Epsom and St Helier University Hospitals NHS Trust

ACCESS POLICY FOR ELECTIVE CARE PATHWAYS

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Trust Lead	**Jackie Sullivan, Chief Operating Officer**
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Contents

1. INTRODUCTION

The Trust is committed to ensuring that all patients on an elective pathway are managed in a timely and effective manner and in line with National Waiting List Guidance, the NHS Constitution and the NHS Operating Framework.

The guidance is derived from the NHS Operating Framework and performance indicator(s) guidance published by NHS England[1]. The Epsom and St. Helier University Hospitals NHS Trust ("the Trust") has applied a local interpretation of these rules, as intended, to provide both clarity and consistency for all patients.

2. PURPOSE

The purpose of the policy is to ensure that patients on an elective pathway are managed appropriately and consistently. This includes patients on an open Referral To Treatment ("RTT") pathway, patients waiting for an outpatient appointment, diagnostic test or elective admission and patients with a suspected cancer diagnosis.

The policy is designed to ensure fair and equitable access to Planned Care services and the appropriate allocation of resources. It outlines the main responsibilities of the Trust, healthcare professionals and patients in managing these pathways. It will be available to the public via the Trust's website.

The policy is intended to support the development and implementation of local waiting list rules and addresses the management of waiting lists and concept of choice and reasonableness as the NHS continues to work to reduce or maintain waiting times and to achieve a maximum wait of eighteen weeks from referral to first definitive treatment.

Although some planned care pathways are not specifically included within the operational targets, the principal of shorter waits and sustained improvement for all elective pathways will be implemented across the Trust.

The policy covers general management of Cancer patients, but more specific detail is included within the Cancer Operational Policy.

3. TRUST PRINCIPLES

The Trust is committed to the following good practice:

Putting Patients First – Treating all patients to specified clinical standards which incorporate and reflect patient choice, satisfaction, dignity and compassion.
Top Level Commitment – Developing an organisational culture of 'getting patients treated', not 'keeping them waiting'.

[1] http://www.england.nhs.uk/statistics/statistical-work-areas/

Working With Primary Care – Providing services in the most suitable locations.
Communication With Patients – Improving communication with patients through the implementation of full booking.
Improving the Efficiency of Services – Introducing 'one stop' and fast track services where appropriate with service re-design.
Continual Improvement in the Effectiveness of Services – Improving outpatient capacity, theatre utilisation, day case rates and service re-design.

In each situation the individual needs of the patient should be taken into account and special consideration in implementing the procedures set out in this document will be given to vulnerable patients such as children, prisoners, the frail elderly and patients with learning disabilities. Special consideration will also be given to patients with exceptional circumstances, or urgent conditions. The Trust will endeavour to ensure that these patients are not disadvantaged by local operating procedures

4. CORE PRINCIPLES

In March 2011, the Department of Health published the NHS Constitution"[2] The NHS Constitution sets out the guiding principles of the NHS and the rights of each NHS patient. One of these rights of the patient is:

> *'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 alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.'*

The Trust has a number of core principles central to managing patients on an elective pathway. These principles are intended to support the process to ensure we meet this obligation and to ensure that patients on an elective pathway are seen and treated appropriately and consistently:

- At present, the Trust's Patient Administrative System ("PAS") is i.Patient Manager ("iPM"). iPM should be used for recording all referrals, outpatient appointments, inpatient/daycase waiting lists, Admitted Patient Care ("APC") spells and relevant RTT events and information. Agreed outpatient waiting lists must also be specifically recorded on iPM.
- i.Clinical Manager ("iCM") is the Trust's present system for the central recording of clinical events and documentation. All relevant clinical documentation should be made available in iCM.
- Communications with patients must be timely, informative, clear and concise. Patients' responsibilities for keeping agreed appointments, if not kept, will also be clearly identified. Procedures for waiting list management should be transparent to the public and Trust staff as well as relevant commissioners. Patients will have access to this policy via the Trust's website or on request.
- Data held on iPM should be timely, accurate and complete and subject to regular audit and validation.

[2] http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

- Comprehensive demographic information must be recorded for all patients. A patient's demographic record should be confirmed and updated as appropriate at each hospital attendance.
- There are different standards for waiting times for various stages in a patient's pathway. Often these waits will run concurrently, for example a patient waiting for a diagnostic test will also be on an RTT pathway. Typically, all elective waits will fall within an RTT pathway.
- The "start" of a waiting time for elective activity ("clock start") is the date that the decision is made within an NHS Secondary Care setting that that activity is required. Typically this will be the date that we receive (accept) an elective referral from the GP, or the date that we decide a diagnostic test is required, or the date that we add the patient to a waiting list for admission.
- Should the patient be referred to an interface service for assessment or to a referral management centre prior to receipt by the Trust, the clock start for an outpatient referral is the date the referral letter is received by the intermediary organisation.
- For referrals made via an Electronic Booking System ("EBS") (e.g. ERS), the clock start is the day on which the patient books their appointment on-line or contacts a Booking Management Service (e.g. RSS) or the Trust to agree an appointment date and time i.e. converts their Unique Booking Reference Number ("UBRN").
- RTT Pathways that started at another NHS Secondary Care Provider and are referred on to this Trust without having been treated will retain the clock start date from the original provider i.e. the patient's RTT waiting time will continue to tick and will not be affected by the decision for the responsibility of that wait to transfer to this Trust.
- For RTT Pathways that started at another NHS Secondary Care Provider and are referred on to this Trust for new treatment having been treated already, will have a new clock start on the date that we receive (accept) the elective referral.
- For RTT Pathways that started at another NHS Secondary Care Provider and are referred on to this Trust for continuation of a treatment plan having already received the start of treatment will not start a new RTT pathway.
- All referrals from another NHS Secondary Care Provider should be accompanied by an appropriate Inter-Provider Transfer Administrative Minimum Data Set ("IPTAMDS")
- Referrals should include full demographic details, including daytime telephone number(s) (work, home and mobile if possible) to reduce administrative time contacting the patient.
- Priority will be given to urgent referrals. Patients of equal clinical priority (e.g. routines) should be treated in chronological order (from clock start date).
- Urgent referrals from GPs for suspected cancer must be seen within fourteen days (however local cancer policy may dictate that these patients should be seen even earlier). These referrals are known as Two Week Rule ("TWR") referrals. Routine referrals, which a hospital specialist believes have symptoms or signs indicating a high suspicion of cancer, must also be seen within fourteen days.
- Military veterans will receive priority treatment for any conditions that are likely to be related to their service, subject to the clinical needs of all patients[3]. In line with December 2007 guidance from the Department of Health all veterans and war pensioners should receive priority access to NHS care for any conditions

[3] http://www.nhs.uk/NHSEngland/Militaryhealthcare/Veteranshealthcare/Pages/veterans.aspx

which are related to their service, subject to the clinical needs of all patients (a veteran is defined as someone who has served at least one day in the UK armed forces). Military veterans should not need first to have applied and become eligible for a war pension before receiving priority treatment. GPs should notify the Trust of the patient's condition and its relation to military service when they refer the patient so that the Trust can ensure that it meets the current guidance for priority service over other patients with the same level of clinical need. In line with clinical policy patients with more urgent clinical needs will continue to receive clinical priority.

- The Trust expects that before a referral is made for potential elective treatment, the patient is both clinically fit for assessment and possible treatment of their condition and ready to start their pathway at the point of the initial referral. There is also an expectation that there is a reasonable level of expected availability of the patient in the eighteen weeks following the date the patient is referred (and in the sixty-two days following the date a patient is referred with suspected cancer). The requirement for pre-referral diagnostics will be service specific and set at a local level. The Trust will work with the local health care community to ensure patients understand this before starting an elective pathway.
- All requests for annual and study leave by clinicians must be formally requested and approved (by a General Manager or Head of Nursing) six weeks before leave is to be taken
- Clinics and theatre lists should not be cancelled within six weeks except through exceptional circumstances and only with the agreement of the appropriate General Manager
- All appointment and inpatient/daycase "To Come In" dates ("TCIs") must be verbally agreed with the patient.
- Clinic templates must be structured appropriately and directly relate to the available new and follow-up capacity for that clinic. Staff should then adhere to the template when booking patients. All requests for template changes must be agreed with the relevant Service Manager and any changes must be made with at least six weeks' notice
- Cancelled slots should not be given to the next "routine" referral that comes to hand. They should be used to bring forward the longest waiting patients
- When booking any appointment or other events or activity on iPM, it must be linked to the appropriate referral, which will already have been recorded. Where patients are on multiple concurrent pathways it is important to take care to ensure that this activity is recorded against the correct referral/pathway.
- Patients must be sent a confirmation letter regarding their booked appointment. The letter must include a point of contact and telephone number to call if they have any queries and should explain the consequences if the patient cancels the appointment or fails to attend the clinic at the designated time
- Where cancellations are initiated by the Trust, patients should be booked to an appointment that is convenient to the patient, which is as close to their original appointment as possible.
- Clinic cancellations must be made six weeks in advance. Any clinic cancellations made less than six weeks in advance should only happen following authorisation from a General Manager.
- When patients cancel their appointments and do not wish to have another appointment, the Trust should contact the patient's GP with this information. The referral must then be closed on iPM.
- Prisoner cancellations (or declined offers) initiated by the prison should (even though technically classified as patient cancellations) be given special

consideration in terms of whether we discharge them or not. Decisions on this need to be agreed with the General Manager for Planned Care & Performance.

- Treatment is defined as "the first definitive treatment that is intended to manage a person's disease, condition or injury … the treatment that is started is intended to avoid further intervention"[4]
- Watchful Waiting (Active Monitoring) is defined as a clinical decision (made in agreement with the patient and following a diagnosis, or where no diagnosis can be made) that no treatment is required, but instead the patient will be reviewed after a defined period of time to review this decision not to treat and to make a new decision on whether to continue with the period of Watchful Waiting or to reconsider whether treatment will be required.
- Any patient in a period of Watchful Waiting should either have a follow-up appointment booked (for a date that is appropriate as per the clinical decision around the length of period for the Watchful Wait) or be on an outpatient waiting list on iPM with an appropriate "See By" date.
- Watchful Wait is not appropriate for where patients are yet to decide how they want to proceed (patient thinking time) or where the clinician is waiting for test results or where the clinician has requested consultation/assessment/diagnostics from a colleague for the same condition
- Diagnostics may take place in an APC, outpatient or other (e.g. radiology) setting. There are specific rules that are particular to diagnostics and these should be applied in conjunction with the rules that relate to the setting in which those tests/procedures take place.
- The date of addition to a diagnostic (e.g. colonoscopy, ECG, MRI etc) waiting list ("diagnostic clock start") is the date that the decision is made that the patient requires that test. If a decision is made that a patient requires multiple diagnostics, then the patient will have multiple diagnostic waiting times running concurrently
- The date of addition to the inpatient/daycase waiting list is the date that the appropriate Trust clinician decides that the patient (unless the patient disagrees at the point of this decision being made) will be admitted for a procedure at an agreed date in the future. This is known as the Decision To Admit ("DTA"). If the patient chooses not to proceed with being added to the inpatient/daycase waiting list, then this decision should be clearly documented on iPM, typically in the outpatient attendance at which this discussion takes place. If a patient is undecided about whether or not to proceed with being added to the inpatient/daycase waiting list, then the patient is added to the waiting list and will be removed if a definitive decision not to proceed is made.
- Patients shall only be added to a waiting list after confirmation by the consultant concerned or an appropriate clinician, if there is a sound clinical indication to do so, that they are fit, willing and able to undergo the procedure and that the Trust has an agreement with the relevant Clinical Commissioning Group ("CCG") to carry out the procedure. Certain procedures have been deemed by commissioners as needing individual review by commissioners under the Effective Commissioning Initiative ("ECI") process before they decide whether they will fund the treatment or not. DTAs for these procedures should result in the patient being added to the waiting list and recorded in a way that identifies them as awaiting confirmation to proceed until such confirmation is received or until there is a decision to not proceed.

