NHS
Maidstone and
Tunbridge Wells
NHS Trust

Ref: FOI/GS/ID 5943

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04 March 2020

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Patient Access Policy.

You asked:

I have found the required policy on your website however am unsure whether it is the most up to date policy.

The specific policy that I would like to request is the most up to date version of the full "Patient Access Policy". If there are any other related documents to this policy such as a summary I would also like to request those. The policy may come under another name such as the Referral to Treatment Access Policy or Elective Access Policy.

Trust response:

Please find below links to the requested documents.

Microsoft Word 97 - 2003 Document | Microsoft Word 97 - 2003 Document | Microsoft Word 97 - 2003 Document | Microsoft Word 97 - 2003 Document | Microsoft Word 97 - 2003 Document

Microsoft Word 97 - 2003 Document | Microsoft Word 97 - 2003 Document | Microsoft Word 97 - 2003 Document | Microsoft Word 97 - 2003 Document | Microsoft Word 97 - 2003 Document

Microsoft Word 97 - 2003 Document | Microsoft Word 97 - 2003 Document

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Patient Access to Treatment

Policy and Procedure (RTT 18 weeks)

Requested/ Required by:	Directorates
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Document lead:	Chief Operating Officer
Directorate:	Surgery, Trauma & Orthopaedics, Critical Care, Women's and Children's, Specialist Medicine
Specialty:	All specialities
Supersedes:	Patient Access to Treatment Policy and Procedure (Version 3.0, September 2013) Patient Access to Treatment Policy and Procedure (Version 3.1, February 2014)
Approved by:	Trust Management Executive, 20th January 2016
Ratified by:	Policy Ratification Committee, 11th February 2016
Review date:	February 2019

Document history

Requirement for document:	Provide guidance for the Access to patient treatment for RTT 18
Cross references:	• Consultant Referral to Treatment consultant led waiting time - rules suite • Right to Start Consultant led treatment within 18 weeks • NHS Constitution for England 2015 • DOH overseas guidance • RCGP Good Medical Practice for GP 2008 • Access to Health Services for Military Veterans
Associated documents:	• Maidstone and Tunbridge Wells NHS Trust. *Escalation policy and procedure for emergency admissions* [RWF-OPPPES-C-AEM8] • Maidstone and Tunbridge Wells NHS Trust. *Escalation to Specialties of Referred Patients A&E Department Tunbridge Wells Hospital* [RWF-OWP-APP586] • Maidstone and Tunbridge Wells NHS Trust. *Medical Staff Leave (Annual Leave and Public Holidays / Study and Professional Leave)* [RWF-OPPPCS-NC-WF42] • Maidstone and Tunbridge Wells NHS Trust. *Health Records Policy and Procedure* [RWF-OPPCS-NC-TM31] • Maidstone and Tunbridge Wells NHS Trust. *Overseas Visitor Policy and Procedure* [RWF-OPPCS-NC-TM24] • Maidstone and Tunbridge Wells NHS Trust. *Wells Suite, Operational Policy and Procedure* [RWF-OPPP-PP-NC1] • Maidstone and Tunbridge Wells NHS Trust. *Cancer Services Access Policy and Procedure* [RWF-OPPPCSS-NC-CAN1]

Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	Version 1	August 2008
2.0	Reviewed and updated	June 2010
3.0	Reviewed and updated	September 2013
3.1	Minor amendments to sections 3.0 (medical secretaries), 5.2b, 5.4d, 5.6, and 5.8e. No further consultation or committee approval / ratification required.	February 2014
4.0	Review and updated whole document to reflect changes in national policy including latest waiting times guidance from Department of Health to be introduced from October 2015. Policy now covers general principles with details of how to make transactions have been moved into the appendices to improve clarity of the document. Policy was also reviewed by Intensive Support Team from NHS England in Sept 2015. Further updates made following PRC comments including ensuring all abbreviations are explained when first used, reviewing formatting and numbering system as well as referencing most up to date documents	February 2016
4.1	Added personal names of staff who have consented to include their email addresses in appendix [RWF-OWP-SOP13]	January 2017

Policy statement for

Patient Access to Treatment Policy

The purpose of this policy and procedure is to outline the Trust and Commissioner requirements for Patient Referral to Treatment (RTT) Access and Waiting Times.

The policy encompasses standard operational procedures for managing patient access to RTT services from booking, notice requirements, patients' choice and waiting list management for all stages of a referral to treatment pathway including discharge to primary care or other provider.

The intention of this policy and procedure is to ensure that referrals are handled efficiently and equitably, in line with national guidance and to ensure that the patient's best interests and wishes are at the forefront of the way Maidstone and Tunbridge Wells NHS Trust (MTW) operates.

The Trust will aim to ensure that:

- The management of patient access to services is transparent and that patients are managed, fairly, timely, accurately and according to clinical priority.
- Data is collected and recorded timely and accurately in order to support best practice and information governance standards and requirements.

This policy and procedure is applicable to all staff involved in managing and caring for a patient through their 18 week pathway. All new members of staff that this policy is applicable will receive information and training on this document.

This policy and procedure is also made available to local commissioners.

Patient Access to Treatment Procedure

Contents

1.0 Introduction and scope (including executive summary)

1.1 This policy and procedure covers the way in which Maidstone and Tunbridge Wells NHS Trust will manage patients who are referred to them for treatment.

1.2 Every process in the management of patients waiting for treatment must be clear and transparent to the staff who manage the patients and to the patients, and must also be open to inspection and audit.

1.3 The Trust will give priority to clinically urgent patients and treat all other non-urgent patients in accordance with their 18 week pathway as set out in the Department of Health Guidelines.

1.4 The Trust will continue to meet the 18 week pathway waiting times as set within the Monitor Compliance framework and by the commissioners for all groups of patients.

1.5 The Trust will also pledge to ensure that no patient waits more than a maximum of 13 weeks for an outpatient appointment.

1.6 The Trust will at all times offer and negotiate appointment and admission dates and times to suit the patients preference/choice.

1.7 The Trust will ensure that fair and equal access to services is available to all patients.

1.8 The purpose of this policy and procedure is to outline the standards for managing patient access to secondary and tertiary care services for patients from referral to treatment, and discharge to primary care.

1.9 The policy and procedure covers the processes for booking, notice requirements, patient choice and waiting list management for all stages of a referral to treatment pathway.

1.10 The Trust will ensure that the management of patient access to services is transparent, fair, and equitable and managed according to clinical priority.

1.11 This document has been designed to give a full reference guide for Referral to Treatment rules and regulations to all users.

1.12 It is designed to assist with the process of efficiently managing patients referred into the Trust for treatment within 18 weeks of referral.

1.13 Further guides that provide 'at a glance' information for staff to use to support the process are available. These can be found on The Trust intranet site on Q-Pulse alongside detailed standard operating procedures (SOP's) with example scenarios (list of those available are shown on the last page of this document).

1.14 This document also includes references to Department of Health 18 week websites for more detailed guidance.

1.15 This policy and procedure will be updated as further guidance becomes available.

Scope

1.16 This policy and procedure applies to all administration and clinical prioritisation processes relating to patient access managed by Maidstone and Tunbridge Wells NHS Trust, including outpatient, inpatient, day case, therapies and diagnostic services.

1.17 This policy and procedure should be adhered to by all staff within the Trust that are responsible for referring patients, managing referrals, adding to and maintaining waiting lists for the purpose of progressing a patient through their treatment pathway.

1.18 This policy and procedure applies to all employees of the Trust in all locations including, temporary employees, bank or agency staff and contracted staff.

1.19 This policy and procedure does not include cancer patients who are covered in a separate document

2.0 Definitions and glossary

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

Active monitoring (watchful waiting)	**Hospital initiated** - Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, however they need to remain under the care of the hospital for monitoring, then the patient can be placed on active monitoring until the hospital and patient agree it is appropriate for treatment to commence **Patient initiated** – When the patient requires time to think about a treatment option prior to listing for treatment, the patient can be placed on active monitoring until they confirm they wish to proceed with the treatment
Active waiting list Waiting list types: **Elective waiting** **Elective booked**	The list of elective patients who are fit and able to be treated at that given point in time. The active waiting list is also the list used to report national waiting times statistics
Cancelled operations or procedures	If the Trust cancels a patient's admission on the day of the admission/procedure for a non-clinical reason (i.e. lack of theatre time) – the Trust is required to rearrange a new operation date within 28 days of the cancelled procedure date, or within target wait time, whichever is the soonest
Chronological order/ 'in-turns'	This is a general principle that applies to patients categorised as requiring routine treatment (as opposed to urgent treatment). All these patients should be seen or treated in the order they were added to the waiting list and within their 18 week pathway
Deferred treatment	Occasionally, an admission may be deferred for clinical or non-clinical reasons once the patient has been admitted (e.g. lack of theatre time). Patients must be returned to the waiting list and a new To Come In (TCI) date arranged. For non-clinical deferred treatments, the Trust is required to offer a new operation date within 28 days of the cancelled procedure.

Did Not Attend (DNA)	Patients, who have been informed of their date of admission or pre-assessment (in-patients/day case), or appointment date (outpatients) and who, without notifying the hospital, did not attend
Elective admission / Elective patients	In-patients are classified into two groups, emergency and elective. Elective patients are so called because the Trust can 'elect' when to treat them
Elective booked	Patients awaiting elective admission who have been given an admission date which was arranged and agreed with the patient at the time of the decision to admit
Elective planned Excluded from active waiting list	Patients who are to be admitted as part of a planned sequence of treatment or investigation. The patient has been given a date, or approximate date at the time a decision to admit was made. The date is set for clinical reasons (e.g. check cystoscopy) and there is no clinical advantage in admitting the patient earlier
Elective waiting	Patients awaiting elective admission who have yet to be given an admission date
Firebreak / reserved clinic	Outpatient clinic time that is left free to accommodate cancelled clinics. Operating list that is left free to accommodate oncology/urgent patients.
Intended management: **In-patient**	Patients who require admission to hospital for therapeutic treatment and are intended to remain in hospital for at least one night
Intended management: **In-patient diagnostic**	Patients who require admission to hospital for a diagnostic procedure/ test/ image and are intended to remain in hospital for at least one night
Intended management: **Day case**	Patients who require admission to hospital for therapeutic treatment and will need the use of a bed but who are not intended to stay in hospital overnight
Intended management: **Day case diagnostic**	Patients who require admission to hospital for a diagnostic procedure/ test/ image and will need the use of a bed but who are not intended to stay in hospital overnight
Intended management: **Regular day patient**	Patients who require admission to the hospital for treatment on a regular planned basis
Korner	Statistical returns made to the Department of Health are called Korner Returns. These include KH07 – Active Inpatient and Day Case Waiting list and QM08 – Out-patient Waiting list

Low priority procedures	There are a number of procedures, which are not purchased by our commissioners. Patients requiring such procedures should only be added to the waiting list if they meet specific criteria or if approval has been sought/given by Clinical Commissioning Groups (CCGs) In some circumstances, CCGs may authorise / agree to fund a procedure that would normally be excluded via a "Panel". In these cases, the patient should not be added to the waiting list until funding approval is received, and their RTT 18 week clock stopped with "decision not to treat". When funding approval has been received the patient can be added to the waiting list with a new start date of CCG funding approval date.
NICE	National Institute for Health and Care Excellence
Outpatients	Patients referred by a General Practitioner (medical or dental) or another consultant/health professional for clinical advice or treatment
Patient Administrative System (PAS)	PAS is the primary record and all significant contacts with the patient must be recorded on PAS. The Comments field in the waiting list record will be used for this purpose with the current PAS. All comments must be dated and initialled.
Patient Choice	From 1st April 2004 patients waiting more than 18 weeks without being offered a TCI date, will be offered the choice of moving to an alternative hospital / provider for faster treatment
Patient Pathway Identifier (PPI)	The unique reference number assigned to a patient's RTT pathway. If the patients' pathway starts with a referral to the hospital, then the PPI will end with either RWF (the Trust's national identifier) or X09 (the E-referral / Choose and Book identifier) The PPI number should also be used, when patients are referred on to other providers, to record the patient's complete care pathway. A patient can have more than one PPI, with each separate medical condition requiring its own unique PPI. Where a patient is referred from another organisation where the pathway has already started, then the PPI will often feature their unique identifier (e.g. RXH for BSUH or RPA for Medway) or E-referral / Choose and Book identifier.
Primary Target List (PTL)	A report used to ensure the maximum waiting times targets are achieved by identifying all patients who will breach the current wait times targets
RMC/RMS	Referral Management Centre or Referral Management Service
RTT	Referral to Treatment. From December 2008 patients only wait 18 weeks (126 days) from Referral to the Treatment
Self-deferrals	Patients who, on receipt of offer(s) of admission (TCIs), notify the hospital that they are unable to attend and the TCI Date is therefore cancelled by the patient
TC	Treatment Centre
TCI	To Come In (date)
Watchful waiting	See "Active monitoring"

3.0 Duties (roles and responsibilities of staff)

External

3.1 Patients

It is vital that patient must inform the hospital of any changes to their name, address, contact number or GP to ensure correspondence reaches them.

