The Dudley Group of Hospitals NHS
NHS Foundation Trust

Patient Access
Referral To Treatment (RTT) Policy

Policy to be agreed by the Operational Implementation Group & 18 Weeks Project Board

Last Review Date:	**December 2009**
Next Review Date:	**December 2010**

CONTENTS PAGE

SECTION A

SECTION B

SECTION A

1.0 INTRODUCTION

The length of time a patient needs to wait for hospital treatment is an important quality issue and is a visible and public indicator of the efficiency of the hospital services provided by the Trust.

The Referral To Treatment (RTT) Access Policy is in response to the national policy requirement stated in the NHS Improvement Plan of June 2004 that, "By 2008, no one will wait longer than 18 weeks from GP referral to hospital treatment"

The policy is intended to ensure that all patients are referred and treated efficiently and in line with National Access Targets. The key access targets are:

- The 18 Week referral to treatment target
- Cancer waiting time standards
- NSF targets for angiography and revascularisation.

The policy places responsibilities on all sectors of the local health community (LHC) and is therefore shared between the Primary Care Trust (PCT), General Practitioners (GPs) and provider Trusts.

All parties accept that patient care in the NHS should be provided in a timely and equitable manner and that they each have responsibilities and actions in order to ensure this. In addition to this policy, each party will have documented operational procedures by which the policy will be implemented. These procedures will be regularly reviewed to ensure that they deliver a timely, accessible and high quality patient centered service.

The Trust is working to national rules for 18 Week pathways, as defined in the Department of Health's *18 Week Rules Suite* (2007).

The Policy takes account of Department of Health (DH) guidance and locally agreed principles on the achievement of the 18-week target.

Giving patients more choice about how, when and where they receive treatment is one cornerstone of the Government's health strategy. Information on this can be found on the Department of Health website.

The supporting procedures will place responsibilities upon patients. It is recognised that no element of compulsion can be applied to these responsibilities but the statutory parties agree to ensure that patients are made fully aware of their responsibilities and the importance of their role in supporting the delivery of 18-weeks.

2.0 KEY PRINCIPLES

The Trust will ensure that there is sufficient capacity available to ensure that all patients can be treated within 18 weeks.

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

Patients will be treated in order of their clinical need. Patients of the same or comparable clinical priority will be treated in chronological order, based on their point on their 18-week pathway.

Patients will be seen and treated within national guaranteed maximum waiting times.

SECTION A

The process of managing waiting lists will be transparent to the public and communications with patients will be timely, informative, clear and concise.

Waiting lists will be managed equitably with no preference shown on the basis of provider or source of referral.

Patients will only be added to a waiting list if there is a real expectation that they will be treated, and that they are willing to make themselves available for treatment within the 18 weeks standards.

All additions to or removals from waiting lists must be made in accordance with this policy.

The principles of a booked appointments system (Choose & Book) will be applied across the Trust: that is, patients will have the opportunity to negotiate their appointment/admission date at each stage in their pathway.

The Trust's Patient Administration System (PAS) and Ardentia Data Warehouse must be used to administer all waiting lists. All information relating to patient activity must be recorded accurately and in a timely manner.

3.0 PRIMARY CARE TRUST

The achievement of the 18-week RTT target is supported by the commissioning processes, which are promoted by the PCT.

The development of patient care pathways and the activity levels required to deliver them is key to the attainment of the 18-week target. The PCT is responsible for ensuring it commissions (directly or through its support of practice based commissioning) activity levels that will support the providers achievement of the required waiting times.

The PCT has responsibilities in communicating to its patient population, the importance of their role in the achievement of the targets. The PCT will endorse the importance of patients attending appointments or notifying providers when they cannot, providing demographic information and taking responsibility for their health status.

The PCT will support General Practitioners and General Dental Practitioners in the development of pathways and procedures that allow them to refer appropriately to other providers.

The PCT will support the ongoing development and use of the Choose and Book system for making appointments with providers. The PCT will work with providers to ensure that the Choose and Book system becomes the principal method by which appointments are made. They will also seek, in liaison with providers, to maximise direct booking of appointments at the time of referral.

4.0 GENERAL PRACTITIONERS (and GDPs)

The responsibilities of General Practitioners and GDPs are both administrative and clinical.

They are responsible for ensuring patients demographic details are correct to support the communication process throughout the 18-week pathway.

They also have a role in emphasizing to the patient, the importance of making and attending appointments with providers.

They are responsible for the clinical decisions prior to referral. They are therefore required to work with other parties in the LHC in the development of care pathways that will assist in the achievement of the 18-week target. They are responsible for their adherence to care pathways that are agreed.

GPs will communicate to the patients that treatment will be provided within 18 weeks and that the patients should be available for that period

GPs will not refer patients for possible elective surgical procedures who they know to be unfit for surgery, or are not available for surgery, because of personal commitments.

5.0 PROVIDERS

The Trust will operate this policy on the basis that no patient should have their appointment or admission cancelled but will ensure that it has clear procedures for dealing with circumstances where cancellation by the Trust occurs as outlined in the NHS Plan Guarantee.

The Trust will work with Primary Care Trusts to ensure patients are seen and treated by the hospital within the NHS Plan Targets.

The Trust has responsibility for ensuring that its operational procedures are functional, clear and straightforward. It will ensure that any procedures relating to this policy are agreed with its staff and clearly communicated to all those who have responsibilities for the delivery of care within the 18-week timescale.

The Trust will ensure that it provides capacity to deliver care within the 18-week timescale. It will also ensure that its procedures adhere to the principles of treating patients in order of their clinical need and in chronological order. Waiting lists will be managed equitably with no preference shown on the basis of provider or source of referral.

Patients will only be added to a waiting list if there is a real expectation that they will be treated, and that they are willing to make themselves immediately available for treatment.

The Trust will manage its waiting lists in a manner transparent to the public and communications with patients will be timely, informative, clear and concise.

The Trust will maintain accurate and up to date electronic records of all patients on the Patient Administration System (PAS). Data held should be timely, accurate, and complete and subject to regular audit and validation.