[4] http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

- Patients for elective surgery under general anaesthetic should undergo pre-operative assessment (“POA”). Some procedures done under local anaesthetic also require POA
- It is good practice to establish pooled waiting lists for services that can be covered by multiple consultants, and to add patients to pooled waiting lists wherever available. Patients added to pooled (generic) waiting lists rather than consultant-specific waiting lists will be informed at the earliest possible stage that this is the case and will be made aware that they may be offered dates for admission with appropriate consultants who were not directly involved with their pathway to date.
- Patients on a waiting list will be offered dates in accordance to their clinical priority and current RTT waiting time (“CPaT” – “Clinically Prioritise and Treat”) i.e. urgent patients are scheduled first and the longest waiting patient scheduled thereafter.
- All patients should be made “reasonable offers” (i.e. a choice of at least two dates with at least three weeks notice with an appropriate clinician at an appropriate location) for all elective events. An appropriate clinician is anyone that is deemed to be clinically appropriate by the responsible consultant. For patients on consultant-specific waiting lists, only that named consultant should be considered to be appropriate in terms of making reasonable offers. An appropriate location is any location used by the Trust for elective activity that is not an unreasonable distance from the main Trust sites.
- Short-notice offers (and other “non-reasonable” offers) can be made (and should be encouraged if available capacity allows this), but patients not accepting these offers should not be considered to be declining offers, and therefore should not be thought of, or recorded as, patient cancellations. Where a patient accepts a “non-reasonable” offer and subsequently cancels it, this should be treated the same as any other patient cancellation.
- Initiators and reasons for cancellations, whether by the patient or the Trust, must be clearly documented on the appointment/TCI on iPM
- Last Minute Cancellations (“LMCs”) (i.e. hospital-initiated, non-clinical cancellations of an elective procedure either following admission or on the day of intended admission) should be avoided whenever possible, and are subject to the relevant escalation policy.
- If a patient is removed from the inpatient/daycase waiting list for any reason other than receiving the intended procedure, the patient and the patient’s consultant and GP will be informed. A clear note will also be made in the ‘comments’ field of the patient’s waiting list on iPM.
- Closing a referral on iPM represents the decision to discharge a patient from that pathway back to the GP or original referrer.
- Where events or activity have been recorded incorrectly, appropriate amendments should be made as soon as possible. If this involves deleting events or activity that have been recorded in error, then this should be raised to the appropriate Assistant Service Manger (or above) since it is Trust Policy to give delete privileges only to people in roles at this level. Appointments or TCIs identified as having been duplicated or recorded in error should not be subsequently recorded as cancellations. Referrals identified as having been duplicated or recorded in error can be flagged for deletion following the appropriate process for doing so – they should not be “closed” in any other way.
- Where decisions, activity or events are recorded retrospectively, any associated dates must be backdated to indicate the actual date that this decision, activity or event happened.

- Planned care services will be delivered in accordance with any formal agreements made between the Trust and commissioning groups. The Trust will participate in clinical and activity audits, as required, to demonstrate reasonableness, clinical validity and administrative process compliance in line with commissioning requirements
- In accordance with training needs analysis, staff involved in the implementation of this Policy, both clinical and clerical, will undertake training provided by the Trust and receive annual updates. Policy adherence will be part of the staff appraisal process.
- It is the responsibility of all members of staff to understand the principles and definitions set out within this policy.
- Although we are only monitored against patients from English commissioners, we plan to treat all patients within eighteen weeks from referral, in line with the NHS Constitution.
- Management of patients on an elective pathway should be in line with the principles of the Trust's Patient First programme.

5. OVERVIEW OF TRUST STANDARDS AND NATIONAL OPERATIONG STANDARDS

There are several national standards relating to elective access. Providers are externally monitored and assessed on various waiting time standards and so all standards will be maintained in the management and administration of all patients referred for and receiving elective care.

Generally there is a degree of tolerance associated with the standard as it is accepted that 100% compliance will usually be unlikely due to clinical or social situations beyond the control of Trusts. Both the waiting time standards and the tolerance levels are subject to change. Standards may be required to be met at different levels of granularity (e.g. at a specialty level).

The following national operating standards apply:

- 95% of non-admitted patients will receive their first definitive treatment within 18 weeks (126 days) of being referred.
- 90% of admitted patients will receive their first definitive treatment within 18 weeks (126 days) of being referred.
- 92% of incomplete pathways will have a wait time within 18 weeks (126 days) of being referred.
- 100% of patients will receive their first definitive treatment with 52 weeks (364 days) of being referred.
- 99% of patients on a diagnostic waiting list for one of the nationally defined "Key 15" diagnostic tests should have a current wait of less than six weeks.
- 100% of patients subjected to a Last Minute Cancellation must be offered the opportunity to be readmitted and receive their intended procedure within 28 days of initial cancellation.

- 93% of all patients with suspected cancer who are referred urgently by their GP will be seen by an appropriate specialist within 14 days of receipt of referral
- 93% of all patients referred for breast symptoms, even if cancer is not suspected, will be seen by an appropriate specialist within 14 days of receipt of referral
- 85% of all patients diagnosed with cancer following a referral from a GP for suspected cancer will receive first definitive treatment within 62 days of receipt of referral.
- 90% of all patients referred from a Screening Service following a positive histology (Breast, Colorectal, Cervical) will receive first definitive treatment within 62 days of receipt of referral.
- 96% of all patients with a new diagnosis of any form of cancer will receive their first treatment within 31 days of diagnosis.
- 98% of patients requiring receipt of second or subsequent treatment with anti-cancer drug treatments will do so within 31 days of decision to treat.
- 94% of patients requiring receipt of second or subsequent treatment with surgery will do so within 31 days of decision to treat.
- 98% of patients requiring receipt of second or subsequent treatment with radiotherapy treatments will do so within 31 days of decision to treat.
- 90% of Audiology Direct Access Referrals will receive their first definitive treatment within 18 weeks (126 days) of being referred?

The following local operating and administrative standards apply:

- No patient should wait longer than 6 weeks for a diagnostic test or image. (Where applicable, the 6-week diagnostic standard occurs within the 18 week pathway).
- 50% of patients should be seen within 6 weeks of being referred to outpatients. 99% of patients should be seen within 10 weeks of being referred to outpatients. All patients must be seen within 13 weeks of being referred to outpatients
- 80% of patients should be admitted and receive their intended procedure within 12 weeks of receiving a DTA. 99% of patients should be admitted and receive their intended procedure within 16 weeks of receiving a DTA. All patients must be admitted and receive their intended procedure within 26 weeks of receiving a DTA
- All planned patients should be admitted and receive their intended procedure within six weeks of their “Due In Date” (as deemed clinically appropriate when added to the planned waiting list)
- Last Minute Cancellations (i.e. hospital-initiated, non-clinical cancellations of an elective procedure either following admission or on the day of intended admission) should amount to less than 0.8% of all elective admissions.
- 90% of all patients diagnosed with cancer following a referral from a consultant for suspected cancer, or following a consultant upgrade of a non-

cancer pathway to a cancer pathway will receive first definitive treatment within 62 days of receipt of referral.

- 100% of all patients diagnosed with cancer following a referral from a GP for suspected rare cancer (children's, testicular and acute leukaemia) will receive first definitive treatment within 31 days of referral.
- 100% of all patients referred to a Rapid Access Chest Pain Clinic should be seen within 14 days of receipt of referral
- 100% of all referral letters to be registered on iPM and scanned onto iCM within one working day of receipt
- All internal referrals or other letters requesting advice/assessment/consultation from Trust colleagues to be scanned onto iCM within five working days of decision to refer.
- All outpatient appointments, diagnostic test appointments and TCIs to be fully or partially booked
- All outpatient appointments to be recorded on iPM at the point of the appointment being made
- All outpatient appointments to be fully outcomed (i.e. to receive an appointment outcome, and an attendance outcome where relevant) within two working days
- All DTAs to be registered on iPM within one working day of the decision being made.
- All first outpatient attendances to result in an outpatient letter to the GP within five working days
- 90% of all outpatient attendances to result in an outpatient letter scanned onto iCM and sent to the GP within ten working days (clinic exclusions apply)
- All inpatient admissions, discharges and transfers to be recorded on iPM within one hour
- All clinical coding for elective APC activity will be undertaken by the Trust's clinical coding team.
- All outpatient clinical coding (where appropriate) will be completed within seven working days of the attendance.
- All RTT dates and statuses to be recorded and validated at each hospital visit

Tolerances are intended to account for specific scenarios which take the ability to achieve compliance with the target for that individual pathway out of the control of the Trust. There are three categories of scenarios that these pathways fall into:

- Patients for whom it is not clinically appropriate to be treated in standard timescales
- Patients who choose to wait longer for one or more elements of their care
- Patients who fail to, or choose not to, attend appointments

It is expected that pathways that do not get treated within the standard timescales fall into one of these categories, and that the tolerance is not used to allow patients to wait longer than the standard due to other reasons (for example capacity issues).

6. WAITING TIME REPORTING

The Trust is required to submit regular waiting time reports to external bodies for monitoring and assessment purposes.

The rules governing waiting time reporting and the adjustment of waiting times to reflect patient choice and/or clinical fitness vary according to the stage of care. All waiting times will be reported in accordance with the associated national guidance and any changes to national guidance will be reflected in reporting.

To facilitate the reporting of adjusted and non-adjusted waiting times the functionality of iPM will be employed to ensure a comprehensive audit trail of all relevant activity and decisions. This is necessary to meet the different waiting time reporting requirements of the various standards.

7. ROLES, RESPONSIBILITIES AND ACCOUNTABILITY

The Chief Operating Officer ("COO") has overall responsibility for delivery of operational standards.

The accountability for effective implementation and adherence to this policy sits with the COO.

Directorate General Managers ("GMs") are responsible for local implementation of the policy and ensuring their staff comply with the policy and are fully trained by receiving the appropriate annual training and to keep records of staff training.

The General Manager for Planned Care & Performance will provide advice and support to all staff in the effective implementation of this policy and will be responsible for annual review of the policy.