Patients should keep their appointments, and make every effort to arrive on time.

If the patient cannot attend, they should inform the hospital with as much notice as possible.

Patients must inform their GP if their medical condition improves or deteriorates in any way which may affect their attendance.

Patients who know that they will be unavailable for any period of time and therefore will not be able to attend an appointment or admission should inform the hospital with as much notice as possible.

Patients who no longer wish to have their outpatient appointment or admission, for whatever reason, must advise either their referrer or the hospital appointment office. Patients are encouraged to ask staff about any aspect of their care and the steps towards their treatments.

Patients are encouraged to feedback comments or suggestions regarding their experience of services provided by the Trust.

Patients are encouraged to ask clinical staff any questions they have regarding their condition, treatment or support before leaving the hospital.

3.2 West Kent Clinical Commissioning Group is responsible for:
Ensuring robust communications links are in place to feed back any changes made by the Trust to GPs.

Promoting use of agreed electronic referrals e.g. E-Referral to improve patient experience and reduce waste.

3.3 General Practitioners

Referrers must ensure that referrals are clear and contain the minimum data set required to process referral effectively and efficiently.

GPs are responsible for ensuring patients are aware of the likely waiting times for a new outpatient consultation and of the need to be contactable and available when referred.

GPs are responsible for ensuring that patients placed on an urgent care pathway are aware of the reasons and urgency of the referral.

GPs are responsible for following established referral pathways to ensure that patient care is not delayed unnecessarily.

Internal

3.4 The **Chief Executive** has overall responsibility for controlling and co-ordinating this policy. However, key tasks have been delegated as follows:

3.5 Chief Operating Officer (COO) and Associate Director of Operations (ADO) for Surgery and Cancer have prime responsibility to ensure the Patient Access to Treatment Policy is implemented. This will be underpinned through **Directorate General Managers**.

3.6 The **Medical Director** is the Trust's Caldicott Guardian and is responsible for the Information Governance aspects of this policy/procedure.

3.7 **Clinical staff** are responsible through their Clinical Director to the Medical Director for ensuring they comply with their administration responsibilities as outlined in this policy and procedure.

- Clinicians are required to provide clinical judgement on further management of patients following a DNA or multiple patient cancellations.
- Clinicians are responsible for vetting and grading referrals within 5 working days
- All clinicians are responsible for effectively managing their waiting lists and patient waiting times in accordance with the maximum guaranteed waiting times and RTT pathway.
- All clinicians are responsible for ensuring patients are not listed unless medically fit and ready for procedure.
- All clinicians are responsible for complying with the Trust *Medical Staff Leave (Annual Leave and Public Holidays / Study and Professional Leave)* policy and procedure, to ensure adequate notice and cover for absences.

Clinicians are also responsible for completing:

- A **discharge summary** for inpatients within 24 hours of patient discharge and shared with GP practices
- The **clinic outcome** information on the day of the clinic and detailed to reception staff
- **waiting list** data at the point of decision and detailed to the booking team within 24 hours
- emergency admissions **notification to GP** practices within 1 hour
- **social care notification** to GP within 48 hours of admission and 24 hours prior to discharge
- An **A&E discharge** summary to GP practice within 24 hours

Patients and / or their carer's must receive good quality, timely and relevant information regarding treatment and care. Information provided must help patients to participate fully in the own healthcare decisions and support in making choices. This will be made as and when required and as defined by the specialty through various routes e.g. specialty specific leaflets provided before or via consultation, copies of clinic letter, copies of discharge etc.

Agreed pathways must be in place which optimises patient outcomes and use of resource.

3.8 **The Director of Health Informatics** is accountable for the maintenance of Patient Centre and other reporting systems on which all waiting lists are held. All **Systems Managers** are responsible in ensuring that data systems are maintained.

3.9 **The Head of Performance and Information** is responsible for providing regular data quality audits of standards of data collection and recording the submission of central returns.

3.10 **The Waiting List Manager** is appointed to make decisions on the direction to be taken in the management of non-compliance with the policies/procedure by Trust staff. They will resolve minor issues and where appropriate escalate issues relating to non-compliance with the policy/procedure to the Directors. This will be managed via investigation reporting (online e-reporting via DATIX).
They will provide advice and support in order that non-compliance is appropriately addressed. They will also ensure that the Trust provides patient information regarding 18 weeks when they are first referred to the hospital and added to waiting list for surgery – this will include information on current waiting times and options available to patients if MTW is not able to offer treatment within 18 weeks of referral.

3.11 **General Managers (GM)** will advise and support the Waiting List Manager in the resolution of issues with non-compliance of the policy/procedure by Trust staff and where necessary will take the lead on these resolutions. General Managers are responsible for delivery of services through the clinical and administration teams. This includes evaluating the impact of any process or service changes on RTT pathways as well as ensuring that staff receive the necessary training to comply with this policy

Support services must be notified by the General Manager where changes are to be introduced to clinic templates or theatre times (templates). Agreement from all support services must be obtained to allow services to be fully resourced and adjustments made ensuring an efficient pathway for our patients.

3.12 **The E-Referral Services co-ordinator** is responsible to ensure that the Directory of Services (DOS) is kept up to date and to ensure MTW consultants fully utilise the system.

3.13 **Ward and Departments** are responsible in ensuring all patients movements are accurately transacted via Patient Centre i.e. admissions, ward transfers, hospital transfer, admitting consultant changes through to discharge. They are also responsible in ensuring case notes are available for admission date.

3.14 **Theatre co-ordinator/ Admission lounge staff are** responsible to escalate cancellations to the speciality GM and ADO of the Day.

3.15 **Theatre staff** are responsible to put the information onto the cancellation report that is then distributed to all GMs, Assistant General Managers (AGMs) and Clinical Administration Units (CAUs) via Trident and daily email.

3.16 **Medical Secretaries** must ensure outpatient clinic outcome correspondence is produced within maximum of 10 working days (the Trust is working towards maximum of 5 days) of patient event and that the letter is stored via the PAS system All correspondence letters must be shared with the patient and GP unless patient opts out within the same timescale.

3.17 **Clinical Administration Staff** including Booking Clerks are responsible to manage the waiting lists on a day to day basis in accordance with this policy under the direction of their service General Manager

3.18 The **Health Records Manager** is responsible for ensuring requests for patient records are actioned and that records are made available for the patients' treatment / outpatient consultation and as outlined in the Health Records Policy and Procedure.

3.19 **Outpatient Administration Clerks/Receptionists** are responsible to ensure that the data entered on PAS accurately reflects the patient's demographic details. To ensure that the outcome data entered onto PAS accurately reflects the information provided by the clinical teams on the clinic outcome pro forma and to accurately record patients who DNA their appointments.

3.20 **All Trust staff**

- have a duty to comply fully with this policy and procedure
- are responsible for attending training provided
- are responsible for bringing this policy and procedure to the attention of any person in breach of it

4.0 Training / competency requirements

4.1 The Trust is committed to providing Referral to Treatment (RTT) training for all relevant staff to ensure accurate and timely data collection to enable the Trust to meet the DH RTT targets.

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

4.3 Each year all relevant staff will undergo compulsory refresher training. The training provided will be divided into two categories:

- ONE - Mandatory Corporate Induction. All staff will receive the Basic Patient Access to Treatment information and presentation according to job role.
- TWO - Patient Administration Training. All staff will attend RTT PAS session according to their job role.

5.0 Referral to treatment in 18 weeks and waiting lists

5.1 No patient should wait more than 18 weeks (126 days) from referral to the start of hospital treatment. This includes all the stages that lead up to treatment, including outpatient consultations, diagnostic tests and procedures.

5.2 The NHS Planning guidance has reinforced the need for organisations to meet the national access targets for 18 weeks. This document therefore outlines the process with which the Trust will continue to sustain 18 weeks and the performance requirements that it will be measured against (see next section).

5.3 All waiting lists must be held and managed on the Trust's Patient Administration System (PAS) or other Trust systems that support MTW services.

5.4 Standard letters of invitation, removal from the list, etc. should be generated from PAS or other Trust systems. This provides an audit trail of all contact with patients.

5.5 Any potential breaches of waiting times standards must be notified to the Speciality General Manager, Waiting List Manager and the Associate Director of Operations – Surgery and Cancer as soon as they come to light.

6.0 National access targets

6.1 The handbook to the NHS constitution and NHS Planning guidance outlines the following access targets which apply to all patients (excluding cancer – see separate policy). These include:

- 92% of patients on an incomplete pathway should have waited no more than 18 weeks
- Where a patient's operation is cancelled for non-clinical reasons (on the day of admission or after admission), a guarantee of admission within 28 days.
- All patients referred to Rapid Access Chest Pain Clinics must be seen within 14 days.
- Less than 1% of patients should wait longer than 6 weeks for a diagnostic test or image
- **No patients should wait longer than 52 weeks** - MTW has also put in place additional safeguards consistent with the NHS Constitution and have zero tolerance on any referral to treatment waits of more than 52 weeks.

6.2 To ensure treatment takes place as described in the NHS Constitution, and no patient waits longer than 52 weeks, MTW will ensure to:

- Respond to patients' requests for treatment at a range of alternative providers where treatment within 18 weeks is at risk;
- Use Primary Target List (PTLs) to proactively manage waiting lists and ensure enough capacity for treatment of all the different conditions and ensure that patients do not wait longer than 18 weeks; and
- Make it a requirement for all letters for first outpatient appointments to include standard information on the right to treatment within a maximum waiting times and what patients can do if they are concerned that they are or will be waiting longer than 18 weeks.

6.3 All breaches must be verified by the Directorate Lead before they are submitted to Information Department

6.4 Any 52 week breach will be fully investigated and reported to the ADO and COO within 24 hours. Actions to prevent any further breach will be effected immediately.

7.0 Key elements of RTT

7.1 The following points summarise the key elements of the standard:

- The management of waiting lists for the different stages of treatment (outpatient, diagnostic, in-patient) is based on a **18 week Referral to Treatment pathway (RTT).**
- All patients will be managed according to their clinical urgency, and within the 18 week Referral to Treatment (RTT) standard.
- The RTT incomplete pathway monitors the patient's journey, from primary care referral to first definitive treatment in secondary care as one continuous waiting time.
- An admitted pathway means that the patient requires admission to hospital, as either a day case or an inpatient, to receive their first definitive treatment.
- A non-admitted pathway means that the patient does not require admission to hospital to receive their first definitive treatment, i.e. that treatment is given or prescribed in outpatients.
- All national access targets (as set out in the previous section) must be achieved as part of the 18 week standard.
- The patients who do not achieve these standards may have very complex diagnostic or treatment pathways or choose to wait longer than 18 weeks (126 days).
- The RTT pathway is based on **clock starts, on-going clocks and clock stops.**
- The 18 week clock starts on the date that a referral is received by the Trust; this is the start of an 18 week clock for that patient. That clock then continues to tick until either the first definitive treatment is given, or another event occurs which can stop the clock.

7.2 There are a number of different activities which may occur during a patient's treatment pathway, and each is defined according to whether they start, stop or continue an 18 week RTT waiting time. Understanding these elements of 18 week pathways is one of the most complicated elements of the 18 week standard. A brief description of each of these possible stages along the treatment pathway is therefore given in the following sections.

7.3 Each step along the patient's pathway (outpatient appointment, diagnostic appointment excluding radiology, pre-assessment, admission, discharge, any decision by the patient or clinician to delay further treatment at any stage) must be correctly recorded in PAS.

7.4 Patients may have more than one 18 week RTT waiting time ticking simultaneously if they have been referred to and are under the care of more than one clinician at any point in time. Each 18 week pathway has to be measured and monitored separately and will have a unique patient pathway identifier (PPI) number in PAS.