The principles of a booked appointments system (Choose & Book) will be applied across the Trust: that is, patients will have the opportunity to negotiate their appointment/admission date at each stage in their pathway. The Trust will ensure that its appointment systems are robust and easy for patients to understand. The Trust will make every effort to ensure that patients can make changes to or cancel appointments in direct and straightforward ways, thus supporting the patients in their responsibilities as well as achieving waiting time targets.

6.0 PATIENTS

All patients have a right to expect to be seen and treated within national operational standards for waiting times. In addition to this, the Department of Health has set out other patients' expectations. These include the following:

- To have choice
- To be seen by a health professional whom they trust
- To get a clear explanation of their condition and what treatments are available

- To know what risks, benefits and alternative treatments there are
- To seek a second opinion on diagnosis and treatments
- To give written consent before any operation or procedure
- To see their patient records (Access to Medical Records Act 1990) and be sure that the information recorded will remain confidential (Data Protection Act, 1998)
- In the event of making a complaint, to receive a written acknowledgement within 2 working days and a response to the complaint within 25 working days.

The patients also have responsibilities under this policy to contribute to the achievement of the waiting time guarantees. They are expected to attend all their clinical appointments and when unable to do so make every effort to ensure that they inform the providers that they cannot.

Patients should also ensure that they inform providers (GPs and Trusts) of changes in their demographic details in order that communication with them is made as easy as possible.

SECTION B

7.0 INTRODUCTION

The Patient Access Referral To Treatment (RTT) Policy provides a reference for managing referrals for outpatient appointments, diagnostic investigations and elective surgery. It provides instruction on the operational management of waiting lists. It also provides policy direction to promote consistency and equitable access. This will help to achieve the strategic aim of providing timely, accessible and high quality patient centred services. This policy will be periodically reviewed in light of appropriate guidance and patient feedback.

Nationally, from December 2008, performance will be judged against the following standards:

- 90% of admitted patients will receive first definitive treatment within 18 weeks from referral to treatment.
- 95% of non-admitted patients will receive first definitive treatment within 18 weeks from referral to treatment.

7.1 Exceptions

It is noted that not all patients can or should be treated within 18 weeks, they are:

- Clinical Reason - Patients for whom it is not clinically appropriate to be treated within 18 weeks
- Patient Choice - Patients who choose to wait longer for one or more elements of their care
- Co-Operation - Patients who do not attend appointments or cancel them at the last minute

These patients will be taken into account in a tolerance set as part of the delivery standard.

8.0 GENERAL PRINCIPLES

The policy reflects the national key access targets:

- Current outpatient, daycase, inpatient and diagnostic waiting times
- The 18-week referral to treatment target
- Cancer waiting time standards, maximum of one month (31 days) from diagnosis to treatment, and two months (62 days) from urgent referral to treatment for all cancers.
- All patients are to be seen in order of referral and where appropriate, clinical priority.
- Referral dates and waiting times are to be correctly recorded and measured.
- Any contact with the patient, should be documented on the PAS system.
- Users will maintain waiting lists on PAS in a timely manner to ensure that waiting times are correctly calculated.
- Any change in the patient's treatment status should be defined on PAS within 1 working day.
- The Trust and Primary Care organisations will continue to work together to ensure **all** referrals are appropriate.
- All staff will have a clear understanding of their roles and responsibilities to ensure that waiting lists are managed effectively.
- Patients will be able to choose/negotiate their appointment time and date (accepting that clinics are held on specific dates at defined time).
- No patient waiting for an outpatient appointment should be suspended for medical or social reasons.
- The primary tool used for validation purposes will be that of the Patient Tracking List (PTL). The PTLs will assist the Trust/Directorates in highlighting capacity shortfalls and identifying remedial action in order that national waiting times are achieved.

9.0 OUTPATIENT

9.1 Referral

It is the responsibility of the referrer to ensure that the referral letter contains accurate and up to date demographic information regarding the patient, including NHS number and both daytime and evening contact telephone numbers.

It is the responsibility of the patient to inform the Trust of any change in their contact details.

All referrals (with the exception of Cancer, Chest Pain and Colposcopy referrals) should come through the Outpatient Booking Team. If referrals are received elsewhere they should be passed immediately to the Outpatient Booking Team.

9.2 Choose & Book Referral

All appointments should, where possible, be booked via Choose and Book. GPs are therefore encouraged to use Choose and Book to refer patients into the Trust.
The waiting time for a first outpatient appointment should be calculated from the date when the confirmed referral request is received. Therefore, In accordance with the DSCN8 02/2006:

- For Choose and Book, the referral is received when the patients' unique booking reference number (UBRN) is used to book the first outpatient appointment slot (i.e. converted) (clock start).

Consultants will have the opportunity to review the appropriateness of referrals into their service and expedite any referrals they consider clinically urgent.

9.3 Referral Letters

If referral letters are to be acted on promptly it is important that they are addressed to a specific Consultant or as 'Dear Colleague' referrals to a specialty, where this is appropriate. The latter will be allocated to the Head of Service.

9.4 Directory of Services

The Head of Service has the responsibility for clinically agreed definitions of the services within the Directory of Services (DoS), the Trust's Choose and Book Manager will ensure that the DoS accurately reflects the services provided by the Trust, all agreed changes and additions will be actioned in a timely manner.

9.5 Responding to Referrals - Choose & Book

Referrals will be accepted, rejected or redirected within 1 week of receipt of the letter, provided that all relevant patient information is available e.g. the referral letter.

9.6 Paper Referrals

Our preferred medium is Choose & Book, however, where this is not possible paper referrals should be sent to the Outpatient Booking Team.
All outpatient referrals received centrally by the Outpatient Booking Team will be logged on the Patient Administration System (PAS) within 1 working day of the receipt of the referral. The referral date will be the date the referral is received by the Outpatient Booking Team and not the date entered on PAS (clock start).

The Consultant or nominee should grade referral letters into priority of 'urgent', and 'routine' on a daily basis. This process will also help to filter out inappropriate referrals.

