with NHS Lincolnshire to agree the application of 18 weeks RTT rules within an RTT pathway and has agreed the following rules for the health system.

4.6.1 RTT Pathway ID

All patients requiring Outpatient or Inpatient/Day Case appointments, will be assigned an RTT pathway ID.

This will be:

- For Choose & Book referrals the UBRN.

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- For written/verbal tertiary referrals, referring hospitals or primary care services an assigned 18 week RTT pathway ID
- For all other referrals the 18 week RTT pathway ID is PAS system generated

All correspondence should include this ID, including requests for diagnostics.

Not all RTT pathway IDs will have an 18 week clock (see Exclusions above)

4.6.2 Active Monitoring and End of Active Monitoring

If an 18 week clock or a 62 day or 31 day cancer clock, is running and a decision is made by either the patient (the RTT Status will be 31 Active Monitoring – Patient initiated) or the clinician (the RTT Status will be 32 Active Monitoring – Consultant initiated) to commence Active Monitoring then the 18 week clock stops, and so does the 62 day or 31 day cancer clock. The clock stops on the date that the decision is made and communicated to the patient.

For patients on Active Monitoring, if a decision to treat is made (e.g. at a routine follow-up appointment), then a new 18 week clock will start on the original RTT pathway ID. The clock starts on the date that the decision is made and communicated with the patient. Consultants will copy details of all 18w clock-starts to the GP and original referrer if not the GP.

For patients on Active Monitoring who are on the 31 and 62 day cancer pathways, if a decision to treat different to active monitoring is made (e.g. at a follow up appointment), then the next cancer treatment must be delivered within 31 days of the new decision being made between Consultant and patient, or 31 days from the patient being fit for treatment. (Action Card 29 Active Monitoring and Appendix A for RTT Status Codes).

4.6.3 Patients who Do Not Attend (DNA) on an 18 week RTT pathway

First Outpatient Appointment Adult

- Non-attenders (DNAs) are patients who fail to attend and provide no advanced explanation or warning.
- Communication/correspondence to patients must clearly state that if the patient fails to attend the normal process would be to discharge the patient back to the care of the GP.
- Where a patient DNA's their 'first appointment' following the initial referral, the 18 week clock will be nullified.
- A further appointment may be offered at the consultant's discretion for patients who do not attend.
- Where a patient is offered a second appointment following the DNA, the 18 week clock will restart on the date that the new appointment is booked with and communicated to the patient and NOT the date of the appointment.
- A 2nd DNA will always result in the patient being referred back to the GP.

First Appointment for Paediatric or Vulnerable Patients

- In the clinical interests of vulnerable and paediatric patients, non-attendance of 1st outpatient appointment will result in the offer of another appointment. The 18 week clock will be nullified on the date of the 1st DNA.
- The 18 week clock will restart on the date the appointment is booked and communicated to the patient and NOT the date of the appointment.
- A 2nd DNA should always result in the patient being referred back to the GP unless clinical decision dictates otherwise.

Follow-up Appointments

Where a patient DNAs any follow-up appointment (including diagnostic test appointments) an offer of a further appointment will only be made if the treating clinician requires the patient to be seen.

Preoperative-Assessment Appointments and Admission

Where a patient DNAs any preoperative-assessment appointment or admission date then an offer of a further appointment or admission date will only be made if the treating clinician requests it, otherwise patient will be referred back to their GP/referrer.

4.6.4 Patients who DNA on a Suspected and/or Diagnosed Cancer Pathway

- “If a patient DNAs their initial outpatient appointment – this would allow for a clock pause from the receipt of the referral (recorded as the cancer referral to treatment period start date) to the date upon which the patient rebooks their appointment. This pause is relevant to the cancer two week wait and the 62-day standard.”
- The patient CANNOT be referred back to GP at the first DNA of the first appointment in the pathway whether this is either an out-patient appointment or straight to test appointment. Within ULHT a patient is allowed two DNAs and is then referred back to the GP.
- When re-booking, at least two days notice should be given to the patient unless the patient agrees to attend at shorter notice.

4.6.5 Patients who Cancel an Outpatient Appointment on an 18 week RTT Pathway

If a patient declines or cancels an outpatient appointment anywhere in an RTT pathway, another appointment must be re-arranged if required. This appointment must be made within two weeks of the original appointment. If an appointment is not available within two weeks, this must be escalated to the appropriate Business Manager for resolution as the RTT clock is still ticking. This will require exception reporting.

If the next appointment cannot be accepted by the patient, then they will be returned to the care of their GP and the 18 week clock will stop. If the patient

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cancels an appointment for a second time the patient will be returned to the care of the GP and the RTT clock will stop. If they are subsequently re-referred by the GP, this will start a new 18 week RTT pathway.

If the hospital cancels an appointment anywhere on an RTT pathway, the clock continues to tick:

For an Out-patient or Diagnostic appointment, the patient should be re-dated within the Trust Stages of Treatment (SOT) target.

4.6.6 Patients who Cancel a Preoperative-Assessment Appointment or TCI Date on an 18 week RTT Pathway

If a patient declines or cancels a preoperative-assessment appointment or TCI anywhere in an 18 week RTT pathway, another 'reasonable' appointment or TCI must be re-arranged, if required. The admission must still be within the 18 Week Pathway. If an appointment/TCI is not available to achieve 18 Weeks then this must be escalated to the appropriate Business Manager for resolution as the 18 week RTT clock is still ticking.

If the next appointment or TCI cannot be accepted by the patient, then they will be offered one further 'reasonable' offer of appointment/TCI using above rules (an 18 Week Pause may be applicable). If the patient declines or cancels a pre-assessment appointment or TCI date for a third time the patient will be returned to the care of the GP and the RTT clock will stop. If they are subsequently re-referred by the GP, this will start a new 18 week RTT pathway.

If the hospital cancels a preoperative-assessment appointment or TCI then this will re-set the patient cancellation count.

4.6.7 Cancellations on the 62-day & 31-day Suspected and/or Diagnosed Cancer Pathways

A patient may be referred back to the GP or referring source in agreement with the patient. The 62 day cancer pathway clock will then stop.

If the patient is re-referred onto the suspected or diagnosed cancer pathway, this will start a new 62 day cancer pathway.

4.6.8 Clinic Cancellation

- A minimum of 6 weeks notice of planned clinic cancellation, reduction or change to the booking rules must be given by all clinical staff, together with the reason for such cancellation.
- Clinic cancellations or reductions at less than 6 weeks notice will only be approved in an emergency or in exceptional circumstances.
- All proposed clinic reductions and cancellations received with less than 6 weeks notice must be discussed with Business Manager and Clinical Lead.

Only in exceptional circumstances, when all possible cover arrangements have been explored, should patients be cancelled. In these instances, medical staff must review the case notes. (Action Card 5 & 7) The clinic appointments will be

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reviewed initially by the Business Manager to ensure that no patients breach the waiting time targets as a result of the cancellation/reduction.

Any potential 18 week breaches caused as a result of clinic cancellation will be brought to the attention of the relevant Business Manager for advice and direction.

Only in very exceptional circumstances, should a patient that has been cancelled be cancelled a 2nd time.

Where cancellations are initiated by the Trust, patients should be rebooked at the time the cancellation takes place and given 2 weeks notice from their original appointment date (unless the patient agrees a mutually convenient appointment with less than 2 weeks notice). (Action Card 4 & 5)

4.6.9 Reasonableness

Outpatients & Diagnostic Appointments

It is good practice that all patients will book their diagnostic test on the same day of their outpatient appointment. On an RTT pathway, a reasonable offer of an outpatient or diagnostic appointment date is considered to be:

- For a verbal offer to a patient to be deemed reasonable the patient must be offered a minimum of two appointment dates on different days with a minimum one calendar weeks notice.
- For a written appointment offer to a patient to be deemed reasonable the patient must be offered an appointment date with a minimum of one calendar weeks notice.

Cancer Outpatients and Diagnostics

On the 62 day or 31 day cancer pathway, a reasonable offer of an outpatient or diagnostic appointment is considered to be:

- For a verbal offer to a patient to be deemed reasonable, the patient must be offered a minimum of one appointment date with minimum of 2 days notice.
-

Elective Patients

On an RTT pathway, a reasonable offer of a TCI date is considered to be:

- for a verbal offer to a patient to be deemed reasonable the patient must be offered a minimum of two admission dates on different days with a minimum three weeks notice.
- for a written offer to a patient to be deemed reasonable the patient must be offered an admission date with a minimum of three weeks notice.

Elective Cancer Patients

For cancer patients, a same day TCI will be considered reasonable if agreed with the patient.

Reinstatement and Re-listing of Patients

Patients cannot normally be reinstated to an RTT pathway once removed (exceptions include Cancelled on the Day, etc). The GP may re-refer and the patient will be re-listed and this will commence a new 18 week RTT pathway and clock start.

Note: If a patient is removed in error from an 18 week RTT pathway, then the Choice & Access Department must be contacted to action a reinstatement.

4.6.10 Primary Care 2 Week Wait Referral Pro-forma onto 62 day Cancer Pathway

ULHT/NHS Lincolnshire has a standard template for primary care 2 week wait referrals to the Trust. A specific template is available for each type of suspected cancer. All referrals should be sent on the standard pro-forma.

4.6.11 Inter-Provider Transfers

Inter-provider transfers will be accompanied with a Minimum Data Set (MDS) and will be forwarded to the receiving organisation electronically (via an NHS Net account) within 48 hours of decision to refer.

The Minimum Data Set must include:

- Pathway id
- 18 week clock start date
- Date of decision to refer to provider

Referrals for diagnostic tests must be sent no later than week 6 on their 18 week pathway.