The Trust's performance team will provide technical support around the policy, particularly in relation to national guidance.

All clinical staff are responsible, through their Clinical Director or Head of Nursing, to the Medical Director and Chief Nurse for ensuring they comply with their responsibilities as outlined in this Policy.

All administrative staff and POD (Point Of Delivery) staff are responsible, through their GM, to the COO for ensuring they comply with their responsibilities as outline in this policy.

Staff involved in managing patients' pathways for planned care must not carry out any action about which they feel uncertain or that might contradict this Policy. The relevant Service Manager ("SM") should be contacted for any advice and support if required. The SM should then contact the General Manager for Planned Care & Performance for further advice and support if required.

Any staff found to be not following this Policy will be reported to their line manager and this may result in action under the Trust's disciplinary policies.

7. DATA PROTECTION AND QUALITY

All patient related data received through the implementation of this Policy will be managed in accordance the Trust's Data Protection Policy (March 2012), Data Quality Policy (October 2012) and Health Records Policy (July 2013) as legally required.

8. ELECTIVE REFERRALS

Receiving referrals

It is a mandatory requirement to record all referrals where clinical responsibility for the care of the patient is accepted by the Trust

Paper referrals for elective assessment, consultation and/or potential treatment should go directly to the Central Registration office where they get date-stamped and recorded on iPM within 24 hours of receipt of the referral letter.

The exception to this is TWR for suspected cancer which should be sent directly to the Cancer Two Week Rule office. For further detail regarding management of Cancer referrals, please see Cancer Operational Policy

Electronic referrals automatically get recorded on iPM via the EBS from which they are made.

If referrals bypass the Central Registration office then they should be date stamped and entered onto iPM immediately where received. This should be in exceptional circumstances only, for example, an urgent referral.

Where clinically appropriate, referrals should be addressed to a service ("Dear Doctor") rather than a named clinician. This will enable the Trust to ensure that patients receive an appointment with the most appropriate clinician. It may also enable the Trust to reduce outpatient waiting times as these referrals will be allocated to the appropriate consultant with the shortest waiting time.

Referrals should be recorded as being to the setting (e.g, outpatient or inpatient/daycase), specialty and consultant that corresponds with where/who we expect to first see the patient, even if this differs to any suggestion made in the referral letter.

Referrals from other consultant-led services (whether internal or external) should be accompanied by an IPTAMDS form which has administrative details around the type of pathway and clock start information.

Referrals should be recorded on iPM with accurate information – including the referral date (which represents the date that the Trust receives the referral), referral source and (for referrals from an elective consultant-led service) the RTT clock start date (see below). If a clock start is unknown it should be left blank – it should not be guessed. Any relevant additional RTT codes should also be recorded at this stage.

Referral letters must be passed to the relevant POD within one working day of receipt.

Reviewing referrals

Consultant annual leave, study leave or sickness must not delay the review of referral letters; Directorates must work with the consultants to ensure there are contingency arrangements to cover periods of leave.

Inappropriate referrals

If a consultant deems a referral to be clinically inappropriate, it must be sent back to the referrer with an explanation as to why the referral is inappropriate. Where appropriate, advice as to alternative services will also be provided at this point. The referring clinician is responsible for contacting the patient and informing them of the Trust's decision.

The referral must be cancelled on iPM with brief commentary as to why this decision has been made.

If a referral has been made and the special interest of the Consultant does not match the needs of the patient, but where such a service is provided by the Trust the Consultant should forward the referral to an appropriate Trust colleague. This should happen as soon as this is identified in order to ensure there are no undue delays to seeing the patient. In this scenario, the referral on iPM should be amended to reflect the updated decision of who is seeing the patient. The clock start date remains unchanged.

GP requested Direct Access diagnostics

Where a GP requests a diagnostic test to determine whether onward referral to secondary care or management in primary care is appropriate, then this does not start an RTT clock. The patient must still have the diagnostic procedure within six weeks of referral, but there is no eighteen week target as there is no intention to potentially treat the patient (at this stage). If the GP subsequently refers the patient to secondary care, then the patient commences on a pathway in line with the operating standards and the clock commences on the date this referral is received.

Note – it is the GPs responsibility to be clear on the referral whether they are sending the patient for treatment or to request a diagnostic to make a decision regarding treatment.

RTT clock starts

An RTT clock starts when a General Practitioner (GP), dentist or other healthcare professional (e.g. physiotherapist, podiatrist, optometrist) as agreed by the local health community, refers a patient to the Trust for any elective service (other than planned care) for the patient to be assessed and, if appropriate, treated before responsibility is transferred back. This includes the following:

- Any referral to a consultant led service (except where the referral is for a diagnostic test/opinion only)

- Any referral to an interface service (All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care). In these cases the clock will commence when the referral is received by the interface service and not when it is subsequently sent on to the Trust.
- Any self-referrals to an audiologist (since this has been agreed to be an appropriate process for the Trust)

Referrals from Primary Care to the following services will not start the clock:

- Therapy, healthcare science or mental health services that are not medical or surgical consultant-led (including multi-disciplinary teams and community teams run by mental health Trusts) irrespective of setting
- Diagnostic services if the referral is not part of a straight-to-test arrangement

For paper referrals from non-elective (e.g. A&E) or non-consultant-led (e.g. GP) services the RTT clock start date is the date the Trust receives the referral. For electronic referrals the clock starts on the date the patient books their appointment on-line or the day they call to make an appointment and give their unique booking reference number.

Where a referral goes initially to a Referral Management Service (RMS) the patient's clock starts on the date on which the RMS receives the referral.

If, following completion of a referral to treatment period, a patient requires treatment for a substantially new or different condition, then a new clock starts. This is a clinical decision made in consultation with the patient. In this situation the patient should be referred back to their GP for a new referral.

The cancer pathway clock starts on the same date as the RTT clock start date where the referral is for suspected cancer.

Overview of Urgent Cancer referrals

GPs will be required to use the current version of the standardised referral proformas produced by the London Cancer Alliance when making an urgent referral for suspected cancer.

Dedicated facilities exist within the Trust for receiving urgent cancer referrals by fax or other electronic referral systems (e.g. dedicated nhs.net e-mail accounts).

The Trust will send a fax reply confirming receipt of the referral once an appointment date has been agreed with the patient. GPs will be encouraged not to send 'hard copies' as well to avoid duplication of clinic appointments.

In the event that a patient declines to accept an appointment date, the appropriate consultant and GP Practice shall be informed by telephone. The referral will then by annotated to record the fact and a fax reply sent to the GP. The annotated referral will then be filed in the patient's medical record.

All patients referred under the Two Week Rule will have this fact recorded on iPM.

All patients with a suspected cancer referred by a GP via the fast track urgent cancer referral system will be seen automatically.

Urgent referrals for suspected cancer that are considered to be inappropriate may be downgraded in priority but only through consultation between the referring GP and hospital consultant and where the downgrade is mutually agreed. The clinical reason for downgrade will be annotated on the patient's referral and filed in the patient's medical record.

Any difficulties in scheduling urgent appointments within the two week timescale must be escalated immediately to the Cancer Services Manager who will liaise with the relevant consultant/clinician and the General Manager for that speciality. In addition the General Manager for Planned Care & Performance should be notified.

Regular liaison and feedback between the Trust and primary care organisations will take place to improve the management and processing of urgent referrals.

The Trust will notify the referring GP of any inappropriate 'fast track' referral received. Feedback will be provided as to why the referral is inappropriate. (Please note that this does not apply to appropriate referrals where a diagnosis of non-cancer is made).

Current versions of the referral proformas for suspected cancer may be sourced internally or externally via the London Cancer Alliance.

Consultant to consultant referrals for conditions unrelated to the original referring condition

Consultant (or consultant-led service) referrals to other consultant-led services can also start the RTT clock, specifically:

- If during a referral for one condition, the consultant newly identifies another condition, this will start a second RTT period, which should be recorded as a separate RTT pathway (this would also constitute a separate Cancer pathway if this is the suspected new condition). A new referral should be recorded to indicate the new elective pathway. The original clock will still be ticking (unless the patient is treated on, or discharged from that elective pathway)
- For separate conditions or complications developed with pregnancy, or if a new-born baby is suspected of having a condition requiring medical or surgical consultant-led treatment
- Where new conditions are identified as a result of a genetic test
- In cases where a decision to treat is made (e.g. at a follow-up outpatient attendance) for a patient whose programme of long-term care needs to be medical or surgical consultant-led
- If a decision that new treatment or potential treatment is required after a period of watchful waiting has ended.
- Where a patient requires a bilateral procedure (e.g. bilateral cataract removal) the initial RTT clock will stop at first definitive treatment for the first procedure. If the second procedure is not undertaken at the same time as the first, a new clock starts when a patient is fit and ready for the second treatment.
- Where a patient has been referred by their GP for separate conditions and where it is clinically deemed in the best interest of the patient that one must be completed prior to the other, a new clock start will commence when the

decision is made that the patient is fit, ready and available for the second procedure to take place.

If a consultant is referring a patient to another consultant as part of an ongoing RTT pathway, a new clock does not start. A new referral should not be recorded, but the decision should be documented on iPM and any subsequent activity should continue to be recorded against the existing pathway (referral) on iPM.

Consultant-to-consultant referrals must meet the criteria agreed with commissioners (i.e. it is deemed to be clinically urgent or suspected cancer or is part of an agreed pathway of care). In other cases where a consultant identifies a new condition, the patient should be formally referred back to the GP with a recommendation as to the referral pathway to be followed. The GP and patient will then have the opportunity to decide (in discussion with the consultant if required) how to proceed and who to refer to. If they decide to refer back to the Trust, then a new referral is recorded and a new RTT clock starts.

Consultant-to-consultant referrals must be communicated to the patient's GP.

If a Trust clinician is making a decision that starts an RTT clock, then the clock starts from the date that that decision is made i.e. the Trust referral (received) date is deemed to be the date that the Trust decides to make that referral. Patients should not be penalised in terms of waiting time by any delays in decisions/referrals being communicated or recorded to Trust colleagues.

The cancer pathway clock starts on the same date as the RTT clock start date for TWR referrals.

Referrals from non-elective care

Referrals from a non-elective pathway can also start the RTT clock, specifically where the patient is referred from A&E onto an elective pathway (as opposed to purely follow-up care on the emergency pathway) or where the patient is referred onto an elective pathway as a result of an emergency admission (again as opposed to purely follow-up care on the emergency pathway).

If a Trust clinician is making a decision that starts an RTT clock, then the clock starts from the date that that decision is made. Patients should not be penalised in terms of waiting time by any delays in decisions/referrals being communicated or recorded to Trust colleagues.

The cancer pathway clock starts on the same date as the RTT clock start date for TWR referrals.

Transfers from another secondary care healthcare provider (tertiary referrals) including referrals from providers acting as secondary care providers

If a patient is referred from one provider to another as part of their RTT period, their patient pathway and clock should keep ticking. This includes referrals from Primary Care services acting as Secondary Care providers. The originating provider should ensure that an appropriate IPTAMDS is sent as part of the referral.