9.7 Consultant-to-Consultant Referrals

When a consultant identifies a medical condition in a patient **other than that identified in the original GP referral** or reason for admission, the consultant will then send an internal tertiary referral to the relevant specialist consultant, which will start a new 18-week clock. The turnaround time for the referral to be graded from one consultant to another will be 2 weeks.

If the patient's condition is identified as clinically urgent, for example, suspected cancer, a cardiology condition, or is a new condition for which the patient was not originally referred/admitted, then a referral to another consultant in the same Trust (where possible) should be made immediately. This referral will then follow the same pathway as external referrals, with equal priority and waiting times. The clinical episode will count as a new clock start for the purposes of monitoring outpatient waiting times and the 18-week pathway.

9.8 Appropriateness of GP referrals

The Trust will continue to work with Primary Care Trusts to ensure that all referrals are made appropriately and to establish protocol driven referrals where appropriate. If a consultant, on reviewing a referral letter, deems the referral to be inappropriate it must be rejected, with an explanation as to why it is inappropriate and giving advice on the best management strategy.

9.9 Cancer Referrals

All suspected cancer referrals are managed and operational standards monitored appropriately by the Trust Cancer Management Team using the National Going Further on Cancer Waits guidance.

All patients referred from their GP or GDP with suspected cancer will be seen for their first hospital assessment by a Consultant within 14 days of date of receipt of referral in the Trust or Unique Booking Reference Number conversion date (Operational Standard 93%)

In addition, in accordance with the Cancer Reform Strategy guidance the existing two week wait standard is expanded so that any patient referred with breast symptoms will be seen within 14 days, whether cancer is suspected or not (Operational Standard 93%)

Cancer waiting times from referral to treatment are reported adhering to 18 weeks methodology and National Cancer Action Team guidance.

DNA

Patients who DNA a Rapid Access for suspected cancer appointment will be telephoned and offered 1 further appointment. If a patient declines this offer or DNA's this appointment they will be referred back to their GP.

9.10 Extended Patient Deferrals

If a patient makes themselves unavailable for an appointment for more than six weeks, the referral will be rejected and the GP will be advised by the Consultant to re-refer the patient when they are willing to attend for an appointment. The patient will be removed from the waiting list (clock stop).

9.11 Hospital cancellations – outpatient appointments

It is the Trust's policy to avoid outpatient cancellations wherever possible. The Trust has an agreed leave policy, which states that a minimum of 6 weeks notice **must** be given by all medical staff in order to minimise disruption to clinics and patient cancellations. This policy states that:

- Medical staff must book leave (annual or study or professional) at a minimum of 6 weeks in advance;
- Medical staff rotas should be produced at least 6 weeks in advance;
- Any "swaps" on the rota can only be allowed if this does not affect a booked clinic;
- Management meetings should be booked at least 6 weeks in advance

- If it is necessary to reduce clinics because of other commitments of members of the clinical team, every action to limit the impact of this upon delivery of service must be made and 6 weeks notice of changes given.
- All relevant staff will be notified of any absence of medical staff from clinic using agreed proformas
- If for reasons of unexpected sickness etc a doctor is not available for a clinic, the Clinical directorate should make every effort to provide cover before any cancellation is authorised.
- RTT pathway clocks will continue

9.12 Cancellation (CNAs, Reschedules) - Patient Initiated

- If an adult patient reschedules an outpatient appointment **twice** then the patient should be discharged back to their GP. When the patient contacts to reschedule the first appointment they should be advised that if they cancel/reschedule a second time they will be discharged back to the care of the GP (clock stop and nullified)
- If a child patient reschedules an outpatient appointment **three** times then the patient should be discharged back to their GP. When the patient contacts to reschedule the second appointment they should be advised that if they cancel/reschedule a third time they will be discharged to the care of the GP (clock stop).
- If a patient cancels an outpatient appointment, and fails to make an alternative appointment then the patient should be discharged back to their GP (clock stop).
- The patient needs to provide a minimum of 5 working days notice.

Where a patient is discharged back to their GP they should be notified of this decision and asked to contact their GP directly (clock Stop).

When a patient reschedules an appointment the clock will manually nullified and restarted from the day the new appointment is made.

9.13 Did Not Attends (DNAs) for New and Follow up Out-Patients

- **New**

  If an adult DNAs, the patient should be discharged back to their GP unless it against the clinical interest of the patient (clock stop and nullified).

  If a child DNAs their **second** consecutive new appointment, then they should be discharged back to their GP, unless this is against the clinical interests of the patient (clock stop and nullified).

  If the Trust chooses to rebook the patient, then their original 18 week clock would be nullified and a new clock starts on the date the Trust rebooks the appointment.

- **Follow up**

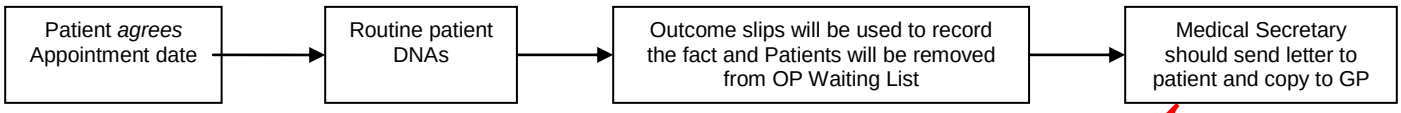
  It an adult patient DNA's they should be discharged back to the care of the GP unless this is against the clinical interests of the patient (clock stop and nullified)

  If a child DNAs their second consecutive follow-up appointment they should be discharged back to the care of the GP unless this is against the clinical interests of the patient (clock stop)

  It the Trust chooses to rebook the patient, then their 18 week clock would continue.

It should also be recorded immediately on the PAS, as an Outpatient attendance by the Outpatient staff.

They should be contacted in writing to explain the reason for their removal and told to contact their GP. The GP should also be informed of their removal. The patient may be re-referred at the GP's discretion.