Referrals for treatment must be sent by no later than week 8 on their 18 week pathway.

Receiving Inter-Provider Transfers

Inter-Provider Transfers will be accepted by ULHT for clinical reasons only. If a patient wishes to change provider for reasons other than clinical need the original provider should refer them back to their GP and this could delay treatment. It is important that patients are aware that Choice of provider is only applicable at the point of referral and does not extend to the whole of the 18 week pathway.

ALL inter-provider transfers into ULHT must be accompanied with an Inter-Provider Minimum Data Set (MDS)

All referrals will be received at Choice & Access via an nhs.net email account.

Administrative decisions should not override clinical decisions; therefore, incomplete administrative RTT data is not an acceptable reason for delaying the acceptance of an appropriate referral.

Any patients received with less than 10 weeks notice of their 18 week breach date must be brought to the attention of the General Manager, Access Booking & Choice, who will advise the appropriate Deputy Director/Business Manager.

Choice & Access will ascertain missing MDS information.

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Inter Provider Referral Letter

A tertiary referral template (Appendix D) available on the Trust intranet will be used by Trust staff to provide the MDS, when referring to other providers. This is to ensure national compliance regarding provision of information for tertiary referrals.

Cancer Patients Inter Provider Referral to Nottingham University Hospitals NHS Trust.

ULHT has a standard template, the format of which has been agreed at Mid Trent Cancer Network level.

Suspected Cancer Patients Inter Provider referred into ULHT (e.g. Boston Treatment Centre). These patients should be referred on a 2ww referral form directly into the 2ww Booking Office at ULHT.

Diagnosed Cancer Patients Inter Provider referred into ULHT, these patients should be referred directly to the relevant Consultant Specialist at ULHT but the patients will go onto the 31 day pathway, not the 2ww - 62 day pathway. The patients will be added to the agenda for the next MDT meeting of the relevant speciality. (A Clinical referral letter is required from the Clinician at the Inter Provider organisation to the Consultant Specialist at ULHT.

4.6.12 Private Patients Transferring to NHS

When a patient who has been seen privately and then requests transfer to the NHS for on-going treatment the patient may be:

- directly referred by the referring consultant or
- via the patient's GP.

Choice of provider will be discussed with the patient by the referring clinician ie the consultant and/or GP. The 18 week RTT clock will start on the date of receipt of the treatment transfer from the private provider or conversion of the UBRN if the referral is via electronic booking. It is the responsibility of the referring clinician to provide the patient 18 week RTT status in order to ensure that the patient joins the 18 week pathway at the appropriate point, for treatment.

Private patients transferring to ULHT for on-going cancer treatment, the 18 week RTT clock will start on the date of receipt of the subsequent treatment referral. In addition, cancer patients will join the 31 day pathway from the date of receipt of the transfer from the Private Provider to ULHT. However, the 31 day cancer clock does not start ticking until the date of the "decision to treat", which is the date the patient and the Consultant agree the treatment plan.

5 Delivery of Policy

5.1 Training

Referral to Treatment (RTT) training will be available for all staff involved in the implementation of this policy, clinical, managerial and clerical (permanent & temporary) to ensure accurate & timely data collection to enable ULHT to meet the DH RTT targets.

To ensure high quality waiting list administration and continual maintenance of data quality, all staff involved in waiting list management will be trained to a standard level, tailored to the individual's responsibilities.

Each year all relevant staff will undergo compulsory refresher training and records of all training will be documented.

5.2 Responsibilities and Accountabilities

- It is the responsibility of the General Manager, Access, Booking & Choice to produce the clinic outcome forms which record the RTT codes, and to ensure that Choice and Access Administrative Officers input the data into PAS.
- It is the responsibility of the Clinicians to complete the clinic outcome forms including the RTT coding. It is advised that a note of the RTT code is recorded in the case notes to guide the choice of RTT code for subsequent attendances, eg if Active Monitoring has previously been started and continues at subsequent appointments, the RTT code for subsequent appointments will be Active Monitoring continuing.
- It is the responsibility of the Clinic Nurses to support the Clinician completing the forms and support the Receptionists to ensure all forms are complete and passed to them for PAS input in a timely manner.
- It is the responsibility of the Business Managers to support the Clinicians and advise of changes and guidance to RTT coding and clinic outcomes.
- It is the responsibility of Business Managers to ensure that the allocation and availability of slots on Choose and Book reflect the requirement for 2 week wait, urgent and routine appointments. Clinicians and Business Managers are responsible for advising Choice & Access of any changes to their Directory of Service (DoS).

5.3 Adherence to Policy

Information Services and the Choice & Access Department will routinely monitor the appropriate application of this policy for RTT pathways. Where issues arise with any member of staff in complying with the policy, the issue will be resolved between the Information Services Team and the individual concerned in conjunction with their line manager. Any failure to reach agreement will be referred to the appropriate Deputy Director/Business Manager and/or Director of Delivery.

6 Outpatient Waiting Lists (Non Choose & Book Patients*)

6.1 General Principles

- Patients are seen in the order of clinical priority and date on list.
- Patients are kept fully informed and have a single point of contact at the Trust.
- Entering referrals on PAS at the point of receipt of letter and within 24 hours.
- Referrals should be accepted or rejected as appropriate within 48 hours by the consultant and amended on PAS.
- There must be a New Referral for a patient with an existing condition if the request for further consultation is 6 months after the discharge of the original referral.
- Referrals and waiting times are correctly counted.
- For a verbal appointment offer to a patient to be deemed reasonable, the patient must be offered a minimum of two appointments dates on different days, with at least one week's notice before the first of these appointments.
- For suspected or diagnosed cancer patients, a verbal appointment offer to a patient to be deemed reasonable, the patient must be offered a minimum of 1 appointment date with at least 2 days notice.
- For a written appointment offer to a patient to be deemed reasonable, the patient must be offered an appointment date with at least one week's notice.
- Staff must abide by the parameters of the clinic structure (booking rules) available; unless vacancies occur thereby swapping new and follow-up slots accordingly to ensure full capacity is maintained. This must only be done in conjunction with the Outpatient Booking Team.
- The Trust will operate a waiting list system based on taking patients in turn except for emergencies and cancer 2 week waits.
- Patients should be given appointments in date order to ensure equity of access.
- Cancelled slots must not be given to the next "routine" referral that comes to hand. They should be used to bring forward the longest waiting patients
- When making the appointment, the booking on clinical systems including PAS must be linked to the appropriate referral, which has already been logged. Staff must ensure that duplicate referrals are not

* Note: Choose & Book Patients do not go onto an Outpatient Waiting List

created as this causes double counting of referrals and miscalculation of the patient's waiting time

- The patient will be sent a confirmation letter regarding their booked appointment. The letter must 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 consequences should the patient cancel the appointment or fail to attend the clinic at the designated time.
- Where cancellations are initiated by the Trust, patients should be booked as close to their original appointment as possible, within 2 weeks of the cancellation date.
- All patients will be given a specified time of appointment, no block bookings of appointment times will be administered to the clinics.
- Never book follow-up appointments into new appointment slots, unless the clinic has vacancies. In these instances to ensure full utilisation, use 2 follow-up slots for 1 new slot, after prior consultation with Outpatient Booking staff.
- Only nominated staff will book appointments into the clinics.
- Six weeks notice of clinic cancellations must be given. The Clinical Lead and Business Manager must give authorisation for cancellations under 6 weeks. The definition of a cancelled clinic is when a clinic is cancelled and another one is not rescheduled within 6 weeks in its place.
- Clinic booking rules changes will only be actioned for:
 - 2 week Cancer Criteria Set
 - help in reducing Waiting Times
 - changes authorised by the Business Manager
- When patients cancel their appointments and do not wish to have another appointment, inform the patient to contact their GP with this information. The referral must then be discharged on the appropriate clinical system including PAS.
- When patients have hospital transport booked, the Transport Department must be notified of any amendments to a patient's appointment
- See Appendix B for the Trust and NHS Lincolnshire Policy on Consultant to Consultant Referrals.

6.2 Key Outpatient Targets for 2011/12

- ULHT aim to achieve the shortest possible waiting times for all patients and deliver services in accordance with the requirements of the NHS Constitution maximum waiting times.

6.3 Referral letters

- The Trust and Primary Care Organisations will continue to work together to ensure all referrals are appropriate.
- If referrals bypass Choice & Access, then they should be date stamped and immediately sent to Choice & Access to be entered onto PAS.
- All referrals (both paper and electronic) must include full demographic details, including NHS number and telephone numbers (both day and evening, if possible) to reduce administrative time contacting the patient.
- Generic 'Dear Doctor' referrals will be allocated to the appropriate consultant with the shortest waiting time.
- Consultant annual leave, study leave or sickness, delaying the review of referral letters, must not disadvantage the patient. Directorates must work with the consultants to ensure there are contingency arrangements to cover periods of leave.
- A Tertiary Referral Template will be used by Trust Staff when referring patients to 'other' Providers. The same template must be used when referring patients within the Trust for the same condition. The template would be used when there is no other pre-existing template in place ie cancer. This is to ensure national compliance regarding provision of information for tertiary referrals.

A copy of this can be found on the Trust Intranet. A similar template is envisaged for receiving Tertiary Referrals from 'other' Providers. See Appendix D for sample template.

6.4 Cancer Referrals

To meet the required NHS Plan and the Cancer Reform Strategy (DH 2007), suspected cancer referrals must be seen by a consultant within 14 days of receipt of referral.