An IPTAMDS must be completed for all inter-provider elective referrals, irrespective of the RTT status of the pathway, including where:

- The care of a patient on an RTT pathway transfers between healthcare providers. This includes transfer to and from independent sector providers

where this transfer is part of National Health Service (NHS) commissioned care.

- The referral is a request for a clinical opinion that results in the patient's care being transferred to an alternative provider.
- RTT pathways commissioned by English NHS commissioners independent of location.
- The referral is a request for opinion or diagnostics, where the care of the patient remains with the original service provider (e.g. penicillin allergy testing)
- The pathway is excluded from the 18 weeks monitoring arrangements for any reason

An IPTAMDS is not required for referrals for non-elective care, and nor is it required for referrals to a non-consultant-led service

The IPTAMDS should include accurate information on the patient's RTT status, most importantly:

- Whether the referral constitutes a new clock start or is part of an ongoing RTT pathway or is not being referred onto an RTT pathway
- If the referral constitutes a new clock start, the reason why (e.g. the patient has been referred following the end of a watchful wait period)
- If the referral is part of an ongoing pathway, the date that the clock started and whether there have been any adjustments to the waiting time.
- If the referral is not part of an RTT pathway for this Trust, the reason why (e.g. the patient is being referred for diagnostic testing only and will return to the originating Trust with the clock continuing to tick for them, as they retain responsibility for the RTT pathway).

The date that the referring provider makes the decision to refer on to another Trust to start a new RTT pathway is not the date that the new RTT clock starts. The clock will start when the receiving provider actually receives the referral. Referring providers will not know what date the clock will start when making these referrals, and so any "clock start dates" on IPTAMDSs for these referrals are likely to be inaccurate. As such there is often a disparity between the date the decision to refer on was made (typically the clinic date on the referral letter) and the subsequent RTT clock start date. Note that this is different to intra-Trust referrals where the decision to refer is deemed to represent the date that the Trust "receives" the referral.

The absence of IPTAMDS information should prompt the receiving Trust to seek the missing information as soon as possible (and within a maximum of five working days) as this will determine where the patient stands in the chronological order of patients waiting, and will avoid the pathway being reported without a clock start date.

Upon receipt of these referrals, the receiving provider will accept clinical and administrative responsibility for the patient. The receiving provider should acknowledge receipt (and acceptance) of these referrals in order for the referring provider to have assurance that the responsibility of the pathway has successfully been transferred.

Referrals from the Private sector into the NHS

For patients who are seen privately but then transfer to the NHS, the RTT clock should start at the point at which clinical responsibility for the patient's care transfers to the NHS i.e. the date when the Trust accepts the referral for the patient.

Patients can choose to convert between the private sector and the NHS at any point during their treatment without prejudice.

Patients who are referred via their GPs from a private service can be added direct to the NHS waiting list on the referral received date.

The patient's GP should be contacted at the point of receiving referrals from the private sector in order to ensure that the GP has the opportunity to review this decision.

Advice and guidance

A GP may wish to make a formal request for advice and guidance ("A&G") from a hospital specialist. An A&G request will not be treated as a referral and as such will not be recorded on iPM or added to the outpatient or inpatient waiting lists without the express consent of the hospital clinician to whom the A&G request was made.

All A&G requests will be responded to by telephone or in writing within one week of receipt. Consultant annual leave, study leave or sickness should not delay the response to A&G requests. As such, all consultants should nominate an appropriate colleague to review A&G requests in their absence.

A&G requests may be managed by EBS. Such referrals do not go onto iPM and no appointments are made.

If a clinician dealing with an A&G request feels that secondary care consultation/assessment is required, the patient should be formally referred back to the GP with a recommendation as to the referral pathway to be followed. It will be for the GP to refer as suggested or to agree with the patient any alternative provision.

Electronic Referrals

The Trust may receive electronic referral from a variety of EBSs. The principles around how these referrals are managed remain the same, irrespective of the system making the referral.

All referrals should be received via an EBS where clinically and socially appropriate.

A GP may schedule a patient to an appointment date and time at the point at which they make the referral. Alternatively a patient may be scheduled to an appointment date and time by a Booking Management Service ("BMS"). Patients will have the facility to schedule their appointment date and time via the internet. If the consultant requires that it be re-scheduled to a more appropriate clinic or clinician, they will provide the POD with information as to which service/clinic a patient should be scheduled. The POD will contact the patient by telephone to agree an alternative appointment date and time. Written confirmation and patient information will then be sent to the patient.

A GP will always have the facility to refer a patient to the Trust regardless of available capacity. Where there is no capacity available for that service at the point at which the referral is made or when the patient contacts a BMS the Appointment Slots Issues ("ASI") process will be implemented by the POD. Should the POD be

unable to source additional capacity they will liaise with the appropriate consultant/clinician and Service Manager to ensure that the patient is scheduled within outpatient waiting time targets.

9. OUTPATIENT APPOINTMENTS

Reasonable Notice

National definitions apply for reasonable notice.

Reasonable notice for an offer for any elective appointment or TCI is defined as a choice of at least two dates with at least three weeks notice with an appropriate clinician at an appropriate location.

An appropriate clinician is anyone that is deemed to be clinically appropriate by the responsible consultant. For patients on consultant-specific waiting lists, only that named consultant should be considered to be appropriate in terms of making reasonable offers. An appropriate location is any location used by the Trust for elective activity that is not an unreasonable distance from the main Trust sites.

Reasonableness definitions apply equally to diagnostic appointments/TCIs, outpatient appointments and elective offers for admission for treatment.

Short-notice offers (and other “non-reasonable” offers) can be made (and should be encouraged if available capacity allows this), but patients not accepting these offers should not be considered to be declining offers, and therefore should not be thought of, or recorded as, patient cancellations.

Booking

iPM will be used as the primary tool for outpatient waiting list management and appointment booking. The date of referral and RTT clock start date **must not** be adjusted on iPM for any reason other than it being recorded incorrectly to start with.

All offers of dates to patients, for outpatient, diagnostic or admissions must be recorded in iPM at the time the offers are made. All outpatient appointment dates will be verbally agreed with the patient. Appointment letters must be delivered to the Post Room on the day of the appointment being booked.

All outpatient letters should clearly explain the consequences if the patient fails to attend the outpatient appointment or fail to contact the hospital to agree an appointment date.

The aim of POD staff will always be to find a date appropriate for a patient’s clinical priority, chronological wait and that is convenient to that patient. Therefore two attempts will always be made to contact every patient by telephone and the attempts will be made at different times and on different days.

Failure to contact a patient should be recorded on iPM, and the correct process should be followed, including writing to the patient to ask that they contact the Trust within seven days with regards to booking the appointment. If there is still no response after seven days, a second letter is sent giving the patient another seven days to respond. If there is still no response, it is assumed that the patient no longer requires an appointment. The patient should now be discharged back to the care of

their GP. A letter will be sent to the patient, the patient's GP and the responsible consultant, and scanned onto iCM within three working days to confirm this decision.

When booking appointments, 'urgent' referrals must be given priority. Service Managers are responsible for reviewing clinic booking patterns regularly to ensure that an appropriate number of slots are reserved for urgent patients. To ensure equity of access, other patients should be given appointments in chronological order (based on their RTT waiting time).

Patients within an EBS may be contacted by a BMS to arrange an appointment date and time and may have the facility to book their appointment via the internet.

Cancelled/unallocated slots should be used to bring forward the longest wait patients who are willing to be moved forward. The relevant POD will telephone patients to fill slots made available from short-notice cancellations.

A nominated representative of the Directorate Team should review clinic templates five working days prior to the planned clinic date to ensure that all clinics are fully and appropriately utilised.

Should a patient be unavailable to attend an appointment date for medical or social reasons for a period exceeding six weeks they will be discharged (unless this is deemed to represent a clinical risk) and the patient and GP will be made aware. Patients declining numerous offers of appointments within a six week period may also be discharged on this basis.

It is the responsibility of individual PODs to identify the most appropriate booking method (full booking or partial booking) for each service, other than for TWR referrals and urgent referrals, where full booking is always utilised.

Full Booking

The full booking method of arranging an outpatient appointment will be utilised to schedule all TWR and 'urgent' referrals. It will also be utilised where the POD has identified this approach to be most appropriate for a particular service.

For non-TWR patients, should the Trust be unable to contact a patient (as per the above) the patient will be sent a letter asking them to telephone in to agree their appointment date and time. Patients will be asked to contact the hospital within one week. Should this not occur the POD will make all reasonable efforts to check the patients' contact details before sending a second letter. Should the patient not respond to the second letter within one week, they will be discharged and the patient, their consultant and GP notified. For TWR patients the process following failure to contact the patient is covered within the Cancer Operational Policy.

Once the appointment date and time has been agreed, written confirmation and relevant patient information will be sent to the patient.

Partial Booking

Patients within in a partial booking system will be contacted once available capacity has been identified, asking them to telephone the Trust to agree their appointment date and time.

At an appropriate time (as deemed by the POD) before a clinic is due to be held, a corresponding number of patients (to match the number of slots available) will be

sent a letter asking them to telephone in to agree their appointment date and time. Patients will be asked to contact the hospital within seven days. Should this not occur the POD will make all reasonable efforts to check the patients' contact details before sending a second letter. Should the patient not respond to the second letter within one week, they will be discharged and the patient, their consultant and GP notified.

Once the appointment date and time has been agreed, written confirmation and patient information will be sent to the patient.

Telephone (or telemedicine) appointments

An outpatient appointment is defined nationally as an appointment for a patient to see or have contact with a care professional at an outpatient clinic. Telephone appointments are considered to be outpatient appointments (and should be recorded as such on iPM) if they meet certain criteria:

- Telephone consultations should directly support diagnosis and care planning and must replace a face-to-face outpatient attendance
- They must be booked in advance with the patient given an accurate date and time that the clinician will contact them
- They must not be used solely for the communication of results
- They are on dedicated clinics (or clinic sessions) solely for telephone appointments

Telephone appointments follow the same rules around templates, booking, recording, outcoming, documentation etc as standard face-to-face appointments. For example if the patient fails to answer then this would be recorded as a DNA
Telephone appointments should not be used for any other reason than for the intention to phone the patient for an outpatient consultation.
Telemedicine appointments follow exactly the same rules as telephone appointments.

Virtual Clinics

Virtual appointments (e.g. time taken out by clinicians to review notes) are not considered to be outpatient appointments and should never be recorded as such.

Cancellation of Outpatient Appointments

The cancellation of an appointment can be made by the patient, GP or the Trust. Cancellations made by the Trust are generally referred to as "Hospital Cancellations"

Any appointment cancelled by the hospital will result in unnecessary delays to the RTT pathway and does not contribute to a positive experience for patients. Outpatient cancellations must be kept to a minimum and should only be made either with at least six weeks' notice or for unforeseen reasons e.g. unexpected absence of a clinician. Clinicians are responsible for minimising short-notice cancellations by advising on planned unavailability at least six weeks in advance.