If it is considered (by the treating consultant) as clinically important for the patient to be seen, appropriate action should be taken. This should include communication with the GP, other Primary Healthcare Team professionals or directly with the patient. Issuing a further appointment without taking this step is not sufficient to ensure that proper care is delivered. However, the 18-weeks clock would be stopped and restarted from the DNA appointment.

9.14 Patient Contact/Outcome Forms

Every clinic attendance must have a definitive outcome recorded on PAS within 1 working day. This includes urgent walk-in patients and patients attending follow-up appointments.

It is the responsibility of a consultant or a member of their team to complete the outcome form of each clinic attendance on a "Patient Contact/Outcome Form" prior to the departure of the patient. This will ensure that the Trust is able to record all the information required to comply with Payment by Results, and to record outcomes for monitoring patients' progress on the 18-week pathway.

This requirement applies equally to consultant-led, non-consultant-led clinics & therapies

9.15 Outpatient Clinic Template Changes

All changes to clinic templates must be discussed and agreed by the Clinician, Medical Service Head and the General Manager for that service using the agreed proforma. This is particularly critical for proposed reductions in "new outpatient" slots. Reductions can only be approved when the provision of patient access times are not compromised as a result of the proposed alterations.

9.16 Inter Provider referrals

Transfers to alternative providers must always be with the knowledge and consent of the patient and the transferring professional. If transferred, the patient must retain their original date on waiting list.
If a patient moves house, they may choose to undertake their treatment at a provider closer to their new address. Under these circumstances the patient would be discharged from the care of Dudley Group of Hospitals NHS Trust and would need to be referred to their alternative choice provider by their GP.

All inter provider transfer (in or out of the Trust) must be accompanied by an appropriately completed Intra Provider Transfer Form (IPTF) in order to ascertain the patients RTT status/pathway commencement date.

9.17 Removals from the Outpatient Waiting list

When a patient is removed from the outpatient waiting list, the free text fields within PAS should record the sequence of events.
Patients will be removed when:

- Patients cannot agree a reasonable date for attendance.
- Patients cancel and do not wish to rebook.
- Advice only, is given by consultant.
- The patient "Does Not Attend".

9.18 Ad-hoc appointments

Ad-hoc appointments will not start an RTT clock.

9.19 Patients Returning to the Trust Post Treatment

Patients that have been discharged back to GP post treatment can return to the Trust within a four month period, providing it is for the same condition. The secretary must ask questions to ascertain that the patient will be returning to the Trust for the same condition/problem. The appointment should be linked to the patient's last appointment.

SECTION B IMAGING AND DIAGNOSTICS

10.0 IMAGING AND DIAGNOSTICS

For specific guidance on the management of referrals for diagnostic imaging, refer to the DGoH Hospital Imaging Appointment Protocol available from Radiology

10.1 General Principles

- The target waiting time is 2 weeks
- All patients are to be seen in order of clinical priority and in chronological order (except for short notice cancellation replacements)
- Referral dates and waiting times are to be correctly recorded and measured
- Patients are to be kept fully informed of their waiting list status and have a clear point of contact at the Trust
- No patient waiting for an imaging appointment should be suspended for social reasons

10.2 Referral Management

- Referral cards will be date and time stamped upon arrival in the department
- Imaging referrals are managed via the department's Radiography Information System (RIS)
- Where it is intended that an appointment is to be made, details of the request must be entered onto RIS on the day of receipt

10.3 Booking Appointments

All patients will be offered appointments within the current guidelines for patient choice and within indicated maximum waiting times, unless the patient specifically chooses to wait outside the standard.

- With the significant reduction in waiting times for imaging investigations, there is no longer a need to make a distinction between referral priorities. For the most part, booked appointments will be made in order of length of wait and resource availability.
- Patients are sent a letter with a specified appointment date and time and asked to contact the imaging department by phone to change the appointment if it is not convenient. Radiology also sends patients a letter asking them to phone in to make an appointment (tends to be the GP requests) if there has been no contact from the patient within 10 days Radiology will attempt to contact the patient by phone. If unsuccessful, the form will be returned and patient removed from waiting list.
- Patients will be given 7 days notice of their appointment date if notified by post

10.4 Cancellation (CNAs, Reschedules) Patient Initiated

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

If a patient cancels more than **twice**, the request will be sent back to the referring clinician to assess the implications and then re-referred if necessary, however, the clock would restart from the new referral.

When a patient cancels their appointment and does not wish to arrange an alternative, a discharge letter should be sent to the patient from the consultant responsible for the patient's care and the patient episode discharged on PAS.

Cancelled appointment slots should be offered to another patient and not left vacant wherever possible.

10.5 Did Not Attends (DNAs)

Patients who do not attend for their diagnostic investigations without notification will be returned to the referring clinician. The referring clinician would need to assess the case notes to see if it is considered

(by the treating consultant) as clinically important for the patient to be seen, then the referring clinician would need to re-request and the clock would be restarted from the date of the new request.

If a child DNAs their **second** diagnostic appointment then they should be discharged back to their GP, unless this is against the clinical interests of the patient.

On both counts, as long as the appointment was clearly communicated to the patient and complied with 'reasonable notice'.

SECTION B ELECTIVE ADMISSIONS

11.0 ELECTIVE ADMISSION

11.1 General Principles

- The decision to add a patient to a Waiting List must be made by a Consultant, or under an arrangement agreed with the Consultant.
- Patients who are added must be **clinically and socially** ready for admission on the day the decision to admit is made.
- Patients who are not fit, ready, and able to come in on the date the decision to admit is made must not be added to the Waiting list. They must be returned to the care of their GP, to be re-referred when they are fit and ready for treatment. (*Unless it is against the clinical interest of the patient*)
- Urgent patients will be prioritised. Routine patients will be treated in chronological order based on their RTT breach date.
- Patients will be kept fully informed in writing by the Medical Secretaries of their waiting list status and have a clear point of contact at the Trust.
- Patients who are undecided about the operation and are given time (a maximum of 6 weeks) to notify the department of their decision, these patients should be recorded as 'active monitoring' (clock stop) on the PAS. These patients should not be added to the waiting list until they have confirmed that they wish to proceed with the treatment that has been offered. Once confirmed and added to the waiting list a new 18 week clock will start.