All 2ww referrals should be booked with ULHT preferably electronically using the choose and book system. If this is not possible, the referral should be faxed into the 2ww office at ULHT. The latest version of the 2ww referral template should be used for the suspected cancer tumour site.

All breast referrals with the exception of family history and reconstruction referrals should be booked with ULHT preferably electronically using the choose and book system. If this is not possible, the referral should be faxed into the 2ww office at ULHT.

6.5 Referral Letter via Primary Care Triage

Referrals received from the CAS will be classified as GP referrals, therefore the national targets for outpatients applies.

6.6 Referrals – Written Advice from Consultant

Where a referral is received that requires the consultant/other medical professional to respond in writing with advice rather than arranging an outpatient appointment, the referral must be updated accordingly on PAS. This must be actioned at the time of the written response being generated by the medical secretary (Action Card 1A).

6.7 Inappropriate Referrals

If a consultant deems a referral to be inappropriate, it must be sent back to the referring GP with an explanation of why. The referral decision must be updated and discharged accordingly on PAS.

If a referral has been made and the special interest of the Consultant does not match the needs of the patient, the Consultant should cross-refer the patient to the appropriate colleague where such a service is provided by the Trust and the referral amended on PAS.

Inappropriate cancer referrals cannot be sent back to the GP or referrer. If a Consultant can “rule out” cancer after seeing the patient, the patient may be removed from the 62 day suspected cancer pathway and join the 18 week pathway. See 6.8 for monitoring of appropriateness.

6.8 Internal Referrals (Consultant to Consultant Appendix B)

- These referrals should follow the same pathway as external referrals.
- Referrals should be prioritised alongside external referrals.
- Book patients as per the booking policy defined in Action Card 1.
- See Appendix B

6.9 Referral Monitoring

Staff are required to ensure that every outpatient referral logged onto PAS is actioned ie checking that all referrals are booked for an appointment, or discharged if no appointment is required.

2 week wait referrals onto the 62 day suspected cancer pathway should be monitored on an annual basis for appropriateness of referral and for ensuring the correct information is entered onto the form. An annual audit needs to be performed with results fed back to the Primary Care sector and GPs to improve the appropriateness of referrals.

6.10 Registration/Post Checking

- All new referrals must be date stamped and registered within 24 hours of receipt of the referral letter.
- Patients already registered must have *the Patient Master Index (PMI)* module checked and their record amended as necessary.
- Referral letters must be passed to the consultant within 24 hours of receipt. It must be ensured that referral letters are delivered prior to and immediately after bank holidays.

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- Referrals should be prioritised by the consultant within 48 hours of receipt by the Consultant and then sent directly to the booking department.
- Appointment letters must be sent to the patient within 24 hours of the appointment being booked.

6.11 Clinic Booking Rules Changes

- New Clinic Set Up – All requests for new and additional clinics must be made on the relevant pro-forma. Having been completed by the Consultant/Business Manager with necessary funding agreed, the completed pro-forma should be sent to Choice and Access for input/set up on PAS
- Clinic templates should reflect the mix of referrals and the capacity required to deliver the Access targets. They identify the number of slots available for new and follow-up appointments, and specify the time each clinic is scheduled to start and finish. The length of time allocated for each clinic varies from three to four hours.
- All requests for template and temporary clinic rule changes will only be accepted in writing on the specified pro-forma with Business Manager sign off. Non-outpatient managed areas should also use this form. All requests for template changes must be made with at least 6 weeks notice to allow Outpatient Services Staff the necessary time to implement the change.
- The administration team are authorised to overbook a clinic following receipt of authorisation from the Consultant and/or Business Manager.

6.12 Cancellation of Clinic Sessions/Part Sessions

All clinics should be monitored closely. An analysis of clinic cancellations including those with less than 6 weeks notice will be circulated on a monthly basis.

6.13 Annual and Study Leave

- All requests for annual and study leave by consultant and 'career grade' doctors must be approved six weeks before leave is to be taken.
- Notification will only be accepted in writing on the appropriate leave form that clarifies the arrangements to cover duties during absence on leave.
- The original form is to be completed and forwarded to the Choice & Access Booking Team, who will then cancel the clinic as per instructions. The reason for the cancellation will be recorded and form part of the monthly cancellation clinic report.
- Clinics that require cancellation as a result of annual /study leave with less than six weeks notice, will require written approval by the Clinical Lead. The Deputy Director and Business Manager must be informed.

- Where cancellations are initiated by the hospital, patients should be booked as close to their original appointment as possible, according to clinical priority, but within the specified annual target.

6.14 Cancellation of Appointments

- The cancellation of an appointment can be by the patient, GP, consultant or ULHT.
- For all new referrals, where the patient cancels an appointment, any further appointment must be offered within the specified target date and two weeks of the cancelled appointment. An alternative appointment will be offered at the time of cancellation whenever possible. All patients will receive an appointment letter confirming their appointment details.
- Patients on the 62 day suspected cancer pathway cancelling their appointments should be offered a further appointment within the specified target date and allowed a minimum of 2 days notice.
- Patients who cancel before the appointment time are recorded on PAS with details of the reason for the cancellation. An alternative appointment is offered.
- When patients cancel their appointments and do not wish to have another appointment, inform the patient to contact their GP with this information. The referral must then be discharged on PAS.
- Patients wishing to cancel their appointment following validation will have their referral discharged and recorded on PAS as patient request and the referral placed in the patient's notes and a letter sent to the GP.
- If a patient cancels an appointment anywhere in an RTT pathway, another appointment should be re-arranged if required. This appointment must be made within two weeks of the original appointment. If an appointment is not available within two weeks, this must be escalated to the Business Manager for resolution as the RTT clock is still ticking. This will require exception reporting. If the next appointment cannot be accepted by the patient, then they will be returned to the care of their GP and the 18 week clock will stop.
- If the patient cancels an appointment date for a second time the patient will be returned to the care of the GP and the RTT clock will stop. If they are subsequently re-referred by the GP, this will start a new 18 week RTT pathway.
- If the Trust cancels a patient's appointment anywhere on an RTT pathway, the clock continues to tick.

(Action Card 5)

6.15 Contents of the Appointment Letter

The appointment letter should contain the following details:

- Patient's full name
- Patient's hospital number & NHS number
- Date letter sent to patient
- Date and time of appointment
- Where to report on arrival
- Who to contact to confirm, postpone or queries relating to the appointment date
- Any other response required from the patient either by telephone (to a named individual) or on an enclosed response slip
- What happens if the patient cancels or DNAs

The associated literature should contain:

- Arrangements for transport
- Any other information about the planned treatment

7 Outpatient Booking

7.1 Introduction

As part of the NHS Plan, patients will be offered more choice in booking their outpatient appointments.

For a verbal appointment offer to a patient to be deemed reasonable, the patient is to be offered a **minimum** of two appointments dates on different days, with at least one week's notice before the first of these appointments.

For a written appointment offer to a patient to be deemed reasonable, the patient is to be offered an appointment date with a **minimum** of one week's notice.

Note: If the patient cannot accept the offered date or it is their second cancellation or a DNA (7.7), then the patient must be returned to the care of the GP/referrer and the clock stopped.)

7.2 New Appointments

7.2.1 No Choice Given

An appointment is booked and sent to the patient, without any negotiation with the patient.

Note: SHA guidance indicates that to offer patient choice you must attempt to phone the patients more than once and at least once out of working hours. A record of each attempt must be recorded in the PAS comments field. An appointment letter can be sent with a sticker on it saying " We are attempting to offer you choice, enclosed is our first offer, please call us to confirm that the date suits you", this can then be recorded as a partial booking patient as every effort has been made to offer the patient choice.

7.2.2 Partial Booking

The patient is contacted by telephone and an appointment is agreed or a letter is sent to the patient, after prioritisation of referral, requesting that the patient telephones ULHT to agree a mutually convenient appointment date.

7.2.3 Full booking

In a full booking system the patient is given the opportunity to agree a mutually convenient appointment date within one working day of the decision to refer.

Patients who have had the opportunity to agree a date within 1 working day but choose to wait longer than that should still be counted as a fully booked patient.

The appointment booking system type must be recorded each time an outpatient appointment is agreed with a patient or sent to a patient.

7.3 Follow-up Appointments

Each follow up appointment should have the appropriate appointment booking system type and the current coding used as appropriate.

7.3.1 No Choice Given

When a follow up appointment is required and the secretary/clinic receptionist/ward receptionist sends the patient a follow up appointment through the post without any negotiation with the patient.

7.3.2 Partial Booking System

When a follow up appointment is required and the patient is sent a letter requesting them to phone in and agree a mutually convenient follow-up appointment date.

7.3.3 Full Booking System

When a follow up appointment is required and the patient agrees a mutually convenient appointment date and time directly after a clinic attendance.

7.4 Appointment cancellations

(See also Action Card 5)

- When a patient rings to cancel a fully booked appointment and arranges another mutually convenient date this remains a full booking.
- When a patient rings to cancel a partial booked appointment and arranges another mutually convenient date this remains a partial booking.
- When a patient rings to cancel a no choice appointment and arranges another mutually convenient date, this remains a 'no choice' booking.
- When the patient cancels, the booking type does not change, provided the patient has a Choice.
- When a patient rings to cancel a fully booked appointment or partially booked appointment and is sent a date this is NOT CHOICE.
- When the Trust cancels a new or follow-up appointment and sends another through the post (without agreeing the next appointment date with the patient) – this is NOT CHOICE.