Where a clinic is cancelled, the Service Manager is responsible for arranging cover, or an additional clinic to replace the lost capacity with minimal delay.

If the **patient** cancels an appointment anywhere on an RTT pathway, any further appointment must be offered within the timeframes stipulated by the relevant operational standards. Where possible, at the time of cancellation patients will be reminded of the Trust policy around discharging patients who cancel on more than one occasion. An alternative appointment should also be offered at this time.

If the **hospital** cancels a patient's appointment anywhere on an RTT pathway, the patient needs to be rebooked into an appropriate slot that is convenient for the patient and within the timeframes stipulated by the relevant operational standards. Patients should be offered an apology and a reason for the cancellation and must have a new appointment offer made on the day of cancellation

If offering an alternative appointment immediately is not possible, it should be done as soon as possible (considering the same policies that apply to the booking of the original offer). If an appointment is not available within the timeframes stipulated by the relevant operational standards, this must be escalated to the relevant Service Manager for resolution

The initiator (i.e. hospital or patient) and reason for cancellation should be recorded accurately on iPM as close to real-time as possible.

All patients will receive an appointment letter confirming their new appointment details

If the patient cancels an appointment date for a second time, the patient will be discharged back to the GP (unless this represents a clinical risk). If they are subsequently re-referred by the GP, this will be a new referral and will start a new patient pathway.

Multiple Patient Cancellations of Outpatient Appointments

Patients on an open RTT pathway who cancel an agreed outpatient appointment will be offered a second appointment, providing that they have not previously cancelled any agreed outpatient appointment, appointment for a diagnostic test or offer for admission on the same pathway.

The patient must be informed that if this second appointment is cancelled, a third appointment may not be offered, resulting in discharge back to the care of their GP and should the patient still wish to receive treatment, this would require a new referral from their GP, which would result in the patient's waiting time for treatment restarting from zero.

Patients on an open RTT pathway who cancel an agreed outpatient appointment having previously cancelled an agreed outpatient appointment, appointment for a diagnostic test or offer for admission on the same pathway, and who have been made aware of the Trust policy on multiple patient cancellations may be discharged back to the GP (unless this is deemed to be a clinical risk or the patient has reasons for cancelling appointments that the Trust deem to warrant retaining the patient in the system).

DNAs

When a patient fails to attend an agreed outpatient appointment, this is known as a Did Not Attend ("DNA").

Patients who DNA the first outpatient appointment in their pathway have their RTT waiting time nullified.

When a patient DNAs a subsequent appointment or a diagnostic test (outside of an outpatient appointment), or a TCI for elective admission, their RTT waiting time does not get nullified. The clock continues to tick for these pathways, unless they are discharged back to the care of the GP or original referrer, in which case the clock stops. Should the patient still wish to receive treatment, then they can be re-referred by their GP – a new clock would start on receipt of the re-referral at the Trust.

Following an outpatient clinic, the responsible clinician should indicate his proposal for the intended management for all patients who DNA'd that clinic and a decision will be made by the clinician on whether to discharge the patient back to the care of the GP or original referrer, or to rebook a new appointment.

In general, all adult patients who DNA will not be offered a new appointment and a standard letter will be sent to the patient and the GP following the DNA explaining that the Trust has made this decision and is discharging the patient back to the care of their GP.

In exceptional circumstances, including patients with learning difficulties and patients who do not have the capacity to achieve their attendance independently (or for example where adverse weather conditions make it unreasonable to expect patients to attend), a clinical decision may be made that the patient should not be discharged. This must be clearly documented in the patient's notes. Where the Trust decides it is appropriate to rebook the appointment, the clock will continue to tick.

Patients will not be recorded as a DNA or discharged where it can not be demonstrated that the appointment was clearly communicated to and received by the patient.

The parent or guardian of paediatric patients will be contacted to ascertain the reason for DNA and an alternative appointment date and time agreed. All paediatric DNAs will be managed in accordance with the Trust's Strategy for Safeguarding Children (2010) and Child Protection Policy (2011).

All patients on a suspected cancer pathway who DNA will be managed in accordance with the Cancer Operational Policy.

Outpatient Appointment and Attendance Outcomes

All outpatient appointments should have an appointment outcome recorded to state whether the appointment resulted in an attendance, a cancellation or a DNA. Cancellations should be recorded within one working day of the cancellation, whether cancelled by hospital or by patient.

All outpatient attendances should have an attendance outcome recorded to state the outcome of the attendance (e.g. "Treatment Initiated", "Add to IP/DC Trust Waiting List", "Referred for Diagnostics", "Discharged from Trust" etc).

A Single Outcome Form will be comprehensively and accurately completed with all necessary information for each patient that attends an outpatient appointment. If not completed this may delay patient treatment. Required information includes but is not limited to:

- The outcome category of the attendance

- All procedures undertaken
- Future requirements (e.g. follow-up appointments, diagnostic tests, additions to the WL etc)

Administrative staff should not assume a decision in order to complete the single outcome form slip on a clinician's behalf – they should check with the clinician if they are uncertain

The clinical staff present in the outpatient clinic will complete the form. It is imperative that as much information as possible is recorded to ensure that all activity is recorded on PAS, that any future treatment required by the patient is appropriately scheduled.

All procedures undertaken in outpatients must be recorded on the form using the codes stated on the outpatient procedures lists. Procedure lists, by speciality, will be made available in each clinic room.

Patients will be asked to return the form to the appropriate outpatient reception desk after their appointment. Patients will be notified that failure to return the form may result in them not being scheduled to receive any further treatment required. On return of the form to outpatient reception, patients will have the opportunity to agree a date and time for their follow-up appointment if required.

If there is no capacity available for the patient to be offered a follow-up date within the time frame requested by the clinician, the patient must be placed on an appropriate outpatient waiting list which the POD will have sight of the following day. The appropriate Service Manager will arrange for capacity to be sourced for the follow-up appointment within an appropriate timeframe.

When scheduling requested follow-up appointments, noted comments should also be recorded in the Comments box of the follow-up appoint to facilitate the greater efficiency of outpatient clinics.

Where the outcome pertains to a decision to refer to another consultant or consultant-led service, an IPTAMDS should be completed. The IPTAMDS must be completed when the referral is to another provider but it is also best practice to complete this for intra-Trust referrals (i.e. internal clinician-to-clinician referrals). All IPTAMDS forms should be scanned onto iPM within three working days of the decision to refer.

Upon receipt and acknowledgement of referrals to other providers, the receiving provider will accept clinical and administrative responsibility for the patient. Acknowledgement should be sought where not immediate as this gives the Trust (as the referring Trust) assurances that the responsibility for the pathway has successfully been transferred.

Note that the recording of an attendance outcome of "Add to IP/DC Trust Waiting List" will result in iPM automatically generating a skeleton waiting list entry that should get picked up by the POD to use to manage the next step in the patient's pathway (see later in "Waiting List Management").

10. DIAGNOSTICS

Diagnostics

Many patients require diagnostics to determine the appropriate diagnosis and therefore subsequent treatment of a patient – examples of diagnostic tests are: a blood test, an endoscopy procedure, a scan or an x-ray. Diagnostic tests must be performed within six weeks of request for the test, to ensure delivery of the national operating standards.

Patients will be contacted by telephone to arrange an appointment for their diagnostic test or be invited to telephone the Trust under the partial booking process. If there is no capacity to book an appointment within six weeks of the decision to test, capacity should be sourced rather than booking the patient into a breach position. Once appropriate capacity has been sourced, the patient should be contacted to offer appropriate dates.

The diagnostic waiting time resets to zero when patients decline reasonable offers, or cancel or fail to attend agreed dates. This does not affect the RTT clock, so it is important to ensure that when rebooking a date for the patient (should this be appropriate) the RTT waiting time is considered as well as the diagnostic waiting time.

Where there is a decision to do multiple diagnostic tests, these diagnostic clocks run concurrently. Wherever possible it is best practice to arrange tests to be done at the same time. Where the decision to do a subsequent diagnostic test is dependent on the results of an earlier diagnostic test, it may be necessary to expedite the booking in order to ensure that consecutive diagnostic waits do not impact too much on the RTT waiting time.

When the patient receives their diagnostic test, the diagnostic clock stops, although if the patient is on an RTT pathway, then their RTT clock is continuing to tick (unless further decisions are taken that do stop the RTT clock, e.g. discharge back to the GP on the basis of negative results).

11. INPATIENT/DAYCASE WAITING LISTS

DTAs

The traditional pathway on to the elective waiting list is for the patient to be referred to a consultant by a GP, seen in Outpatients, and receive a Decision To Admit. There are, however, other routes onto the list, for example a consultant reviewing a referral and deciding to admit the patient for an endoscopy prior to an outpatient consultation.

The decision to add a patient to a waiting list must be made by the consultant or a member of their team, in conjunction with and the agreement of the patient.

A patient may only be added to the waiting list if they are believed to be fit, willing and able to receive the intended procedure. Patients who are added must be clinically ready at the point the decision to admit is made, i.e. if there was a bed available tomorrow in which to admit a patient there would be no clinical reason for the patient not to come in. Patients who are not immediately available for social reasons should still be added unless the period of unavailability is significant enough to warrant discharging the patient from the care of the Trust (see below)

Those patients who do not fulfil these criteria at the point of the decision to admit must not be added to the waiting list. This includes patients who do not require

intervention at this stage of the disease process or where further investigations are necessary in order to determine whether or not the procedure should take place (unless the investigations are a part of the treatment process, e.g. an ERCP prior to a laparoscopic cholecystectomy).

If it is not known whether the patient is clinically fit for admission or not, the assumption is made that they are until it is determined that the opposite is true.

Patients not clinically ready will either be given another outpatient appointment or referred back to their GP care together with advice on re-referral when they are fit and ready; whichever is the more appropriate to the individual patient. This also applies to patients who need to lose weight before surgery. The decision on clinical readiness rests with the consultant.

Patient “thinking time”

Patients will occasionally require “thinking time” before deciding for sure that they wish to proceed with an admission for a procedure that has been suggested by the clinician.

Where it is the case that the clinician has recommended that the patient should be admitted for a procedure and the patient wishes to consider this, the patient should be added to the waiting list with the expectation that they will proceed. If at any point prior to the admission, the patient informs the Trust that they do not wish to proceed with the intended procedure, then they should be removed from the waiting list and the RTT clock would stop for this pathway.

Where it is the case that the clinician has offered a choice of alternative treatments to the patient (at least one of which being non-admitted treatment (e.g. injections or physio) and at least one of which being admitted treatment) and the patient wishes to go home and consider their options, the patient should not be added to the waiting list until such a point when the patient informs us of a decision to proceed with surgery. The RTT clock continues to tick for these pathways until the patient receives their chosen treatment. If a patient fails to make a decision within three weeks, they may be discharged from the care of the Trust, so it is important that this is communicated to the patient at the point of offering them their treatment options.