11.2 Adding Patients to Waiting Lists

It is the consultant's responsibility to notify the medical secretary of any patients requiring addition to the waiting list by immediately completing the Waiting List proforma, compiling the letter, putting it in their diary or ringing the secretary on the day of the decision to admit. The patient will be prioritised as being urgent or routine by the treating clinician. If no clinical priority is indicated, the patient will be assumed to be routine.

The patient must have agreed to the proposed treatment and have agreed to be placed on a waiting list providing that they are clinically and socially ready for treatment on the day that the decision to admit is made. Patients who are not fit, ready and able to come in on the day the decision to admit is made must not be added to the waiting list and instead will be referred back to the care of their GP in order to be re-referred when fit or reviewed again in outpatients.

11.3 Pre Assessment

All patients requiring elective intervention should be pre assessed to avoid any unnecessary theatre and ward cancellations.

11.4 Cancellation (CNAs, Reschedules) of Pre Assessment appointment

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

If a patient cancels more than **twice**, the request will be sent back to the referring clinician to assess the implications and then re-referred if necessary, however, the clock would restart from the first cancelled appointment.

When a patient cancels their appointment and does not wish to arrange an alternative, a discharge letter should be sent to the patient and a copy to the GP from the Medical Secretary and the patient episode discharged on PAS (clock stop).

11.5 Did Not Attends (DNAs) of Pre Assessment appointment

If an adult DNAs any appointment, first or follow-up, for pre assessment appointment then they should be discharged back to their GP, unless this is against the clinical interests of the patient (clock stop).
If a child DNAs their **second** pre assessment appointment then they should be discharged back to their GP, unless this is against the clinical interests of the patient.

On both counts, as long as the appointment was clearly communicated to the patient and complied with 'reasonable notice'.

All additions to elective waiting lists must be recorded on PAS on the same day as the decision to admit, with the exception of any clinics that take place on weekends or bank holidays, which should go on PAS on the next working day.

11.6 Elective Planned Waiting Lists

Planned Waiting List patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or surgical investigation. These patients are waiting for treatment for planned continuation of treatment. They will not be classified as being on an active Waiting List and are not included in waiting times of the 18 week RTT target.
Examples include:

- "Check" endoscopic procedures
- Age/growth surgery
- Investigation/treatment sequences

11.7 Hospital Cancellation

No patient should have his or her admission cancelled. However, this may occur in exceptional circumstances.

In the event that the Trust has to cancel a patient's elective procedure on the day of admission or day of surgery – the patient must be offered another TCI date within their 18 week breach date and within 28 days of the cancelled operation date, which ever is the soonest. Where a patient's admission date is cancelled by the hospital in advance, contact will be made with the patient and an explanation given as to the reason for the cancellation (clock continue).

11.8 Cancellation (CNAs)

Unless against the clinical interests of the patient, if a decision to admit has been made and a patient has declined at least two reasonable appointment offers for admission and been given three weeks notice, the clock may be paused. (The clock is paused for the duration of the time between the earliest reasonable offer and the date from which the patient makes themselves available again for admission.)

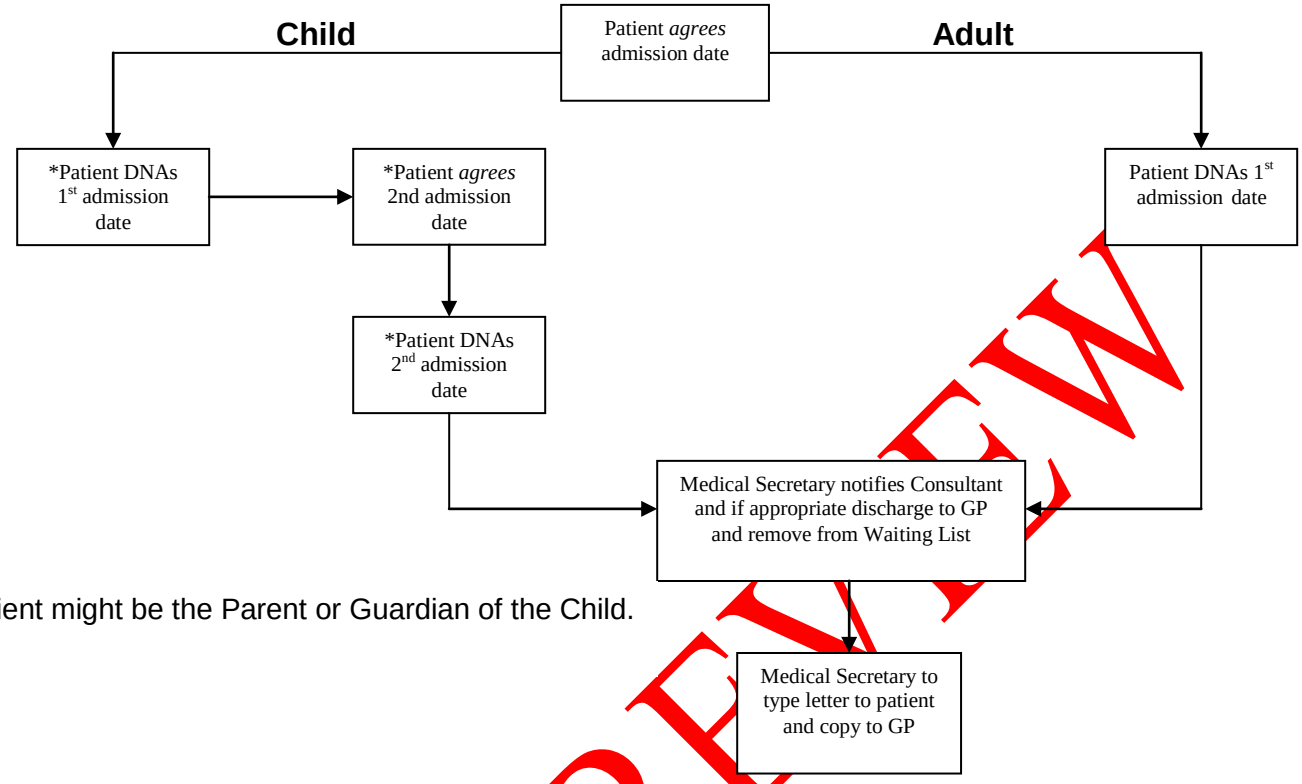
If a decision to admit has been made, 'reasonable notice' is defined as three weeks notice and a choice of two dates.