7.5 Appointment Cancellations/DNAs

(See Action Card 27)

- Patients who do not attend their outpatient appointments will be discharged back to the referrer and their 18 week clock will be stopped ONLY if ULHT can demonstrate that the appointment was offered to the patient with a minimum of one week's notice and clearly communicated to the patient AND IF discharging the patient is not contrary to their best clinical needs eg children, cancer or very urgent patients. A new clock starts on the date ULHT receives a subsequent referral for the patient.
- Following two patient cancellations, the patient will be referred back to their GP/referrer.

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- If a patient wishes a further appointment the GP must re-refer.
- If a cancer patient DNA's their appointment, they are to be offered another appointment. If a patient DNAs more than once, the Trust will refer the patient back to their GP/referrer.

7.6 Removals from Outpatient Waiting List

Where there is no response by a patient or GP/referrer to partial booking letters, the patient will be removed from the waiting list and the referral discharged accordingly after one week.

If a GP then contacts the Trust for another appointment, this should be treated as a new referral as per date of telephone call/letter.

7.7 Use of Blue 2 Week Wait Sticker for Patients on the 62 day Suspected or 31 day Cancer Pathways

- A blue 2 week wait sticker denotes that the patient is suspected of having cancer or has already been diagnosed with cancer and denotes that an urgent appointment is required for either a diagnostic investigation or an outpatient appointment.
- The blue 2 week wait sticker does *not* mean that a patient's appointment needs to be booked within 2 weeks of the referral being received into the diagnostic service department or the outpatient booking area. A blue 2 week wait sticker means that the patient needs an urgent appointment within the shortest timeframe possible ie within days not weeks.
- A blue 2 week wait sticker should not be used for patients where cancer is not suspected or diagnosed.

7.8 Seven key points

The following points must be adhered to with regard to Outpatient clinics.

1. DNA and patient cancellation policy to be enforced. For one DNA or two patient cancellations the patient must be referred back to GP/referrer if discharging the patient is not contrary to their best clinical needs eg children, cancer or very urgent patients.
2. "Six week hospital cancellation" policy applied and adhered to. All leave taken with less than six weeks notice must have a contingency plan for seeing patients e.g. another clinic or another consultant/doctor.
3. All referrals to be date stamped and registered on receipt. This must include referrals sent directly to consultants, where it is the secretary's responsibility to forward to Choice & Access for logging on PAS. Prioritised letters must be sent to Choice & Access within 48 hours.
4. Referrals should be prioritised by consultant within 48 hours of receipt and then sent directly to the booking department.
5. Templates should be reviewed and amended to include only one queue. No follow-up appointments to go into new slots.

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6. Any request for booking template changes where the number of new patients seen will be reduced should be referred to the Directorate Deputy Director and approved by Clinical Lead/Business Manager.
7. Close monitoring of waiting times will be undertaken to ensure that the 4 week target is achieved and the 13 week target is maintained. If a breach is predicted, a contingency plan should be put into operation (e.g. referrals to another consultant/doctor or additional clinics).

8 Diagnostics

8.1 Introduction

Diagnostics is an integral part of the patient 18 week RTT pathway and covers imaging, endoscopy, pathology and the elements of physiological measurement.

'A 'diagnostic' test is defined as a test or procedure used to identify a person's disease or condition and which allows a medical diagnosis to be made.

A therapeutic procedure is defined as a procedure that involves actual treatment of a patient's disease, condition or injury.

In some cases, procedures are intended as diagnostic up until a point during the procedure, when the healthcare professional makes a decision to undertake a therapeutic treatment at the same time. These procedures should still be reported ie include all tests/procedures that are intended to be diagnostic.^{1,2}

Some procedures will include both a diagnostic test and a therapeutic treatment. However, if the procedure is part diagnostic or intended to be part diagnostic, these should also be reported. An example of this is electrophysiology studies (EPS) – this is a diagnostic cardiac procedure that often results in an immediate treatment eg insertion of a pacemaker.

Patients will receive all diagnostic tests within a maximum of six weeks with the aim to achieve the shortest possible waiting times for all patients in accordance with national maximum waiting times guidance.

8.2 Diagnostic Wait

A patient's wait for a diagnostic test/procedure begins for:

- GP straight to test, when the request is received by ULHT or on conversion of the UBRN through Choose & Book or
- a ULHT internal request, on the date the decision to refer is made.

8.3 Referral Review, Acceptance, Rejection

There will be a maximum time limit of 24 hours to review diagnostic referrals and change the priority set by the referrer, if necessary.

Referrals will be accepted in Diagnostics according to internal protocols and IRMR regulations. Rejected referrals will be returned to the referring clinician and the diagnostic wait time stopped. Resubmitted referrals will start a new diagnostic wait time.

Note: the 18 week RTT clock position will not be altered whether the diagnostic referral is accepted or not. The 18 week clock will continue until a legitimate clock stop as defined in the DH 18 week Rules eg 1st definitive treatment, decision not to treat etc (4.5.5).

² DH Developing a diagnostics data collection (2006)

8.4 Exclusions from Diagnostic Recording

For the purpose of 18 weeks RTT diagnostic recording, this does not include waits for diagnostic tests/procedures where:

- The patient is waiting for a planned procedure (example interventional diagnostic is therapeutic not diagnostic, but may be planned) or surveillance diagnostic test/procedure ie a procedure or series of procedures as part of a treatment plan which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency eg 6 month check cystoscopy;
- The patient is waiting for a procedure as part of a screening programme e.g. routine repeat smear test etc.;
- The patient is an expectant mother booked for confinement;
- The patient is currently admitted to a hospital bed and is waiting for an emergency or unscheduled diagnostic/test procedure as part of their inpatient treatment.

8.5 Diagnostic test from GP

'Direct to Test' requests from a GP will not start an 18 week clock.

8.6 Reasonableness

It is good practice that all patients will book their diagnostic test on the same day of their outpatient appointment. The same principles and guidelines for Outpatient appointments apply.

For patients requiring an Endoscopy procedure, it is good practice that all patients will book their diagnostic test on the same day of their outpatient appointment. The same principles and guidelines for Outpatient appointments apply.

For a verbal appointment offer to a patient to be deemed reasonable, the patient must be offered a **minimum** of two appointments dates on different days, with **at least one week's notice** before the first of these appointments

- For suspected or diagnosed cancer patients, a verbal appointment offer to a patient to be deemed reasonable, the patient must be offered a minimum of 1 appointment date with at least 2 days notice
- For a written appointment offer to a patient to be deemed reasonable, the patient must be offered an appointment date with **at least one week's notice**

7.7 Did Not Attend (DNA)

Patients who do not attend their first diagnostic appointment will be discharged back to the referrer and their diagnostic wait time stopped IF it is clear that the appointment was clearly communicated to the patient AND IF it is not contrary to the patient's best clinical interests ie where the patient is on a cancer pathway,

urgent or a child. If, however, it is decided to offer the patient a further appointment, then the diagnostic wait time will stop at the date of the appointment they failed to attend and a new diagnostic wait will start from the date of the appointment that the patient missed (4.6.3). While the patient is waiting for a diagnostic test, the 18 week RTT status is on-going and the 18 week clock has not stopped.

The patient on the cancer pathway CANNOT be referred back to GP/referrer at the first DNA of the first appointment in the pathway whether this is either an out-patient appointment or Straight to Test appointment. Within ULHT a patient is allowed two DNAs and is then referred back to the GP/referrer (4.6.4)

Cannot Attend (CNA)

If a patient cancels an outpatient appointment anywhere in an RTT pathway including Diagnostics, another appointment must be re-arranged if required. This appointment should be made within two weeks of the original appointment. If an appointment is not available within two weeks, this must be escalated to the appropriate Business Manager for resolution as the RTT clock is still ticking. This will require exception reporting (4.6.5).

If the next appointment cannot be accepted by the patient, then they will be returned to the care of their GP/referrer and the 18 week clock will stop. If the patient cancels an appointment for a second time the patient will be returned to the care of the GP/referrer and the RTT clock will stop. If they are subsequently re-referred by the GP/referrer, this will start a new 18 week RTT pathway.

A cancer patient may ONLY be referred back to the GP/referrer in agreement with the patient. The 62 day cancer pathway clock will then stop.

8.8 Test Not Performed (TNP)

Patients who attend but whose diagnostic test is not performed due to the patients' condition or ability to undertake the procedure ie:

- physical capability
- claustrophobia
- allergies
- unco-operative
- obesity

will have an alternative test where possible at the time of attendance or will be discharged back to the GP/Consultant care for resubmission or cancellation and the diagnostic clock will stop.

Patient Access Policy v6

8.9 18 Week Pause

An 18 Week patient choice pause (PCP) *cannot* be applied to a diagnostic waiting list procedure eg endoscopy.

8.10 Private Patients

Private patients are excluded from the diagnostic waiting time target³.

³ Diagnostic Waiting times & Activity v3 Mar 2007

9 Inpatient and Day Case Waiting List

9.1 General Principles – Inpatient & Day Case Waiting lists

- As part of the NHS Plan, patients will be offered more choice in booking their inpatient or day case admission dates and 100% of all inpatient and day cases will be booked.

Note: - Booking relates to Full or Partial bookings.

- Patients who require a procedure that is in the PCT Exclusion policy should not be added to the waiting list until approval is confirmed. Approval can be sought by the case being put forward by the Clinical staff at ULHT, to NHS Lincolnshire Individual Funding Request Team.

For Further Guidance see ULHT Intranet, Patient Access Policy then follow the link to NHS Lincolnshire Exclusion Policy.