7.5 Access to health services for military veterans

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

7.6 Exclusions from 18 weeks

The following activities are excluded from the 18 week RTT standard:

- Emergency admissions
- Elective patients undergoing planned procedures (removal of metalwork, procedures related to age/growth, female patients requiring specific gynaecological surgery which has to be timed within their menstrual cycle etc.). *Please note - Planned patients without a TCI date by their EAD (expected admit date) who are clinically ready and available must be activated on to an elective pathway. Additional information on management of planned cases - see* **Appendix Four**.
- Patients receiving on going care for a condition where the first definitive treatment for that condition has already occurred.
- Patients whose 18 week clock has stopped for active monitoring, and has not yet been restarted, even though they may still be followed up by their consultant.

8.0 RTT pathway

8.1 Clock starts

The following can all start 18 week clocks for patients: GPs; General Dental Practitioners (GDPs); General Practitioners with specialist interests (GPwSI); Optometrists; Orthoptists; GUM services; A&E; Walk In Centre; National Screening Programmes; Prison Health Services; and specialist nurses and Allied Health Professionals (AHPs) who have CCG authorisation to refer directly to consultants.

A clock starts when a GP, dentist or other healthcare professional 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.
- Any referral to an interface / referral management service (All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care)
- Includes self-referrals to these services (where agreed by commissioners and providers)

For paper referrals the clock start date is the date the Trust receives the referral.

For E-referrals the clock starts on the date the patient calls to make an appointment and gives their unique booking reference number.

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

8.1.1 Referral received from Primary Care - For most patients, the clock will begin after the GP refers the patient to a consultant in secondary care. The date that the secondary care provider receives the patient's referral is the date the clock starts.

Note that this should only be used for the very first receipt of the referral and logging onto PAS. All referrals should be sent to the relevant CAU's within 24hours of receipt to ensure that they are logged onto the PAS system within 48 hours of the Trust receiving the referral.

For referrals made through E-Referrals, the clock starts on the date on which the patient makes the appointment. When a patient is referred to hospital by their GP, they receive a Unique Booking Reference Number (UBRN). When the patient calls the Choose and Book appointment line to arrange an appointment with their UBRN, the clock starts.

The 18 Week Patient Pathway clock starts with referrals from primary care to any of the following services:

- Medical or surgical consultant-led services - irrespective of setting.
- Cancer services, for which a 62 day cancer target clock also starts if a 2WW referral has been used.[1]

[1] **Upgrade Cancer referral** - If a referral letter has, in the GP's opinion, not met the specified criteria for a 2ww referral or has not been referred on the appropriate pro-forma, a Consultant, can on prioritising the referral, 'Upgrade' the referral letter to a suspected cancer referral, an appointment should be booked within 2 weeks of receipt of referral and the Consultant must notify the 2ww office (see Cancer Access Policy and Procedure Document - Consultant Upgrades Section 8.0 and Appendix 5). On PAS in 'notepad' staff should highlight that the referral has been upgraded.

- Diagnostic services provided the patient will be assessed and, if appropriate, treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional.
- Referral Management Services which cover arrangements known as clinical advisory centres, integrated clinical assessment and treatment services, interface services etc.
- Practitioners with special interests if they are part of a referral management arrangement as defined e.g. dentists, physiotherapists, optometrists etc.
- Where a patient has been seen privately and then is referred by the GP or the Private consultant in consultation with the patients GP to a NHS service after being offered choice.

However it should be noted that referrals from Primary Care to the following services will **not** start a 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.
- Primary dental services provided by dental students in hospital settings.

8.1.2 Consultant to consultant referral for a condition unrelated to the original referring condition

Consultant (or consultant-led service) referrals can start the clock as follows:

- If during a referral for one condition (A), the consultant newly identifies another totally different condition (B). This will start a second 18 Week Pathway clock from the date the patients was advised they would be referred e.g. the patients outpatients clinic attendance. (a 31 day clock will start if cancer is the new condition). The 18 week clock which was started by the original referral for condition A continues to tick. *Please note - If the patient is referred to another consultant for the same condition (A) this does not start a new clock*
- New conditions are identified as a result of a genetic test.
- In cases where a decision to treat is made (at follow-up outpatients) for a patient whose programme of long-term care needs to be medical or surgical consultant-led.
- If further treatment is required after active monitoring (watchful waiting) then a new 18 Week Patient Pathway would begin.

As per the West Kent CCG policy on Consultant to Consultant Referrals, patients referred to another consultant for a different condition, should be referred back to their GP to decide on where the patient should be referred onto (except in the case of patients where cancer is suspected or clinical urgency ensuring that the patients GP is copied into any onward referral correspondence).

8.1.3 End of active monitoring

If, after a period of active monitoring, the patient or the Care Professional then decides that treatment is now appropriate, a new 18 week clock starts. This new clock starts at 0 weeks; it does not restart at the point at which the previous clock was stopped. There is then a new 18 week period in which the patient must receive their first definitive treatment.

8.1.4 Subsequent new treatment

If, after the 1st definitive treatment has been given, the Care Professional then decides that a subsequent treatment is now appropriate, a new 18 week clock will start. This new clock starts at 0 weeks; it does not restart at the point at which the previous clock was stopped. There is then a new 18 week period in which the patient must receive their first definitive treatment.

8.2 On-going clocks

A patient has an on-going clock if they have had a clock start but have not yet had either their first definitive treatment or decision not to treat or been placed on active monitoring (watchful waiting).

8.2.1 Activity within an 18 week RTT period which does not stop the clock: This might be a follow up appointment, or request for a diagnostic test/image or adding a patient to a waiting list for admission.

8.2.2 Transfer to another healthcare provider: If a patient is referred from one provider to another as part of their RTT period, their 18 week clock should keep ticking. Where the patient will be returning to the originating Trust for further follow following 1st definitive treatment the clock would stop, but for all others such as diagnostic testing or opinion the clock continues to tick.

8.2.3 Referral received from secondary care to tertiary provider - If a patient is referred from one provider to another as part of their RTT period, their 18 week clock may still be ticking if they have not yet received first definitive treatment. The referring organisation is required to submit an Inter Provider Transfer (IPT) form with the referral indicating the current status of the patient pathway (see section 9.5 for further details).

Any patients referred for planned elective treatment e.g. reconstructive surgery post chemotherapy would only start a clock again once the patient is fit and ready to be added to the waiting list for surgery.

8.3 Clock stops

A clock stop is when a clinical decision is made that treatment is not required or when first definitive treatment begins. First definitive treatment can be described as the start of the first treatment that is intended to avoid further intervention to manage a person's disease, condition or injury. This can occur in either an Outpatient or Inpatient setting. Clinical speciality flowcharts should be referred to by staff in order to clarify the first definitive treatment as agreed within individual departments.

8.3.1 First definitive treatment given: This is the point at which the patient receives their first definitive treatment. A patient's first definitive treatment is an intervention intended to manage a patient's disease, condition or injury and avoid further intervention. This stops the current 18 week clock previously started.

8.3.2 **Start of a period of active monitoring/watchful waiting:** This is where it is clinically appropriate to monitor the patient in secondary care without clinical intervention or further diagnostic procedures to determine what treatment options should be offered, or where a patient wishes to continue to be reviewed as an outpatient, or have an open appointment, without progressing to more invasive treatment. Active monitoring (watchful waiting) can be initiated by either the patient or the clinician. The start of a period of active monitoring stops the RTT waiting time.

8.3.3 **Patient does not attend (DNAs) their first care activity following referral:** When a patient fails to attend the first activity (appointment or diagnostic test) in their pathway, their 18 week is restarted from the date they are contacted to re-book a new appointment.

8.3.4 **Patient DNAs subsequent activity on pathway prior to first treatment:** When a patient DNAs a subsequent appointment, diagnostic test or image, pre-assessment appointment or TCI for elective admission; their clock will be stopped and they will be returned to the care of the GP. Consultants may choose to review the patient's notes and if they feel the patient should be reappointed then their 18 Week clock continues. Should the GP wish the patient to receive treatment after discharge, then they can re-refer them – a new clock would start on receipt of the re-referral at the Trust.

8.3.5 **Patient cancels care activity prior to treatment for the second time:** When a patient cancels care activity for the second occasion on their pathway (e.g. patient cancels an outpatient appointment and then cancels a pre-op assessment appointment), then their clock will be stopped and they will be returned to the care of the GP. Should the patient 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.

8.3.6 **Decision not to treat/no treatment required:** When the clinician determines that treatment is not required or a decision that no treatment is to occur; the patient's clock is stopped. The patient can either be returned to the care of the GP or remain under the care of the Consultant as required. A decision not to treat/no treatment required may occur outside a clinical consultation, for example if a patient is discharged on the basis of a test result which is communicated to the patient and their GP by letter. This can occur at any stage of the patient's pathway and will stop the clock.

8.3.7 **Patient declines offered treatment:** Patients may choose not to proceed with the treatment offered and therefore their clock is stopped.

8.3.8 **Patient dies before treatment:** When a patient dies before they receive treatment, their RTT clock will be stopped. This is automatically entered onto the patient's pathway on the date the patient is deceased on PAS.

8.4 Non RTT codes

8.4.1 **Patient attends during active monitoring** - This is where a patient attends a follow up appointment during a period of active monitoring and no change is made to their 18 week pathway status.

8.4.2 **Patient attends for follow up after first definitive treatment has taken place** - This is where a patient attends a follow up appointment after the first definitive treatment has taken place.

However it should be noted that this should only be used if no further treatment is required. If a patient requires subsequent treatment, which is significantly different to the first definitive treatment that has already been received, then a new pathway should be started from the date that decision is made e.g. wider excision, revision of surgery etc.

9.0 Eligibility and transfers

9.1 Entitlement to NHS Treatment

The Trust has a legal obligation to identify patients who are not eligible for free NHS treatment. The NHS provides healthcare for people who live in the United Kingdom. People who do not normally live in this country are not automatically entitled to use the NHS free of charge – regardless of their nationality or whether they hold a British Passport or have lived and paid National Insurance contributions and taxes in this country in the past.

All NHS Trusts have *legal obligation* to:

- Ensure that patients who are not ordinarily resident in the UK are identified.
- Assess liability for charges in accordance with Department of Health Overseas Visitors Regulations.
- Charge those liable to pay in accordance with Department of Health Overseas Visitors Regulations.

The Human Rights Act 1998 prohibits discrimination against a person on any ground such as race, colour, language or religion. The way to avoid accusations of discrimination is to ensure that everybody is treated the same way.

This Trust needs to check every patient's eligibility. An NHS card or number does not give automatic entitlement to free NHS treatment. Therefore the following questions should be asked of **all** patients commencing a new course of treatment or referral for treatment.

1. What is the patient's nationality?

   This question should be followed by:

2. Where has the patient lived for the past 12 months?
3. What date did the patient arrive in the UK?"

If a member of staff has any queries regarding patients' eligibility, then please contact the Overseas Visitor Manager for further advice. Please also refer to MTW Overseas Visitor Policy and Procedure.

9.2 Patients transferring from the private sector to the NHS

A patient who chooses to be treated privately is entitled to NHS services on exactly the same basis of clinical need as any other patient.

Any patient seen privately is entitled to change his or her status subsequently and to seek treatment as an NHS patient.

Any patient changing their status after using private services must not be treated differently from other NHS patients.

Any patients referred to an NHS service following a private consultation or private treatment should join an NHS waiting list at the same point as if the consultation or treatment had been an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients. Patients will be listed in line with this policy i.e. dated in chronological order and clinical priority.

Any patient referred to an NHS service from the private sector should have a letter written to their GP by the accepting clinician to inform them of this change.

If a patient admitted to an NHS hospital as a private inpatient subsequently decides to change to NHS status before receiving treatment, there should be an assessment to determine that patient's priority for NHS care.

Joining the waiting list:

- Following any private consultation or private treatment, a patient will join the waiting list as if the consultation or treatment was an NHS service. Therefore, the patient should not be referred back to general practice for a decision about onward referral unless the patient wishes to take this course of action.
- In the event that the referring clinician has not seen the patient prior to treatment patients must be given an outpatient referral in line with this policy prior to treatment. However, those patients that may have already seen the referring clinician in the private sector may not require and outpatient appointment before an inpatient or day case procedure.

9.3 Patients transferring from the NHS to private

NHS patients already on NHS waiting lists opting to have a private procedure must be removed from the NHS waiting list.