11.9 Did Not Attends (DNAs)

Provided that the admission appointment was clearly communicated to the patient and complied with 'reasonable notice', then:

- If an adult DNAs their **first** elective admission then they should be referred back to their GP, unless this is against the clinical interests of the patient (clock stop).
- If a child DNAs their **second** elective admission then they should be discharged back to their GP, unless this is against the clinical interests of the patient (clock stop).

SECTION B ELECTIVE ADMISSIONS



*Patient might be the Parent or Guardian of the Child.

11.10 Clock Pauses (Reasonableness rules)

A clock may be paused only where a ***decision to admit (patient added to the waiting list)*** has been made, and the patient has declined at least 2 reasonable appointment offers for ***admission***. The clock is paused for the duration of the time between the earliest reasonable offer and the date from which the patient makes themselves available again for admission.

Clocks may only be paused for non-clinical (Social) reasons and only where a patient chooses to wait longer for admission than two *reasonable offers* made by the provider.

A patient's paused clock should be restarted from the date that the patient makes themselves available for admission again.

For example:

> *"A patient who has declined 2 reasonable offers of 4 June and 7 June will have their clock paused from 4 June (the earliest reasonable offer date). The patient says they would be available anytime after 15 July, but the first date the provider can offer is 18 June. In principle, in this case the clock should restart from 15 July – i.e. the date that the patient made themselves available from."*

11.11 Clock Pauses (Patient Availability Rules)

Where a patient is unavailable for admission from the point at which the decision to admit is made

For example:

> *"A patient who is a teacher who wishes to delay their admission until the summer holidays"*

Then this may mean that offering actual dates which meet the reasonableness criteria would be inappropriate because the patient would be being offered dates that the provider already knew they

couldn't accept. In these circumstances, the clock should be paused from the date of the earliest reasonable admission date that the provider would have been able to offer the patient. (See also Section 9.10 Extended Patient Deferrals)

Where known, the end of the pause period should also be agreed with the patient, and the patient should be made aware of the effect their clock pause has on their likely treatment date.

Where a patient accepts a 'reasonable' offer for admission, but subsequently cancels/reschedules, their clock should only be paused if, when rebooking their admission date, they subsequently turn down 2 reasonable offers for admission.

Where a clock has already been paused due to a patient turning down 2 reasonable offers, and the patient cancels the agreed admission date, then the existing clock pause period may be extended to that of the new date that the patient makes themselves available again for admission (see 'how to measure' for technical guidance on applying clock pauses from DH website).

A patient will be paused for a maximum of six weeks before being discharged back to the GP with a letter to confirm why.

11.12 Patient Unfit for Treatment

If a patient becomes unfit for a period of six weeks or more, the patient should be removed from the waiting list and returned to the GP (clock Stop). When the patient is confirmed fit by the GP the medical secretary may add the patient directly to the waiting list (new clock start) or make an appointment to be seen in clinic (new clock start).

12.0 REASONABLE NOTICE TO PATIENTS

For all types of booking a patient must be able to choose from two dates with at least three weeks' notice.
When offering a patient an admission date with less than 3 weeks notice, the patient will be informed that they would not be penalised for refusing to accept a date with less than three weeks notice.

Some patients may be willing to attend at short notice, (to fill gaps caused by late cancellations). However, if a patient declines such an offer the patient cannot be recorded as having deferred their treatment and their waiting time will continue. All reasonableness must have been demonstrated prior to self-deferral being implemented.

If a patient accepts an offer of an admission date with less than 3 weeks notice and then subsequently cancels that appointment, this can then be recorded as a patient cancellation.
The spirit of reasonable notice should also be applied when patient's admission dates are changed, in circumstances such as cancelling clinics or bringing appointments forward to meet reducing waiting times. DSCN 07/2003.

13.0 INTERFACE BETWEEN NHS & PRIVATE PATIENTS

A large numbers of patients opt to have some or all of their investigations and treatment privately. Some use private health insurance whilst others are willing to pay to be seen more quickly or for the added convenience or comfort of receiving their care in private facilities. In addition to increasing emphasis on patient choice within the NHS, it is also increasingly recognised that patients are entitled to choose whether to receive their treatment within the NHS or privately. In addition there has been a general blurring of the boundaries between NHS and private treatment, with patients switching relatively freely between the two sectors.

SECTION B

While patients are entitled to move between providers at any stage, the NHS Consultant or responsible clinician retains the right to make a choice on whether to accept any previous medical opinion or recommendation. For example:

- A patient may choose to have a diagnostic investigation undertaken privately. However, if the patient's responsible NHS clinician is concerned about the quality or reliability of the results they retain the right to refuse to accept to proceed with the patient's care on the basis of these results. Patients should therefore ensure that when seeking to have investigations undertaken privately they should be by a provider whose results their clinician will accept.
- A patient seen and investigated privately should not be added to an elective waiting list if the NHS consultant is not convinced of the medical opinion of the referring private sector consultant or the results of any investigations (e.g. imaging) that the patient may have had. It may be the case that they will need to be seen in an outpatient setting and even investigated under the NHS before a decision to treat can be made. If the consultant agrees with the diagnosis, the patient can be added directly to the Waiting List providing they are not having diagnostic procedure.
- A patient who has been seen privately as an outpatient cannot be referred directly into the NHS for a diagnostic test, since no NHS request will have been made. The patient will first need to be seen under the care of the NHS (usually in an outpatient setting) so that an NHS request for the service can be made.
- Private patients will be put on the waiting list in chronological order depending upon clinical priorities.
- For patients that are seen privately but then transfer to the NHS, if they are transferring on to an RTT pathway, the 18 week clock will start at the point at which the clinical responsibility for the patient's care transfers to the NHS i.e. the date when the NHS Trust accepts the referral of the patient.