- Patients who are from PCTs which the Trust does not have a contract with are classed as non-contracted activity (NCAs).
- ULHT currently operates a two queue waiting list, urgent or routine, but is moving towards a single queue in line with the 18 week RTT target.
- All patients will be kept fully informed from the point of entry onto a waiting list to their admission offer and have a known point of contact at the Trust
- Users will maintain waiting lists on PAS in a timely manner to ensure that waiting times are correctly calculated
- For a verbal admission offer to a patient to be deemed reasonable, the patient must be offered:
 - Therapeutic patient - a **minimum** of two admission dates on different days, with at least **three** weeks notice before the first of these admissions.
 - Diagnostic patient - a **minimum** of two admission dates on different days, with at least **one** week's notice before the first of these admissions

Exception: - If a patient accepts a short notice TCI date and does not decline it within **one** working day, then it will be deemed a reasonable offer.

- For a written admission offer to a patient to be deemed reasonable, the patient must be offered:
 - Therapeutic patient – an admission date with at least **three** weeks notice
 - Diagnostic patient - an admission date with at least **one** week's notice

For cancer patients: a same day appointment can be considered reasonable.

Patient Access Policy v6

- Patients will be offered a TCI date, where appropriate, at any of the hospitals within ULHT, with the procedure being undertaken by an appropriate surgeon with the exception of cancer patients. Cancer patients will be offered at TCI date at a hospital within ULHT in keeping with Cancer Improving Outcomes Guidance (IOGS).

9.2 Responsibilities of Waiting List Holders:

- To maintain an up to date and accurate waiting list
- To enter patients onto Waiting lists within 24 hours of Decision to Admit (DTA) being made and to inform the patient that they are on a waiting list.
- To ensure when a decision to admit is made in a clinic, the clinic attendance date = Original Date on list and Date this Provider on PAS WL entry screen.
- To ensure patients are given adequate notice and choice relating to admission dates.
- To ensure 18 Week Pause periods are entered according to policy (Action Card 17 & 18).
- To ensure any changes to an entered 18 Week Pause are sanctioned by the Access, Booking & Choice General Manager or his/her representative.
- To enter the reasons for the 18 Week Pause and cancellation onto PAS.
- To regularly validate the Waiting Lists to ensure lists are complete and correct at all times.
- To ensure PAS is updated correctly and timely with any patient Choice decisions.
- To ensure the appropriate Referral to Treatment (RTT) status is accurately & timely recorded on PAS.

9.3 The Key Inpatient and Day Case Targets from 2008

- From December 2008, the maximum waiting time from GP Referral To inpatient Treatment is 18 weeks, which will include any diagnostic tests. ULHT aim to achieve the shortest possible waiting times for all patients and deliver services in accordance with the requirements of the NHS Constitution
- Cancer waiting time standards. There is a maximum of 31 days from Decision to Treat to Treatment, and 62 days from urgent referral to treatment for all cancers.
- Maintain improved access to services across the patient pathways of 3 months maximum wait for angiography and revascularisation, reducing in line with the overall 4 week diagnostic and 10 week elective targets.

- Other targets for inpatients are given in Section 3, National Priorities.

9.4 Overview of the Inpatient & Day Case Waiting Lists (incl Private Patients)

- The traditional pathway on to the Inpatient/Day Case waiting list is for the patient to be referred to a consultant by a GP, seen in Outpatients, added to the waiting list and treated. There are, however, other routes onto the list and not every patient goes straight on to treatment.
- Patients on the Active Waiting List are waiting for elective admission for treatment and are currently available to be called for admission. These patients are included in the National Waiting List Monitoring return KH07.
- Patients on the Planned Waiting list are waiting to be admitted as part of a planned (time dependant) sequence of treatment or investigation, e.g. check cystoscopy (Action Card 15)

9.5 Structure of Waiting Lists

- The structure of waiting lists is critical if they are to be effectively managed. These may consist of Elective Partially Booked, Elective Fully Booked and Elective Planned.
- The Trust currently operates a two queue waiting list, urgent or routine, but is moving towards a single queue in line with the 18 week target.
- From January 2008 patients have been informed that an admission date may be offered at any of the hospitals within ULHT, with the procedure being undertaken by an appropriate surgeon.
- Waiting lists should be divided into as few separate lists as possible. The following is suggested for each consultant (where applicable):
 - Live/active
 - Planned
- It is recommended that the waiting lists should only be sub-divided into a limited number of smaller lists in exceptional circumstances.
- The 'active waiting list' should only consist of patients awaiting admission who are available to come in.

9.6 Elective Partially Booked

A patient added to a waiting list having been given no date of admission on the day a decision was made to admit

9.7 Elective Fully Booked

A patient added to a waiting list, having been given a date to come on the day the decision to admit was made

9.8 Elective Planned

A patient added to a planned waiting list for a planned sequence of clinical care (eg check cystoscopy). The patient is added to a waiting list, having been given a date or approximate date at the time that the decision to admit was made.

- These patients are not on an active waiting list, and are not included in national waiting times. (Action Card 15)
- Ensuring appropriate patients are allocated to a 'planned' waiting list will aid waiting list management.

9.9 Contents of the To Come In (TCI) Letter

The 'To Come In' letter should contain the following details:

- Patient's full name
- Patient's hospital number
- Patient's NHS number
- Date letter sent to patient
- Date and time of admission
- Procedure Date
- Instructions re medication
- Eating/drinking instructions
- Where to report on arrival
- Who to contact to confirm, postpone or queries relating to the admission dates
- Expected length of stay or date of discharge
- Request to check if bed is available on the day of admission
- Any other response required from the patient either by telephone (to a named individual) or on an enclosed response slip (with a business reply envelope)

The associated literature should contain:

- Arrangements for transport
- Who to contact to discuss the operation.
- What the patient can expect if the admission has to be postponed
- How long it is likely to be before they can return to work or resume normal lifestyle
- Any special care needs that are normal to expect on discharge
- Any other information about the planned treatment
- The Trust Policy on what happens if the patient cancels or DNAs
- No patient should have his or her admission cancelled by the hospital. However this may occur in exceptional circumstances.
- The Business Manager must authorise a non-clinical cancellation.

In the event that ULHT has to cancel a patient's elective procedure on the day of admission or day of surgery for a non-clinical reason – the

patient must be offered, at that time, another TCI date within 28 days of the cancelled operation date. ULHT is monitored on the number of breaches of this national key indicator. Action Card 20 Inpatients: Cancelled Operations

- If the patient or hospital cancels an elective procedure on the day of admission or day of surgery for any reason, a new TCI date arranged to be inside 28 days will be deemed as a reasonable offer.

9.10 Private Patients – Private to NHS

- Where a patient is added to an NHS waiting list following a private consultation, they should be added according to their clinical priority.
- The 18 week clock will start at the point at which the clinical responsibility for the patient's care transfers to the NHS. This will be the date when the Trust accepts the referral for the patient.
- If the patient is referred to ULHT as a patient choice for treatment - there is no requirement for a subsequent NHS Outpatient Appointment. The patient may be added directly to the NHS Waiting List if clinically appropriate.
- A referral should be created on the day the Trust receives notification and this date used as the Original Referral date and Received Date.
- Cancer private patients must be referred within 3 days of decision to transfer and will join the 31 day cancer pathway from the date of receipt of transfer from the Private Provider to ULHT. The 18 week RTT clock start for cancer patients will start from the date the referral is received in the Trust.

9.11 Private Patients – NHS to Private

NHS patients already on NHS Waiting Lists opting to have a private procedure must be removed from the NHS Waiting List and from the 62 day and/or 31 day cancer pathway. ULHT private patients must be recorded on PAS as status 'Private'.

9.12 Patient TCI cancellations

A patient may cancel an arranged TCI date on or before the day of admission.

Examples of reasons for patient cancellations are:

- Patient becomes unavailable due to social reasons
- Patient advises they feel unwell e.g. a cold, chest infection
- Patient is currently an inpatient

In these circumstances the cancellation will be recorded as a patient cancellation, the 18 week clock is still on-going, the cancellation is recorded and another TCI date must be offered to the patient which should be within 28 days.

If the patient's non-attendance or cancellation is due to a third party fault e.g. the ambulance did not arrive, it will be recorded as a patient cancellation.

9.13 Hospital TCI cancellations

The national standard is that patients must not have their admission cancelled within 3 weeks before their guarantee date because it may not be possible to offer a further reasonable TCI date to the patient.

Prior to any patient being cancelled, the appropriate operational manager and Choice & Access manager must be contacted to identify the length of wait of the patient and any options available to prevent the cancellation. Only the appropriate operational manager can sanction the cancellation.

A patient whose admission is cancelled due to the hospital must be offered a choice of alternative dates at the time of the cancellation. The alternative dates must be within the guarantee date and should be within 28 days unless clinically inappropriate.

10 Management Information

10.1 Waiting List Management

- Patients will be managed via a booking system.
- To assist staff involved in the process of selecting patients, the Trust will publish a Patient Tracking List (PTL) at patient level. This list will contain the details of all the patients that each consultant will need to treat before the end of the following month in order to deliver 18 weeks.

10.2 Information for Internal Hospital Management

- Detailed information on the Waiting List and expected waits will be published monthly. This will be distributed routinely to Deputy Directors, Business Managers, Consultants and the Executive Management Team and will be available from the Information Services department intranet page, under the reports section.
- Summary waiting list and times information will regularly be presented to the Trust Board and Executive Board.
- Consultant level information summary of waiting list dynamics will be published monthly and is available to be shared with clinicians by General Managers.

10.3 Information to GPs and Consultants

- A discharge summary will be generated electronically and forwarded to the GP at the point of discharge and will reach the GP within 10 working days following the patient's discharge. Further detailed letters /communication will be generated where it is clinically appropriate.
- Detailed information by Consultant will be reported monthly to GPs via the Department of Health website.