For patients who are not already on PAS, a new referral must be created and then the decision that patient has subsequently chosen to go private must be recorded. This then stops the clock as treatment not required in the NHS.

9.4 Patients requiring commissioner approval

No referral for any low priority procedure (LPP) should be accepted without an exceptional treatment approval form. If the referral does not have the relevant approval, the referral should be rejected and returned to the GP for them to request exceptional treatment funding via the relevant CCG panel.

In some instances it will not be apparent until the outpatient consultation that the patient requires an excluded LPP, when it is identified at the outpatient consultation the relevant clinician should refer the patient back to the GP for them to progress the exceptional treatment panel approval

When funding approval is required for treatment, the patient will not be placed on the waiting list until approval is obtained from commissioners. If approval is granted, the date this notification is received by the Trust will be the new clock start for this patient.

9.5 Patients transferring between providers

These are likely to fall into 3 groups:

1. Patients who are medically unsuitable for the other provider to which they have been referred.
2. Cases where another provider is having trouble meeting waiting times and asks MTW to take some of its patients.
3. Patients seen by a MTW consultant at another provider, added to the waiting list there and subsequently found to be unfit for operation at that provider.

Custom and practice has been for the patient to transfer to the same consultant's waiting list at MTW.

From January 2008, it is mandatory for all providers to supply an Inter Provider Transfer form (IPT) to accompany every patient transferred between providers along with the standard referral letter. This is now a statutory requirement within the NHS for all patients whose care is transferred between Trusts. This will include the current clock start and RTT status.

- A IPT form must be obtained for
  1. Referrals or transfers from other providers
  2. Referrals and direct additions to the waiting list from offsite services.
- A IPT form must be provided for
  1. Patients transferred or referred to another provider.

It is the responsibility of anyone making an inter-provider referral or transfer to provide the correct information.

If the minimum dataset is not supplied by the referring provider then it will be necessary for anyone accepting an inter-provider transfer to obtain the correct information (see following table for the information required for all provider to provider referrals both in receipt and on sending).

IPT information required on provider to provider referrals

The IPT form should contain the following information:-

- Patient name and date of birth
- Patient address
- NHS number
- Contact number (including mobile)
- Registered GP
- All of the above patient details
- Unique PPI number allocated to the pathway
- Name and designation of the member of staff from referring organisation
- Contact telephone number and internal email address of member of staff from referring organisation
- The consultant making the referral
- The date of the decision to refer (may be the clinic date or the date the letter was dictated)
- The date the RTT clock originally started / 62 day breach date
- The receiving organisation's address
- The receiving consultant's name and speciality
- Any other relevant comments e.g. "for Diagnostics only", "for advice only" etc.

If available – the consultant's referral letter should be included as an attached document.

9.6 Transfers between consultants

If the patient has been added to a particular consultant's waiting list, he or she has the right to remain on that list with the consultant, without prejudice to the waiting time.

A consultant may decide to transfer a patient for the same condition from his or her care to that of another consultant internally within the Trust to further the patient's treatment. This must be agreed between the patient and the consultant. **The patient's waiting time cannot be adjusted for this transfer; the clock will continue to tick.**

If a consultant leaves or retires all their patients must be written to explain that they are being transferred to another consultant for care. For patients waiting surgery they should be offered the choice to meet their new consultant in outpatients before going ahead with treatment. **The patient's waiting time cannot be adjusted for this transfer; the clock will continue to tick.**

10.0 Management of patient pathways

10.1 General RTT rules

This section covers the general principles that govern progressing patients through the RTT and non-RTT pathways.

- The specific standards for each stage of treatment (outpatient, diagnostic, inpatient or day case) must all be followed. This includes:
  1. Recording and grading a referral/addition to the list.
  2. Agreeing all offers of appointment/admission with the patient.
  3. Reasonable offers.
  4. Minimising hospital-initiated cancellations.
- The minimum data that must be recorded at all times are:
  1. The referral received date (this will be used as the clock start date.)
  2. The outcome of attendance (this will be used for the RTT pathway status.)
- The following information must also be recorded for every patient to maintain data quality.
  1. Registered GP.
  2. NHS number (if available on any documentation).
  3. Ethnic coding (may need to be collected when the patient attends).
  4. Contact telephone numbers, including mobile telephone number.
  5. Overseas visitor status.
- It will only be possible to measure the referral to treatment time and the Trust's compliance with the 18 week standard if pathway details are recorded.
- Department of Health guidance on the 18 week pathway states that providers will need to be able to demonstrate (to an auditor or the Care Quality Commission or in the event of a patient complaint) that cases that take longer than 18 weeks to reach the start of first definitive treatment are delayed for legitimate clinical reasons.
  1. Staff must document every contact with the patient by recording all offered dates on PAS and recording other contact details on the patient's notes.
  2. Every contact must be logged, dated and initialled by the member of staff involved.
  3. Use of 'Note Pad' within Patient Centre should be used to provide an audit trail of interactions with patients to record reasons for cancellations or offers of dates.

- Any removal from the waiting list must be discussed / agreed with the Consultant and must be communicated by letter to the patient and GP/ referrer.

10.2 Referral letters

- The aim of the Trust is to receive the majority of referrals via Choose & Book.
- The Trust and CCG's will continue to work together to ensure all referrals are appropriate for the services the Trust provides.
- All referrals (both paper and electronic) must include full demographic details, including NHS number and telephone numbers (both day and evening, if possible) to reduce administrative time contacting the patient.
- Generic 'Dear Doctor' referrals will be allocated to the appropriate consultant with the shortest waiting time and based on geographical area.
- Consultant annual leave, study leave or sickness, delaying the review of referral letters, must not disadvantage the patient; Directorates must work with the consultants to ensure there are contingency arrangements to cover periods of leave.

10.2.1 Cancer referrals (see separate policy for further details on cancer pathway management)

- Any referrals received by the Trust for suspected cancer **must** be sent to the 2ww office for immediate registration the 2ww office team before booking an appointment or before passing to a Consultant.
- 93% of all suspected cancer referrals must be seen by a consultant within 14 days of receipt or referral.

10.2.2 Referrals from a Primary Care Referral Management System (RMS)

- Referrals received from the RMS will be classified as GP referrals; therefore the national targets for outpatients apply. The waiting time accrued in triage forms part of the patients 18 week pathway waiting time.

10.2.3 Referrals – Written advice from consultant

- Where a referral is received, that requests the consultant/other medical professional to respond in writing with advice, this is should be initially recorded on PAS but once it is established that it is for advice only the referral should be discharged by the relevant CAU.

10.2.4 Inappropriate referrals

- If a consultant deems a referral to be inappropriate, it must be sent back to the referring GP, with an accompanying letter. The referral decision must be updated and discharged accordingly on PAS, and the patient removed from the OP Wait List.
- If a referral has been made and the special interest of the consultant does not match the needs of the patient, the consultant should cross-refer the patient to the appropriate colleague where such a service is provided by the Trust and the referral amended on PAS immediately. (Note: a GP referral that has been redirected from one consultant to a more appropriate colleague remains a GP referral. It does not become a consultant referral since the patient has not yet been seen and the clock start does not change).

- Referrals that do not meet the Low Priority Procedure Referral Protocol should be recorded appropriately on PAS and returned to the referring practitioner.

10.2.5 Internal referrals (primarily consultant to consultant)

- This type of referral should only occur where it is for the same condition as the original referral from the GP or for an urgent patient or a cancer patient. All other patients should be returned to the GP for choice to be offered (except in the case of patients where cancer is suspected or clinical urgency). (See also section 8.1.2).
- Referrals should be prioritised alongside the external referrals.
- If a referral is being made for a second opinion and treatment options are unclear then the patient should be placed on active monitoring whilst they await a decision or have an opportunity to discuss their options with the second clinician.

10.2.6 Self-referrals

- Self-referrals should only be used in certain circumstances, such as follow up appointments after discharge. It is usually acceptable to make a self-referral within 6 months of discharge. Patients requesting appointments after this time should be asked to contact their GP/GDP for re referral. If a patient self refers within 6 months they should be booked as a follow up appointment otherwise patients should be booked as 'new'.

10.3 Referral monitoring

- Staff are required to ensure that every outpatient referral logged onto PAS is actioned i.e. are entered onto an outpatient waiting list or booked for an appointment, or discharged if no appointment is required.
- Pathways with no activity should be closed without authorisation from Service General Manager, Assistant General Manager or CAU Team Leader.

10.4 Add to outpatient wait list, prior to grading

- Appropriate 18 week RTT referrals will be added to new waiting list.
  - In **chronological order** i.e. first on list, first to be booked.
  - Within **one working day** of receipt.
  - Clinician with the **relevant specialism** and the **shortest wait time** (therefore may not necessarily be the clinician originally requested unless a clear indication for a specific clinician is requested).
  - **Any** of the **hospital sites** (the Trust will aim to appoint at the closest site to patient address). If a patient particularly requests to be treated in one hospital but an earlier date is available at another, the original date offered must be transacted via Patient Centre as an appointment offer made and refused by the patient if more than 3 weeks' notice has been given.

    Manual i.e. paper: waiting times must be calculated from the date that the referral was received.

    Electronic i.e. C&B: waiting times must be calculated from the date that the UBRN is converted i.e. an appointment is either made or attempted to be made.

10.5 Dispatch referral letter for grading

- Referral letters will be dispatched to the relevant consultant within ONE working day of receipt.

10.6 Vetting and grading referral letter

- Clinical staff must confirm:
  - **Vetted for appropriateness** (with the exception of Cancer 2 week waits (C2WW), these will be booked without vetting).
  - **Graded for clinical need** i.e. referral fits with most appropriate clinician
  - **Graded for priority outcome** i.e. C2WW, urgent, routine or advice only

10.7 Update waiting list entry, post grading

- Booking staff must record outcome of grading via Patient Centre and either 1) book referral 2) re-direct referral or 3) remove referral.

10.8 Rejected referrals

- A referral may be rejected under the following conditions:
  1. Clinical decision that the patient does not need a specialist opinion.
  2. Rejected because the patient's needs cannot be met by the service offered.
  3. If the referral does not meet the Low Priority Procedures Referral Protocol set by the CCG, it should be recorded appropriately on PAS and returned to the referring practitioner.
- The patient and the referrer (includes both GP and GDPs) must be advised by letter that the referral has been returned. The individual department is responsible for making sure this happens.

10.9 Reasonable notice

For all TCIs or outpatient appointments (with the exception of Cancer patients who should be offered dates ASAP), at **least two dates** should be offered, with at **least three weeks**' notice.

Patients can be offered earlier dates if available e.g. when waiting lists are shorter than three weeks or unallocated slots/ appointments are available, however patients will have the opportunity to decline without any adverse effect on their waiting times or 18 week clock.

The aim of clinic and admissions booking staff will always be to find a date appropriate for a patient's clinical priority and convenient to that patient.

If the referral has not been made through E-Referral, the patient should be contacted within 2 working days, after the referral has been received at the Trust, inviting him or her to phone in and book an appointment. The date and time of the appointment is negotiated when the patient phones in.

Urgent suspected cancer referrals (2 WW); patients must be offered appointments so that they can be seen within 2 weeks of the GP's referral being received by the Trust. For cancer patients, any offered date is considered as reasonable in line with national guidance - please refer to separate Trust Cancer Services Access Policy and Procedure for these patients.

If a patient is offered an appointment which is not reasonable notice (see definition above) and they are not able to attend or refuse, their 18 week pathway is not affected and no clock stops can be applied.

11.0 Booking appointments

For all appointments the reasonableness guidance as described in the previous section must be followed. In addition to this patients are also entitled to be offered more choice in booking their outpatient appointments. There are three types of booking methods that can be used outlined overleaf.

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

If the appointment is re-scheduled then the actual appointment booking type used to make each appointment should be recorded at the time the appointment is agreed or sent to the patient.

The two preferred methods for booking patients within the Trust are as follows

- **Partial booking** – The patient is contacted by telephone and an appointment (new or follow-up) is agreed OR a letter is sent to the patient, requesting the patient telephones the Trust to agree a mutually convenient appointment date OR the patient is given the opportunity to agree a mutually convenient TCI date
    - **Outpatients and operation dated process** - This involves contacting the patient, by letter (or by phone if appropriate) which asks the patient to contact Trust to arrange a date and time for consultation, if the patient does not respond within 7 days a reminder letter is sent. If the patient fails to respond after a further 7 days the Trust will refer the patient back to their GP.
- **Full booking** - the patient is given the opportunity to agree a mutually convenient new appointment date within one working day of the decision to refer OR the patient agrees a mutually convenient follow-up appointment directly after a clinic attendance OR the patient agrees a mutually convenient admission date within one working day of the decision to admit them (i.e. add them to the waiting list). Patients who have had the opportunity to agree a date within 1 working day but choose to wait longer than that should still be counted as a fully booked patient.