Where it is the case that the clinician has recommended that the patient should be admitted for a procedure but the patient chooses not to proceed at the point of this being offered, this would stop the patient’s RTT clock. If the patient subsequently chose to accept the offer of treatment, a new RTT clock would start, so it is important that the patient is clearly informed of the consequences of deciding not to proceed with suggested treatment in case they would prefer to take the “thinking time” option instead. If the patient does choose not to proceed with suggested treatment the clinician would decide with the patient to either review after an appropriate period of time (which would constitute a Watchful Wait decision initiated by the patient) or to discharge the patient back to the care of the GP. These principles also apply where the patient is choosing not to proceed with all treatment options offered to them, irrespective of the setting in which the treatment is to take place.

Where there is no evidence that appropriate discussions have taken place around patients’ decisions not to proceed with treatment options, then it should be assumed that they have requested thinking time in order to not unfairly penalise them in terms of waiting times.

Active and Planned Waiting Lists

Patients on the Active Waiting List are waiting for elective admission for treatment and are currently clinically available for admission.

Patients on the Planned Waiting List are those whose waiting time is determined (solely) by their clinical requirements. They include patients waiting for subsequent admissions as part of a planned sequence of treatments or investigations (e.g. check (also known as review or planned follow-up) endoscopies) or where the procedure has to be performed at a set point linked to clinical criteria, e.g. where a child needs to be four years old before a procedure can be performed or where the date of admission is determined by the needs of the treatment, e.g. metalwork needs to be removed, but this should not happen for another three months.

All planned waiting lists should have the “Due In Date” accurately recorded. This is the date that the clinically defined period of unavailability ends (e.g. six months after the colonoscopy for a “six-month check colonoscopy”). For planned sequences of admissions the due in date should be calculated based on the date or intended date of the previous admission, and so this may need to be changed for each planned list where an earlier part of the plan changes.

Waiting List Management

PODs are responsible for maintaining an up-to-date and accurate waiting list position at all times.

DTAs should result in the full waiting list detail (including waiting list type (planned or active/booked), waiting list name, intended management, clinical priority and intended procedure code and description) being on iPM within one working day. This may involve adding the waiting list to iPM, or updating the skeleton waiting list if it has been added at the outpatient attendance outcoming stage. Any known detail relating to periods of social unavailability should be recorded at this stage in the form of a patient-initiated suspension period.

The Original Date On List (“ODOL”) should always represent the date that the DTA was made and is not necessarily the date that the waiting list is being recorded on iPM. Late recording of Waiting Lists must always include the retrospective recording of this date.

Patients on an active waiting list should be categorised into clinical priority (TWR (for Cancer patients), Urgent or Routine) within four working days of the DTA. This clinical priority should reflect the patient’s clinical need for admission.

Any relevant decisions or changes should be documented on iPM in a timely manner in order to ensure that patients on a waiting list are being managed appropriately.

It is best practice for all patients requiring elective treatment to be asked if they are able to come in at short notice by the clinician at the point of making the DTA. Patients who say yes will have this decision recorded on the waiting list on iPM and would be prioritised when trying to fill gaps created from short-notice cancellations.

The appropriate PPC will meet with consultants weekly to review all forthcoming theatre lists to which patients have been scheduled. This is to ensure that theatre lists are scheduled appropriately to maximise theatre utilisation.

Patients removed from the Inpatient/Daycase waiting list for any reason will receive a decision on whether they will be discharged back to the care of their GP / original referrer, or whether a next step in their Secondary Care pathway is required.

Patients requiring commissioner approval for funding

Certain procedures have been deemed by commissioners as needing individual review under the Effective Commissioning Initiative ("ECI") process before they decide whether they will fund the treatment or not. DTAs for these procedures should result in the patient being added to the "ECPCTX (IP EC Panel approval still required)" waiting list until a decision on funding is received.

Any decision to admit a patient for a procedure that is in this list of procedures must result in the completion of an "exceptional treatment approval form" in order for the funding approval to be sought from the relevant CCG before proceeding to offer the patient TCI dates.

Whilst approval is being sought the pathway will remain open and the clock will continue to 'tick'. Where there is no funding decision made within three weeks of the DTA, this should be escalated to the General Manager for Planned Care & Performance.

If confirmation of funding to proceed is granted, then the patient is moved to the appropriate consultant or pooled waiting list. If confirmation of funding to proceed is denied the patient will be removed from the waiting list and discharged back to the care of their GP.

Where there is a decision to remove a patient from the waiting list due to potential lack of funding, the patient will be discharged back to the GP and the patient, patient's GP and responsible consultant will be written to (with the letter scanned onto iCM) to inform them of the decision and the reasons for it.

Booking

Reasonable Notice applies to the booking of TCI Dates in the same way as it does for the booking of outpatient appointments (see earlier). Patients should always be offered the next available date even if it is at short notice. If the patient declines an offer that is not made with reasonable notice, they will not be penalised from a waiting time perspective (i.e. their wait time does not get adjusted). If a patient declines a reasonable offer (i.e. a choice of at least two dates with at least three weeks notice with an appropriate clinician at an appropriate location) for social reasons then they can be paused (see later).

If a patient has been placed onto a pooled waiting list, then patients should be offered TCI dates with the consultant with the most appropriate capacity.

Offers of TCI dates to patients should be recorded in iPM at the time the offers are made. If during discussions with patients, a number of dates are proposed to the patient, not all dates have to be recorded on iPM. If a patient declines at least one reasonable date, then the earliest reasonable date that is declined should be recorded. If other dates (reasonable or otherwise) are declined, then this can be recorded in the freetext comments of the declined offer that is being recorded.

Written offers should not be sent under any circumstances. If the Trust is unable to contact the patient, a letter should be sent to the patient inviting them to call to arrange a TCI date.

When booking TCI dates the patient should be made aware of their responsibilities in relation to accepting treatment and the consequences should they cancel or fail to attend the hospital at the designated time.

Priority will be given to patients who have been deemed to be on an urgent waiting list. Patients of equal clinical priority (e.g. routines) should be offered TCI dates in accordance to CPaT ("Clinically Prioritise and Treat") – i.e. on their clinical priority and then in chronological order. This chronological order is based on the RTT clock start date / waiting time, irrespective of the date the DTA is made. Patients may only be expedited for social reasons with the agreement of the General Manager for Planned Care & Performance.

Patients who have been deemed to be on an urgent waiting list should be booked immediately after this clinical priority has been determined, and will be booked to the next available list (which should be within three weeks of their DTA). Patients on a routine waiting list may be booked via full or partial booking. It is the responsibility of individual PODs to identify the most appropriate booking method for each service, other than for TWR referrals and urgent referrals, where full booking is always utilised.

Outcomes of offers for admission should be accurately recorded (including the correct reason and initiator of cancellation) within one working day.

Full Booking

The full booking method of arranging a POA appointment and TCI date will be utilised to schedule all patients on a TWR or 'urgent' waiting list. It will also be utilised where the POD has identified this approach to be most appropriate for a particular service.

For non-TWR patients, should the Trust be unable to contact a patient, the patient will be sent a letter asking them to telephone in to agree their POA and TCI dates and times. Patients will be asked to contact the hospital within one week. Should this not occur the POD will make all reasonable efforts to check the patients' contact details before sending a second letter. Should the patient not respond to the second letter within one week, they will be removed from the waiting list and discharged and the patient, their consultant and GP notified. For TWR patients the process following failure to contact the patient is covered within the Cancer Operational Policy

Once the TCI date and time has been agreed, written confirmation and relevant patient information will be sent to the patient.

Partial Booking

Patients within in a partial booking system will be contacted once available capacity has been identified, asking them to telephone the Trust to agree their POA and TCI dates and times.

At an appropriate time (as deemed by the POD) before required capacity is due to be available, a corresponding number of patients (to match the capacity) will be sent a letter asking them to telephone in to agree their POA and TCI dates and times. Patients will be asked to contact the hospital within one week. Should this not occur the POD will make all reasonable efforts to check the patients' contact details before sending a second letter. Should the patient not respond to the second letter

within one week, they will be removed from the waiting list and discharged and the patient, their consultant and GP notified.

Once the TCI date and time has been agreed, written confirmation and patient information will be sent to the patient.

Pre-Operative Assessments

All patients requiring a general anaesthetic will attend pre-operative assessment at a clinically appropriate time prior to admission by an appropriate member of clinical staff. The length of time that a pre-operative assessment can be completed in advance of the TCI will be service specific and set at local level. If a patient cancels or DNAs a pre-operative assessment the same rules apply as if attending for an outpatient or TCI.

POA will assess a patient's clinical and social fitness for surgery. Discharge planning will be instigated at pre-operative assessment and patients will be given specific discharge information.

POAs should be outcomed as ""Pre-admission Clinic" and should be attached to the appropriate WL on iPM.

POA Nurses will inform the relevant POD if there is a requirement to change the treatment plan. The POD will then initiate this change of treatment plan.

Clinically initiated delays

If a patient becomes unfit for their intended procedure whilst on the inpatient/daycase waiting list, an appropriate clinician will ascertain the likely nature and duration.

If the responsible clinician considers it necessary to monitor the patient's condition within primary care, the patient will be removed from the waiting list and discharged back to the care of their GP.

If the reason is self-limiting and expected to last no more than four weeks (such as a cold or chest infection) then a clinical suspension should be recorded and they will be offered a date that is appropriate in terms of the patient's anticipated recovery time and waiting time. This will allow patients with minor acute clinical reasons for delay, time to recover without them being penalised in terms of their waiting time (as the clock will continue to run during this time). If it becomes apparent that a patient is still not going to be fit by their TCI Date, an individual review should take place to determine whether or not they are to be kept on the waiting list and given a new TCI date, or whether they are removed/discharged. This decision is to be made by the Service Manager, although they may defer the decision to the General Manager for Planned Care & Performance.

If there is a subsequent decision by the GP to refer the patient back in for treatment (whether the same treatment as originally planned or different treatment) when the patient becomes clinically ready again, then this constitutes a new referral, RTT pathway and clock start. The Trust may agree to expedite this patient on the basis of their previous pathway, but is not necessarily expected to do so.

Patient initiated delays for social reasons

If a patient is unavailable for admission for social reasons for a period of twelve weeks or more from the point of the DTA (whether this is a continuous period or the sum of multiple periods of social unavailability), the patient should be discharged back to the care of their GP. The patient will be reminded of this fact at the point of notifying us of any period of social unavailability.

Exceptional circumstances or the clinical condition of the patient may lead to a decision to not discharge a patient despite them being unavailable for a total of more than twelve weeks from the point of DTA. Any such decision must be agreed with the General Manager for Planned Care & Performance

Suspensions

Patients who are ready for treatment at the point of receiving a DTA may become unavailable for periods of time for either social or clinical reasons. These periods, when known in advance, should be documented appropriately (via suspension periods on iPM) in order to ensure TCI dates are offered appropriately and not when it is known that patients are unavailable.

Note that significant periods of unavailability may (unless felt to be a clinical risk) result in patients being discharged back to the care of their GP. A significant period of unavailability is defined locally as a period of twelve weeks or more. This may be one continuous period or a culmination of multiple periods.