Appendices

Appendix A: National 18 week RTT Status Codes

| Description | Code |
|---|------|
| First activity in pathway | 10 |
| Active monitoring end and treatment is now needed | 11 |
| Referral to consultant for separate, new condition | 12 |
| On-going activity in pathway | 20 |
| Request to Phlebotomy | 20 |
| Request to Physiology | 20 |
| Request to Cardiology | 20 |
| Request to Imaging test | 20 |
| Request to Urodynamics | 20 |
| Request to Endoscopy | 20 |
| Request to Neurophysiology | 20 |
| Referral to another consultant for the same condition | 20 |
| Request to Nuclear Medicine | 20 |
| Request to Therapy Services | 20 |
| Request to Sleep Studies | 20 |
| Request to Vestibular test | 20 |
| Request to Audiology | 20 |
| Add to diagnostic elective waiting list | 20 |
| Add to therapeutic elective waiting list | 20 |
| Admit from Waiting List for diagnostic procedure | 20 |
| Transfer to another Health Care Provider | 21 |
| First definitive treatment given (medical or surgical) | 30 |
| Active monitoring – patient initiated | 31 |
| Active monitoring – consultant initiated | 32 |
| Did Not Attend 1 st appointment after referral – DNA | 33 |
| Decision not to treat (discharge back to GP) | 34 |
| Patient declined offered treatment (discharge back to GP) | 35 |
| Patient died before treatment | 36 |
| First treatment already given | 90 |
| Active monitoring continuing | 91 |
| Not yet referred – diagnostic for GP to decide onward referral | 92 |
| Activity not applicable – not part of 18 week pathway | 98 |
| RTT status not yet known | 99 |

Appendix B: Consultant to Consultant Referral (diagram 2 Consultant-to-Consultant Referrals)

Introduction

The requirement to offer patients a choice of provider adds a layer of complexity to the issue of Consultant-to-Consultant referrals. This is a local agreement about when Consultant-to-Consultant referral without choice may be appropriate and when patients should be referred back to their own GP.

A. Consultant- to- Consultant referrals within the same speciality

Choose and Book will eventually result in GPs making direct referrals using protocol driven care pathways. This should improve the likelihood of referrals reaching appropriate specialists. However in the meantime, the following proposals will assist in improving the process of referral management:

- GPs are asked to provide comprehensive information in the referral letter to a specialty (rather than a specific consultant). Hip, knee and gynaecology referrals should include the patient's BMI and smoking status.
- ULHT staff screening referrals are asked to then ensure that referrals are directed to the appropriate specialist.

This should help to avoid unnecessary consultant-to-consultant referrals within the same specialty. However, there may be occasions when additional information is required from the GP and clinician-to-clinician contact is needed to facilitate direction to the appropriate consultant within the speciality.

Where another condition is identified, a consultant to consultant (same speciality) referral may be made in agreement with the patient. A copy of the referral letter will be sent to the patient's GP.

B. Inter-specialty Consultant-to-Consultant referrals

The referrer must identify (in the referral letter) if the patient is being referred for an 'existing' or 'new' condition.

All Inter-Consultant referrals will be booked as per the booking policy defined in Action Card 1.

Times when direct referral is appropriate

- Suspected cancer
- Urgent problems for which delay would be detrimental to the patient's health – the expectation here would be that the patient needs to be seen within 2 weeks
- Part of the recognised protocol/pathway of care of the condition or as part of a pre-op assessment e.g. cardiology network pathways; hepatobiliary referrals.

Times when referral back to GP is appropriate

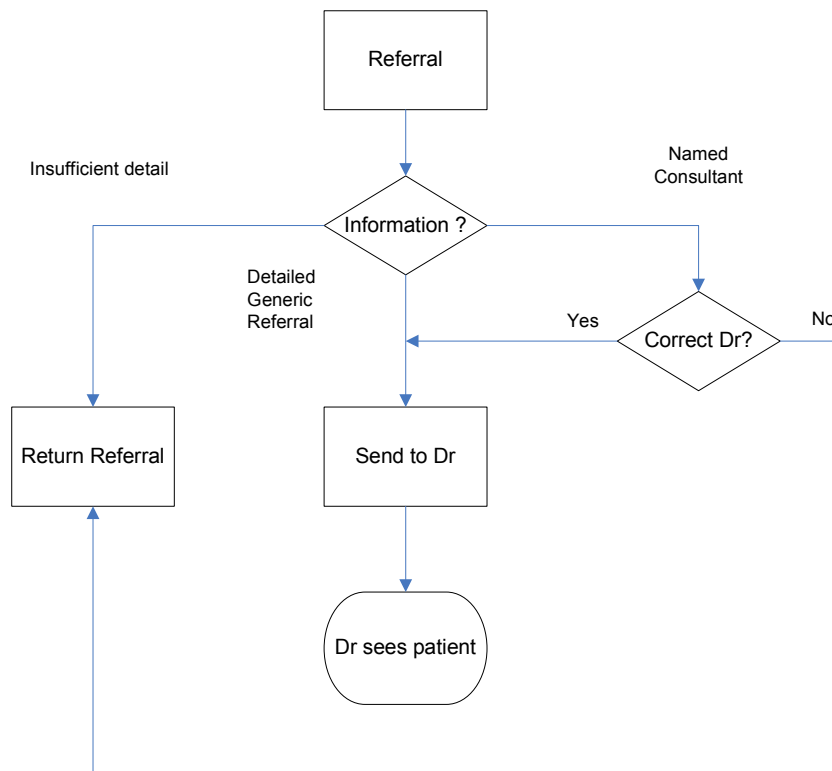
- Conditions that can be dealt with by the Primary Care team, for example hypertension, diabetes, asthma, COPD, thyroid disease, lipid disorder
- When patient requests a second opinion

When referrals are sent back to the patient's GP, it is important to ensure that this information is available to the GP before the patient books an appointment with them. UHLT fully supports this principle and consultants are requested to work towards a two week standard for returning the recommendation for onward referral to the GP.

Patients will be sent a copy of the letter to their GP and advised to arrange to see their GP on receipt of this. This should help to avoid patients making unnecessary visits to their GP

Consultant-to-Consultant Referrals

Flow Chart 1: Getting the Original referral to the Correct Person



Flow Chart 2: Consultant-to-Consultant Referrals Guidance

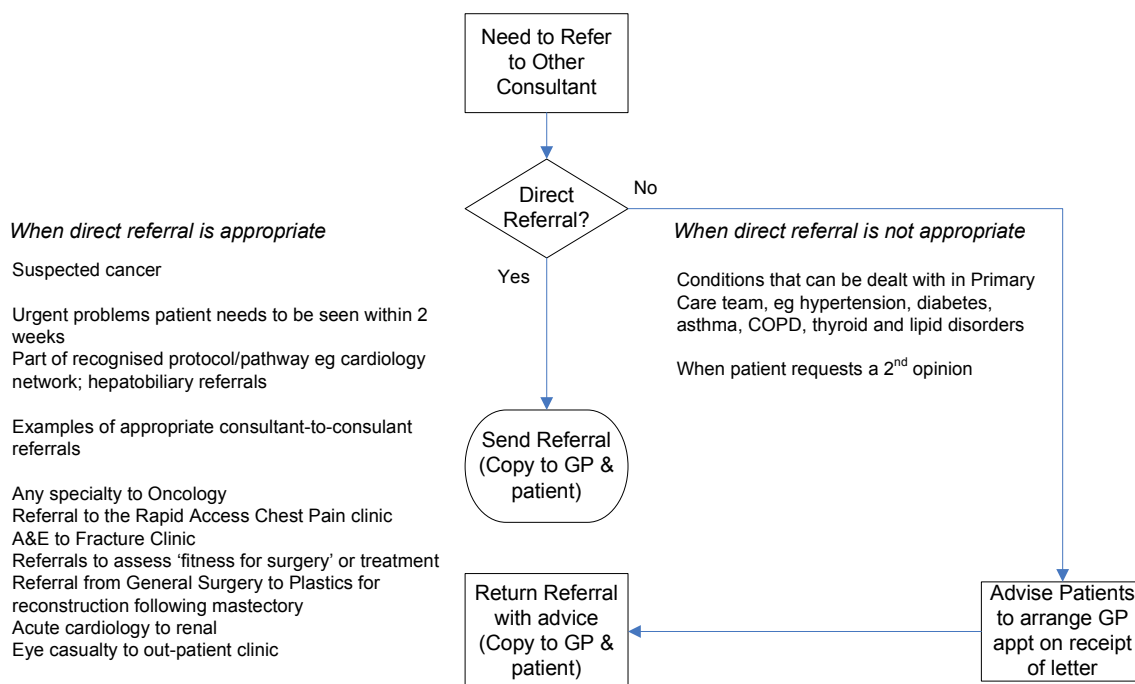


Diagram 2: Consultant-to-Consultant Referrals

Appendix C: Glossary

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

| Term | Definition |
|--|--|
| 18 week referral to treatment period | The part of a patient's care following initial referral, which initiates a clock start, leading up to the start of 1 st definitive treatment or other 18week clock stop point. |
| A | |
| Active monitoring | <p>An 18 week clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at this stage.</p> <p>A new clock will start when a decision to treat is made following a period of active monitoring.</p> <p>A patient may be referred back to primary care for on-going management after a period of active monitoring.</p> <p>If a patient is subsequently referred back to a consultant led service, then this referral starts a new 18 week clock.</p> |
| Active Waiting List types: Elective Partially Booked Elective Fully Booked | The list of elective patients who are fit and able to be treated at that given point in time. The active waiting list is also the list used to report national waiting times statistics. |
| Admission | The act of admitting a patient for a day case or inpatient procedure |
| Admitted pathway | A pathway that ends in a clock stop for admission (day case or inpatient) |
| Admitted patient | <p>If a patient needs to occupy a bed at all, they should be regarded as an admission to hospital.</p> <p>If the patient does not occupy a bed, any procedure undertaken should be classed as having been carried out during an outpatient attendance (see definition of a Bed).</p> <p>If the patient is admitted under a consultant and is not an emergency, they should have been placed on an elective list. If they are admitted under a responsible nurse, the admission should be recorded as a nurse episode.</p> |