Sending out a letter offering no choice of date and time, for any appointment or TCI to the patient, is being phased out within the organisation. This should only be used in exceptional circumstances such as if the patient needs an urgent appointment and cannot be reached by phone, despite numerous attempts.

A letter offering an appointment should be sent; the letter should ask the patient to phone in and confirm if the suggested date is acceptable or book another more suitable appointment.

All offers of dates to patients, for outpatient, diagnostic or inpatient episodes must be recorded in PAS (and within Note Pad) at the time the offers are made and a letter of confirmation must be sent when the appointment is agreed.

A maximum of 2 dates must be offered with 3 weeks' notice.

If the patient is not willing to accept these dates, then they should be discharged and returned to the care of their GP, after discussion with clinician and clock stop recorded on pathway as date of discharge.

11.1 Booking status after cancelling appointment/TCI

- When a patient rings to cancel a fully/partial/no-choice booked appointment/TCI and arranges another mutually convenient date the booking type remains the same.
- When a patient rings to cancel a fully/Partial booked appointment/TCI and is sent a date this is **NO CHOICE.**
- When the Trust cancels a new or follow-up appointment/ TCI and sends another through the post (without agreeing the new date with the patient) – this is **NO CHOICE.**

11.2 Patient doesn't respond to booking process – removal from waiting list

Where there is no response by a patient or GP to partial booking/contact letters, the patient will be removed from the waiting list (Non response to Partial Booking) and the referral discharged accordingly and the 18 week pathway closed (decision not to treat)

- If a GP then contacts the Trust for another appointment, this should be treated as a new referral as per date of telephone call/letter.
- Free text notes highlighting the sequence of events should be recorded in Note Pad within Patient Centre on PAS.

11.3 Patients making an appointment via E-Referral

- When a patient makes a booking via the E-Referral system their details including their clock start are automatically entered onto PAS.
- If a patient is unable to book, their details are sent to MTW via the Appointment Slot Issue system (ASI) and they are given a unique booking reference number (UBRN). They must be contacted within 1 working day and an appointment booked. The clock start must be amended to the date the patient tried to make the appointment – i.e. contacted the ASI.
- Sufficient Choose and Book slots should be made available on each template to ensure that ASIs' are kept to a minimum and waits are equal for E-Referral and paper referrals.
- All changes should ideally be made on the E-Referral system but both PAS and E-Referral must be updated when booking or changing a referral.
- CAU staff should print off any new referrals received each day from the 'referrals for review work list'.
- Appointments may show on PAS but if the GP practice has not yet attached the referral it will not be possible to view it. This can be checked in the 'view history' function or the 'missing referrals' function.
  - National guidelines state that GP practices must attach urgent and 2 week wait referrals within 1 working day and routines within 3 working days.
  - CAU Team Leader or the nominated individual should contact individual GP practices requesting missing referral letters. If the referral cannot be obtained in this way, the PCT lead can be asked for help.
  - Every effort should be made to obtain the referral, including informing the patient that their practice has not provided referral information at least one week prior to the appointment.
- If the referral is to be printed off for the consultant to review, then it must be passed to the consultant as quickly as possible.
- If consultants are reviewing their E-Referrals on line, or offering advice and guidance through this system, then the appropriate Directorate must ensure that there is cover in place for when the consultant is away from the Trust.
- Once the referral has been received and accepted by the consultant, it must be accepted on E-Referral. The patient must be sent a confirmation letter.

- If the referral has been directed to an inappropriate consultant or sub-specialty, it must be redirected to the appropriate consultant immediately. E-Referral must be updated to show that the referral has been redirected. (Note: a GP referral that has been redirected from one consultant to a more appropriate colleague remains a GP referral. It does not become a consultant referral since the patient has not yet been seen and the start of the wait does not change).
- A referral may be rejected under the conditions set out in section 10.8.
- E-Referral system must be updated to show the referral has been rejected; a full explanation must be entered. The patient and GP must be advised that the referral has been returned. The appropriate Directorate is responsible for making sure this happens. A referral cannot be rejected due to the location of the patient's address as this contravenes patient choice legislation.
- Patients who have booked through E-Referral have by definition chosen their appointments to fit in with their other commitments. Rescheduling must be kept to an absolute minimum.

12.0 Cancellations

12.1 General principles

- The cancellation of an appointment can be by the patient, GP, consultant or hospital.
- For all new referrals, where the patient cancels an appointment, any further appointment must be offered within the specified target date. An alternative appointment will be offered at the time of cancellation whenever possible. All patients will receive an appointment letter confirming their appointment details.
- If the hospital cancels a patient's appointment anywhere on an RTT pathway, the clock continues to tick. All patients cancelled must be contacted to agree a new appointment date with minimal further delay. As the patient's waiting time cannot be adjusted for hospital cancellations, these must be kept to an absolute minimum as per the commitment given by the Trust. (These cancellations should be limited to sickness, family bereavement etc.)
- A patient clock is not affected if they refuse an unreasonable offer of a date.
- No urgent/2ww appointment must be cancelled by the hospital without the consultant and the General Manager being informed.
- Consultants must give the appropriate staff (i.e. General Manager) a minimum of 6 weeks' notice of all planned leave, in accordance with departmental leave policies.

12.2 Patient cancellations

If a patient cancels an appointment or TCI anywhere in an RTT pathway, another appointment or TCI must be re-arranged, if required, as soon as possible.

If the patient cancels an appointment or TCI date for a second time the patient will be returned to the care of the GP and the RTT clock will be stopped. If they are subsequently re-referred by the GP, this will start a new 18 week RTT pathway. In all cases when a patient has cancelled two appointments, the clinician should be informed to check if there is a clinical need to offer a 3rd appointment.

From the 1st of October 2015 there is no longer any provision to report pauses or suspensions under any circumstances. Patients on an elective waiting list should still be offered 2 reasonable offers with a least 3 weeks' notice within 18 weeks.

However if they are not able to attend but can accept a 3rd offer then the patient should be booked for their TCI as normal.

It should be noted that if the 3rd offer is beyond 18 weeks then the patient's consultant must be informed. The patient should also be escalated to the relevant General Manager to ensure all available options are offered to the patient including alternative providers to ensure that the patient is treated within 52 weeks. If they cannot accept any of these offers then they should be removed from the waiting list and their clock stopped.

If a patient needs to cancel their TCI due to a period of illness which is expected to last less than 3 weeks e.g. cold, coughs a new date should be agreed with the patient for a time when they are likely to be better/fit. The 18 week clock will continue for this short term illness. This should be recorded on PAS.

If a patient needs to cancel their TCI due to a period of illness which is expected to last longer than 3 weeks; the patient should be advised that they will be removed from the waiting list and the RTT clock is stopped and the clinician informed. If they are subsequently re-referred by the GP, this will start a new 18 week RTT pathway and they should attend pre-assessment again for a medical review prior to surgery.

Each department should use their discretion depending on the reasons given by the patient before referring the patient back to a GP and should seek advice from their Consultant/Team Leader/ Service Manager/Access and Performance Manager if unsure. Consideration must be given to vulnerable patients at all times.

Note: if the patient is cancelled by the hospital, then the 2-strike process of agreeing a date begins again. However if the patient then also is unable to attend (UTA)/DNAs in between hospital cancellations for more than 2 times then this should be escalated to the General Manager/Waiting List manager for a decision.

12.3 Hospital cancellations

The Trust aspires to ensure that no patient will have their appointment cancelled and seeks to only cancel appointments in exceptional circumstances (e.g. consultant sickness etc.) In the event of hospital cancellation the following principles apply

- If the hospital cancels an appointment or TCI anywhere on an RTT pathway, the clock continues to tick using the original start date
- Patients will be notified as soon as possible and offered an alternative appointment
- For an inpatient / day case therapeutic TCI Date - the 28 day rule will continue to apply and the patient should be re-dated within which-ever target date is first (RTT target or 28 day target).

12.4 Did Not Attends (DNAs)

Department of Health definition of a DNA is a patient who has failed to attend an appointment without prior notice up until the exact time they were due to attend. Therefore if a patient contacts the Trust beforehand this would not be classed as a DNA.

To minimise DNAs each Directorate must make sure that the following are in place:

1. The patient has been made a reasonable offer
2. There are processes in place to make it simple and easy for patients to cancel or reschedule their appointments or admissions or to notify last-minute problems (e.g. transport not available)
3. It has been made clear to the patient through any verbal and all written communication about the appointment/admission that the patient will be returned to the care of the GP if he or she DNAs
4. All cases where the patient, GP or other referrer believes that this was not a true DNA, the patient should be reinstated and the occurrence should be referred to the GM/AGM/Waiting List Manager.

DNA at 1st appointment- When an adult patient fails to attend the first activity (appointment or diagnostic test) in their pathway then the RTT clock is stopped and their 18 week is restarted from the date they are contacted to re-book a new appointment. If the patient cannot be contacted as per booking process then they should be discharged back to the care of the GP/GDP after discussion with the clinician.

DNAs subsequent appointment, or diagnostic appointment (adult) - If an adult patient DNAs an appointment, then the referral will be cancelled and returned to the care of the GP, after discussion with the clinician, and the RTT clock is stopped.

DNA at inpatient admission (adult) - If a patient DNAs their admission date they should be contacted straight away to establish the reason. If the patient has decided that they do not want treatment then they should be discharged from the waiting list back to the care of the GP/Referrer. If the DNA is for any other reason and the patient still wants treatment, another date should be negotiated and the patient's pathway will restart from the date the patient arranges new date. If no date can be agreed then should be removed from the Waiting list and returned to the care of the GP, after discussion with the clinician, and a clock stop recorded on PAS.

For all of the above the following patients should all be offered another date.

1. Cancer and suspected cancer patients
2. Vulnerable patients
3. Children – see special notes below

If a patient DNAs a subsequent inpatient date, their RTT clock should be stopped and they are referred back to their GP.

If the patient is subsequently re-referred by the GP, then this will be logged as a new referral and will start a new 18 week RTT pathway.

Paediatric – special notes

New and follow up appointments – Special notes

The consultant or relevant health practitioner will make a decision as to whether the appointment needs rescheduling (urgently or routinely) or if the patient can safely be discharged back to the care of the GP.

Particular attention must be paid to those children who are known to be in receipt of a child protection plan, who are children in need or looked after children. The consultant or relevant health practitioner will record the actions in the notes, will write informing the GP of the actions taken and will communicate with any social worker or other health professional as necessary.

If the child fails to make a follow up appointment using the **partial booking** system this will be identified by the booking team and an appointment sent out to the child. If the child then fails to attend this appointment the risk will be assessed using the Trust's Assessment Framework

12.5 Active monitoring (watchful waiting)

An RTT clock may be stopped where it is clinically appropriate to start a period of monitoring without clinical intervention or diagnostic procedures.

If a patient needs diagnostic test to determine what treatment options should be offered then the patient is not on active monitoring and clock would continue to tick.

If a patient is to be reviewed in clinic in 6 months with a repeat diagnostic test e.g. echo to see how their condition has progressed then the patient can be placed on active monitoring and the clock would stop.

A new RTT clock would start when a decision to treat is made following a period of Active monitoring[2] .

Active monitoring can either be decided by the clinician or at the patient's request.

Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to refer the patient back to primary care for on-going management, then this is a decision not to treat and should be recorded as an RTT clock stop

If the patient is subsequently referred back to a consultant led service then this referral starts a new RTT clock.

If patient requires CCG funding approval or mental capacity assessment then active monitoring by hospital should be recorded and clock stopped. In order to keep delays to a minimum the relevant department should continue to chase agencies for a response. Once it has been confirmed that treatment can proceed then the patient's RTT clock should be restarted.