SECTION B DEFINITIONS

14.0 DEFINITIONS

The aim of these definitions is to provide clear and unambiguous definitions of terms used where they have a particular meaning within the context of 18 weeks.

18-week referral to treatment period

The part of a patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other 18 week clock stop point.

Active monitoring

An 18-week clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage. E.g. Patients requires to lose weight, give up smoking, patient not sure about procedure offer, monitoring of patients health prior to procedure taking place. This can be patient or Consultant initiated (clock stop).

A new 18-week clock would start when a decision to treat is made following a period of watchful waiting/active monitoring.

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 ongoing management, then this constitutes a decision not to treat and should be recorded as such and also stops an 18-week clock.

If a patient is subsequently referred back to a consultant-led service, then this referral starts a new 18-week clock.

Ad-hoc appointment

- This is where a patient is seen on the ward as a ward attender.
- When a patient is admitted under a specialty and is reviewed by another specialty for a separate condition

Admission

The act of admitting a patient for a day case or inpatient procedure

Bilateral (procedure)

A procedure that is performed on both sides of the body, at matching anatomical sites. For example, removal of cataracts from both eyes.

Choose and Book

A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic

Clinical decision

A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements

Consultant-led

A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.

DNA– Did Not Attend

The definition of DNA is that the patient arrived too late and could not be seen, or the patient did not attend and no advance warning was given.

SECTION B DEFINITIONS

Decision to admit
Where a clinical decision is taken to admit the patient for either a day case or inpatient

Decision to treat
Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatments performed in other settings e.g. as an outpatient

First definitive treatment
An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes First Definitive Treatment is a matter for clinical judgment, in consultation with others as appropriate, including the patient. Examples below:

- Inpatient or day-case treatment; the clock stops on the date of admission[1]
- Diagnostic tests turned into therapeutic procedures during the investigation; for example, a colonoscopy which reveals a polyp that can be removed there and then
- The fitting of a medical device, with the clock stopping on the date on which definitive fitting or trial fitting begins, and with no undue delay in subsequent fitting sessions thereafter
- Outpatient treatment (medical or surgical consultant-led treatment irrespective of setting) if no subsequent inpatient or day-case admission is expected, with the clock stopping on the date of attendance
- First-line treatment – less intensive treatments or medical management attempted with the intention of avoiding more invasive procedures or treatment, with a new clock starting if a decision is later taken to provide more aggressive treatment; for example intra uterine insemination could constitute first definitive infertility treatment and clock-stop, with consultant referral for IVF at a later date starting a new clock subject to communication with primary care and possible primary care veto
- Receipt of first definitive advice from a consultant geneticist may reasonably stop the clock if treatment by the genetics service (e.g. counselling) is not required and if the original referral was direct to the consultant geneticist; however, this rule will be kept under review as genetics services and treatments develop
- Therapy (for example physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science interventions (e.g. hearing-aid fitting) if that is what the medical or surgical consultant-led service decides is the intervention intended to manage the patient's disease, condition or injury and avoid further intervention

Fit (and ready)
A new 18 week clock should start once the patient is fit and ready for a subsequent bilateral procedure. In this context, fit and ready means that the clock should start from the date that it is clinically appropriate for the patient to undergo that procedure, and from when the patient says they are available.

Pause/ clock pause
The act of pausing a patients' 18-week clock. Clocks may only be paused for non-clinical reasons and only where a patient chooses to wait longer for admission than two reasonable offers made by the provider

[1] If decision to treat involves two-part treatment (e.g. two cataracts) as part of a single pathway of treatment, the patient should be offered a date for part two based on their clinical condition and with no undue delay, or an early date for a planned outpatient appointment for review, before being discharged from part one. If the need for the second treatment is identified separately from the first, a new 18-week clock starts for the second.

SECTION B DEFINITIONS

Reasonable offer

Where a decision to admit, as either a day case or inpatient has been made, many patients will choose to be admitted at the earliest opportunity. However, not all will, and it would not be appropriate to pause a clock for patients who cannot commit to come in at short notice.

A clock may only be paused therefore when a patient has turned down two or more 'reasonable offers' of admission dates or when a patient has requested not to be given a date for procedure to be completed for a period of time.

A reasonable offer is an offer of a time and date three or more weeks from the time that the offer was made.

If patients decline these offers and decide to wait longer for their treatment, then their clock may be paused from the date of the first reasonable offer and should restart from the date that patients say they are available to come in.

Substantively new or different treatment

Upon completion of an 18-week referral to treatment period, a new 18-week clock starts upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan;

It is recognised that a patients' care often extends beyond the 18-week referral to treatment period, and that there may be a number of planned treatments beyond first definitive treatment.

However, where further treatment is required that was not already planned, a new 18-week clock should start at the point the decision to treat is made.

Scenarios where this might apply include:

- where less 'invasive/intensive' forms of treatment have been unsuccessful and more 'aggressive/intensive' treatment is required (e.g. where Intra Uterine Insemination (IUI) has been unsuccessful and a decision is made to refer for IVF treatment);
- Patients attending regular follow up outpatient appointments, where a decision is made to try a substantively new or different treatment. In this context, a change to the dosage of existing medication may not count as substantively new or different treatment, whereas a change to medication combined with a decision to refer the patient for therapy might.

Ultimately, the decision about whether the treatment is substantively new or different from the patients agreed care plan is one that must be made locally by a care professional in consultant with the patient.

Tolerance

We will define success by what our patients tell us, but patients' views need to be underpinned by measures of delivery that organisations can report and monitor progress on operationally.

The measure of delivery for organisations that we will continue to judge progress against will be the monthly referral to treatment data for admitted and non-admitted patients.