| Term | Definition |
|--------------------------|---|
| B | |
| Bed | <p>A bed includes any device that may be used to permit a patient to lie down when the need to do so is a consequence of the patient's condition rather than the need for active intervention such as examination, diagnostic investigation, manipulation/treatment or transport.</p> <p>A trolley or a special chair may be counted as a bed if it is regularly used as such e.g. trolley in day care unit or recliner chair in renal dialysis unit.</p> |
| Bilateral procedure | A procedure that is performed on both sides of the body, at matching anatomical sites eg removal of cataracts from both eyes. See 'fit and ready'. |
| C | |
| Cancelled clinic | When a clinic is cancelled and another one is not rescheduled within 6 weeks in its place. |
| Cancelled Ops/procedures | <p>When a patient/hospital cancels an appointment the waiting time will continue to be calculated from the original RTT period.</p> <p>If the Trust cancels a patient's admission on the day of the admission/procedure for a non-clinical reason (ie lack of theatre time) – the Trust is required to rearrange a new operation date within 28 days of the cancelled procedure date, or within target wait time, whichever is the soonest. Action Cards 20, 21 & 22.</p> |
| Cancer clock | |
| 31 day | The 31 day cancer clock begins ticking from the date of the "decision to treat", which is the date that the patient and consultant agree the treatment plan. |
| 62 day | The 62 day cancer clock begins ticking from |
| Cancer 'vital signs' | A new set of cancer standards introduced from December 2008. |
| 'Call to needle' time | The call is the initial call for help by the patient (or presentation at A&E) to receipt of treatment ie patient receiving the thrombolytic. |
| Care professional | A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health care Professions Action 2002. |
| CAS | Clinical Assessment Service |
| CHD | Coronary Heart Disease |

| Term | Definition |
|------------------------------|---|
| Choose & Book – C&B | A national electronic referral service that gives patients a choice of place, date and time for their first outpatient appointments. |
| Chronological Order | This is a general principle that applies to patients categorised as requiring routine treatment (as opposed to urgent treatment). All these patients should be seen or treated in the order they were added to the waiting list. |
| Clinical decision | A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements. |
| Clock pause | <i>See pause</i> |
| Consultant | A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. 18 weeks excludes non-medical scientists of equivalent standing (to a consultant) within diagnostic departments. |
| Consultant-led | A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care. |
| Could Not Attend - CNA | Patients who, on receipt of reasonable offer(s) of admission, notify the Trust that they are unable to attend. |
| D | |
| Date Referral Received (DRR) | This date should be recorded in the case notes and used to calculate the total waiting time. |
| Day Case Patient | An elective patient who attends hospital for an interventional procedure and is discharged home, who does not require the use of a hospital bed overnight. These patients are on an admitted pathway. |
| Decision to Admit - DTA | The date on which a consultant decides a patient needs to be admitted for an operation as a day case or inpatient. This date should be recorded in the patient's notes. |
| Decision to treat | Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, and includes treatments performed in other settings eg as an outpatient. |

| Term | Definition |
|--|--|
| Deferred treatment | <p>Occasionally, an admission may be deferred for clinical or non-clinical reasons once the patient has been admitted (e.g. lack of theatre time). Patients must be returned to the waiting list and a new TCI date arranged.</p> <p>For non-clinical deferred treatments, the Trust is required to offer a new operation date within 28 days of the cancelled procedure.</p> |
| Did Not Attend (DNA) | <p>Patients, who have been informed of their date of admission or pre-assessment (inpatients/day case), or appointment date (outpatients) and who, without notifying the hospital, did not attend.</p> |
| Direct Access | <p>An arrangement where a GP can refer a patient directly to secondary care for a diagnostic test/procedure. The GP manages the ongoing care. This will not start an 18 week RTT clock.</p> |
| Direct bookable outpatient appointment | <p>The patient will be able to choose and book an appointment with their chosen provider via their GP surgery.</p> |
| Directory of Services -DoS | <p>The Directory of Service is the core of the Choose & Book application. It holds information that describes the services the Trust offers, enabling the referring clinician to search for appropriate services for their patients. The DoS provides patients with a list of suitable providers for their treatment.</p> <p>It is the Trust responsibility to ensure that they supply accurate and up to date information on the DoS.</p> |
| Door to needle - DTN | <p>Patient presentation at the hospital (self or by ambulance) to treatment. If the patient is a self presenter then CTN and DTN will be the same.</p> |
| E | |
| Elective admission /elective patients | <p>Inpatients are classified into two groups, emergency and elective. Elective patients are so called because the Trust can 'elect' when to treat them and they can be admitted for treatment as an inpatient or a day case.</p> <p>The decision to admit is made at least 24 hours before the admission. These patients have been identified previously by a consultant or GP as requiring admission for a bed, for an operation, diagnostic procedure or tests.</p> <p>Examples:</p> <p>Waiting list admission</p> |

| Term | Definition |
|--|--|
| | Admission date arranged in the future at clinic. |
| | Urgent patients who can wait longer than 24 hours |
| Elective Fully Booked | Patients awaiting elective admission who have been given an admission date which was arranged and agreed with the patient within one working day of the decision to admit. |
| Elective Partially Booked | Patients awaiting elective admission who have yet to be given an admission date. |
| Elective Planned Excluded from Active Waiting List | Patients who are to be admitted as part of a planned sequence of treatment or investigation. The patient has been given a date, or approximate date at the time a decision to admit was made. The date is set for clinical reasons (e.g. check cystoscopy) and there is no clinical advantage in admitting the patient earlier. |
| F | |
| Fit (and ready) | A new 18 week clock should start once the patient is fit and ready for a subsequent bilateral procedure. In this context, fit and ready means that the clock should start from the date that it is clinically appropriate for the patient to undergo the procedure and from when the patient says they are available. |
| First Definitive Treatment | An intervention intended to manage the patient's disease, condition or injury and avoid further intervention. This is a matter of clinical judgement in consultation with others including the patient. |
| G | |
| GPwSI | General Practitioner with Special Interest. |
| I | |
| Indirect bookable outpatient appointment | Some provider services are not directly bookable through Choose and Book so patients cannot book directly into clinics from a GP practice. Instead they contact the hospital by phone and choose an appointment date. |
| Interface Service (non consultant-led interface service) | <p>All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care.</p> <p>The 18 week target relates to hospital/consultant-led care. Therefore, the definition of the term 'interface service' within the context of 18 weeks does not apply to similar 'interface' arrangements established to deliver traditionally primary care or community provided services, outside of their traditional (practice or</p> |

| Term | Definition |
|---|--|
| | <p>community based) setting.</p> <p>The definition of the term does not also apply to: referrals to 'practitioners with a special interest' (GPwSI) for triage, assessment and possible treatment, except where they are working as part of a wider interface service type arrangements as described above.</p> |
| Inpatient | <p>A patient who requires admission to hospital for treatment and needs to remain in hospital for at least one night. These patients are on an admitted pathway.</p> |
| M | |
| Minimum Data Set - MDS | <p>The minimum data that must be provided with a tertiary referral:</p> <ul style="list-style-type: none"> Pathway id RTT start date RTT status <p>see Appendices D & E Tertiary Referral Templates</p> |
| N | |
| NICE | <p>National Institute for Clinical Excellence</p> |
| Non-admitted pathway | <p>A pathway that results in a clock stop for treatment that does not require an admission or no treatment.</p> |
| Non consultant-led Non-elective admission | <p>Where a consultant does <u>not</u> take overall clinical responsibility for the patient. These patients require admission to the hospital usually within 24 hours. These patients cannot be admitted from a waiting list. Patients who require a bed as soon as one is available is a non-elective admission.</p> <p>Examples:</p> <ul style="list-style-type: none"> Urgent admission via GP Patient seen in clinic and asked to return to hospital the same day Admission following test/scan From Outpatient Department Transfer from another Trust <p>See <i>interface service</i></p> |
| O | |

| Term | Definition |
|------------------------------------|--|
| Out of hours | <p>When trying to contact patients to arrange an appointment or admission, at least 1 attempt must be made 'out of hours'. This is deemed to be:</p> <p>7:00am – 8:00am</p> <p>5:30pm – 8:30pm</p> |
| Outpatients | <p>Patients referred by a General Practitioner (medical or dental) or another consultant/health professional for clinical advice or treatment. These patients are on a non-admitted pathway.</p> |
| P | |
| Pathway ID | <p>Unique pathway identifier for each pathway which is generated when the patient is referred to the Trust. Patients may have more than 1 pathway in more than 1 specialty.</p> |
| Patient Administration System: PAS | <p>Computerised hospital record keeping system</p> |
| Pause Patient Choice Pause - PCP | <p>Where patients for social reasons, cannot be treated within 18 weeks, they will be shown as an 18 Week Patient Choice Pause which must be recorded on PAS detailing a date by which treatment will be given and that both the patient and GP are aware.</p> <p>A clock may be 'paused' when a patient has turned down 2 or more 'reasonable' offers of admission with at least 3 weeks notice.</p> |
| Patient Tracking List - PTL | <p>A report/system used to ensure the maximum waiting times targets are achieved by identifying all patients that will breach the current wait times targets with regular reductions to achieve 4 weeks for outpatients, 4 weeks for diagnostics and 10 weeks for inpatients from December 2008.</p> |
| Planned procedure | <p>A planned list holds the details of patients who cannot be admitted at any time but need a procedure after a specified period or are following a specified process. Even if there were no constraints on resources, the procedures would not be undertaken any sooner.</p> <p>The usual procedures listed as planned are:</p> <p>Check endoscopies. These patients receive an endoscopy following an identified period of time e.g. 3 months, 6 months, 12 months</p> <p>Removal of screws/metalwork which can only be removed after being placed for an identified period of</p> |