[2] (Note this can be during an outpatient attendance or by a clinician in the absence of the patient when reviewing case notes / information provided)

13.0 Outpatients

13.1 General principles

- The Trust has agreed no patient shall wait longer than 13 weeks for an outpatient appointment although individual services will have their own target which must be set at 13 weeks or less.
- Urgent/2WW patients must be seen by a consultant within 2 weeks.
- Patients are seen in the order of clinical priority and date on list.
- Patients are kept fully informed and have a single point of contact at the Trust.
- Any contact with the patient, should be documented on the PAS system using Note Pad within Patient Centre.
- All referrals should be sent to the relevant CAUs within 24 hours of receipt to ensure that they are logged onto the PAS system within 48 hours of the Trust receiving the referral.
- E-Referrals should be accepted or rejected as appropriate within 24 hours by the consultant and amended on PAS.
- There must be a new referral for a patient with an existing condition if the request for further consultation is 6 months after the discharge of the original referral.
- Referrals and waiting times are correctly counted.
- The Trust will operate a waiting list system based on taking patients in turn except for emergencies and cancer 2 week waits.
- Patients should be given appointments in date order to ensure equity of access.
- Cancelled slots must not be given to the next "routine" referral that comes to hand. They should be used to bring forward the longest waiting patients.
- When making the appointment, the booking on PAS must be linked to the appropriate referral, which has already been logged. Staff must ensure that duplicate referrals are not created as this causes double counting of referrals and miscalculation of the patient's waiting time.
- The patient will be sent a confirmation letter regarding their booked appointment. The letter must be clear and informative and should include a point of contact and telephone number to call if they have any queries. The letter should explain clearly the consequences should the patient cancel the appointment or fail to attend the clinic at the designated time.
- Where cancellations are initiated by the Trust, patients should be booked as close to their original appointment as possible, and within 2 weeks of the cancellation date.
- Only nominated staff will book appointments into the clinics.
- The policy of this Trust is that 6 weeks' notice of clinic cancellations must be given. The Clinical Director and General Manager must give authorisation for cancellations under 6 weeks. The definition of a cancelled clinic is when a clinic is cancelled and another one is not rescheduled within 6 weeks in its place.

- When patients cancel their appointments and do not wish to have another appointment, inform the patient to contact their GP with this information. The referral must then be discharged on PAS and clinician notified.
- When patients have hospital transport booked, the patient must be advised to contact the Transport Provider with any amendments to their booking.
- In an Outpatient setting, the RTT status is provided when:
  1. The clinician completes the 18 week RTT details on the clinic outcome sheet and,
  2. The Outpatient staff/secretary uses the appropriate treatment status codes when cashing up the clinic.
- The clinician must complete the RTT status on the clinic outcome sheet for all patients, whether new or follow-up. The Outpatient staff must input these details when closing/"Cashing Up" the clinic.

13.2 Inadequate clinic capacity

Every effort must be made by the Trust to ensure capacity matches demand. In the event of inadequate clinic capacity booking staff must escalate to the General Manager within 24 working hours

13.3 Clinic template changes

- Templates should reflect the mix of referrals and the capacity required to deliver the access targets. They identify the number of slots available for new and follow-up appointments, and specify the time each clinic is scheduled to start and finish. The length of time allocated for each clinic varies from three to four hours
- All requests for template and temporary clinic rule changes will only be accepted in writing on the specified pro-forma with GM/ AGM / Service Manager sign off. Non-Outpatient managed areas should also use this form. All requests for template changes must be made with at least 6 weeks' notice to allow Outpatient Services Staff the necessary time to implement the change
- The relevant booking team is authorised to overbook a clinic following receipt of the specified pro-forma signed by the Consultant/ General Manager/AGM.

13.4 Cancellation of clinic sessions/part sessions

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

13.5 Annual and study leave

- All requests for annual and study leave by consultant and 'career grade' doctors must be approved six weeks before leave is to be taken (as per Trust policy).
- Notification will only be accepted in writing on the appropriate leave form that clarifies the arrangements to cover duties during absence on leave.
- The original form is to be completed and forwarded to the General Manager to approve and will then be passed to the relevant CAU team, who will then cancel the clinic as per instructions. The reason for the cancellation will be recorded and form part of the monthly cancellation clinic report.

- Clinics that require cancellation as a result of annual /study leave with less than six weeks' notice, will require written approval by the Clinical Director and General Manager. The AGM must also be informed.
- Where cancellations are initiated by the hospital, patients should be booked as close to their original appointment as possible, according to clinical priority.

13.6 Diagnostics and therapies

- Many patients require diagnostics to determine the appropriate diagnosis and therefore subsequent treatment of a patient.
- Examples of diagnostic tests include echocardiogram, stress test, X-rays, blood tests, punch biopsies, sleep studies, nerve conduction studies etc.
- Diagnostic tests must be performed within 6 weeks of request for the test, to ensure delivery of the national waiting time target with the exception of a suspected cancer referral, breast pain, rapid chest pain or urgent. These will need to be seen sooner i.e. within 0-2 weeks. In many instances they will also form part of the patient's RTT 18 week journey.
- Where the service is managed on PAS as an outpatient service, the standards for outpatients apply i.e. DNA and cancellations.
- Where the service is run on a Trust system other than PAS (e.g. Radiology, Physiotherapy), the clock start and the RTT status must be recorded on that system and the standards for Outpatients apply i.e. DNA and cancellations.
- If any service is run on a diary or card basis, then it must transfer to a Trust PAS system without delay.

The Trust is required to report breaches of the 6 week diagnostic standard (6 week target) for specific diagnostic tests and for the purpose of this standard

- If a patient cancels or misses an appointment for a diagnostic test/procedure, then the diagnostic waiting time for that test/procedure is set to zero and the waiting time starts again from the date of the appointment that the patient cancelled/missed
- If a patient turns down reasonable appointments, i.e. 2 separate dates and 3 weeks' notice, then the diagnostic waiting time for that test/procedure can be set to zero from the first date offered.

Neither of the above affects the patients 18 week status but DNAs will be managed the same way as those for an outpatient (see section 12.4)

Six week target exceptions – special notes
• Patients waiting for a diagnostic procedure as part of a screening programme e.g. routine repeat smear test etc. • Expectant mothers booked for confinement. • Patients currently admitted to a hospital bed and are waiting for an emergency or unscheduled diagnostic as part of their inpatient treatment. Where it would be clinically inappropriate to proceed with the procedure or have had the procedure as part of their admission.

13.7 GP requested diagnostics

- Where a GP requests a diagnostic to determine whether onwards referral to secondary care or management in primary care is appropriate, then the patient is not on an RTT pathway and the 18 week clock does not start. The patient must have the diagnostic procedure within 6 weeks of referral. If the GP subsequently refers the patient to secondary care, then the patient commences on an RTT pathway and the clock commences on the date the referral is received.
- Where a GP refers a patient for a diagnostic prior to an Outpatient appointment with a consultant, as part of an agreed pathway then the patient is on an RTT pathway and the clock starts on receipt of the referral. The patient must have the diagnostic procedure within 6 weeks of referral.[3]

13.8 Other requested diagnostics

- Where a diagnostic is requested by a health care professional from the hospital, then the patient must have the diagnostic procedure within 6 weeks of the decision.

14.0 Elective admissions

14.1 General principles – Inpatient and day case waiting lists

- Points 13.2, 13.3 and 13.4 relating to templates, cancelled sessions and leave policy are also applicable to elective theatre lists.
- No referral for any low priority procedure (LPP) should be accepted without an exceptional treatment approval form. If the referral does not have the relevant approval, the referral should be rejected and returned to the GP for them to request exceptional treatment funding via the relevant CCG panel.
- In some instances it will not be apparent until the outpatient consultation that the patient requires an excluded LPP, when it is identified at the outpatient consultation the relevant clinician should refer the patient back to the GP for them to progress the exceptional treatment panel approval
- When funding approval is required for treatment, the patient will not be placed on the waiting list until approval is obtained from commissioners. If approval is granted, the date this notification is received by the Trust will be the new clock start for this patient.
- Patients who are from CCGs which the Trust does not have a contract with are classed as non-contracted activity (NCAs). If such a patient requires a procedure approval must be sought prior to adding to the waiting list. Examples include NHS Scotland, Wales, Northern Ireland etc.
- Patients must not be added to the list unless they
  - are fit and ready for surgery (as per pre-assessment policy)
  - have agreed that they want the operation/procedure
  - are available to come in within reasonable notice, be "socially" available for all reasonably offered dates
  - the procedure must have been prior approved if it is one of the Low Priority Procedures as per guidelines.

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[3] Note – it is the GP's 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.

- Patients who currently need to lose weight or give up smoking or have other medical conditions which prevent them from receiving surgery **must not be added to the waiting list.** The Trust is not able to offer these patients surgery, for reasons beyond the Trust's control. These patients should be referred back to their GP, their RTT pathway stopped (either as active monitoring by hospital or decision not to treat) and re-referred when they are fit and able to undergo surgery.
- When the patient is subsequently fit (and the Trust is notified by their GP / by the patient themselves) and a decision is made to add them to a waiting list, this starts a new pathway and clock start date from the most recent decision. **The date a patient is added to a list must not be backdated to the first appointment.**
- Additions to the waiting list must be recorded on PAS within 2 working days of the decision to admit once fitness for surgery has been established.
- The Trust must make sure through one of the following ways that patients understand that they have been added to the list:
  1. The admission date is agreed with the patient at the outpatient appointment after being assessed at pre-assessment, or
  2. Patients are sent a letter confirming that they have been added to the list, giving the maximum current waiting time and explaining that the date of admission will be discussed with them nearer the time.
- Patients are admitted depending on their clinical priority and 18 week target wait time
  - Clinically urgent patients such as cancer patients must have priority.
  - "Planned" admissions must come in at the clinically appropriate time.
  - All other patients should be admitted in turn and before their 18 week breach date (under 18 week rules, this is based on the 18 week RTT waiting time, which takes into account any time already spent waiting in outpatients and diagnostics).
- Each patient must be categorised into clinical priority (urgent or routine) by the Consultant or a member of their team. The category should reflect the patient's need for surgery. Each specialty and sub-specialty should have a documented definition for urgent and routine, based on NCEPOD guidance.
- All patients will be kept fully informed from the point of entry onto a waiting list to their admission offer and have a known point of contact at the Trust.
- Users will maintain waiting lists on PAS in a timely manner to ensure that waiting times are correctly calculated.
- Patients must be managed as a day case unless an inpatient stay is indicated by the medical staff on the waiting list form or at the time of pre- assessment.
- To ensure that patients whose intended management is day case are counted as such, the 'intended management' data field on PAS must be completed. Any change in the intended management of the case must be recorded.
- Patients referred for outpatient procedure under local anaesthetic should be placed on a pooled waiting list and treated in order of clinical priority and fair turn.
- If a patient referred from another provider is placed straight onto a MTW elective waiting list, then the clock start date must be obtained from the original referral source (via IPT form) and recorded as part of the waiting list record.

- Waiting lists (both active and planned) must be regularly validated to ensure that the patient still requires surgery (i.e. decided to have treatment elsewhere / condition improved), their medical condition has not changed or they have moved out of the area or have died. In all instances the consultant must be informed before the patient is removed from the waiting list and GP notified.

14.2 Pre-operative assessment

14.2.1 Managing pre-assessment

- Following a decision to treat patients must be referred for a pre-operative assessment. There may be some cases where this is not clinically required.
- All patients added to the elective waiting list will complete a health screening questionnaire as part of the process to determine fitness for surgery. Assessments must be made within a reasonable time frame. Repeat assessments must be avoided.
- Patient will attend pre-operative assessment or undergo a telephone fitness assessment.
- Patients who attend pre-assessment, if surgery is required and the patient is fit the patient will be offered a procedure date as soon as possible.
- If a patient fails to attend a pre-assessment appointment on the day the patients consultant may request a further appointment and the patients 18 week clock will continue

Pre-operative assessment criterion for tests - special notes

Bloods and swabs tests are valid for 8 weeks prior to surgery

Where there is a gap of more than 8 weeks between the pre-operative assessment and surgery bloods and swabs will need to be repeated.

All other pre-operative assessments are valid for 12 weeks prior to surgery

Where there is a gap of more than 12 weeks between the pre-operative assessment and surgery a further pre-operative assessment will be required.

Should group and save be required this is only valid for 6 weeks.

14.2.2 Managing non-attendance (DNA) at pre-assessment

DNAs will be managed the same way as those for an outpatient (see section 12.4)

14.3 Cancer treatment

Cancer treatments must be separately identified on the PAS system so that they can be automatically dropped into the Cancer Waiting Times Database and be monitored under the Cancer PTL. See separate policy relating to further details on Cancer Waiting list and management.