When the Trust becomes aware in advance of a period of social unavailability (e.g. the patient informs the clinician at their outpatient appointment of a forthcoming holiday) then a social suspension should be recorded on the waiting list on iPM. The suspension period should accurately reflect the start and end dates of the patient's period of unavailability.

When the Trust becomes aware of a period of clinical unavailability that does not result in the patient being discharged (e.g. the patient cancels an agreed TCI date as they have a chest infection) then a clinical suspension should be recorded on the waiting list on iPM. The suspension period should accurately reflect the start and estimated end dates of the patient's period of unavailability.

The clock continues to tick for patients during periods of social or clinical suspension. POA and TCI dates can be arranged for appropriate times in consideration of suspension periods.

Patient Declinations

There is an important differentiation between the patient declining a reasonable offer and cancelling an agreed TCI, so it is important the recording accurately reflects this.

Where a reasonable offer is made to a patient and the patient declines to accept the offer, then it should be recorded on iPM as declined by the patient. If a patient declines several dates that form a reasonable offer, then the earliest (reasonable) date that was declined should be recorded as the offer on iPM. It is not necessary to record all dates offered on iPM as individual offers, although these dates (or as a minimum the latest date offered) should be documented within the freetext of the "confirmation notes" for the declined offer.

Where a patient declines an offer which is not reasonable (as per earlier definitions), the offer should still be recorded – but should be outcomed as the

patient declining a non-reasonable offer. If the patient also declines a reasonable date as part of the same offer, then it is the reasonable date that should be recorded as the offer on iPM, although any other dates offered should also be documented within the “confirmation notes” for the declined offer.

Implicit offers

It is common for the Trust to contact a patient to offer available dates, but not explicitly offer them due to the patient communicating unavailability within the same conversation. In this scenario, any date that we were planning (at the point of contacting the patient) to potentially offer, but did not do so due to the patient now making us aware that they would not be able to accept it (and so making the explicit offer redundant) is known as an implicit offer and can be recorded as a declined offer on iPM in the same way as we would had we explicitly made the offer.

Implicit offers do not cover the scenario where we the patient tells us of any period of unavailability before us contacting them to offer dates which fall in that period.

Changes to Theatre Sessions

Any theatre list being cancelled should be done so with at least six weeks’ notice and with approval from the Specialty Service Manager, who will then communicate this to the PPC.

Service Managers should only be approving the cancellation of a theatre list if all avenues to avoid the cancellation (e.g. arranging cover for consultant’s annual leave) have been exhausted.

Service Managers approving the cancellation of a theatre list should, where possible, offer this list to colleagues in other specialties.

An appropriate ASM within Surgery will co-ordinate all changes to the published theatre schedule. Changes then get discussed at the weekly Theatre Review meetings.

Changes to the theatre schedule will be made a minimum of three weeks in advance of the theatre session. Changes required within three weeks of the theatre session will only be made in exceptional circumstances and at the request of the relevant General Manager. All changes will require approval at Theatre Review.

No changes to the theatre timetable will be made without written confirmation and appropriate authorisation.

Hospital Non-Clinical Cancellations

Every effort must be made not to cancel patients “at the last minute”. The definition of a Last Minute Cancellation (“LMC”) is a cancellation of an elective procedure by the Trust for non-clinical reasons on the day of intended admission or after the admission has taken place. This is monitored nationally and is perceived to be one of the most important measures of a patient’s poor experience on an elective care pathway. When an LMC occurs, the patient has the right (as per the NHS Constitution) to be admitted for their procedure within 28 days of the cancellation (and still before their RTT breach date).

Where a patient is admitted, but has their planned procedure cancelled, this is not considered to be an LMC (or a cancellation) if the planned procedure is rearranged for another time and then carried out prior to the patient being discharged.

If a planned procedure is cancelled on the day of intended admission or after the admission has taken place, but is rearranged for (and carried out on) the following day then this is considered to be a postponement rather than an LMC.

No patient will be subjected to an LMC without consultation with the relevant General Manager. If the General Manager is unable to identify an alternative to cancelling the patient, they must seek authorisation to cancel from the Deputy Chief Operating Officer or General Manager for Planned Care & Performance before cancelling the patient.

Where an LMC is deemed to be unavoidable and the patient is cancelled, the General Manager will immediately notify the relevant Service Manager and PPC of the cancellation. The Service Manager is responsible for sending an e-mail on the day of the cancellation to the Cancelled Ops e-mail group. Patients subjected to an LMC will be given an explanation of the circumstances and an apology at the earliest possible opportunity. They will also be informed of their right to be given a new TCI date that is within 28 days of the cancellation.

If not offered another date at the time of cancellation the PPC will contact the patient within five working days to agree an alternative date. The PPC should escalate any LMC that cannot be dated within 28 days of cancellation to their Service Manager, who will seek a resolution (including seeking capacity within the private sector). If no resolution can be found, then escalation to the General Manager for Planned Care & Performance is required within seven days of the cancellation

If a patient is offered a date within 28 days of their original LMC, and they decline this date, the offer should be recorded on iPM. Normal reasonable notice rules apply in terms of RTT waiting times, but the rules around reasonableness for stopping the 28-day clock are more flexible. Local decisions can be made as to whether the declination of a short-notice offer is a made with enough notice for it to be deemed as “reasonable” to stop the 28-day clock. Typically, it is considered that significantly less notice can be given for a 28-day offer to be considered reasonable, but where there is any doubt, this is a decision that should be made by the General Manager for Planned Care & Performance.

If there is a clinical or social reason for a patient not being able to be admitted within 28 days of an LMC, then this stops the 28-day clock, and so providing this decision is made within 28 days of the LMC, this does not result in a 28-day breach.

LMCs are robustly monitored to ensure that they are not cancelled for a subsequent time and are offered appropriate dates within 28 days of the initial cancellation. All LMCs and subsequent TCI dates and outcomes are documented in detail on the Cancelled Ops Tool (an in-house web-based recording system for cancellations of TCIs).

Where patients are subjected to a hospital non-clinical cancellation made with prior notice (i.e. at least one day before their intended admission), the patient does not have the right to be admitted within 28 days of the cancellation, although, given the inconvenience to the patient, the Trust would still try to secure a further TCI date at the point of cancellation, that is with minimal delay and convenient to the patient.

Patients subjected to a hospital non-clinical cancellation made with prior notice will receive a verbal explanation and apology by a member of the POD

Clinical Cancellations

Should an agreed TCI date be cancelled by the Trust for clinical reasons, the patient must be informed by an appropriate clinician. Administrative staff may not inform a patient that they are cancelled for clinical reasons.

The patient and the POD will be given the reasons for the cancellation and any required action to be taken prior to a new TCI being agreed (if required)

A new TCI Date will be offered that is appropriate in terms of the clinical condition of the patient and their RTT waiting time (bearing in mind that the clock continues to tick following the cancellation).

Patient Cancellations

Where a TCI date has been agreed with a patient, and the patient subsequently cancels this TCI date, the history of the pathway should be reviewed in order to consider whether or not it would be appropriate to discharge the patient from the care of the Trust.

Patients who cancel a previously agreed TCI Date and have not previously cancelled any TCI Dates or outpatient appointments should be offered a new date as soon as possible, and reminded of their responsibilities around cancelling dates.

Patients who cancel a previously agreed TCI Date for a subsequent time, or who cancel a previously agreed TCI Date having already cancelled an outpatient appointment previously in the pathway may be informed that they are being removed from the waiting list and discharged back to their GP. However, consideration will be given to the reasons for the cancellation and the patient's clinical condition before this decision is made.

Patients who are discharged due to multiple cancellations will be notified by letter. This letter should be sent to the patient, the consultant and the patient's GP, and scanned onto iCM within three working days of the decision to discharge.

Patient Non-compliance (Pre-op guidance not followed)

There may be occasions where patients fail to comply with medical advice prior to admission and as a result TCIs are cancelled e.g. a patient eating on the morning of their procedure, or not stopping medication prior to admission, or failing to advise us (when asked) of allergies.

Where this is the case, there must be suitable evidence that the Trust has clearly and appropriately communicated the relevant guidance to the patient. If such evidence exists, then the cancellation should be recorded as a patient cancellation (pre-op guidance not followed) and should be treated the same as any other patient cancellation.

Patient Request Removal from the Waiting List

When a patient confirms that they no longer need, or wish to have, their intended procedure and are requesting removal from the waiting list, a clear note will be made in the 'comments' field on iPM. A letter is forwarded to the patient's GP and a copy letter is sent to the patient's consultant. The letter should also be scanned onto iCM. The waiting list entry should be removed on the PAS system after the comments section has been completed. The patient may wish to remain under the care of the Trust and be seen in outpatients, or be discharged from the care of the Trust altogether.

Patients who cancel or decline offers are only requesting removal from the waiting list if it is their intention to not be admitted for the procedure at any time. Patients who cancel or decline offers but wish to be admitted on a different date are not requesting removal from the waiting list, although the Trust may decide to remove the patient from the waiting list if this in accordance with policy on patients cancelling multiple offers (see earlier).

Patients requesting more information or a second opinion prior to deciding whether or not to proceed with their intended procedure are not deemed to be removing themselves from the waiting list and should be offered reasonable opportunity to get the assurances that they require to make the decision.

If the GP (with the patient's consent) requests the patient be placed back on the waiting list, then the Trust must decide whether it is appropriate to reinstate the patient back onto the waiting list (i.e. reopen the waiting list and/or referral) or request a new formal referral from the GP. The person receiving the request to reinstate to the waiting list must refer the case to the Service Manager for discussion with the General Manager for Planned Care & Performance. The process for reinstating patients back onto an RTT pathway is covered later (see "Reinstatement to an RTT Pathway").

FTAs

A Fail To Attend ("FTA") (or DNA) includes all patients who Fail To Attend an agreed offer for admission without prior warning of cancellation.

Effort must be made to contact the patient to establish the reason for FTA and if appropriate agree a new TCI date.

Alternative TCI dates will only be offered in exceptional circumstances. Otherwise a patient should be removed from the waiting list and returned to their GP's care.

Patients will not be removed from the waiting list following a FTA where it can not be demonstrated that the appointment was clearly communicated to and received by the patient.

If a patient is removed from the waiting list following an FTA, the patient, their GP and the appropriate consultant will be notified in writing of this action.

The parent or guardian of paediatric patients will be contacted to ascertain the reason for FTA and an alternative TCI date and time agreed. All paediatric DNAs will be managed in accordance with the Trust's Strategy for Safeguarding Children (2010) and Child Protection Policy (2011).

Patients with suspected cancer will also be contacted to ascertain the reason for FTA. This is to ensure that an alternative TCI date and time may be agreed, appropriate action taken or any problem escalated if the patient is not well enough to attend as agreed.

If it is the patient's wish not to attend and to refuse alternative appointment dates, a letter will be sent to the GP and/or referring clinician informing them of the decision.