The tolerances for December 2008 onwards will take into account other patient initiated delays and clinical exceptions, are 10% for admitted patients and 5% for non-admitted patients, making the operational standards 90% and 95% respectively.

SECTION B FAQ's

15.0 FREQUENTLY ASKED QUESTIONS

What starts a clock?

A referral to any of the following services:

- Medical or surgical consultant-led service
- Obstetrics, although pregnancy referrals should only start a clock when there is a separate condition or complication requiring medical or surgical consultant-led attention
- Diagnostic services
- Referral letter, Choose and Book booking or Assessment service

What defines a start date?

- The clock-start date is the date on which the provider receives notice of the referral.
- For referrals made through Choose and Book the clock starts on the date on which the patient converts their unique booking reference number (UBRN) either directly from the referral point e.g. GP practice or via the appointment booking service.

What does not start a clock?

Referrals to the following services will not start the clock:

- Therapy, healthcare science e.g. audiology 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.

What stops a clock?

The clock stops when the following occurs:

- A clinical decision is made that treatment is not required
- First definitive treatment begins.
- Patient declines treatment
- Patient DNAs First Activity (the clock is nullified and not reported)
- Clinical decision to stop the clock
- Decision to embark on a period of active monitor
- Decision to add a patient to a transplant list
- Decision to return the patient too primary care for non-medical/surgical consultant-led treatment in primary care

What is first definitive treatment?

First definitive treatment is defined as an intervention intended to manage a patient's disease, condition or injury and avoid further intervention. First definitive treatment can be:

- Inpatient or day case treatment
- Diagnostic test turned into therapeutic procedure during investigation
- Fitting of a medical device
- Out patient treatment
- Receipt of first definitive advice from a consultant geneticist
- Therapy, for example physiotherapy. Speech and language therapy, podiatry, counseling or healthcare science interventions e.g. hearing aid fitting

What does not stop a clock?

The following examples do not stop a clock:

- Administration of pain relief before a surgical procedure takes place. Or other steps to manage a patient's condition in advance of definitive treatment.
- Consultant-to-consultant referrals where the underlying condition remains unchanged

- The mere act of making a tertiary referral or a referral from one provider to another.
- Diagnostic tests/Procedures that are not considered definitive treatment, whether carried out on a non admitted or admitted pathway

Can pauses be added for out patients, imaging and diagnostics?
Pauses (previously known as suspensions) can not be used in these areas of a patient's pathway.

If a patient on an 18-week pathway is admitted as an emergency, then does this stop the 18-week clock?
If the patient has the procedure that they were waiting for electively carried out after the emergency admission, then the 18-week clock would stop. If the patient is admitted as an emergency but does not have the procedure carried out that they were waiting for electively, then their original 18-week clock does not stop. Two scenarios may now apply:

- If as a result of their emergency admission, the patient is no longer fit to have the original procedure they were waiting for and a clinical decision is made to refer the patient back to primary care, then this decision would stop the original 18-week clock. The clock stops on the date that the decision is made and communicated to the patient.

- If the patient is deemed to be temporarily unfit due to the circumstances around their emergency admission e.g. patient admitted as an emergency overnight with a chest infection, but the consultant decides to retain the patient for the procedure that they were originally waiting for. In this case, the 18-week clock would continue to tick. A clock pause is not applicable as pauses cannot be applied for clinical reasons. The operational tolerance accounts for clinical complexity such as this.

Does a new clock start if less intensive treatment has failed and more aggressive treatment is necessary for the same condition?
Yes, a new clock would start if this additional treatment did not form part of the patient's agreed care plan.
The new clock starts on the date that the decision to refer for additional treatment is made and communicated to the patient. It should be noted that the initial clock will not stop if the purpose of the first treatment was to administer pain relief for a condition before a surgical procedure take place as part of management of a patient's condition.

How should we deal with inpatient admissions for diagnostic procedures?
Generally, an inpatient/ day case admission signifies the start of treatment and hence an 18 week clock stop. However if the inpatient/ day case admission is for a diagnostic procedure only, then this does not stop the 18 week clock. If this is the only procedure carried out on the patient during their admission, then the 18 week clock should not be stopped.

Are referrals from A&E covered by 18 weeks?
Elective referrals to consultants from A&E e.g. patient attends A&E after a fall at home, A&E consultant suspects patient also has a cataract and refers them for an ophthalmology consultant outpatient appointment are covered by 18 weeks.

However, emergency admissions from A&E e.g. heart attack patient admitted to critical care unit following initial treatment in A&E or planned follow-ups at A&E e.g. patient to attend A&E clinic in two weeks for removal of stitches would not start an 18 week clock.

SECTION B FAQ's

Are fracture clinics covered by 18 weeks?

No. In general, activity carried out in fracture clinics is planned care following initial treatment/stabilisation of the fracture in A&E and so is out of scope of 18 weeks. By planned care, this means an appointment/procedure or a series of appointments/procedures as part of an agreed programme of care which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Examples include a check up x ray two to three weeks after the fracture has occurred to check that it is healing as intended. Although activity in fracture clinics is out of scope of 18 weeks, an attendance at a fracture clinic could initiate a new 18 week clock start if an elective referral is made to a service that is covered by 18 weeks.

The Dudley Group NHS
NHS Foundation Trust

Trust Headquarters
Russells Hall Hospital
Dudley
West Midlands
DY1 2HQ

Date: 29/05/2013

FREEDOM OF INFORMATION ACT 2000 - Ref: FOI/011455

With reference to your FOI request that was received on 09/05/2013 in connection with 'Waiting lists for elective care'.

Your request was for copy of the Trust's elective patient access policy.

Please find attached the Trust Policy which is currently under review. The reviewed Policy will be available around the middle of June.

Further information about your rights is also available from the Information Commissioner at:

Information Commissioner
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF
Tel: 0303 123 1113
Fax: 01625 524510
www.ico.gov.uk

Yours sincerely

Information Governance Manager
Room 34a, First Floor, Esk House, Russells Hall Hospital, Dudley, DY1 2HQ
Email: FOI@dgh.nhs.uk