14.4 Structure of waiting lists

- **Active waiting list**
  Patients on the active waiting list are waiting for elective admission for treatment and are currently available to be called for admission. These patients are included in the National Waiting List Monitoring return KH07.

  The 'active waiting list' should only consist of patients awaiting admission who are ready, fit and available to come in.

Elective waiting - A patient has been added to a waiting list with no date of admission at the time the decision to admit was made.

Elective booked – A patient added to a waiting list who has been given a date to come in at the time the decision to admit

- **Non-active waiting list**
  Patients on the non-active waiting list are waiting for elective admission for treatment and are currently not available to be called for admission. These patients are not included in the National Waiting List Monitoring return KH07.

  Elective planned – A patient on the planned waiting list (classified as 13) is waiting to be admitted as part of a planned sequence of treatment or investigation or where the procedure has to be performed at a set point linked to a clinical criteria, e.g. where a patient needs to wait a set time before a procedure can be performed OR where the date of admission is determined by the needs of the treatment, e.g. a child needs to be 4 years old or a certain size before a procedure can be performed.

  The patient is added to the planned waiting list, having been given a date or approximate date at the time that the decision to admit was made

  Where a patient has been given an estimated date this should be reviewed regularly and once the patient is ready for surgery the patient **must** then be placed on the active waiting list. If they are not ready for treatment then a new estimated date should be inserted with comments recorded in Note Pad in Patient Centre.

  Appendix 4 shows the types of procedures within the Trust that are 'planned cases' can be found on the Trust intranet (Q-Pulse) and this will be updated regularly.

14.5 Booking and choice for elective surgery

All patients are entitled to receive reasonable offers (as per section 10.9)

1. A letter should be sent to the patient giving at least 3 weeks' notice of operation date and asking them to call in to agree an admission date if they are unable to accept this date.
2. If operation date is less than 3 weeks' notice patients should be contacted by phone
3. Patients are asked to contact the hospital as soon as possible if they are unable to accept the offered date
4. Patients must be informed of the rules of the waiting list policy with regard to the consequences of deferring or not attending on the agreed date for their surgery.
5. **Offered dates at any** of the **hospital sites** - the Trust will aim to appoint at the closest site to the patients' address. If a patient particularly requests to be treated in one hospital but an earlier date is available at another, the original date offered must be transacted on PAS as a TCI offer made and refused by the patient if more than 3 weeks' notice given (reasonable notice).

Patients may be offered short-notice admission dates if available and if they refuse their clock cannot be adjusted.

14.6 Bilateral procedures

Patients may be referred to MTW for the treatment of a bilateral condition. These are primarily cataract procedures but can include some carpal tunnels and other hand procedures, where the referral applies to both hands.

Often patients are referred for both left and right on one referral but both procedures cannot be done at the same time. Therefore the second procedure should only be agreed after the first procedure has been completed and the patient is fit enough for surgery again.

Therefore only one pathway should be opened on receipt of the referral and the clock stop will be the treatment date of the first procedure. Patients should not be added to a planned waiting list for their second procedure

A new RTT pathway should only be opened for the second procedure on the day that the patient is fit and ready to be offered dates for the second treatment.

Special notes

Patient requiring more than one procedure, performed on the same occasion with more than one consultant

Patient must be only added to ONE list i.e. the consultant's list for the primary procedure.

Patients requiring more than one procedure non-bilateral (e.g. knee and eyes) to be performed on separate occasions with same or different consultant:

Patient must be:

1) Added to the active waiting list for the first procedure
2) Added to the planned list (treatment control) for the subsequent procedure

Once the patient has undergone the first procedure and is declared fit, willing and able they must be:

1) Removed from the planned list (treatment control)
2) Added to the active list for subsequent procedure

Patients cannot be listed (on an active list) for more than one procedure at any one time

14.7 Corneal transplants

If a patient is placed on the corneal transplant for a matched donor transplant, then the patient should be put onto active monitoring whilst waiting for the correct match. If no specific match is required the clock continues.

14.8 Cancellations specifically pertaining to elective surgery

14.8.1 Cancelled by hospital

No patient should have his or her admission cancelled. However this may occur in exceptional circumstances. Any potential cancellation must be escalated to the ADO /GM to authorise a hospital cancellation.

In the event that the Trust has to cancel a patient's elective procedure on the day of admission or day of surgery for a non-clinical reason – the patient must be offered another TCI date within 28 days of the cancelled operation date and before their 18 week breach date. The Trust is monitored on the number of breaches of the 28 day national key target.

Where an operating list or an individual patient is cancelled by the hospital, all patients booked must be contacted to be informed and agree a new TCI date with minimal further delay.

The patient's waiting time cannot be adjusted for hospital cancellations. These cancellations must be kept to an absolute minimum.

14.8.2 Cancelled as patient found to be unfit on day of surgery

If the patient on the date of surgery is found unfit to proceed for one of the following

1. Patient is not fit, e.g. has a cold or other minor illness, on the day of operation the clock continues to tick and a new TCI date needs to be agreed.
2. If the patient is expected to be unfit in the longer term i.e. not expected to become fit in the next 3 weeks as advised by the clinician cancelling the patient (some examples are: may need to stop smoking, demonstrates a heart condition), then he or she should be removed from the waiting list and returned to the care of the GP and clock stop recorded on pathway as Active Monitoring Hospital.

14.8.3 Cancelled as operation not carried out

Commissioners are not prepared to pay for the admission if the patient is admitted for a procedure which is not carried out. The only exceptions are:

1. Patient had given informed consent but changed his or her mind on admission.
2. Condition that could not have been anticipated or picked up at preoperative assessment.

Therefore it is important to record the exact details within PAS.

14.9 Removal from waiting list

Patients may be removed for the following reasons:

1. Patient decides not to proceed with treatment.
2. Patient is removed for reasons described in this policy (e.g. DNA).
3. Patient is removed following a clinical decision not to proceed.

In the case of (1) or (2), the consultant must be made aware that the patient is to be removed from the list. A letter must be sent to the patient and copied to the GP or the referrer.

It is strongly recommended that the letter is generated from PAS, since this provides an audit trail. It should be recorded on PAS in the waiting list comments field, dated and initialled. (E.g. Advised today by Mr XX that patient is not going to be fit for operation. To be removed 05.10.09). This provides a system-based audit trail.

15.0 Patients not on an RTT pathway

15.1 Activity which is not part of an 18 week RTT pathway

Many patients continue to have on-going treatment after their first initial treatment, sometimes for many years for the same chronic condition. 18 weeks (126 days) only applies to the time immediately following referral from a GP to the first definitive treatment, or from any new clock being started later in a patient's pathway to treatment being given.

Once a patient has received their first definitive treatment any further treatment is called non-RTT activity.

15.2 When to start an RTT pathway clock

When a patient has previously received their first definitive treatment, and a substantial different or new treatment is required for the patient, then this will start a new RTT pathway at the date the decision was made for the new treatment.

15.3 Patients who DNA or cancel

The same rules apply to patients who are not on an RTT pathway as those that are, however the responsible clinician may decide to retain a patient under their care rather than return to their GP if the patient DNAs or has multiple cancellations.

16.0 Equality

The Trust recognises the diversity of the local community and those in its employ. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. The Trust recognises that equality impacts on all aspects of its day to day operations and has produced an Equality Policy Statement to reflect this. All policies and procedures are assessed in accordance with the equality impact assessment tool, the results of which are monitored by the Equality and Diversity Group.

17.0 Quick guides

Quick guides, standard operating procedures and example scenarios that provide a simple explanation of the rules that have been explained in this policy and procedure are available. These can be found on the Trust Intranet site (Q-Pulse) and are available for use by staff involved with RTT 18 in conjunction with their training and will be updated regularly.

18.0 Monitoring and audit

Detailed daily information on RTT target performance, the waiting list and expected waits is provided by the Trust's business information team.

Daily - via email
All patients on open pathway by week wait (Daily PTL)

Daily – On Trust intranet site – (Trident)

- RTT PTL – by week wait all patients by FU WL, IP WL. Non QM08 and OP WL with and without TCIs
- Planned waiting list
- Uncashed outpatients
- C&B slot availability
- Future outpatient clinic free slot availability
- Theatre Cancellation Report

Weekly – via email

- Patient level detail of all outpatients 11 weeks and over without an appointment
- Patient level detail of all patients 18 weeks and over without a TCI
- Planned patients without an EDT or ones that have passed
- All diagnostic patients with and without a date over 6 weeks and those without a date under 6 weeks

Each department will review weekly 18 week performance using the information detailed above for the respective speciality. Where there are pressures on 18 week performance these will be raised for discussion at the weekly 'access meeting'.

The waiting list manager and team will monitor monthly the appropriate application of this policy and procedure for RTT pathways. This will be achieved by:

- Validation of RTT pathways for monthly performance reporting purposes
- Review of individual speciality performance against all RTT performance targets
- Monthly review of the types of planned cases on the waiting list and the adherence to policy for these particular patients ensuring that no patients have gone past their 'treat by date'
- Ad hoc spot checks on themes or specialities

Where issues arise with any member of staff in complying with the policy and procedure, the issue will initially be resolved between the waiting list manager and the individual concerned. Any failure to reach agreement will be referred to the relevant GM. Failure to reach agreement at this stage will also be referred to the Associate Director Operations with responsibility for RTT performance.

Waiting lists must be maintained by regular validation to ensure entries are timely and accurate. Any administration errors must be corrected as soon as they are discovered. Any errors that may have an effect on patient care must be escalated to the relevant General Manager and an incident report should be raised on Datix.

Pathways should be devised and maintained within each directorate showing clock starts and stops for the most common presenting conditions. Directorates must work with other departments to ensure that they offer the most direct access for patients, which provides timely and effective services.

Every effort must be made to ensure patients are seen within target. In the event that a patient cannot be appointed within target then booking staff must escalate this to the General Manager within one working day. General Managers must use the Trust FOCAL tool or contact the Cancer Service Team to ensure patients do not breach their target date. They may require another patient being moved to accommodate the potential breach patient.

Before a breach is declared, full validation must be carried out to exclude anything that may alter the situation e.g. has the patient pathway been outcome correctly as per this policy, have they been treated elsewhere etc.

Any potential 52 week breach must be escalated to the Associate Director of Operations within 24 hours and a full investigation carried out.

Summary waiting list and times information will be presented to the Trust Board and Clinical Operations & Delivery meeting monthly.

Snapshot audits of 20 patients across specialities will be undertaken to review accuracy of the data / validation being recorded at least twice a year.

APPENDIX ONE

Process requirements

1.0 Implementation and awareness

- Once ratified the document lead or author will submit this policy/procedural document to the Clinical Governance Assistant who will activate it on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.
- A monthly publications table is produced by the Clinical Governance Assistant which is published on the Trust intranet under "Policies"; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.
- This policy and procedure is available on the Trust intranet. All staff are notified via email, of the policy and any amendments by the ADO for Surgery and Cancer services. Printed copies of this document are uncontrolled.

This policy and procedure will be shared will all relevant CCGs, Cancer Networks, and Patient groups by the Associate Director of Operations – Surgery and Cancer

2.0 Review

- This policy and procedure is regularly reviewed and updated every 3 years. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.
- Please see Appendix Two for full consultation list.

3.0 Archiving

The Trust intranet retains all superseded files in an archive directory in order to maintain document history.