| Term | Definition |
|---|--|
| | <p>time. Note: urgent removal of metalwork should be on the Live list</p> <p>Corneal grafts – these patients should be added to a planned list and once the cornea is available, moved to the active list and a TCI (“to come in”) date agreed with the patient.</p> <p>Procedures that can only be undertaken following a drug regime e.g. TCAEs.</p> <p>Pain relief injections. These patients are identified for a course of injections. The first injection must be added to the active list with an identified period of time between future injections. Subsequent injections should be added to the planned lists.</p> |
| R | |
| Ready, willing and able | Patients must only be added to the waiting list if they are ready, willing and able. (All patients must receive pre-operative screening to identify the patient’s fitness and availability prior to addition to the list). |
| Reasonable offer | A reasonable offer is an offer of a time and date 3 or more weeks from the time the offer is made. (time elapsed in calendar days NOT working days). |
| Referral Management or Assessment Service | <p>Referral Management or Assessment Services are those that do not provide treatment, but accept GP (or other) referrals and provide advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service, they may, or may not, physically see or assess the patient.</p> <p>Referral Management or Assessment Services should only be in place where they carry clinical support and abide by clear protocols that provide benefits to patients. They must not be devices either to delay treatment or to avoid having clinical discussions with GP practices about good referral practice.</p> <p>An 18 week RTT clock only starts on referral to a Referral Management or Assessment Service where that service may onward-refer the patient to a surgical or medical consultant-led service before responsibility is transferred back to the referring health professional.</p> |

| Term | Definition |
|-----------------------------|--|
| Referral to Treatment - RTT | The part of the patient's care following initial referral, which initiates a clock start of 1 st definitive treatment or other 18 week clock stop point. From December 2008 patients will only wait 18 weeks from the Referral to Treatment. |
| Regular Day Patient | Patients who require admission to the hospital for treatment on a regular planned basis |

S

| | |
|--|--|
| Straight to test | A specific type of direct access diagnostic service whereby a patient will be assessed and might, if appropriate, be treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional. |
| Self-deferrals | Patients who, on receipt of offer(s) of admission (TCIs), notify the hospital that they are unable to attend and the TCI Date is therefore cancelled by the patient. |
| Substantively new or different treatment | <p>A new 18 week RTT clock starts upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.</p> <p>It is recognised that a patients' care often extends beyond the 18 week referral to treatment period, and that there may be a number of planned treatments beyond 1st definitive treatment.</p> <p>However, where further treatment is required that was not already planned, a new 18 week clock should start at the point the decision to treat is made.</p> <p>Examples include:</p> <ul style="list-style-type: none"> - where less invasive/intensive forms of treatment have been unsuccessful and more aggressive/intensive treatment is required eg Intra Uterine Insemination (IUI) has been unsuccessful and a decision is made to refer for IVF treatment); - patients attending regular follow up outpatient appointments, where a decision is made to try a substantively new or different treatment. In this context, a change to the dosage of existing medication may not count as substantively new or different treatment, whereas a change to medication combined with a decision to refer the patient for therapy might. <p>Ultimately, the decision must be made locally by a care professional in consultation with the patient.</p> |

T

| Term | Definition |
|--|---|
| Therapy or Healthcare science intervention | Where a consultant-led interface service decides that Therapy (eg physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science (eg hearing aid fitting) is the best way to manage the patient's disease, condition or injury and avoid further interventions. |
| Tolerance: 18 weeks RTT | From December 08: 10% Admitted patients and 5% non-admitted patients. The tolerance levels take into account patient initiated delays and clinical exceptions. Operational standards are therefore 90% and 95% respectively. |
| Cancer: | A nationally agreed tolerance for the 62-day and 31 day cancer pathways will be set in 2009. |
| U | |
| Unique Booking Reference Number - UBRN | The reference number that a patient receives on their appointment request letter when generated by the referrer through Choose & Book. The UBRN is used in conjunction with the patient password to make or change an appointment. At the point the appointment is booked on Choose & Book, the UBRN is 'converted' |

Appendix D: Tertiary Referrals from ULHT

Inter Provider Transfer Minimum Data Set

Referring Organisation

| | |
|--|--|
| Organisation Name: Organisation Code: Referring Clinician: Referring Clinician Registration Code: Specialty: | United Lincolnshire Hospitals NHS Trust RWD |
|--|--|

Contact for this Referral

| | |
|----------------------------------|--|
| Name: Phone Number: Email: | |
|----------------------------------|--|

Patient Details

| | |
|-------------------------|---------------------------|
| Family Name: | Forename: |
| Title: | Date of Birth: |
| NHS Number: | Local Patient Identifier: |
| Correspondence Address: | |
| Post Code: | |
| Home Phone: | Mobile: |
| Work Phone: | Email: |

GP Details

| | |
|----------|-------------------|
| GP Name: | GP Practice Code: |
|----------|-------------------|

18 Week Pathway Information

| | |
|--|---|
| Is the Patient on an 18 Week Pathway? Yes/No <i>(If Yes, then complete the following)</i> | |
| Patient Pathway Identifier: | |
| Allocated by (Organisation Code where referral originally received that started the clock) | |
| Is this referral the: | Start of a new pathway (New condition or change of treatment) Yes/No Continuation of an active pathway (1 st definitive treatment <u>not</u> already given) Yes/No Continuing treatment for a stopped pathway (1 st definitive treatment already given) Yes/No |
| | Is this referral for Diagnostic tests or opinion only: Yes/No Date of decision to refer to receiving organisation: Clock Start of existing pathway or date of this referral if starts a new pathway: |

RECEIVING ORGANISATION DETAILS

| | |
|------------------------------|------------|
| Receiving Organisation Name: | |
| Receiving Organisation Code: | |
| Receiving Consultant: | Specialty: |
| Date MDS Sent: | |

For receiving organisation

| |
|----------------|
| Date Received: |
|----------------|

**Inter Provider Return
Notification**

When treatment has been completed, please can this form be returned so we can amend the 18 Week clock position for this pathway

Please return to

| | |
|--|--|
| <p><i>Name:</i> <i>Address:</i></p> <p><i>Phone Number:</i> <i>Safe Haven Fax Number:</i></p> | |
|--|--|

Returning Organisation

| | |
|---|--|
| <p>Organisation Name: Returning Clinician: Specialty:</p> | |
|---|--|

Sender of this Return

| | |
|---|--|
| <p>Name: Phone Number: Email:</p> | |
|---|--|

Patient Details

| | |
|---------------------|----------------------------|
| <i>Family Name:</i> | <i>Forename:</i> |
| <i>Title:</i> | <i>Date of Birth:</i> |
| <i>NHS Number:</i> | <i>ULH Patient Number:</i> |

18 Week Pathway Information

| | |
|---|--|
| <i>Patient Pathway Identifier:</i> | |
| Has your treatment stopped the 18 Week clock? | |
| If yes, when was the 18 Week clock stopped? | |
| What is the current RTT status code? | |

For ULH

| |
|----------------|
| Date Received: |
|----------------|

Appendix E: Tertiary Referrals to ULHT

Inter Provider Transfer Minimum Data Set

Referring Organisation

| | |
|--|--|
| Organisation Name: Organisation Code: Referring Clinician: Referring Clinician Registration Code: Specialty: | United Lincolnshire Hospitals NHS Trust RWD |
|--|--|

Contact for this Referral

| | |
|----------------------------------|--|
| Name: Phone Number: Email: | |
|----------------------------------|--|

Patient Details

| | |
|-------------------------|---------------------------|
| Family Name: | Forename: |
| Title: | Date of Birth: |
| NHS Number: | Local Patient Identifier: |
| Correspondence Address: | |
| Post Code: | |
| Home Phone: | Mobile: |
| Work Phone: | Email: |

GP Details

| | |
|----------|-------------------|
| GP Name: | GP Practice Code: |
|----------|-------------------|

18 Week Pathway Information

| | |
|---|---|
| Is the Patient on an 18 Week Pathway? Yes/No <i>(If Yes, then complete the following)</i> | |
| Patient Pathway Identifier: | |
| Allocated by (Organisation Code where referral originally received that started the clock) | |
| Is this referral the: | Start of a new pathway (New condition or change of treatment) Yes/No Continuation of an active pathway (1 st definitive treatment <u>not</u> already given) Yes/No Continuing treatment for a stopped pathway (1 st definitive treatment already given) Yes/No |
| Is this referral for Diagnostic tests or opinion only: Yes/No Date of decision to refer to receiving organisation: Clock Start of existing pathway or date of this referral if starts a new pathway: | |

RECEIVING ORGANISATION DETAILS

| | |
|------------------------------|------------|
| Receiving Organisation Name: | |
| Receiving Organisation Code: | |
| Receiving Consultant: | Specialty: |
| Date MDS Sent: | |

For receiving organisation

| |
|----------------|
| Date Received: |
|----------------|

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