Pauses

Pauses are RTT waiting time adjustments that reflect a patient's decision to delay admission for intended treatment having been made a reasonable offer for that admission.

A pause can be applied to a pathway where the patient is on an inpatient/daycase waiting list for a therapeutic procedure and they decline a reasonable offer for admission due to social unavailability. Pauses temporarily stop the RTT clock (from the earliest reasonable date declined by the patient due to a period of social unavailability) for the duration of that unavailability, the end of which triggers the pause to end and the clock to start ticking again. The patient should inform the Trust (at the point of declining the offer) the date that they are available again, or some indication of when this will be.

Patients should not be paused for periods of unavailability that they have informed the Trust about prior to being contacted to offer a TCI date.

Patients cancelling agreed TCI Dates or FTA'ing or declining offers due to clinical reasons or declining non-reasonable offers may not be paused unless they subsequently decline offers as above. The pause would then begin from the first date offered that meets the relevant pause criteria.

Patients cannot be paused if they have a TCI date – i.e. a patient cannot be paused for declining to be brought forward from a TCI date that has already been agreed.

Patients declining offers of outpatient appointments or diagnostic procedures may not be paused unless they subsequently decline offers for admission for a therapeutic procedure as above.

Pauses cannot be applied where the Trust is cancelling an offer for admission.

Patients unavailable for a period of less than one full day should not be paused.

Pauses may be recorded where patients are making themselves unavailable to be admitted under a particular consultant on a pooled list where they have already been informed that they are on a pooled list. The pause ends the day before the first date of available capacity for a consultant that the patient is prepared to be admitted under. The patient is informed of this capacity within this conversation in order that they may wish to reconsider delaying their admission on these grounds.

Pauses may be recorded where patients are making themselves unavailable to travel to a particular site where the same service is offered at another site that the patient is prepared to be admitted to. The pause ends the day before the first date of available capacity for a site that the patient is prepared to be admitted to. The patient is informed of this capacity within this conversation in order that they may wish to reconsider delaying their admission on these grounds.

Patients must be informed at the point of declining the offer that they are entering a pause period and their clock will be temporarily stopped until the point they are making themselves available for. Wherever possible, the date that the patient will first be available from will be ascertained at this point so that clarity is provided to the patient and the Trust on when the pause period ends.

Wherever possible a convenient TCI date should be agreed at the point of the patient informing us of the end of their period of unavailability. This TCI date should be as soon as possible after the patient is available for admission.

Where a patient is unavailable for social reasons for more than twelve weeks, a pause would not normally be appropriate as the patient would normally be discharged back to the care of their GP. Where exceptional circumstances or the patient's clinical condition mean that the Trust has decided not to discharge the patient, then a pause should be applied in the normal way.

12. CLOCKSTOPS

Overview

The majority of RTT clockstops take place in an outpatient clinic. The other two main methods of stopping an RTT clock are admitting a patient for a therapeutic procedure, or discharging the patient without treatment. These actions are routinely recorded on iPM.

However, there are other actions that stop an RTT clock, for example the communication of negative test results by telephone, or treatment in a non-consultant-led setting that do not routinely get recorded on iPM. It is important that, where relevant, local recording methodology is utilised in order to capture clockstops appropriately. These clockstops must be recorded in accordance with recording and clockstop rules and with accurate dates (i.e. the date that the clock actually stopped) in order to ensure appropriate reporting of waiting times.

Watchful Waiting

The concept of Watchful Waiting (also known as "Active Monitoring") is essentially a definitive decision that there is no requirement to proceed with any further clinical intervention (e.g. assessment or diagnostic testing) at this stage but that the patient still requires monitoring in a Secondary Care environment and so is not ready to be discharged. The period between this decision being made and the agreed point that the next stage of monitoring should take place is known as the Watchful Wait period and stops the RTT clock on the basis that the patient is no longer "waiting" for the Trust to actively do anything.

A period of Watchful Wait should be agreed between the appropriate clinician and the patient. It covers where a patient wishes to continue to be reviewed as an outpatient, without progressing to more invasive treatment that is available for the patient.

Examples of decisions to start (or continue) periods of Watchful Wait include:

- An MRI shows some changes to the condition of the knee but the patient does not yet require surgery, so the Trust will review the patient in clinic in four months time
- A decision to start or continue three monthly routine check ups for diabetic patients

- A decision to regularly review a paediatric patient where treatment cannot be carried out until a child reaches a pre-determined age
- A consultant offers the patient a choice of invasive surgery or a further review in clinic in three month's time to see if there is any change in condition that may influence a new decision on whether or not surgery will be the required – and the patient opts for the latter
- A clinical decision that there is no treatment that would be beneficial for the patient at this stage, but that this decision may be different in three months time depending on how the condition develops
- A clinical decision that the patient's condition will resolve itself over the next few months without the need for intervention, and that a review in four months will determine whether or not this has been the case

Examples of decisions that do not start periods of Watchful Wait include:

- A decision to test the patient in order to gain a diagnosis
- A provisional decision that the patient does not require treatment, but that this will be confirmed by the results of a forthcoming diagnostic test
- A patient becoming unavailable for treatment/assessment for social reasons
- A patient requiring a second opinion on the extent of their condition and whether or not invasive surgery is required
- A consultant requesting that another clinician with a more relevant expertise sees the patient for assessment

A period of watchful wait can be initiated by either the patient or the clinician, but where initiated by the clinician, the patient should be made aware of the decision and given the opportunity to challenge it.

At the end of a period of Watchful Wait, a new decision is made on whether to continue the Watchful Wait period (e.g. follow-up again in another three months), to discharge the patient (e.g. confirmation that the patient does not require treatment and no longer requires further review) or to start a new clock. Examples of where a new clock starts include:

- A decision to add the patient to an inpatient waiting list for treatment following an unsuccessful period of Watchful Wait
- A patient having previously decided against an invasive procedure now deciding to proceed with that procedure
- A worsening of the condition leading to a decision to undertake diagnostic tests
- A change in the condition leading to a decision to request consultation from a clinical colleague

Decisions to do tests or seek advice in order to routinely monitor a patient in a Watchful Wait period do not start a new clock.

Where a patient leaves a period of Watchful Wait, and a new clock starts, the same requirements to treat the patient within 18 weeks of the decision to stop the period of Watchful Wait apply, as they would if the patient was referred in a new referral from the GP.

If at any point within a Watchful Wait period, a new condition or a requirement for substantially different treatment is established (e.g. starting a diabetic on insulin, when they have previously been treated with tablets), a new clock start will be recorded on the date this was identified and agreed with the patient.

Patient declining treatment

Patients may choose not to proceed with advised treatment. If this happens then the RTT clock stops.

This only covers where a patient chooses not to proceed with the treatment, and not where the patient is just declining a date for that treatment.

Discharges

Patients who are discharged from Secondary Care without having been treated (including where they have not had a Watchful Waiting decision) stop the RTT clock. This includes patients who choose not to proceed with care at the Trust, patients who die prior to treatment, patients who are discharged due to multiple cancellations or DNAs etc, patients who are discharged following a clinical decision that they no longer require to be seen in Secondary Care and patients who inform us of a decision to opt to be transferred to the Private Sector to continue their pathway of care.

Note that patients who attend private consultations in order to gain more information about their condition, but wish to remain under the care of the Trust for potential treatment do not get discharged and their RTT clock continues to tick.

Reinstatement to an RTT Pathway

A reinstatement is a decision to return a patient who had previously been discharged back to their original pathway in the place that they would have been had they not been discharged. This enables patients to not be penalised unfairly where it has been deemed appropriate to reverse a decision to discharge a patient.

If a patient has been removed from an RTT pathway in error (e.g. incorrectly discharged), then they should be reinstated as soon as the error is realised.

There are occasions where the Trust has appropriately followed this Access policy and discharged a patient but the patient, the patient's GP or a Trust consultant subsequently requests that we reconsider this decision to discharge and reinstate the patient back onto their original RTT pathway. In these cases, the Trust should decide whether to uphold or reject this request:

These decisions are at the discretion of the relevant Service Manager, with the ultimate responsibility being with the General Manager for Planned Care & Performance, from whom advice should be sought whenever required.

Generally, if the request to reinstate is made within fourteen days and the Trust deems the reason for the request for reinstatement to be acceptable, then the request will be upheld. The decision should factor in the reasons for the events that led to the patient being discharged (e.g. the reasons for the patient DNAing appointments). The waiting time that the patient would return to must not be a factor in the Trust's decision on whether to reinstate or not.

If the request to reinstate is made more than fourteen days after the decision to discharge a patient, then irrespective of the reason to request reinstatement (apart from exceptional circumstances or Trust failure to appropriately follow policy), the request should be rejected.

If the Trust upholds a request to reinstate a patient to an RTT pathway, the original referral will be reopened on iPM, as will any outpatient, diagnostic or inpatient waiting lists that the patient was on at the point they were discharged. Wherever possible, appointments or TCI dates that were cancelled due to the decision to discharge the patient should be returned to the patient. Where this is not possible, then appropriate dates should be agreed with the patient with minimal delay. All waiting times are reinstated and continue to tick as if the discharge had never happened.

If a Trust rejects a request to reinstate a patient to an RTT pathway, then the referral on iPM remains closed, and any subsequent re-referral from the GP would be recorded as a new referral and would start a new RTT pathway.

Nullifications

On occasion, it may be necessary to transfer the care of an open RTT pathway to an alternative provider. Where this is done, a referral letter and accompanying IPTAMDS form (including the accurate clock start date for the pathway) will be sent to the receiving Trust and scanned onto iCM within three working days of the decision to refer.

The confirmation of receipt of this documentation from the receiving Trust triggers the transfer of responsibility and at this point we can record the transfer on iPM and also discharge the patient if necessary (sometimes patients will not be discharged as they will receive routine follow-up care here). The receiving Trust is now responsible for the care of the patient and inherit the waiting time position from us. The waiting time at this Trust gets nullified and is no longer reportable by us.

Where confirmation of receipt of documentation is not received within two working days of referral, it must be actively chased on a daily basis until it is received.

Note that the policy and timeframes for the transfer of cancer pathways is covered in greater detail in the Cancer Operational Policy.

Note that where the transfer of the care of a closed RTT pathway (or a pathway that is not part of RTT) takes place, the referral letter and accompanying IPTAMDS form (including the accurate RTT status detail) will still need to be sent to the receiving Trust and scanned onto iCM within three working days of the decision to refer and confirmation of receipt of documentation is still required.

Where a patient is referred to another Trust for diagnostic testing or advice only, then the responsibility for the pathway and any potential treatment remains with this Trust. An IPTAMDS form still needs to be completed (with accurate RTT status detail) and sent to the receiving Trust, but the clock continues to tick at this Trust until the point that we treat the patient (i.e. typically until we have received results or advice from the other Trust and have taken appropriate subsequent actions to lead to treatment). It is important to ensure that any actions required from third parties are not subject to unnecessary delays and so we need to monitor progress until the point where the required actions are taken and we can continue to plan the pathway for the patient.