APPENDIX TWO

Consultation on: Patient Access to Treatment Policy and Procedure

Please return comments to: Associate Director of Operations, Surgical & Cancer Services

By date: Two weeks from receipt

Job title:	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Intensive Support Team Manager	Aug 15	Aug 15	Y	Y
Chief Operating Officer	Aug 15	3/9/15	N	
Head of Information	Aug 15	3/9/15	N	
Medical Director	Jan 16			
Chief Nurse	Jan 16			
Head of Nursing Surgical, Cancer & Clinical support	Aug 15	3/9/15	N	
Associate Director of Operations, Emergency Services	Aug 15	3/9/15	N	
Head of Midwifery, W&C & Sexual Health Services	Aug 15	3/9/15	N	
General Managers				
W&C	Aug 15	3/9/15	N	
General Medicine	Aug 15	3/9/15	N	
General Surgery & Urology	Aug 15	3/9/15	N	
Head & Neck	Aug 15	3/9/15	N	
Head of Service Improvement	Aug 15	3/9/15	N	
Outpatient Manager	Aug 15	3/9/15	N	
Clinical Director for Surgery	Jan 16		N	
Clinical Director for Cancer and Haematology	Jan 16		N	
Clinical Director for Paediatrics	Jan 16		N	
Co Clinical Director for Maternity Services	Jan 16		N	
Clinical Director for Trauma and Orthopaedics	Jan 16		N	
Clinical Director for Critical Care	Jan 16		N	
Clinical Director for Speciality Medicine	Jan 16		N	
Clinical Director for Diagnostics	Jan 16		N	
Clinical Director for Acute and Emergency Medicine	Jan 16		N	
Clinical Director for Obstetrics, Gynaecology and Sexual Health Services	Jan 16		N	
Clinical Governance Assistant	09.12.2015	16.12.2015	Y	Y

The following staff have given consent for their names to be published within this policy and its appendices:

Louise Dunkley, Sharon Briggs, Rose Cottenden

The role of those staff being consulted upon as above is to ensure they have shared the policy for comments with all staff with their sphere of responsibility that would be able to contribute to the development of the policy

APPENDIX THREE

Equality impact assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality. The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. **Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.**

Title of policy or practice	Patient Access to Treatment Policy and Procedure
What are the aims of the policy or practice?	The policy sets out the Trust's approach to the management of patients being treated on a 2 week wait or 31/62 day cancer target to ensure that all patients are treated efficiently, equitably and in line with National Access guidelines
Identify the data and research used to assist the analysis and assessment	Staff consultation as defined in appendix two.
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Males or Females	No
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak English as a first language	Yes as they may have difficulty reading the policy but an interpreter can be sourced / provided.
People who have a physical disability	No
People who have a mental disability	Yes as they may have difficulty understanding the policy but assistance can be sourced to aid understanding if necessary.
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	The potential discrimination identified above is minimal and justifiable and therefore a stage 2 assessment is not required.
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database on the intranet (Trust policies, procedures and leaflets):

No.	Title	Unique ID
4	Management of planned waiting lists	RWF-PLC-PLC-GUI-1
5	Training matrix	RWF-OWP-APP696
6	Standard Operational Procedures (SOP)	RWF-OWP-APP697
7	Definitions	RWF-OWP-APP698
8	Outpatient referral address and contact details	RWF-OWP-APP700
9	Standard referral form	RWF-OPF-CS-NC-TM4
10	Consultant to consultant referral guide	RWF-OPG-CORP51
11	Quick guide to Referral to Treatment (RTT) clock starts	RWF-OPPM-CORP148
12	Quick guide to Referral to Treatment (RTT) clock stops	RWF-OPPM-CORP149
13	Quick guide to Referral to Treatment (RTT) clock adjustments	RWF-OPPM-CORP150
14	Key Performance Indicators (KPI's)	RWF-OWP-APP701

Management of planned waiting lists

Introduction

This procedure is to ensure that the planned waiting list is effectively managed and all patients are booked or removed from the waiting list in accordance with National guidance and Maidstone and Tunbridge Wells NHS Trust's Patient Access to Treatment Policy and Procedure [RWF-OPPPCS-C-TM2].

Definition - a patient admitted, having been given a date or approximate date at the time that the **decision to admit** was made. This is usually part of a planned sequence of clinical care determined mainly on clinical criteria. There should be no patients on a planned waiting list for social reasons; other referral to treatment (RTT) rules should be applied to these patients.

Patients should only be added to a planned list where clinically they need to wait for a period of time. This includes planned diagnostic tests or treatments or a series of procedures carried out as part of a treatment plan, that are required for clinical reasons. Some examples include

- Radiotherapy must happen before surgery can be carried out
- Chest X-ray, which needs to be carried out at a specific time or repeated at a specific frequency.

When patients on planned lists are clinically ready for their care to commence and reach the date for their planned treatment, they should either receive that treatment by the treat by date, or if the Trust is unable to treat them by the treat by date, the patient should be activated on to an active pathway starting an RTT 18 pathway and be transferred to an active waiting list.

Planned lists will be reviewed regularly to ensure that patient safety and standards of care are not compromised to the detriment of outcomes for patients.

Which patients should be on the planned waiting list?

Patients must only be included on planned waiting lists if there are clinical reasons why the patient cannot have the procedure or treatment until a specified time. Examples include:

- **More than one stage operation** e.g. removal of metal work, sequences, or skin grafting / breast / plastic reconstruction etc.
- **Medication intervention / work-up** e.g. Patient requiring chemotherapy, change of drug regime (this excludes patients on warfarin), or hormones etc.
- **Surveillance endoscopies** e.g. follow up or repeat procedure
- **Anatomy cycles** e.g. female patients requiring specific gynaecological surgery which have to be timed within their menstrual cycle.
- **Any injections** (2nd and subsequent sessions only).
- **Child who needs to be a set age** before surgery can be performed.

(N.B. Above is not a finite list).

If in any doubt then patient should be added to an RTT18 pathway and further advice sought.

Do not add patients to the planned admission list if:

1. They will require another procedure but it is unknown when this will occur e.g. bilateral joint replacements will require the new procedure to take place and the patient to become fit again before the second can occur.
2. The second admission is not related to the initial admission.
3. The course of treatment is uncertain.

Patients on planned waiting list will have an RTT clock status of 'treatment already commenced or on-going' or 'watchful wait / active monitoring'.

Consultants must state on the booking form, or on patients discharge from their first treatment, a 'treat by date' i.e. a date on which the patient can be expected to be offered the treatment for their second and subsequent procedures and /or the frequency of repeated treatments. This will ensure that patients are brought in when medically appropriate and are not left sitting on the list indefinitely or treated too soon.

All patients on the planned list must have the correct intended procedure recorded and an indicative To Come In (TCI) date. If there is no date provided patients must have an indicative date set for 1 month to ensure they are reviewed.

Examples of patients who should NOT be added to the planned waiting list

Patients who wish to delay their surgery or admission for personal reasons i.e. family wedding, holiday or school and work commitments. A future date:

- should be agreed or the patient should be removed.
- when a sequence of procedures is required, the first admission should be **"elective"** whilst the remainder should be **"planned"**.

Adding patients to the planned waiting list

- Details from the booking form are to be entered into the relevant fields on the PAS system.
- The admission reason field must be completed with any consultant instructions from the booking form.
- **The date the procedure is due must also be added 'Expected Admit Date'.**
- The date on the waiting list must be entered. This date must always be the same as the decision to treat date.

Expected admit date

Planned procedures are reported on the planned Primary Target List (PTL).

Although planned patients are not on an 18 week pathway and will not breach they still need to be treated within reasonable timescales, i.e. in line with their 'Expected Admit Date' and always within 52 weeks.

If a patient is unavailable to be treated by their 'Expected Admit Date', the unavailable dates offered must be recorded in Note Pad.

All patients must be reviewed 8 weeks ahead of their 'Expected Admit Date', for the purpose of optimising patient for surgery, to validate and confirm whether review is still appropriate (e.g. clinical guidance endoscopy). If the Trust is unable to agree a date for surgery on or before the treat by date, the patient should be moved to the active waiting list entry. This will ensure that the patient will be treated within a maximum of 18 weeks.

Cancellations and DNAs

All cancellations and DNAs should be dealt with in accordance with Maidstone and Tunbridge Wells NHS Trust's Patient Access to Treatment Policy and Procedure [RWF-OPPPCS-C-TM2] section 11.8, with exception of paediatric cases, vulnerable adults and patient deemed high clinical risk. These patients should be referred to the admitting consultant who will decide upon further clinical exception.

Validation

Directorate validation of the planned PTL must be undertaken, at least monthly to ensure only patients defined within the above procedures are listed, and that no patients are left waiting past their 'Expected Admit Date'. All patients should be treated in accordance with clinical priority and suitability, as defined by the appropriate specialty. An audit report will be done weekly to identify patients inappropriately added to the planned waiting list.

Corneal surgery planned visits

Patients should be added to a planned list for the second and any subsequent stages/treatments of multi staged procedures or courses of treatment or the second side of a bilateral procedure if decision to treat both sides was made at the same time.

These patients are not on an 18 week pathway as the clock will have stopped with the first treatment.

NB. Corneal graft patients waiting for graft material, will have their pathway closed at decision to treat date (active monitoring by hospital) once graft material is available the pathway will be restarted.

If in any doubt then patient should be added to an RTT18 pathway and further advice sought.

Surgery planned patients

Patients should be added to a planned list for the second and any subsequent stages/treatments of multi-staged procedures or courses of treatment or the second side of a bilateral procedure if decision to treat both sides was made at the same time.

These patients are not on an 18 week pathway as the clock will have stopped with the first treatment.

If in any doubt then patient should be added to an RTT18 week pathway and further advice sought.

TRAINING MATRIX

	Corporate Induction Overview to Patient Access principles and Patient Administration standards	**Patient administration training and Presentation** Roles and responsibilities
Statutory/ Mandatory	M	M
Initial Training Provision	Welcome Day Pack and Local Induction	Waiting List Manager
Completion Timeframe	Within 1 month from employment date	Within 1 month from employment date
Refresher	n/a	Yearly or following service change or audit.
Driver/References	National Guidance	National Guidance
***Nursing and Midwifery Registered**	✓	✓ ***Applies to staff who manage patient administration**
***Allied Health Professionals**	✓	✓ ***Applies to staff who manage patient administration**
***Healthcare Scientists**	✓	✓ ***Applies to staff who manage patient administration**
***Additional Professional Scientific and Technical (Additional Prof Sci and Tech)**	✓	✓ ***Applies to staff who manage patient administration**
***Additional Clinical Services**	✓	✓ ***Applies to staff who manage patient administration**
***Administrative and Clerical**	✓	✓ ***Applies to staff who manage patient administration**
***Estates and Ancillary**	✓	✓ ***Applies to staff who manage patient administration**

*Porters	✓	✓ *Applies to staff who manage patient administration
*First Line Managers	✓	✓ *Applies to staff who manage patient administration
*Middle/Senior Managers	✓	✓ *Applies to staff who manage patient administration
*Executive Managers (including Board & Non-Exec)	✓	✓ *Applies to staff who manage patient administration

Patient access to treatment: Index to SOPs (standard operating procedures)

SOP No	Title	Q-Pulse Unique ID
5.1.1	Managing a referral to an outpatient clinic	RWF-OWP-SOP1
5.1a.1	Referral content standards and receipt of referral	RWF-OWP-SOP2
5.1b.1	Validate and register referral	RWF-OWP-SOP3
5.1c.1	Managing inter-provider transfer forms	RWF-OWP-SOP4
5.1d.1	Consultant to Consultant referrals	RWF-OWP-SOP5
5.1f.1	Add to waiting list, prior to grading	RWF-OWP-SOP6
5.1g.1	Dispatch referral letter for grading	RWF-OWP-SOP7
5.1h.1	Vetting and grading referral letter	RWF-OWP-SOP8
5.1j.1	Update waiting list entry, post grading	RWF-OWP-SOP9
5.1k.1	Choose and Book	RWF-OWP-SOP10
5.2a.1	Booking an appointment from outpatient list	RWF-OWP-SOP11
5.2b.1-5.2g.1	Managing Outpatient appointment, cancellations and amendments	RWF-OWP-SOP12
5.3a.1	Clinic template and service management	RWF-OWP-SOP13
5.3b.1	Maintaining waiting list and validation guidance and checklist	RWF-OWP-SOP14
5.3d.1-5.3e.1	Escalation for inadequate clinic & potential breach patients	RWF-OWP-SOP15
5.3f.1	Managing breach reporting	RWF-OWP-SOP16
5.4a.1	Patient non-attendance (DNA)	RWF-OWP-SOP17
5.4c.1	Patient attended: no further appointment required (including transfer to inter-provider)	RWF-OWP-SOP18
5.4d.1	Managing partial booking waiting lists and booking of follow up appointments	RWF-OWP-SOP19
5.4f.1	Adding patient to (procedure) waiting list	RWF-OWP-SOP20
5.4g.1	Patient attendance: unknown	RWF-OWP-SOP21
5.6a.1	Book pre-operative assessments	RWF-OWP-SOP22
5.7a.1	Dating TCI patients	RWF-OWP-SOP24
5.7b.1	Patients on a planned waiting list	RWF-OWP-SOP25
5.7d.1	Patients referred for excluded procedures	RWF-OWP-SOP26
5.8a.1-5.8h.1	Managing amendment and / or cancellation to booked day case / inpatient	RWF-OWP-SOP27